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Rules in the *Code* have been codified through the first quarter of 2023 (Supp. 23-1). The updated Chapters were filed for publication between the dates of January 1 through March 31, 2023. Rule Sections effective on and after March 31, 2023, are current in the [*Administrative Register*](#).

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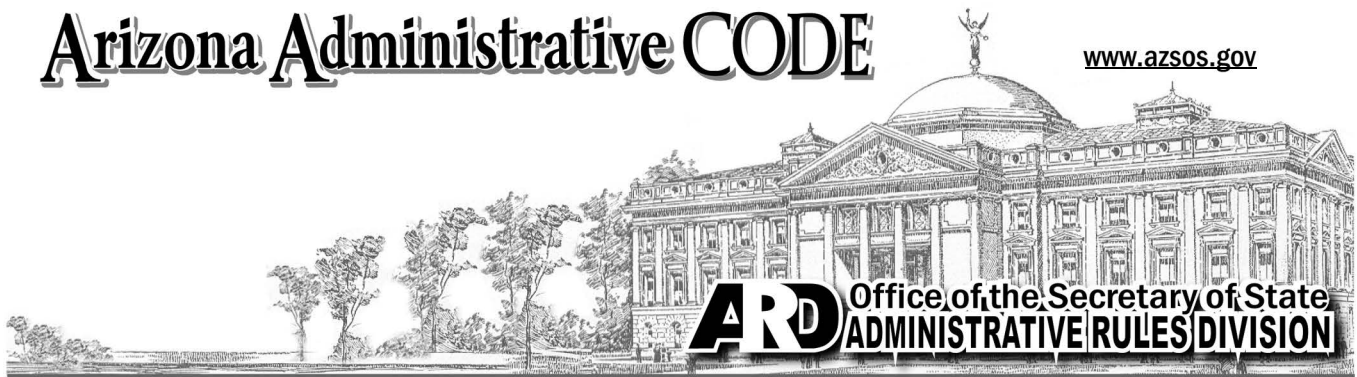
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Arizona Administrative CODE

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TITLE 3. AGRICULTURE

CHAPTER 7. DEPARTMENT OF AGRICULTURE - WEIGHTS AND MEASURES SERVICES DIVISION

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of
January 1, 2023 through March 31, 2023

Refer to the Historical Notes to learn about the Sections updated in Supplement 23-1.

Questions about these rules? Contact:

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Weights and Measures Services Division
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The release of this Chapter in Supp. 23-1 replaces Supp. 18-3, 1-54 pages.

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, www.azsos.gov under Services-> Legislative Filings.

EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.

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Administrative Rules Division

The Arizona Secretary of State electronically publishes each A.A.C. Chapter with a digital certificate. The certificate-based signature displays the date and time the document was signed and can be validated in Adobe Acrobat Reader.

TITLE 3. AGRICULTURE

CHAPTER 7. DEPARTMENT OF AGRICULTURE - WEIGHTS AND MEASURES SERVICES DIVISION

Authority: A.R.S. §§ A.R.S. 3-107 and 3-3414

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Editor's Note: Chapter 7, including new Articles 1 through 10, were recodified from 20 A.A.C. 2 by the Department of Agriculture at 22 A.A.R. 2786. When recodified, all former Section references were revised to the new numbering scheme in this Chapter. Sections in this Chapter were originally adopted in 20 A.A.C. 2 under certain exemptions from the provisions of the Administrative Procedure Act, A.R.S. Title 41, Chapter 6. Refer to Laws 1997, Chapter 117, § 3 for more information (Supp. 16-3).

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Article 9, consisting of Sections R3-7-901 through R3-7-913, recodified from R20-2-901 through R20-2-913, at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

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ARTICLE 1. ADMINISTRATION AND PROCEDURES**R3-7-101. Definitions**

The definitions in A.R.S. §§ 3-3401, 3-3414, 3-3436, and 3-3511 and the following definitions apply to this Chapter:

1. "ADEQ" means the Arizona Department of Environmental Quality.
2. "Administrative order" means a notice that the Division issues for a violation of A.R.S. Title 3, Chapter 19, or this Chapter, that orders a person to take corrective action, and may include hold or removal orders, and Warning, Out-of-Service, and Stop-Sale, Stop-Use tags.
3. "Application" means, for purposes of R3-7-108, forms and all documents and additional information the Division requires an applicant to submit when applying for a license.
4. "ASTM" means ASTM International.
5. "Area A" has the same meaning as in A.R.S. § 49-541.
6. "Area B" has the same meaning as in A.R.S. § 49-541.
7. "Area C" has the same meaning as in A.R.S. § 3-3401.
8. "Authority to Construct" means written pre-approval by the Division to allow construction of vapor recovery systems.
9. "CARB" means the California Air Resources Board.
10. "CARB-certified" means, with respect to a vapor recovery system or component, that the system or component has been certified in a CARB Executive Order.
11. "Day" means a calendar day unless otherwise specified.
12. "EPA" means the United States Environmental Protection Agency.
13. "Field calibration standard" has the same meaning as "secondary standards" in A.R.S. § 3-3401(38), and includes all test equipment such as weights, weight sets, measures, meters, counters, or other devices that are required for use by registered service agencies and representatives to certify the accuracy of commercial devices, and are required to be approved annually by the state metrology laboratory under A.R.S. § 3-3416.
14. "Gasoline vapors" means volatile organic compounds in a gaseous state.
15. "Handbook 44" means the United States Department of Commerce, Office of Weights and Measures, NIST Handbook 44, *Specifications, Tolerances, and Other Technical Requirements for Weighing and Measuring Devices*, Government Publishing Office, P.O. Box 979050, St. Louis, MO 63197-9000 or bookstore.gpo.gov (2022 edition), incorporated by reference and on file with the Division. This incorporation by reference contains no future editions or amendments.
16. "Handbook 130" means the United States Department of Commerce, Office of Weights and Measures, NIST Handbook 130, *Uniform Laws and Regulations*, Government Publishing Office, P.O. Box 979050, St. Louis, MO 63197-9000 or bookstore.gpo.gov (2022 edition), incorporated by reference and on file with the Division. This incorporation by reference contains no future editions or amendments.
17. "Handbook 133" means the United States Department of Commerce, Office of Weights and Measures, NIST Handbook 133, *Checking The Net Contents of Packaged Goods*, Government Publishing Office, P.O. Box 979050, St. Louis, MO 63197-9000 or bookstore.gpo.gov (2020 edition), incorporated by reference and on file with the Division. This incorporation by reference contains no future editions or amendments.
18. "Monthly throughput" means the total amount of gasoline transferred into or dispensed from a gasoline dispensing site during one calendar month.
19. "NCWM" means the National Conference on Weights and Measures.
20. "Net quantity" means that quantity of packaged product remaining after all necessary deductions for tare have been made.
21. "NIST" means the National Institute of Standards and Technology.
22. "Operator" means a person in control of, or having responsibility for, the daily operation of a gasoline dispensing site.
23. "Out-of-Service tag" means a red rejection tag that prohibits the further commercial use of a device, signifying that a commercial device does not meet the requirements of A.R.S. Title 3, Chapter 19, Handbook 44, or this Chapter.
24. "Person" has the same meaning as prescribed in A.R.S. § 3-3401, but includes an owner or operator of a commercial device or vapor recovery system, retail seller, wholesaler, registered supplier, pipeline, third-party terminal, packer, manufacturer, licensee, transporter, or consignee.
25. "Placed in service" means the certification by a registered service agency or representative that a commercial device meets the requirements of Title 3, Chapter 19, Handbook 44, and this Chapter and may be used, unless the Division orders otherwise.
26. "Placed-in-service report" means the form that a registered service representative completes and submits to the Division after newly installing a commercial device or restoring a commercial device into service.
27. "Retail" means the sale of a commodity to a consumer.
28. "Retail price inspection" means the inspection of a retail location for compliance with retail price posting or retail price verification requirements.
29. "Seal of Authority" means a physical or electronic stamp or press of the Division official mark, issued to a public weighmaster, certifying the public weighmaster's authority to issue weight certificates.
30. "Service counter" means a display staffed by a sales associate and requires a customer to receive assistance in order to purchase a product.
31. "Stage I vapor recovery system" has the same meaning as in A.R.S. § 3-3511.
32. "Stage II vapor recovery system" means a system where at least 90% by weight of the gasoline vapors that are displaced or drawn from a vehicle fuel tank during refueling are transferred to a vapor-tight holding system or vapor control system.
33. "Stop-Sale, Stop-Use tag" means a blue tag or blue tape that signifies that a commercial device, including a vapor recovery system or vapor recovery component, or a commodity or liquid fuel, does not meet the requirements of A.R.S. Title 3, Chapter 19, Handbook 44, Handbook 130, Handbook 133, CARB Executive Orders, or this Chapter.
34. "Underground storage tank" means a tank as described in A.R.S. § 49-1001.
35. "Vapor recovery registered service representative" means an individual to whom the Division has issued a license authorizing the individual to conduct all vapor-recovery tests required under A.R.S. Title 3, Chapter 19, or this Chapter including annual vapor-recovery tests.

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36. "Vapor recovery test equipment" means all test equipment such as measures, meters, counters or other devices that are required for use by registered service agencies and representatives to verify the performance of vapor recovery systems, and are certified according to CARB test procedures, manufacturer specifications or this Chapter.
37. "Warning tag" means a yellow tag that signifies a commercial device, vapor recovery system, or vapor recovery component does not comply with Title 3, Chapter 19, Handbook 44, CARB Executive Orders, or this Chapter.
38. "Weight certificate" means a document, issued by a public weighmaster in a form approved by the Division, which certifies the accuracy of the weight of the commodity measured.

Historical Note

New Section R3-7-101 recodified from Section R20-2-101 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2666, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-102. Metrology Laboratory Testing and Calibration Fees

- A. For all services of the Division's Metrology Laboratory, the Division shall charge \$110 per hour with a minimum charge of \$50.
- B. In addition to the fee in subsection (A), the Division shall charge for travel and per diem at the rates established under A.R.S. §§ 38-623(D) and 38-624(C) for tests or calibrations conducted outside the Metrology Laboratory.

Historical Note

New Section R3-7-102 recodified from Section R20-2-102 at 22 A.A.R. 2786, effective August 16, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3).

R3-7-103. Licensing and Fees

- A. A license is effective on the first day of the month following the date that the license application is determined by the Division to be complete and accurate.
- B. A payment is delinquent if not received or postmarked on or before the due date. The Division shall not process a license or renewal application for which payment is delinquent.
- C. If the Division receives payment for a license that excludes the payment of applicable fees or past due civil penalties, the Division shall apply the license fee payment to the licensee's account and issue a separate invoice for the additional monies owed to the Division. The license will not be issued by the Division until all fees due are paid.

Historical Note

New Section R3-7-103 recodified from Section R20-2-103 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-104. Administrative Enforcement Action

- A. For a violation of A.R.S. Title 3, Chapter 19, CARB Executive Orders, Handbook 44, Handbook 130, Handbook 133, or this Chapter, the Division may:
1. Issue a Warning, Out-of-Service, Stop-Sale, Stop-Use tag, or issue another administrative order under A.R.S. § 3-3415;
 2. Seize or condemn a Seal of Authority, weight, measure, or other commercial device under A.R.S. §§ 3-3414 and 3-3415;
 3. Impose a civil penalty under A.R.S. §§ 3-3473 and 3-3475;
 4. Revoke or suspend a license under A.R.S. § 3-3472;
 5. Utilize appropriate progressive enforcement action; or
 6. Implement any combination of subsections (A)(1) through (6).
- B. The Division may inspect or examine premises, equipment, or relevant records to determine compliance with A.R.S. Title 3, Chapter 19, CARB Executive Orders, Handbook 44, Handbook 130, Handbook 133, or this Chapter. Failure of a regulated person to comply with such inspection or examination shall be considered a violation under A.R.S. § 3-3473(A)(1).
- C. In addition to the enforcement action in subsection (A), the Division may issue an administrative order requiring a person to excavate a vapor recovery system if the person buries a vapor recovery system or component prior to a Division pre-burial inspection.

Historical Note

New Section R3-7-104 recodified from Section R20-2-104 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-105. Repealed**Historical Note**

Repealed Section R3-7-105 recodified from repealed Section R20-2-105 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-106. Repealed**Historical Note**

Repealed Section R3-7-106 recodified from repealed Section R20-2-106 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-107. Repealed**Historical Note**

Repealed Section R3-7-107 recodified from repealed Section R20-2-107 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-108. Time-frames for Licenses, Renewals, and Authorities to Construct

- A. For each type of license, renewal, or authority issued by the Division, the overall time-frame described in A.R.S. § 41-1072(2) is set forth in Table 1.
- B. For each type of license, renewal, or authority issued by the Division, the administrative completeness review time-frame described in A.R.S. § 41-1072(1) is set forth in Table 1 and begins on the date the Division receives an application.
1. If the application is not administratively complete, the Division shall send a deficiency notice to the applicant.

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- a. The deficiency notice shall state each deficiency and the information needed to complete the application.
 - b. Within the time-frame provided in Table 1 for response to the deficiency notice, the applicant shall submit to the Division the missing information specified in the deficiency notice. The time-frame for the Division to finish the administrative completeness review is suspended from the date the Division mails or e-mails the deficiency notice to the applicant until the date the Division receives the missing information.
 - c. If the applicant does not submit the missing information within the time-frame to respond to the deficiency notice set forth in Table 1, the Division shall send a written notice to the applicant informing the applicant that the application is deemed withdrawn. An applicant who desires to reapply shall begin the application process anew.
2. If the application is administratively complete, the Division shall send a written notice of administrative completeness to the applicant. If the Division, within 10 days of submittal, fails to send a written notice of administrative completeness or deficiency notice outlined in subsection (B)(1), the application shall automatically be deemed administratively complete.
- C.** For each type of license, renewal, or authority issued by the Division, the substantive review time-frame described in A.R.S. § 41-1072(3) is set forth in Table 1 and begins on the date the Division sends written notice of administrative completeness to the applicant.
1. During the substantive review time-frame, the Division may make one comprehensive written request for additional information. The applicant shall submit the additional information within the time-frame provided in Table 1 for response to a comprehensive written request for additional information. The time-frame for the Division to finish the substantive review is suspended from the date the Division mails or e-mails the request until the Division receives the information.
 2. If the applicant does not submit the requested additional information within the time-frame provided in Table 1, the Division shall issue a written notice informing the applicant that the application is deemed withdrawn. An applicant who desires to reapply shall begin the application process anew.
 3. The Division shall issue a written notice of denial of license, renewal, or authority if the Division determines that the applicant does not meet all of the substantive criteria required by A.R.S. Title 3, Chapter 19, and this Chapter for a license, renewal, or authority. The notice of denial shall include:
 - a. Reasons for the denial, with citations to the statutes or rules on which the denial is based; and
 - b. The name and telephone number of a Division employee who can answer questions regarding the application process.
 4. If the applicant meets all of the substantive criteria required by A.R.S. Title 3, Chapter 19, and this Chapter for a license, renewal, or authority the Division shall issue the license, renewal, or authority to the applicant.
- D.** The time-frame for an applicant to respond to a deficiency notice or request for additional information shall commence on the date of personal service or the postmark date.
- E.** In computing any time-frame prescribed in this Section, the day of the act, event, or default shall not be included. The last day of the period shall be included unless it is Saturday, Sunday, or a state holiday, in which event the period runs until the end of the next day that is not a Saturday, Sunday, or state holiday. Unless otherwise specified herein, the computation shall include intermediate Saturdays, Sundays and holidays.

Historical Note

New Section R3-7-108 recodified from Section R20-2-108 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-109. Administrative Hearing Procedures

A person who is adversely affected by an action made by the Division may request a hearing to dispute license denial, inspection results, a violation, or enforcement action under A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

New Section R3-7-109 recodified from Section R20-2-109 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-110. Motion for Rehearing or Review

- A.** Except as provided in subsection (I), any party in a contested case or appealable agency action before the Division who is aggrieved by a decision rendered in the case may file with the Division, not later than 10 days after service of the decision, a written motion for rehearing or review of the decision, pursuant to A.R.S. Title 41, Chapter 6, Article 10, specifying the particular grounds for the motion. For purposes of this subsection, a decision shall be deemed to have been served when personally delivered or mailed by certified mail to the party at the party's last known residence or place of business; or by electronic mail if the party has agreed to receive electronic notifications.
- B.** A motion for rehearing or review may be amended at any time before it is ruled upon by the Division. A party shall provide a copy of any pleading on all opposing parties or parties who may be directly affected by the issues presented, and the pleading shall contain a certification of delivery to listed recipients. A response may be filed within 15 days after service of the motion or amended motion by any other party. The Division may require the filing of written briefs upon the issues raised in the motion and may provide for oral argument.
- C.** A rehearing or review of the decision may only be granted for any of the following reasons materially affecting the moving party's rights:
1. Any irregularity in the hearing, order, or abuse of discretion depriving the moving party of a fair hearing;
 2. Misconduct of the Division, the administrative law judge, or the prevailing party;
 3. Accident or surprise that could not have been prevented by ordinary prudence;
 4. Newly discovered material evidence that could not have been discovered with reasonable diligence and produced at the original hearing;
 5. Excessive or insufficient penalties;

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6. Error in the admission or rejection of evidence or other errors of law occurring at the hearing or during the progress of the proceedings; or
7. That the decision is not justified by the evidence or is contrary to law.
- D. If a rehearing is granted, the Division may hear the case or may refer the case to the Office of Administrative Hearings. The decision of the administrative law judge becomes the decision of the Division unless rejected or modified by the Division in accordance with A.R.S. Title 41, Chapter 6, Article 10. A decision of the Division at this level of review is a final decision.
- E. Except for a decision under subsection (I), a rehearing or review of the final Division decision shall be requested in order for the aggrieved party to have the right to appeal under A.R.S. Title 12, Chapter 7, Article 6.
- F. The Division may affirm or modify its decision, or grant a rehearing or review. After giving the parties or their counsel notice and an opportunity to be heard, the Division may grant a rehearing or review for a reason not stated in a party's motion. An order granting a rehearing or review shall specify the grounds on which the rehearing or review is granted. The rehearing or review shall cover only those matters so specified.
- G. The Division, on its own initiative, within the time-frame for filing a motion for rehearing or review under this Section, may order a rehearing or review for any of the reasons set forth in subsection (C), after giving the parties notice and an opportunity to be heard.
- H. When a motion for rehearing or review is based upon affidavits, the moving party shall serve the affidavits with the motion. An opposing party has 15 days from the date of service to serve opposing affidavits. The Division may extend the period to respond up to 20 days for good cause, or by written stipulation of the parties. If the Division permits reply affidavits, the replying party has five business days in which to serve them.
- I. If the Division makes specific findings that the immediate effectiveness of a decision is necessary for the immediate preservation of the public peace, health, and safety and that a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the Division may issue the decision as a final decision without an opportunity for a rehearing or review. If a decision is issued as a final decision without an opportunity for rehearing or review, any application for judicial review of the decision shall be made within the time limits permitted for applications for judicial review of the Division's final decision.

Historical Note

New Section R3-7-110 recodified from Section R20-2-110 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-111. Repealed

Historical Note

Repealed Section R3-7-111 recodified from repealed Section R20-2-111 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-112. Repealed

Historical Note

Repealed Section R3-7-112 recodified from repealed Section R20-2-112 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-113. Renumbered

Historical Note

Renumbered Section R3-7-113 recodified from renumbered Section R20-2-113 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-114. Renumbered

Historical Note

Renumbered Section R3-7-114 recodified from renumbered Section R20-2-114 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-115. Renumbered

Historical Note

Renumbered Section R3-7-115 recodified from renumbered Section R20-2-115 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-116. Renumbered

Historical Note

Renumbered Section R3-7-116 recodified from renumbered Section R20-2-116 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-117. Renumbered

Historical Note

Renumbered Section R3-7-117 recodified from renumbered Section R20-2-117 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

Table 1. Time-frames

Type of License	Authority	Administrative Completeness Review	Response to Completion Request	Substantive Review	Response to Request for Additional Information	Overall Time-frame
Commercial Device	R3-7-201	14	28	30	30	44
Public Weighmaster	R3-7-501	14	28	30	30	44
Registered Service Agency/ Representative	R3-7-601	14	28	30	30	44
Authority to Construct	R3-7-1004	14	28	30	30	44

Historical Note

Article 1, Table 1, Time-frames (in days), recodified from 20 A.A.C. 2, Article 1, Table 1, Time-frames (in days), at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

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ARTICLE 2. COMMERCIAL DEVICES

R3-7-201. Licensing Process

- A. Before using a commercial device, a person or a contracted registered service representative shall apply for a commercial device license. The commercial device may be used without a license for up to 30 days after an application is filed with the Division. The application shall be on a form supplied by the Division that includes:
1. The applicant's name, address, and telephone number;
 2. The name, address, and telephone number of the location where the commercial device will be operated;
 3. A description of the commercial device;
 4. The applicant's signature; and
 5. The email address of the commercial device owner or operator for the Division to provide licenses, invoices, inspections and reports, enforcement action, and other notifications.
- B. A licensee shall notify the Division of a change in business name or address within 30 days of the change. The Division does not charge a fee to process a change in business name or address.
- C. Change of business ownership requires an application to transfer a license.

Historical Note

New Section R3-7-201 recodified from Section R20-2-201 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-202. Repealed**Historical Note**

Repealed Section R3-7-202 recodified from repealed Section R20-2-202 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-203. Approval, Installation, Use, and Sale of Devices

- A. A commercial device installed or placed in use after January 1, 1975, shall have an NCWM National Type Evaluation Program ("NTEP") Certificate of Conformance or have a California Type Evaluation Program ("CTEP") Certificate of Approval.
1. If a commercial device has been continuously licensed, or evidence shows it has been in use by the owner in Arizona since January 1, 1975, the commercial device is exempt from NTEP or CTEP approval requirements.
 2. If a commercial device exempt under subsection (A)(1) fails the specifications, tolerances, or other technical requirements of Handbook 44 during a Division inspection, the Division shall issue a Stop-Sale, Stop-Use tag or seize the device per R3-7-104(A) and revoke the commercial device license under A.R.S. § 3-3472. A person shall no longer use the device commercially.
- B. A person shall not use a commercial device that has an Out-of-Service or Stop-Sale, Stop-Use tag until the person repairs the commercial device as ordered by the Division, the commercial device meets the requirements of A.R.S. Title 3, Chapter 19, Handbook 44, and this Chapter, and approval is obtained from the Division to resume use of the device. If a person sells a commercial device that has an Out-of-Service or Stop-Sale, Stop-Use tag, the seller shall not remove the tag and must disclose to the buyer that the commercial device is not in compliance.

Historical Note

New Section R3-7-203 recodified from Section R20-2-203 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-204. Repealed**Historical Note**

New Section R3-7-204 recodified from Section R20-2-204 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

ARTICLE 3. PACKAGING, LABELING, AND METHOD OF SALE

R3-7-301. Repealed**Historical Note**

Repealed Section R3-7-301 recodified from repealed Section R20-2-301 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-302. Packaging, Labeling, and Method of Sale

- A. A person shall comply with all packaging, labeling, and method of sale requirements in Handbook 130, except as otherwise stated in this Chapter. A person shall ensure that packaged commodities kept, offered, exposed for sale, sold, or in the process of delivery are weighed, measured, and inspected using sampling and testing procedures designated in Handbook 133, except as otherwise stated in this Chapter.
- B. A retail seller shall ensure that a package that is offered for sale in a random weight, measurement, or count, and that is weighed, measured, or counted at the time of sale, includes a label on the package identifying the net weight, measurement, or count, item description, and packer's name if the packer is not the retailer. Pre-packaged produce does not require a label on each package if the retailer:
1. Clearly labels the price-per-pound where the packaged produce is displayed, and
 2. Deducts a tare for the packaging from the gross weight at the time of sale.
- C. If the Division issues an administrative order to a person at location where a package inspection is held, for a package that is not in compliance with a requirement in Handbook 130 or Handbook 133, the person to whom the administrative order is issued shall correct the package violation by:
1. Removing the package from sale;
 2. Labeling the package to reflect its correct net quantity;
 3. Placing a notice on the package that corrects the package violation, and pricing the package to reflect its correct net quantity; or
 4. Repackaging the commodity so the package contains the net quantity represented.

Historical Note

New Section R3-7-302 recodified from Section R20-2-302 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final

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rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-303. Repealed**Historical Note**

Repealed Section R3-7-303 recodified from repealed Section R20-2-303 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-304. Repealed**Historical Note**

Repealed Section R3-7-304 recodified from repealed Section R20-2-304 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-305. Repealed**Historical Note**

Repealed Section R3-7-305 recodified from repealed Section R20-2-305 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-306. Repealed**Historical Note**

Repealed Section R3-7-306 recodified from repealed Section R20-2-306 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-307. Repealed**Historical Note**

Repealed Section R3-7-307 recodified from repealed Section R20-2-307 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-308. Repealed**Historical Note**

Repealed Section R3-7-308 recodified from repealed Section R20-2-308 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-309. Repealed**Historical Note**

Repealed Section R3-7-309 recodified from repealed Section R20-2-309 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-310. Repealed**Historical Note**

Repealed Section R3-7-310 recodified from repealed Section R20-2-310 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-311. Repealed**Historical Note**

Repealed Section R3-7-311 recodified from repealed Section R20-2-311 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-312. Repealed**Historical Note**

Repealed Section R3-7-312 recodified from repealed Section R20-2-312 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-313. Repealed**Historical Note**

Repealed Section R3-7-313 recodified from repealed Section R20-2-313 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

ARTICLE 4. RETAIL PRICING**R3-7-401. Repealed****Historical Note**

Repealed Section R3-7-401 recodified from repealed Section R20-2-401 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-402. Retail Price Requirements; Initial Inspections; Violations and Exceptions

- A.** Retail price requirements. In addition to the requirements in A.R.S. § 3-3431, a person who offers, exposes, or advertises a commodity for sale or rent shall:
1. Price a commodity at the date and time that it is ordered by a customer;
 2. Post a definite, plain, and conspicuous price on the commodity or adjacent to where the commodity is displayed;
 3. If the price of the commodity is by weight, measure, or count, place the price per weight, measure, or count on the commodity or adjacent to where the commodity is displayed;
 4. If a price is reduced by a percentage or a fixed amount from a previously offered price, place the reduction or reduced price on the commodity or adjacent to where the commodity is displayed;
 5. Label each commodity offered for sale within a plant nursery with its identity and price, or post a sign with this information adjacent to the point of display; and
 6. Ensure that the price of each item purchased is displayed visibly to the public at each check-out location.
- B.** Initial retail price inspections. The initial retail price inspection of a location is for educational purposes and administrative enforcement action will not be imposed for a violation identified during an initial inspection. An initial inspection is the first retail price inspection conducted at a location when no prior retail price inspections have occurred at that location under the current ownership.
- C.** Price verification.
1. Violations. Items sampled for price verification that scan at a price higher than the marked or posted price are considered overcharges. An inspected location shall be found in violation if more than one overcharge is recorded in a price verification sample.
 2. Violation exceptions. Items sampled for price verification that scan at a price lower than the marked or posted price are considered undercharges, and are not a violation.
- D.** Price posting.
1. Violations. The following are price posting violations:
 - a. No price is posted or displayed for an inspected item;
 - b. Less than 98% of the items sampled for price posting during a retail price inspection have a marked or posted price; or
 - c. A percentage or quantity discount is provided, but there is no price displayed for the item on which the consumer may calculate or compare the discounted price to the regular price.
 2. Violation exceptions. The following are not price posting violations:

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- a. A price is posted or displayed as allowed in A.R.S. § 3-3431(L) and (N);
- b. A price is posted on the shelf or on a hook in front of or behind a row of items at the farthest left side of all items with the same price for up to 3 feet of shelf space, or at the farthest left and farthest right side of the shelf or hooks displaying items of the same price. For items of the same price, the Universal Product Code ("UPC") may differ for the commodities with prices labeled in this manner, as long as the price posted is a generic price and does not refer to a specific product;
- c. A price is posted in a location clearly visible to the consumer on a vertical display containing items of the same price;
- d. A price is posted on the inside or outside of the door of a self-contained refrigerated cooler on or in front of the shelving units in a location clearly visible to the consumer;
- e. Items contained in a clearly marked storage or restocking area where a customer must ask for employee assistance to obtain an item;
- f. A price is posted on a hook in front of or behind a row of items but the price is clearly visible or a notice is clearly visible stating that the price is posted behind the row of items;
- g. An item is located in an advertising display without a posted price but a notice is posted informing a customer to ask an employee for price information regarding an item contained in the display;
- h. A menu-type sign at a point of display that lists the name and price of every item at the point of display in legible text. A menu-type sign may also be used to display single-item purchase prices in areas where space is limited, or used to display a price for purchase of multiple items and single-item purchase prices at the point of display as long as it is posted at, above, or adjacent to the point of display;
- i. A point of display contains more than one item posted with the manufacturer's name or logo and the price and name of each item contained within the point of display is posted at, above, or adjacent to the point of display;
- j. A price is posted only at each entrance to a store and the posted price is the price of each item displayed for sale within the store, or a price is posted at each entrance to a department within a store and the posted price is the price of each item displayed for sale within the department;
- k. A notice states that there is an additional charge based on an item's size and the additional charge for each size is posted at, above, or adjacent to the point of display; and
- l. An item that does not have a price displayed but is located in or behind a service counter and available only with the assistance of a sales associate as allowed in A.R.S. § 3-3431(M). If a price is displayed, it must meet the requirements of this Chapter.

Historical Note

New Section R3-7-402 recodified from Section R20-2-402 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final

rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-403. Repealed**Historical Note**

Repealed Section R3-7-403 recodified from repealed Section R20-2-403 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-404. Repealed**Historical Note**

Repealed Section R3-7-404 recodified from repealed Section R20-2-404 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-405. Repealed**Historical Note**

Repealed Section R3-7-405 recodified from repealed Section R20-2-405 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-406. Repealed**Historical Note**

Repealed Section R3-7-406 recodified from repealed Section R20-2-406 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-407. Repealed**Historical Note**

Repealed Section R3-7-407 recodified from repealed Section R20-2-407 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-408. Repealed**Historical Note**

Repealed Section R3-7-408 recodified from repealed Section R20-2-408 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-409. Repealed**Historical Note**

Repealed Section R3-7-409 recodified from repealed Section R20-2-409 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-410. Repealed**Historical Note**

Repealed Section R3-7-410 recodified from repealed Section R20-2-410 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-411. Repealed**Historical Note**

Repealed Section R3-7-411 recodified from repealed Section R20-2-411 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-412. Repealed

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Historical Note

Repealed Section R3-7-412 recodified from repealed Section R20-2-412 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

ARTICLE 5. PUBLIC WEIGHMASTERS**R3-7-501. Qualifications; License and Renewal Application Process**

- A. In addition to the requirements of A.R.S. § 3-3453, to be a public weighmaster or a deputy public weighmaster, a person shall:
 1. Be at least 18 years old, and
 2. Be able to execute weight certificates properly.
- B. A person shall not perform the duties of a public weighmaster until the person passes the written public weighmaster examination administered by the Division with a minimum score of 75%. A person may not take the examination more than three times in six months and must wait seven days before retaking the exam.
- C. A person that meets the qualifications for public weighmaster or deputy public weighmaster may apply for a license on a form supplied by the Division. A separate application shall be submitted for each location where the public weighmaster or deputy public weighmaster will issue weight certificates.
 1. The application form includes:
 - a. The applicant's name, address, telephone number, and email address;
 - b. A statement by the applicant that the applicant knows and understands public weighmaster laws and rules;
 - c. The name, address, and telephone number of each of the applicant's public weighmaster locations; and
 - d. The applicant's signature.
 2. The public weighmaster's application form also includes:
 - a. The name of each deputy public weighmaster operating at each location;
 - b. A statement that the public weighmaster understands they are responsible to ensure that any deputy public weighmasters working at the location are adequately trained and licensed;
 - c. The name and address of the scale; and
 - d. The scale description.
 3. The deputy public weighmaster application shall be on a form provided by the Division, and include a certification that the applicant understands the requirements in this Article. The deputy public weighmaster application shall be signed by both the public weighmaster and the applicant.
 4. An applicant may be required to submit evidence of qualifications.
 5. The public weighmaster shall ensure all deputy public weighmasters are licensed for the location prior to their issuance of weight certificates.
 6. An applicant shall submit information and documentation concerning lawful presence required by A.R.S. § 41-1080.
- D. Before the Division issues or renews a public weighmaster or deputy public weighmaster license, the applicant shall pay the required fees and provide information required in A.R.S. Title 3, Chapter 19, and this Chapter.
- E. A public weighmaster licensee shall notify the Division of a change in business name or address within 30 days of the change. The Division does not charge a fee to process a change in name or address.

- F. Change of business ownership requires an application to transfer a license.
- G. In the event a public weighmaster leaves employment, a licensed deputy public weighmaster may utilize a public weighmaster stamp that contains only the location identity as issued under R3-7-506(B) for 30 days at a location while a public weighmaster license application is underway. A public weighmaster stamp containing the public weighmaster's name may not continue to be used following a public weighmaster's departure.

Historical Note

New Section R3-7-501 recodified from Section R20-2-501 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-502. Duties

A public weighmaster shall:

1. Be responsible for the daily operation and maintenance of the licensed scale used when performing public weighmaster duties;
2. Use scales according to applicable laws and rules;
3. Be responsible for all acts performed by any deputy public weighmaster designated by the public weighmaster; and
4. Ensure that deputy public weighmasters are licensed prior to their issuance of a weight certificate and cancel deputy public weighmasters licenses within 10 days of their leaving employment to ensure each location has the correct number of licensed deputy public weighmasters. A deputy public weighmaster license may be canceled by sending an email or other written notification to the Division.

Historical Note

New Section R3-7-502 recodified from Section R20-2-502 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-503. Grounds for Denying License or Renewal; and Disciplinary Action

- A. The Division may deny a public or deputy public weighmaster license for any of the following reasons:
 1. Providing false or misleading information;
 2. Failing to meet the requirements stated in this Article; or
 3. Any of the reasons stated in subsections (B)(1) through (8).
- B. The Division may impose disciplinary action against, or refuse to renew a public weighmaster's license for any of the reasons stated in subsection (A)(1) or (2), or if the Division has determined that the public weighmaster:
 1. Does not have the ability to conduct an accurate weighing for producing weight certificates;
 2. Has produced an incorrect, inaccurate, or falsified weight certificate;
 3. Has been found to violate any provision of A.R.S. Title 3, Chapter 19, or this Chapter;
 4. Has delegated authority to someone other than a licensed public weighmaster or deputy public weighmaster;
 5. Has improperly used a public weighmaster's Seal of Authority;

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6. Has pre-signed certificates for later use;
7. Has issued a weight certificate on which changes or alterations were made; or
8. Has used a scale for public weighing that is not properly licensed.

Historical Note

New Section R3-7-503 recodified from Section R20-2-503 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-504. Scales and Vehicle Weighing

- A. When making a weight determination, a public weighmaster shall use a scale that is suitable for the function.
- B. The public weighmaster shall not use a scale to weigh a load that exceeds the normal or rated capacity of the scale.
- C. The owner or user of a scale is responsible for the accuracy of the scale used by a public weighmaster. The owner or user shall comply with Handbook 44.
- D. If a scale is equipped with a printing device, it shall be used for all relevant entries on the weight certificate.
- E. The Division shall separately license and regulate each scale location.
- F. A public weighmaster or deputy public weighmaster shall weigh any vehicle or combination of vehicles on a scale having a platform that fully accommodates the vehicle or combination of vehicles as one unit.
- G. If a combination of vehicles is divided into separate units to be weighed, each separate unit shall be entirely disconnected before weighing and a separate weight certificate shall be issued for each unit.

Historical Note

New Section R3-7-504 recodified from Section R20-2-504 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-505. Weight Certificates

- A. In issuing a weight certificate, a public weighmaster shall enter only weight information or other required information that the public weighmaster or deputy public weighmaster has accurately and personally determined.
- B. A public weighmaster or deputy public weighmaster shall not make any entries on a weight certificate issued by another person.
- C. By signing a weight certificate, a public weighmaster or deputy public weighmaster shall be responsible for the accuracy of all entries on the weight certificate.
- D. A weight certificate is valid only when marked with the Seal of Authority and signed by the issuing public weighmaster or deputy public weighmaster.
- E. A Seal of Authority may be printed electronically on a weight certificate if it is identical in appearance to the Seal of Authority issued by the Division.
- F. A public weighmaster or deputy public weighmaster's signature may be printed electronically on the weight certificate in lieu of a handwritten signature if the electronic signature is that of the public weighmaster or deputy public weighmaster who weighed the commodity. To issue a weight certificate with an electronic Seal of Authority and signature, the public

weighmaster or deputy public weighmaster shall have an individual login associated with the electronic Seal of Authority and signature or other security measures in place to prevent unauthorized persons from use.

- G. If an error is made on a weight certificate, the public weighmaster or deputy public weighmaster shall void the certificate and issue a new certificate. No changes or alterations shall be made on a weight certificate.
- H. A weight certificate shall state:
 1. The date of issuance;
 2. The name of the declared owner, agent, or consignee of the material weighed;
 3. The accurate weight of the material weighed or counted;
 4. The means by which the material is being transported at the time it is weighed or counted;
 5. The license plate number of the transporting unit;
 6. The printed name, signature, and license number of the public weighmaster or deputy public weighmaster issuing the weight certificate; and
 7. The following statement: "PUBLIC WEIGHMASTER'S CERTIFICATE OF WEIGHT AND MEASURE. This is to certify that the described merchandise was weighed, counted, or measured by a public or deputy public weighmaster, and when properly signed and sealed, is prima facie evidence of the accuracy of the weight, count, or measure shown as prescribed by law."
- I. A public weighmaster shall maintain a legible copy of each weight certificate issued at each scale location, for a minimum of one year. A public weighmaster shall also ensure that weight certificates are consecutively numbered and filed numerically, including voided weight certificates. A public weighmaster shall not use another filing system without Division approval.
- J. A public weighmaster is liable for any forged physical, printed, or electronic signatures.

Historical Note

New Section R3-7-505 recodified from Section R20-2-505 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-506. Seal of Authority

- A. A public weighmaster shall obtain a Seal of Authority for the certification of weight certificates at cost through the Division.
- B. The Division shall assign a number to a Seal of Authority that identifies the specific location for which the Seal of Authority is issued.
- C. A Seal of Authority is the property of the state. A public weighmaster shall surrender their assigned Seal of Authority to the Division within 30 days after the public weighmaster no longer operates as a licensed public weighmaster if the Seal of Authority contains the public weighmaster's name. If the Seal of Authority was issued under R3-7-506(B) and only contains the location identification number, it may be retained for use by the next licensed public weighmaster at the location if it is still legible. Illegible seals or seals used in violation of an administrative order shall be seized by the Division.
- D. A public weighmaster shall have one Seal of Authority for use at each scale location.
- E. A Seal of Authority shall be accessible to the public weighmaster and authorized deputy public weighmasters during all

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business hours at the scale location for the timely and proper certification of weight certificates.

- F. A public weighmaster shall keep a Seal of Authority at each scale location and make it available for inspection by the Division during all business hours.
- G. A public weighmaster may recreate the Seal of Authority assigned by the Division in an electronic format for use as provided under R3-7-505(E) and (F). The Division shall provide a template of the Seal of Authority.

Historical Note

New Section R3-7-506 recodified from Section R20-2-506 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-507. Prohibited Acts

- A. A person shall not:
 - 1. Issue a certified weight certificate without being a licensed public weighmaster or a deputy public weighmaster authorized to act for a public weighmaster;
 - 2. Procure, print, or cause to be printed any public weighmaster weight certificate without being a licensed public weighmaster or a deputy public weighmaster authorized to act for a public weighmaster;
 - 3. Possess unfilled or unused weight certificates without being a licensed public weighmaster or a deputy public weighmaster authorized to act for a public weighmaster;
 - 4. Furnish or give false information to a public weighmaster or deputy public weighmaster for use in the completion of a weight certificate;
 - 5. Present a weight certificate for payment falsified by the insertion of any weight, measure, or count not determined by the issuing public weighmaster;
 - 6. Use without authorization the title "licensed public weighmaster" or any similar title; represent oneself to be a public weighmaster without holding a license issued by the Division; or engage in public weighing without holding a valid license as a public weighmaster or a deputy public weighmaster authorized to act for a public weighmaster; or
 - 7. Use an unlicensed scale in the performance of public weighmaster duties.
- B. Nothing in subsection (A) shall be construed to prevent administrative staff of the public weighmaster or deputy public weighmaster from performing administrative duties such as filing weight certificates.
- C. People engaged in the business of printing weight certificate forms, their representatives, and the Division are exempt from the prohibitions specified in subsections (A)(2) and (3).

Historical Note

New Section R3-7-507 recodified from Section R20-2-507 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

ARTICLE 6. REGISTERED SERVICE AGENCIES AND REPRESENTATIVES**R3-7-601. Qualifications; License and Renewal Application Process**

- A. Registered service agency.

1. To obtain a license as a registered service agency, an applicant shall provide evidence that:
 - a. The applicant's registered service representative has a thorough knowledge of all appropriate laws within A.R.S. Title 3, Chapter 19, Handbook 44, CARB Executive Orders, and this Chapter;
 - b. The applicant provided its representative with a copy of the portions of A.R.S. Title 3, Chapter 19, Handbook 44, CARB Executive Orders, and this Chapter relating to registered service representative duties;
 - c. The applicant:
 - i. Possesses the necessary certified field calibration standards that meet the requirements of A.R.S. § 3-3416 for installing, repairing, or servicing commercial devices; and
 - ii. Possesses the necessary vapor recovery test equipment calibrated in the time-frame required by the equipment manufacturer or CARB Executive Orders to perform the required testing of a vapor recovery system or vapor recovery component; or
 - iii. Has pre-filed with the Division documentation that the applicant has:
 - (a) Access to the necessary field calibration standards and vapor recovery test equipment belonging to another registered service agency;
 - (b) Written approval from that registered service agency to use its field calibration standards and vapor recovery test equipment;
 - (c) Documentation supporting that the field calibration standards meet the requirements of A.R.S. § 3-3416(F); and
 - (d) Documentation supporting that the vapor recovery test equipment meets the calibration requirements established by the CARB test procedure or this Chapter.
 - d. The applicant shall ensure that its registered service representative operates field calibration standards and vapor recovery test equipment according to A.R.S. Title 3, Chapter 19, Handbook 44, CARB Executive Orders, and this Chapter.
2. The Division shall not issue a registered service agency license until at least one of the applicant's employees passes a registered service representative competency exam.
3. An applicant for a registered service agency license shall submit an application form, obtained from the Division that provides:
 - a. Name, address, telephone number, and email address;
 - b. License information from other states;
 - c. Types of devices serviced, repaired, or installed, or vapor recovery systems or components repaired or tested;
 - d. A list of all of the applicant's field calibration standards and vapor recovery test equipment with corresponding serial or identification numbers;
 - e. Branch office information;
 - f. Names of registered service representatives and their experience with other registered service agencies or states;

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- g. License and disciplinary history; and
- h. Applicant's signature.
- B. Registered service representative.**
 - 1. To obtain a license as a registered service representative, an applicant shall provide evidence that:
 - a. The applicant has a thorough knowledge of all appropriate laws within A.R.S. Title 3, Chapter 19, Handbook 44, CARB Executive Orders, and this Chapter;
 - b. The applicant possesses the necessary training or experience regarding appropriate field calibration standards and vapor recovery test equipment to service the specific commercial device, vapor recovery system, or vapor recovery system component indicated on the application; and
 - c. The applicant has passed the competency examination specified in subsection (C).
 - 2. An applicant for a registered service representative license shall submit an application on a form obtained from the Division that provides:
 - a. Name, address, telephone number, and email address;
 - b. License information from other states;
 - c. An indication of whether the applicant is applying to be a registered service representative or a vapor recovery registered service representative;
 - d. A summary of the types of devices serviced, repaired, or installed, or vapor recovery systems or components repaired or tested;
 - e. Work experience with other registered service agencies in Arizona or other states;
 - f. License and disciplinary history; and
 - g. Applicant's signature.
 - 3. An applicant for a vapor recovery registered service representative license shall maintain and make available to the Division upon request evidence of being certified by the manufacturer to test or repair all vapor recovery systems and components.
 - 4. An applicant shall submit information and documentation concerning lawful presence required by A.R.S. § 41-1080.
- C. Competency examination.** Before an applicant is issued a registered service representative license, the applicant shall pass a Division-administered competency examination.
 - 1. An applicant for a vapor recovery registered service representative license shall complete the Division's training class before taking the competency examination. The Division may waive the training class requirement for up to 12 months for new applicants.
 - 2. An applicant shall bring a copy of Handbook 44 to the examination site. An applicant for a vapor recovery registered service representative license shall additionally bring copies of CARB test procedures, Executive Orders, and Division Standard Operating Procedures.
 - 3. An applicant shall complete the competency examination within the time specified by the Division and pass with a score of 75% or greater.
 - 4. The Division shall not allow an applicant to take the competency examination more than three times in six months and the applicant must wait seven days prior to retaking the exam.
 - 5. The associate director may contract with a third-party testing company to administer competency examinations to provide added convenience to registered service representative applicants. Taking exams through a third party is optional and the registered service representative shall be responsible for payment of any additional costs related to third-party testing.
- D.** As required under A.R.S. § 3-3454(G), the Division shall specify on a registered service representative license the type of service that the registered service representative is approved to perform.
- E.** Renewal of a registered service representative license. Under A.R.S. § 3-3454(D), a registered service representative license is valid for 12 months and expires unless renewed. To renew a registered service representative license, the registered service agency employing the registered service representative shall submit the renewal fee for the agency license and the agency's registered service representative licenses by the first day of the month that each license expires. Before submitting the renewal fee, the registered service agency shall ensure that once every 36 months a vapor registered service representative completes the Division's training class and takes and passes the Division's written vapor recovery competency examination.
- F.** A registered service agency licensee shall notify the Division of a change in business name or address within 30 days of the change. The Division does not charge a fee to process a change in business name or address.
- G.** Change of business ownership requires application for a new license. Existing registered service representatives may move their license to a new registered service agency without being subject to the requirements in subsection (C).

Historical Note

New Section R3-7-601 recodified from Section R20-2-601 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-602. Duties

- A. Registered service agency.**
 - 1. A registered service agency shall:
 - a. Maintain all field calibration standards used for commercial device certification according to standards traceable to NIST;
 - b. Use the appropriate type and quantity of field calibration standards when testing, repairing, or certifying a commercial device according to A.R.S. Title 3, Chapter 19, Handbook 44, and this Chapter; and
 - c. Maintain and use vapor recovery test equipment according to this Chapter, CARB test procedures, and manufacturer specifications.
 - 2. When a registered service agency restores or newly places a commercial device into service, or restores a commercial device into service as the result of an Out-of-Service or Stop-Sale, Stop-Use tag, or an administrative order, the registered service agency shall complete a placed-in-service report form prescribed by the Division.
 - a. Within seven days after the commercial device is newly placed into service or restored into service, the registered service agency shall complete an online placed-in-service report to the Division. If an online placed-in-service report is not available for the device, a paper report shall be submitted;
 - b. The registered service agency shall provide a copy of the placed-in-service report to the person who owns or operates the commercial device;

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- c. The registered service agency shall retain a copy of the placed-in-service report for one year;
 - d. The registered service agency shall ensure that the placed-in-service report contains the assigned license number of the registered service representative who installs or restores the commercial device and completes the report;
 - e. The registered service agency shall ensure that the placed-in-service report is completed and signed by the registered service representative noting each commercial device newly installed or restored into service; and
 - f. The registered service agency shall ensure that the placed-in-service report includes the serial or identification number of each field calibration standard used by the registered service representative to calibrate each commercial device newly installed or restored to service.
3. A registered service agency shall have all field calibration standards certified annually as required under A.R.S. § 3-3416. Vapor recovery test equipment shall be certified as required by the CARB test procedure or this Chapter.
 4. A registered service agency shall not use a new field calibration standard until it is certified as required under A.R.S. § 3-3416.
 5. A registered service agency shall ensure that its employee does not perform registered service representative duties until the Division licenses the employee as a registered service representative. A registered service agency may train an employee in registered service representative duties only if the employee is within the direct line of sight and hearing of a supervising licensed registered service representative.
 6. A registered service agency shall use a form approved by the Division to record vapor recovery test results and violations. The test results shall be e-mailed to the Division within seven days after completion of the test.
 7. A registered service agency shall retain a copy of a required vapor recovery test report for a period of one year.
 8. A registered service agency shall ensure that its registered service representative provides a vapor recovery system owner or operator with written test preparation instructions, at least five business days before an initial or annual test.
- B. Registered service representative.**
1. A registered service representative shall:
 - a. Perform only the type of service that they are approved by the Division to perform;
 - b. Install only commercial devices that meet the requirements of this Chapter;
 - c. Perform all vapor recovery tests according to this Chapter;
 - d. Perform all appropriate tests before a commercial device is placed in service, including when a commercial device is newly installed or restored to service, to ensure that the requirements of A.R.S. Title 3, Chapter 19, this Chapter, Handbook 44 are met;
 - e. Perform all appropriate tests when installing, repairing, or replacing a vapor recovery system or component to ensure that the requirements of A.R.S. Title 3, Chapter 19, this chapter, and CARB Executive Orders are met;
 - f. Report to the user equipment or commercial devices that do not conform to NIST standards;
 - g. Complete placed-in-service reports accurately;
 - h. Obtain and keep current, during the term of the registered service representative license, all required federal, state, and local licenses and ensure compliance with all federal, state, and local laws, rules, regulations, and policies governing the occupation of a registered service representative.
 2. A registered service representative shall report to the Division within one hour by email or telephone of finding a device that is not certified as part of the NTEP Certificate of Conformance under R3-7-203(A) and is installed to fraudulently obtain motor fuel or consumer payment card information, and the registered service representative shall contact the local law enforcement agency for collection of the device as evidence.
 3. If a vapor recovery registered service representative cannot correct a violation and has to leave the vapor recovery site, the registered service representative shall secure the non-compliant vapor recovery system or component from commercial use. The non-compliant system or component shall not be used for commercial purposes until it is repaired and passes the test required by R3-7-1010. The registered service representative shall notify the Division of the secured, non-compliant vapor recovery system or component prior to leaving the site. The registered service representative shall notify the Division regarding retest of the site by 6:00 a.m. of the day after the non-compliant vapor recovery system or component is secured or one hour before the test, whichever is sooner, so that the Division may witness the test.

Historical Note

New Section R3-7-602 recodified from Section R20-2-602 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-603. Grounds for Denying License or Renewal; Suspension, Revocation, or Other Disciplinary Action

The Division may deny a license or renewal, suspend or revoke a license, or impose other discipline, for any of the following reasons:

1. Providing false or misleading information;
2. Failure to meet annual certification requirements for field calibration standards or vapor recovery test equipment;
3. Failure to pay required fees;
4. Violating any requirements stated in A.R.S. Title 3, Chapter 19, or this Chapter.; or
5. If an applicant, registered service agency, or registered service representative is not qualified to perform the duties of a registered service representative or registered service agency.

Historical Note

New Section R3-7-603 recodified from Section R20-2-603 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-604. Prohibited Acts

- A.** A person shall not:

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1. Perform any duty or do any act required to be done by a registered service agency or registered service representative without holding a registered service agency or registered service representative license issued by the Division;
 2. Use the title of registered service agency or registered service representative, any similar title, or hold oneself out as a registered service agency or representative without a valid license; or
 3. Remove an official Out-of-Service or Stop-Sale, Stop-Use tag except as authorized in this Chapter, or by the Division.
- B.** A registered service agency or registered service representative shall not:
1. Fraudulently complete or file an incomplete placed-in-service report;
 2. Delegate licensed authority or responsibility to an unlicensed person;
 3. Perform a function without certified field calibration standards or vapor recovery test equipment;
 4. Newly install or restore a commercial device into service before satisfying all requirements of A.R.S. Title 3, Chapter 19, or this Chapter;
 5. Fail to report a commercial device to the Division that is found to be out of compliance under R3-7-602;
 6. Calibrate a commercial device without placing a decal or label on the device as prescribed by the associate director;
 7. Leave a location where there is a non-compliant commercial device without securing the commercial device from commercial use; or
 8. Leave a vapor recovery site where there is a non-compliant system or component without securing the system or component from use.

Historical Note

New Section R3-7-604 recodified from Section R20-2-604 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-605. Repealed**Historical Note**

New Section R3-7-605 recodified from Section R20-2-605 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

ARTICLE 7. MOTOR FUELS AND PETROLEUM PRODUCTS**R3-7-701. Definitions**

In addition to the definitions in A.R.S. § 3-3401 and R3-7-101, the following definitions apply to this Article unless the context otherwise requires:

1. "Address" means a street number, street name, city, state, and zip code.
2. "Arizona CBG" means Arizona cleaner burning gasoline, and is a gasoline blend that meets the requirements of this Article for gasoline produced and shipped to or within Arizona and sold or offered for sale for use in motor vehicles within the CBG-covered area, except as provided under A.R.S. §§ 3-3493(I) and 3-3494(H).
3. "AZRBOB" means "Arizona Reformulated Blendstock for Oxygenate Blending" and is a combination of gaso-

line blendstocks that is intended to be or represented to constitute Arizona CBG upon the addition of a specified amount (or range of amounts) of an oxygenate not prohibited by A.R.S. § 3-3491(E) after the blendstock is supplied from the facility at which it was produced or imported.

4. "Batch" means a quantity of motor fuel or AZRBOB that is homogeneous for motor fuel properties specific for the motor fuel standards applicable to that motor fuel or AZRBOB.
5. "Biodiesel" has the same meaning as prescribed under A.R.S. § 3-3401.
6. "Biodiesel blend" has the same meaning as prescribed under A.R.S. § 3-3401. Per ASTM D975, diesel fuel may contain 5% or less biodiesel and is not considered to be a biodiesel blend.
7. "Biofuel" has the same meaning as prescribed under A.R.S. § 3-3401.
8. "Biofuel blend" has the same meaning as prescribed under A.R.S. § 3-3401.
9. "Biofuel blender" means a person that modifies a motor fuel by adding a biofuel.
10. "Biofuel producer" means a person that owns, leases, operates, controls, or supervises a facility at which biofuel is produced.
11. "Biofuel Supplier" means a marketer or jobber of a biofuel or biofuel blend.
12. "Biomass" has the same meaning as prescribed under A.R.S. § 3-3401.
13. "Biomass-based diesel" has the same meaning as prescribed under A.R.S. § 3-3401.
14. "Biomass-based diesel blend" has the same meaning as prescribed under A.R.S. § 3-3401.
15. "Blendstock" means any liquid compound that is blended with another liquid compound to produce a motor fuel, including Arizona CBG. A deposit-control or similar additive registered under 40 CFR 79 is not a blendstock.
16. "CARBOB Model" means the requirements and procedures incorporated by reference in R3-7-702(12) and (13).
17. "CBG Blender" means a person that owns, leases, operates, controls, or supervises any facility, other than a refinery or transmix processing facility, where AZRBOB or Arizona CBG is produced by combining blendstocks or by combining blendstocks with fuel. Types of blending facilities include, but are not limited to, terminals, storage tanks, plants, tanker trucks, retail outlets, and marine vessels.
18. "CBG-covered area" means:
 - a. A county with a population of 1,200,000 or more persons according to the most recent United States decennial census;
 - b. Any portion of a county within area A; and
 - c. Any portion of a county within area C from June 1 through September 30 of each year.
19. "Conventional gasoline" means gasoline that conforms to the requirements of this Chapter for sale or use in Arizona, but does not meet the requirements of Arizona CBG or AZRBOB.
20. "Diesel fuel" or "Diesel" has the same meaning as prescribed under A.R.S. § 3-3401. Per ASTM D975, diesel fuel may contain 5% or less biodiesel.

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21. "Duplicate" means a portion of a sample that is treated the same as the original sample to determine the accuracy and precision of an analytical method.
22. "E15" means gasoline that contains more than 10 and no more than 15 volume percent ethanol.
23. "EPA waiver" means a waiver granted by EPA as described in "Waiver Requests under Section 211(f) of the Clean Air Act," which is incorporated by reference in R3-7-702(6).
24. "Ethanol" means an alcohol of the chemical formula C_2H_5OH . Ethanol is provided in gasoline-ethanol blends by blending denatured fuel ethanol.
25. "Ethanol flex fuel" has the same meaning as prescribed under A.R.S. § 3-3401.
26. "Final destination" means the name and address of the location to which a transferee will deliver motor fuel for further distribution or final consumption.
27. "Final distribution facility" means a stationary motor-fuel transfer point at which motor fuel or AZRBOB is transferred into a cargo tank truck, pipeline, or other delivery vessel from which the motor fuel or AZRBOB will be delivered to a motor-fuel dispensing site. A cargo tank truck is a final distribution facility if the cargo tank truck transports motor fuel or AZRBOB and carries documentation that the type and amount or range of amounts of oxygenates designated by the registered supplier will be or have been blended directly into the cargo tank truck before delivery of the resulting motor fuel to a motor-fuel dispensing site.
28. "Fleet" means at least 25 motor vehicles owned or leased by the same person.
29. "Fleet vehicle fueling facility" means a facility or location where a motor fuel is dispensed for final use by a fleet.
30. "Fuel ethanol" means denatured ethanol that meets the requirements in ASTM D4806, which is incorporated by reference in R3-7-702(4).
31. "Fuel property" means any characteristic listed in R3-7-751(A)(1) through (8), R3-7-751(B)(1) through (7), R3-7-751(D), or any other motor fuel standard referenced in this Article.
32. "Gasoline" has the same meaning as prescribed under A.R.S. § 3-3401.
33. "Isobutanol" means butanol isomer 2-methyl-1-propanol that meets the requirements in ASTM D7862, which is incorporated by reference in R3-7-702(9).
34. "Jobber" means a person that distributes a motor fuel from a bulk storage plant or terminal to the owner or operator of an underground or above-ground storage tank.
35. "Marketer" means a person engaged in selling or offering for sale motor fuels.
36. "Motor Fuel" has the same meaning as prescribed under A.R.S. § 3-3401.
37. "Motor fuel dispensing site" means a facility or location where a motor fuel is dispensed into commerce for final use.
38. "Motor vehicle" means a vehicle equipped with a spark-ignited or compression-ignition internal combustion engine except:
 - a. A vehicle that runs on or is guided by rails, or
 - b. A vehicle designed primarily for travel through air or water.
39. "MTBE" means methyl tertiary butyl ether.
40. "Neat" means pure or 100%.
41. "NOx" means oxides of nitrogen.
42. "Octane" or "octane rating" means the anti-knock characteristic of gasoline as determined by the resulting arithmetic test average of ASTM D2699 and ASTM D2700.
43. "Oxygenate" has the same meaning as prescribed under A.R.S. § 3-3401.
44. "Oxygenate blender" means a person that owns, leases, operates, controls, or supervises an oxygenate-blending facility, or that owns or controls the blendstock or gasoline used, or the gasoline produced, at an oxygenate-blending facility.
45. "Oxygen content" means the percentage by weight of oxygen contained in a gasoline oxygenate blend as determined under ASTM D4815.
46. "Pipeline" means a transporter that owns or operates an interstate common-carrier pipe or is subject to Federal Energy Regulatory Commission tariffs to transport motor fuels into Arizona.
47. "PM" means predictive model.
48. "Predictive Model Procedures" means CARB's "California Procedures for Evaluating Alternative Specifications for Phase 2 Reformulated Gasoline Using the California Predictive Model," as adopted April 20, 1995.
49. "Premium diesel" means a diesel fuel meeting the requirements in ASTM D975 and in Handbook 130, Uniform Engine Fuels and Automotive Lubricants Regulations, Section 2.2.1(a) through 2.2.1(f).
50. "Producer" means a refiner, CBG blender, or other person that produces a motor fuel, including Arizona CBG or AZRBOB.
51. "Production facility" means a facility at which a motor fuel, including Arizona CBG or AZRBOB, is produced. Upon request of a producer, the associate director may designate, as part of the producer's production facility, a physically separate bulk storage facility that:
 - a. Is owned or leased by the producer;
 - b. Is operated by or at the direction of the producer; and
 - c. Is used to store or distribute motor fuels, including Arizona CBG or AZRBOB, that are supplied only from the production facility.
52. "Product transfer document" has the same meaning as prescribed under A.R.S. § 3-3401.
53. "Refiner" means a person that owns, leases, operates, controls, or supervises a refinery in the United States, including its trust territories.
54. "Refinery" means a facility that produces a liquid fuel, including Arizona CBG or AZRBOB, by distilling petroleum, or a transmix facility that produces a motor fuel offered for sale or sold into commerce as a finished motor fuel.
55. "Reproducibility" means the testing method margin of error as provided in the ASTM specification or other testing method required under this Article.
56. "Supply" means to provide or transfer motor fuel to a physically separate facility, vehicle, or transportation system.
57. "Terminal" means an owner or operator of a motor fuel storage tank facility that accepts custody, but not necessarily ownership, of a motor fuel from a registered supplier, oxygenate blender, pipeline, or other terminal and relinquishes custody of the motor fuel to a transporter or another terminal.

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58. "Test result" means any document that contains a result of testing including all original test measures, all subsequent test measures that are not identical to the original test measure, and all worksheets on which calculations are performed.
59. "Transferee" means a person that receives title to or custody of a motor fuel.
60. "Transferor" means a person that relinquishes title to or custody of a motor fuel to a transporter, marketer, jobber, or motor fuel dispensing site.
61. "Transmix" means a mixture of petroleum distillate fuel and gasoline that does not meet the Arizona standards for either petroleum distillate fuels or gasoline.
62. "Transmix facility" means a facility at which transmix is processed into its components and then the components either are combined with a finished product or further processed to produce a finished motor fuel.
63. "Transporter" means a person that causes motor fuels, including Arizona CBG or AZRBOB, to be transported into or within Arizona.
64. "Vapor pressure" means dry vapor pressure equivalent of gasoline or blendstock as measured according to ASTM D5191.
65. "VOC" means volatile organic compound.

Historical Note

New Section R3-7-701 recodified from Section R20-2-701 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2666, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-702. Material Incorporated by Reference

The following documents are incorporated by reference and on file with the Division. The documents incorporated by reference contain no future editions or amendments.

1. 16 CFR 306 - Automotive Fuel Ratings, Certification and Posting, December 8, 2021 Edition, Government Publishing Office, 732 North Capitol Street, NW, Washington, D.C. 20401-0001 or bookstore.gpo.gov (herein referred to as "16 CFR 306").
2. API Recommended Practice 1637 (API RP 1637), "Using the API Color-Symbol System to Mark Equipment and Vehicles for Product Identification at Gasoline Dispensing Facilities and Distribution Terminals," 4th edition published April 2020, American Petroleum Institute (API), 200 Massachusetts Avenue NW Suite 1100, Washington, DC, 20001-5571 (herein referred to as "API 1637").
3. ASTM Standard D975-21, "Standard Specification for Diesel Fuel," published 2021, ASTM International, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959 or www.astm.org (herein referred to as "ASTM D975").
4. ASTM Standard D4806-21a, "Standard Specification for Denatured Fuel Ethanol for Blending with Gasolines for Use as Automotive Spark-Ignition Engine Fuel," published 2021, ASTM International, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959 or www.astm.org (herein referred to as "ASTM D4806").
5. ASTM Standard D4814-21c, "Standard Specification for Automotive Spark-Ignition Engine Fuel," published 2021, ASTM International, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959 or www.astm.org (herein referred to as "ASTM D4814").
6. Waiver Requests under Section 211(f) of the Clean Air Act, (Document EPA-420-B-19-054, October 2019 edition), United States Environmental Protection Agency, Transportation and Regional Programs Division, Fuels Program Support Group, Mail Code 6406-J, Washington, D.C. 20460 (herein referred to as "Section 211(f) of the Clean Air Act").
7. ASTM Standard D5798-21, "Standard Specification for Ethanol Fuel Blends for Flexible-Fuel Automotive Spark-Ignition Engines," published 2021, ASTM International, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959 or www.astm.org (herein referred to as "ASTM D5798").
8. ASTM Standard D6751-20a, "Standard Specification for Biodiesel Fuel Blend Stock (B100) for Middle Distillate Fuels," published 2020, ASTM International, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959 or www.astm.org (herein referred to as "ASTM D6751").
9. ASTM Standard D7862-21, "Standard Specification for Butanol for Blending with Gasoline for Use as Automotive Spark-Ignition Engine Fuel," published 2021, ASTM International, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959 or www.astm.org (herein referred to as "ASTM D7862").
10. California Air Resources Board, "California Procedures for Evaluating Alternative Specifications for Phase 2 Reformulated Gasoline Using the California Predictive Model," adopted April 20, 1995. A copy may be obtained at: CARB, P.O. Box 2815, Sacramento, CA 95812 or www.arb.ca.gov (herein referred to as "PM" or "Predictive Model Procedures").
11. The Federal Complex Model contained in 40 CFR 80.45, January 1, 1999. A copy may be obtained at: Government Publishing Office, 732 North Capitol Street, NW, Washington, D.C. 20401-0001 or bookstore.gpo.gov (herein referred to as "Federal Complex Model").
12. California Air Resources Board, The California Reformulated Gasoline Regulations, Title 13, California Code of Regulations, Section 2266.5 (Requirements Pertaining to California Reformulated Gasoline Blendstock for Oxygen Blending (CARBOB) and Downstream Blending), as of April 9, 2005. A copy may be obtained at: CARB, P.O. Box 2815, Sacramento, CA 95812 or www.arb.ca.gov.
13. California Air Resources Board, Procedures for Using the California Model for California Reformulated Gasoline Blendstocks for Oxygenate Blending (CARBOB), adopted April 25, 2001. A copy may be obtained at: CARB, P.O. Box 2815, Sacramento, CA 95812 or www.arb.ca.gov.
14. ASTM Standard D7467-20a, "Standard Specification for Diesel Fuel Oil, Biodiesel Blend (B6 to B20)," published 2020, ASTM International, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959 or www.astm.org (herein referred to as "ASTM D7467").
15. SAE International, SAE J285, "Dispenser Nozzle Spouts for Liquid Fuels Intended for Use with Spark Ignition and Compression Ignition Engines," published April 2019, SAE International, 400 Commonwealth Drive, Warrendale, PA 15096 or www.sae.org (herein referred to as "SAE J285").
16. ASTM Standard D4057-19, "Standard Practice for Manual Sampling of Petroleum and Petroleum Products,"

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published 2019, ASTM International, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959 or www.astm.org (herein referred to as "ASTM D4057").

17. NIST Handbook 158, Field Sampling Procedures for Fuel and Motor Oil Quality Testing, Government Publishing Office, P.O. Box 979050, St. Louis, MO 63197-9000 or bookstore.gpo.gov (April 2016), incorporated by reference and on file with the Division (herein referred to as "Handbook 158"). This incorporation by reference contains no future editions or amendments.
18. ASTM Standard D2699-21, "Standard Test Method for Research Octane Number of Spark-Ignition Engine Fuel," published 2021, ASTM International, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959 or www.astm.org (herein referred to as "ASTM D2699").
19. ASTM Standard D2700-22, "Standard Test Method for Motor Octane Number of Spark-Ignition Engine Fuel," published 2022, ASTM International, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959 or www.astm.org (herein referred to as "ASTM D2700").
20. ASTM Standard D7717-11(Reapproved 2021), "Standard Practice for Preparing Volumetric Blends of Denatured Fuel Ethanol and Gasoline Blendstocks for Laboratory Analysis," published 2021, ASTM International, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959 or www.astm.org (herein referred to as "ASTM D7717").
21. American Petroleum Institute (API) Manual of Petroleum Measurement Standards, Chapters 3.1A (Third Edition, August 2013, Reaffirmed December 2018) and 3.1B (Fourth Edition, October 2021), American Petroleum Institute, 1220 L St., N.W., Washington, D.C. 20005-4070 (herein referred to as "API Manual of Petroleum Measurement Standards").

Historical Note

New Section R3-7-702 recodified from Section R20-2-702 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2666, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-703. Return of Motor Fuels Collected During Volumetric Inspection

After completing an inspection, and if made possible by the motor fuel dispensing site owner or operator, the Division shall return all motor fuel collected during the volumetric inspection of motor fuel dispensers to the location where the inspection occurred.

Historical Note

New Section R3-7-703 recodified from Section R20-2-703 at 22 A.A.R. 2786, effective August 15, 2016 (Supp.

16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-704. Motor Fuel Dispensing Site Price and Grade Posting

- A. Any roadside or other sign, including, but not limited to, prices on poles, monument signs, canopies, 'A-frame' signs, or other structures, that advertises or displays motor fuel prices and is not connected to a motor fuel dispenser shall comply with subsections (1) through (4), and shall comply with either method listed in subsections (5) and (6):
 1. Display the self-service and full-service prices, if different;
 2. Display the unit of measure of the price if other than per gallon;
 3. Display fractions of a cent, if the fuel price is not charged at a whole cent; and
 4. Display a decimal point when a dollar sign precedes the posted price.
 5. Display the undiscounted price for any motor fuel product and applicable grade advertised; or
 6. Display the discounted price for any motor fuel product and applicable grade advertised along with the conditions under which the discount is available, including, but not limited to, "Cash", "Cash Only", or "Membership."
 - a. Any discount conditions must be clearly presented on a sign in a font no less than 1/5 the size of the largest number posted on the sign or 2 1/2 inches, whichever is larger, and may not be abbreviated.
 - b. The discount conditions must appear immediately next to, above or below the discounted price and with equal illumination as the discounted price.
- B. All motor fuel prices displayed must include all applicable federal and state taxes.
- C. Motor fuel Descriptions. Motor fuel types, grades, and blends shall be described on signs listed in subsection (A) as indicated in Table 1. Motor Fuel Descriptions.
- D. A person may use an alternative to the descriptions provided in Table 1 upon receipt of written approval by the associate director.

Historical Note

New Section R3-7-704, including Table, Antiknock Index, recodified from Section R20-2-704 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

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Table 1. Motor Fuel Descriptions

Motor Fuel Type	ASTM Standard	Fuel Properties	Allowable Description
Diesel	D975	Min. flash point 38° C Min. viscosity 1.3 mm2/S, max. 2.4 mm2/S	No. 1 Diesel, #1 Diesel, Diesel No. 1, or Diesel #1
		Min. flash point 52° C Min. viscosity 1.9 mm2/S, max. 4.1 mm2/S	No. 2 Diesel, #2 Diesel, Diesel No. 2, Diesel #2, or Diesel
	D975 or D7467	Meets definition of Premium Diesel in R3-7-101	Premium Diesel
	D7467	More than 5 and no more than 20 volume percent biodiesel	Biodiesel Blend or B-20 Biodiesel Blend
Ethanol Flex Fuel	D5798	51-83 volume percent ethanol	Ethanol Flex Fuel
Gasoline	D4814	Minimum 87 octane	Regular, Reg, Unleaded, UNL, or UL
		Minimum 89 octane	Midgrade, Mid, or Plus
		Minimum 91 octane	Premium, Prem, Super, Supreme, High, or High Performance
		Contains more than 10 but no more than 15 volume percent ethanol	E15

Historical Note

New Table 1 made by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-705. Dispenser Labeling at Motor Fuel Dispensing Sites

A. The owner or operator of a motor fuel dispensing site shall label dispensers in accordance with pricing, motor fuel grade, octane rating, and lead substitute. A motor fuel dispensing station owner or operator shall ensure that information regarding pricing, motor fuel grade, octane rating, and lead-substitute addition displayed on a motor fuel dispenser:

1. Displays the highest price of each grade of motor fuel sold from the dispenser prior to any deliberate action of the customer resulting in a discounted price being displayed, provided the dispenser is capable of dispensing and computing the price of motor fuel at more than one price;
2. Displays a sign or label explaining the terms or conditions of any discounted price available to the consumer including whether the price differs based on method of payment or is conditional based on the sale of another product or service;
3. Complies with the requirements of R3-7-704(A)(3) through (A)(6) and (B);
4. Complies with the allowable fuel descriptions indicated in the table in R3-7-704(C);
5. Displays the octane rating of each grade of gasoline; and
6. Displays the legend required by Handbook 130 for motor fuel dispensers that dispense gasoline with lead substitute. The legend shall be presented in block letters on a sharply contrasting background with lettering no smaller than 1/4 inch in height.

B. Motor fuel dispensers that are used exclusively for fleet sales and other price contract sales are exempt from the requirements in subsections (A)(1) and (2).

C. All motor fuels shall meet the labeling requirements of 16 CFR 306. Additionally, the following requirements apply:

1. Gasoline containing ethanol.
 - a. Gasoline containing greater than 1.5% by weight oxygen or 4.3% by volume ethanol shall be labeled with the following statement to indicate the maximum percent by volume of ethanol contained in the gasoline: "May contain up to ____% ethanol."

b. Gasoline for sale with an ethanol content greater than 10 volume percent and less than or equal to 15 volume percent shall additionally be labeled in accordance with 40 CFR 1090.1510, as it existed on December 4, 2020, and is incorporated by reference and on file with the Division. A copy may be obtained at the Government Publishing Office, P.O. Box 979050, St. Louis, MO 63197-9000 or bookstore.gpo.gov.

2. Gasoline containing an oxygenate other than ethanol. Gasoline containing greater than 1.5% by weight of an oxygenate other than ethanol shall be labeled with the following statement to indicate the type and maximum percent by volume of oxygenate contained in the gasoline: "May contain up to ____% ____."
3. The label in subsection (C)(1)(a) shall be printed in block letters on a sharply contrasting background with lettering no smaller than 1/4 inch in height.

D. Unattended retail motor fuel dispensers. In addition to all labeling and sign requirements in this Article, the owner or operator of a motor fuel dispensing site that is unstaffed shall post a sign or label at the motor fuel dispensing site, in public view, that conspicuously lists the owner's or operator's name, address, and telephone number.

E. Motor fuel dispensers shall display a decal that contains the Division's name and telephone number. A template of the decal shall be placed on the Weights and Measures Services Division website for use by retailers. The seal placed by the Division under A.R.S. § 3-3414(A)(13) satisfies this requirement.

F. All labels and information required under this Section to be posted on a motor fuel dispenser shall be displayed on the upper 50% of the front panel of each motor fuel dispenser and shall be clean, legible, and visible at all times.

Historical Note

New Section R3-7-705 recodified from Section R20-2-705 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final

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rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-706. Repealed**Historical Note**

New Section R3-7-706 recodified from Section R20-2-706 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Repealed by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3).

R3-7-707. Product Transfer Documentation and Record Retention for Motor Fuel other than Arizona CBG and AZRBOB

- A. When a transferor transfers custody or title to a motor fuel that is not Arizona CBG or AZRBOB, and the motor fuel is not sold or dispensed at a motor fuel dispensing site or fleet vehicle fueling facility, the transferor shall provide to the transferee documents that include the following information:
1. The grade of the motor fuel;
 2. The volume of each grade of motor fuel being transferred;
 3. The date of the transfer;
 4. The product transfer document number;
 5. For conventional gasoline:
 - a. The minimum automotive fuel rating of each grade as prescribed by 16 CFR 306;
 - b. A legible and conspicuous statement that the gasoline being transferred contains an oxygenate and lists the type and percentage concentration of the oxygenate by volume; and
 - c. If transported in or through the CBG-covered area, the statement, "This gasoline is not intended for use inside the CBG-covered area";
 6. If a lead substitute is present in the gasoline, the type of lead substitute present;
 7. The following information regarding biofuel or biofuel blends:
 - a. Ethanol flex fuel shall contain a declaration of the volume percent of ethanol in the blend; or
 - b. Biodiesel and biomass-based diesel blends containing more than 5% biodiesel or biomass-based diesel shall contain a declaration of the volume percent biodiesel or biomass-based diesel in the blend, as well as the grade of diesel in the blend; and
 - c. All other biofuel or biofuel blends shall contain the percentage of biofuel in the finished product; and
 8. The final destination, as follows:
 - a. When a terminal is the transferor, the owner or operator of the terminal shall include on the product transfer document the terminal name and address and the transporter name and address;
 - b. When a transporter is the transferor, the transporter shall include on the product transfer document the name and address of the transporter and the final destination, which is the location at which the motor fuel will be delivered and off loaded from the truck; and
 - c. When a jobber or marketer is the transferor, the jobber or marketer shall include on the product transfer document the name and address of the jobber or marketer and the final destination, which may be a final distribution facility or a motor fuel dispensing site.

- B. To enable a transferor to comply fully with the requirement in subsection (A)(8)(b) and (c), the transferee shall provide to the transferor information regarding the final destination.
- C. A registered supplier, oxygenate blender, third-party terminal, or pipeline may use standardized product codes on pipeline tickets as the product transfer documentation.
- D. A transferor identified in subsection (A) shall retain product transfer documentation for each delivered shipment for 12 months. For 30 days following the transfer, such documentation shall be kept at the transferor's address listed on the product transfer documentation.
- E. An owner or operator of a motor fuel dispensing site or fleet owner shall keep, available for Division review, product transfer documentation for the three most recent deliveries of each grade of motor fuel at the motor fuel dispensing site.
- F. A person transferring custody or title of Arizona CBG or AZRBOB shall comply with R3-7-757.
- G. Upon request by the Division, a person shall present product transfer documents to the Division within two business days. Legible photocopies or electronic copies of the product transfer documents are acceptable.

Historical Note

New Section R3-7-707 recodified from Section R20-2-707 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-708. Gasoline Oxygenate Blends

- A. A person that has custody of gasoline blended with an oxygenate shall ensure that the amount of oxygenate does not exceed the amount allowed by EPA waivers, Section 211(f) of the Clean Air Act, and meets the requirements of A.R.S. §§ 3-3491, 3-3492, and 3-3495.
- B. Fuel ethanol specifications. A person that uses fuel ethanol as a blending component with conventional gasoline, conventional gasoline blendstocks, ethanol flex fuel, AZRBOB, or Arizona CBG shall ensure that the fuel ethanol meets the following requirements:
1. A sulfur content not exceeding 10 ppm by weight;
 2. The fuel ethanol must be composed solely of carbon, hydrogen, nitrogen, oxygen, and sulfur;
 3. Only gasoline previously certified under 40 CFR Part 1090, Subpart C, (including previously certified blendstocks for oxygenate blending), gasoline blendstocks, natural gas liquids, or certified ethanol denaturant that meets the requirements in 40 CFR § 1090.275 may be used as denaturants; and
 4. The concentration of all denaturants is limited to a maximum of 3.0 volume percent.
- C. For oxygenates other than ethanol, the oxygenate shall meet the applicable ASTM standard for the oxygenate, and the finished blend shall meet ASTM D4814.
- D. Special provisions for gasoline-ethanol blends.
1. Gasoline-ethanol blends shall meet ASTM D4814, except as provided in subsection (D)(2) or (D)(3).
 2. The maximum vapor pressure for gasoline blended with fuel ethanol may exceed the vapor pressure requirements outlined in ASTM D4814 by no more than 1.0 psi (referred to as the 1.0 psi waiver) for the following gasoline-ethanol blends:
 - a. Outside of the CBG-covered area if the concentration of ethanol, excluding the required denaturing

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agent, is at least 9% by volume and no more than the maximum concentration of ethanol that is allowed for the 1.0 psi waiver to apply under federal law;

- b. In area B from October 1 through March 31 if the concentration of ethanol, excluding the required denaturing agent, is at least 6% by volume and no more than 15% by volume.

- c. Inside the CBG-covered area during April only.

- 3. Gasoline blended with no more than 15% by volume of ethanol shall be blended using one of the following alternatives:

- a. The base gasoline complies with the standards in ASTM D4814, the fuel ethanol complies with the standards in ASTM D4806, and the finished blend complies with the standards in ASTM D4814 with the following permissible exceptions:

- i. The distillation minimum temperature at the 50 volume percent evaporated point is not less than 66°C (150°F), and
- ii. The minimum test temperature at which the vapor/liquid ratio is equal to 20 is waived; or

- b. The finished blend complies with the standards in ASTM D4814.

- E. Ethanol flex fuel sold or offered for sale within the CBG-covered area shall:

- 1. Use fuel ethanol that meets the standards in this Chapter, and
- 2. Have a maximum vapor pressure that does not exceed the maximum vapor pressure requirements in R3-7-751(A)(6).

- F. E15 sold or offered for sale within the CBG-covered area shall:

- 1. Use fuel ethanol that meets the standards in this Chapter, and
- 2. Be blended with ethanol flex fuel that meets the requirements of subsection (E), or
- 3. Be blended with Arizona CBG or AZRBOB.

Historical Note

New Section R3-7-708 recodified from Section R20-2-708 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2666, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-709. Repealed**Historical Note**

New Section R3-7-709 recodified from Section R20-2-709 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Repealed by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3).

R3-7-710. Oxygenate Blending Requirements

- A. A person that has custody of or transports an oxygenated gasoline blend shall ensure that no neat oxygenate blending occurs in a retail storage tank at a motor fuel dispensing site or fleet vehicle fueling facility.
- B. If a motor fuel dispensing site storage tank contains an oxygenated gasoline blend that does not contain the amount of oxygen required by A.R.S. §§ 3-3491, 3-3492, 3-3495, or R3-7-751, the owner or operator of the motor fuel dispensing site shall do one of the following:

- 1. Add a gasoline blend that dilutes the non-compliant oxygenated gasoline blend to the level of oxygen content required by A.R.S. §§ 3-3491, 3-3492, 3-3495, or R3-7-751;
- 2. Empty the storage tank and replace the non-compliant oxygenated gasoline blend with a required oxygenate blend;
- 3. Upon written permission of the associate director, add gasoline that contains no more than 20% by volume of the same oxygenate to the non-compliant oxygenated gasoline blend.

Historical Note

New Section R3-7-710 recodified from Section R20-2-710 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-711. Gasoline-Alcohol Blend Storage Tank Requirements

- A. Before a person adds the initial gasoline-alcohol blend into a storage tank, the person shall:

- 1. Test the storage tank for the presence of water and, if any water is detected, remove the water from the storage tank; and
- 2. Install a fuel filter designed for use with gasoline-alcohol blends in the fuel line of all motor fuel dispensers that dispense gasoline-alcohol blends.

- B. If water is detected in a storage tank containing a gasoline-alcohol blend, the owner or operator shall empty the storage tank.

Historical Note

New Section R3-7-711 recodified from Section R20-2-711 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3).

R3-7-712. Water in Motor Fuel Dispensing Site Storage Tanks

A motor fuel dispensing site owner or operator shall ensure that water in a motor fuel storage tank containing a product other than a gasoline-alcohol blend, does not exceed 1" in depth when measured from the bottom of the tank through the fill pipe. The owner or operator shall remove all water from the tank before delivery or sale of motor fuel from that tank.

Historical Note

New Section R3-7-712 recodified from Section R20-2-712 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-713. Motor Fuel Storage Tank Labeling

- A. An owner or operator of a motor fuel dispensing site shall ensure that all motor fuel storage tank fill pipes and gasoline vapor return lines located at the motor fuel dispensing site are labeled to identify the contents accurately as:

- 1. Unleaded gasoline;
- 2. Unleaded midgrade gasoline;
- 3. Unleaded premium gasoline;
- 4. No. 1 diesel or #1 diesel;
- 5. No. 2 diesel, #2 diesel, or diesel;

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6. Premium diesel;
 7. Gasoline vapor return, gasoline vapor recovery, or vapor recovery;
 8. Biodiesel or biodiesel blend, for blends containing more than 5% biodiesel by volume; or
 9. Ethanol flex fuel.
- B.** For gasoline-ethanol blends containing more than 10 but no more than 15 volume percent ethanol, storage tank labels shall describe the gasoline grade as specified in subsections (A)(1), (A)(2), and (A)(3), along with the designation "E15".
- C.** Any motor fuel not specified in subsection (A) shall be labeled at the storage tank fill pipe as designated on the product transfer document.
- D.** An owner or operator of a motor fuel dispensing site shall ensure that the label required under subsection (A) is at least 1 1/2 inches by 5 inches in size with block letters on a sharply contrasting background, and with lettering no smaller than 1/4 inch in height. The label shall be clean, legible, and visible at all times.
- E.** An owner or operator of a motor fuel dispensing site may display other information on the reverse side of a two-sided label.
- F.** An owner or operator of a motor fuel dispensing site shall not put motor fuel into a storage tank without attaching the proper label as specified in this Section.
- G.** A person shall not deliver motor fuel to a motor fuel dispensing site unless the product transfer documents confirm the motor fuel is the correct type as indicated on the tank fill pipes labeled under subsection (A) or (B) or the product being delivered meets or exceeds the standards of the labeled product.
- H.** If tank fill pipe and vapor recovery manhole covers are color-coded, the color coding shall comply with API 1637.

Historical Note

New Section R3-7-713 recodified from Section R20-2-713 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-714. Repealed**Historical Note**

New Section R3-7-714 recodified from Section R20-2-714 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-715. Motor Fuel Standards and Testing Methods

- A.** Unless otherwise stated in this A.R.S. Title 3, Chapter 19, or this Chapter, all motor fuel sold or offered for sale, and oxygenates blended with motor fuel, shall meet the applicable standards incorporated by reference in R3-7-702(3), (4), (5), (7), (8), (9), (14), (18), and (19).
- B.** October 1 through March 31 of each year, gasoline shall meet the requirements in A.R.S. § 3-3433(E).
- C.** Unless otherwise required in A.R.S. Title 3, Chapter 19, or this Chapter, the producer of a motor fuel shall test and certify the motor fuel for its motor fuel properties using the methodology-standards incorporated by reference in R3-7-702(3), (4), (5), (7), (8), (9), (14), (18), and (19).
- D.** The automotive fuel rating of a motor fuel shall be determined and certified in accordance with 16 CFR 306.

Historical Note

New Section R3-7-715 recodified from Section R20-2-715 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-716. Sampling and Access to Records

- A.** The Division shall obtain motor fuel samples for testing from:
1. The same motor fuel dispenser used for sales to customers;
 2. The same motor fuel dispenser used for dispensing motor fuel into fleet vehicles;
 3. A bulk storage facility;
 4. A pipeline having custody of motor fuel, including Arizona CBG or AZRBOB;
 5. A transporter of motor fuel, including Arizona CBG or AZRBOB;
 6. A final distribution facility;
 7. A third-party terminal having custody of motor fuel, including Arizona CBG or AZRBOB;
 8. An oxygenate blender or registered supplier; or
 9. A transmix or production facility.
- B.** Unless otherwise specified in this Chapter, an owner or operator of a motor fuel dispensing site, pipeline, third-party terminal, or storage, transmix, production, or distribution facility, or a transporter, registered supplier, or oxygenate blender shall maintain for five years records relating to producing, importing, blending, transporting, distributing, delivering, testing, or storing motor fuels, including Arizona CBG or AZRBOB, and, upon Division request, shall make the records available within 15 days for Division inspection.

Historical Note

New Section R3-7-716 recodified from Section R20-2-716 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-717. Motor Fuel Dispensing Site Equipment

- A.** Hold-open latch. If an owner or operator of a motor fuel dispensing site operates a motor fuel dispenser that utilizes a nozzle equipped with a hold-open latch, the owner or operator shall ensure that the latch operates according to the manufacturer's specifications.
- B.** Nozzle requirements for diesel fuel. An owner or operator of a motor fuel dispensing site operating a motor fuel dispenser from which diesel fuel is sold at retail shall ensure that the dispenser utilizes a diesel nozzle with a spout diameter that conforms to SAE J285.
- C.** Motor fuel dispenser filters. An owner or operator of a motor fuel dispensing site shall ensure that:
1. All gasoline, gasoline-alcohol blends, and ethanol flex fuel dispensers have a 10 micron or smaller nominal pore-sized filter;
 2. Dispensers that dispense gasoline-alcohol blends shall have fuel filters designed for use with gasoline-alcohol blends;
 3. All biodiesel, biodiesel blends, diesel, and kerosene dispensers have a 30 micron or smaller nominal pore-sized filter; or
 4. In the event a motor fuel dispenser is not manufactured to be equipped to use fuel filters, they shall be installed in

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line with the fuel dispensing hose at the base of the dispenser. If this is not feasible, the motor fuel dispensing site owner may provide evidence that fuel filters cannot be installed at the site due to the configuration and apply for a waiver from these requirements from the associate director.

- D. All retail diesel fuel dispensers and ethanol flex fuel dispensers shall be equipped with nozzles that meet the grip guard color requirements in § 3-3436(B). No other nozzles shall be equipped with these color grip guards.
- E. Motor fuel dispensers shall meet appropriate Underwriters Laboratories ratings and be compatible with the motor fuel being dispensed.

Historical Note

New Section R3-7-717 recodified from Section R20-2-717 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-718. Additional Requirements for Production, Transport, Distribution, and Sale of Biofuels and Biofuel Blends

- A. Biofuel blenders, biofuel producers, and biofuel suppliers of biofuels or biofuel blends in Arizona shall meet the following requirements:

1. Register with the Environmental Protection Agency under 40 CFR 80.1450 or 40 CFR 1090, subpart I, as they existed on December 4, 2020.
2. Upon request by the associate director, report the total volume of biofuel or biofuel blends produced or supplied for the previous calendar year, including the total volume of each blend component. The report shall be provided to the Division within 15 days of the request. Any information reported to the Division shall remain confidential under A.R.S. § 44-1374.

- B. Quality Assurance and Quality Control ("QA/QC") program requirements.

1. A biofuel producer or biofuel blender shall implement a QA/QC program to ensure the quality of a biofuel or biofuel blend produced in or supplied in or into Arizona;
2. The QA/QC program implemented by a biofuel producer shall include the following minimum requirements:
 - a. A sampling and testing program to certify that the biofuel meets applicable ASTM requirements that apply to the biofuel produced. All samples shall be collected in accordance with ASTM sampling methods following the addition of any applicable blend components. The plan shall include a policy for sample retention;
 - b. A Certificate of Analysis with a unique identification number generated for each batch produced and indicated on the product transfer document;
 - c. The Certificate of Analysis required under subsection (B)(2)(b) and any other supporting sampling and testing documentation required under this Section is made available to the Division within 24 hours of a request; and
 - d. Any storage tank containing biofuel that is inactive for more than 30 days is resampled and analyzed to verify the fuel meets ASTM standards.
3. The QA/QC program implemented by a biofuel blender shall include the following minimum requirements:
 - a. Retention of:

- i. Documentation that demonstrates the applicable biofuel blend components were received from a facility registered with the EPA under 40 CFR 80.1450 or 40 CFR 1090, subpart I;
- ii. Certificates of Analysis for the biofuel used as a blend component in the blending process; and
- iii. Documentation such as a product transfer document that demonstrates the diesel fuel used in the blending process meets the requirements of ASTM D975;

- b. For biodiesel blending, all diesel fuel used as a blend component is analyzed to verify the biodiesel content before blending if the initial volume percent of biodiesel content in the diesel fuel component is unknown; alternatively, for biodiesel blends blended at a motor fuel dispensing site, the biofuel blender may assume the diesel contains 5% biodiesel and prepare and maintain calculations demonstrating the biodiesel content of the final biodiesel blend if it is advertised to consumers as a biodiesel blend containing more than 5 and no more than 20 volume percent biodiesel and the calculations demonstrate the biodiesel blend will be compliant with the biodiesel content advertised;
- c. Any storage tank containing biofuel that is inactive for more than 30 days is resampled and analyzed to verify the fuel meets ASTM standards; and
- d. All biodiesel used as a blend component in biodiesel blends consists of at least 99% biodiesel unless approved by the Division.

4. All records required under this subsection are maintained either onsite or at an offsite location for at least five years and made available to the Division upon request.
5. In the event the Division identifies biofuel or biofuel blends that do not meet ASTM standards, the producer or biofuel blender shall evaluate the QA/QC program and make any additional changes that may be required to bring the fuel into compliance.

C. Exemptions

1. A producer, supplier, or blender of diesel fuel containing 5% by volume or less biodiesel is exempt from this Section if the following conditions are met:
 - a. The diesel fuel meets the standards of ASTM D975; and
 - b. If the initial volume percent of biodiesel content is unknown, the person blending the biodiesel into diesel fuel analyzes the diesel fuel to verify the initial biodiesel content and ensure the resulting blend meets the requirements in ASTM D975.
2. A biofuel producer, biofuel supplier, or biofuel blender who produces, supplies, or blends diesel fuel blended with a biomass-based diesel where the resulting fuel meets the requirements in ASTM D975 is exempt from this Section.
3. Gasoline containing up to 15% ethanol is exempt from this Section.

Historical Note

New Section R3-7-718 recodified from Section R20-2-718 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final

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rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-719. Repealed**Historical Note**

Repealed Section R3-7-719 recodified from repealed Section R20-2-719 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-720. Renumbered**Historical Note**

Renumbered Section R3-7-720 recodified from renumbered Section R20-2-720 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-721. Renumbered**Historical Note**

Renumbered Section R3-7-721 recodified from renumbered Section R20-2-721 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-722. Reserved**Historical Note**

Reserved Section R3-7-722 recodified from reserved Section R20-2-722 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-723. Reserved**Historical Note**

Reserved Section R3-7-723 recodified from reserved Section R20-2-723 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-724. Reserved**Historical Note**

Reserved Section R3-7-724 recodified from reserved Section R20-2-724 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-725. Reserved**Historical Note**

Reserved Section R3-7-725 recodified from reserved Section R20-2-725 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-726. Reserved**Historical Note**

Reserved Section R3-7-726 recodified from reserved Section R20-2-726 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-727. Reserved**Historical Note**

Reserved Section R3-7-727 recodified from reserved Section R20-2-727 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-728. Reserved**Historical Note**

Reserved Section R3-7-728 recodified from reserved Section R20-2-728 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-729. Reserved**Historical Note**

Reserved Section R3-7-729 recodified from reserved Section R20-2-729 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-730. Reserved**Historical Note**

Reserved Section R3-7-730 recodified from reserved Section R20-2-730 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-731. Reserved**Historical Note**

Reserved Section R3-7-731 recodified from reserved Section R20-2-731 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-732. Reserved**Historical Note**

Reserved Section R3-7-732 recodified from reserved Section R20-2-732 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-733. Reserved**Historical Note**

Reserved Section R3-7-733 recodified from reserved Section R20-2-733 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-734. Reserved**Historical Note**

Reserved Section R3-7-734 recodified from reserved Section R20-2-734 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-735. Reserved**Historical Note**

Reserved Section R3-7-735 recodified from reserved Section R20-2-735 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-736. Reserved**Historical Note**

Reserved Section R3-7-736 recodified from reserved Section R20-2-736 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-737. Reserved**Historical Note**

Reserved Section R3-7-737 recodified from reserved Section R20-2-737 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-738. Reserved**Historical Note**

Reserved Section R3-7-738 recodified from reserved Section R20-2-738 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-739. Reserved

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Historical Note

Reserved Section R3-7-739 recodified from reserved Section R20-2-739 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-740. Reserved**Historical Note**

Reserved Section R3-7-740 recodified from reserved Section R20-2-740 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-741. Reserved**Historical Note**

Reserved Section R3-7-741 recodified from reserved Section R20-2-741 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-742. Reserved**Historical Note**

Reserved Section R3-7-742 recodified from reserved Section R20-2-742 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-743. Reserved**Historical Note**

Reserved Section R3-7-743 recodified from reserved Section R20-2-743 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-744. Reserved**Historical Note**

Reserved Section R3-7-744 recodified from reserved Section R20-2-744 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-745. Reserved**Historical Note**

Reserved Section R3-7-745 recodified from reserved Section R20-2-745 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-746. Reserved**Historical Note**

Reserved Section R3-7-746 recodified from reserved Section R20-2-746 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-747. Reserved**Historical Note**

Reserved Section R3-7-747 recodified from reserved Section R20-2-747 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-748. Reserved**Historical Note**

Reserved Section R3-7-748 recodified from reserved Section R20-2-748 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-749. Definitions Applicable to Arizona CBG and AZRBOB

The following definitions apply only to R3-7-750 through R3-7-762:

1. "Designated alternative limit" means a fuel property specification, expressed in the nearest part per million by weight for sulfur content, nearest 10th percent by volume for aromatic hydrocarbon content, nearest 10th percent by volume for olefin content, and nearest degree Fahrenheit for T90 and T50, that is assigned by a registered supplier to a final blend of Type 2 Arizona CBG or AZRBOB for purposes of compliance with the Predictive Model Procedures, which are incorporated by reference in R3-7-702(10).
2. "Importer" means any person that assumes title or ownership of Arizona CBG or AZRBOB produced by an unregistered supplier.
3. "Oxygenate-blending facility" means any location (including, but not limited to, a truck) where an oxygenate or ethanol flex fuel is added to Arizona CBG or AZRBOB, and nothing further is added to the resulting Arizona CBG except for the addition of a deposit-control or similar additive registered under 40 CFR 79. An oxygenate-blending facility includes a facility that recertifies Arizona CBG under R3-7-755(F).
4. "Performance standard" means the VOC and NO_x emission reduction percentages in R3-7-751(A)(8) and R3-7-751(D)(1).
5. "PM alternative gasoline formulation" means a final blend of Arizona CBG or AZRBOB that is subject to a set of PM alternative specifications.
6. "PM alternative specifications" means the specifications for the following fuel properties, as determined using a testing methodology in R3-7-759:
 - a. Maximum vapor pressure, expressed in the nearest 100th of a pound per square inch;
 - b. Maximum sulfur content, expressed in the nearest part per million by weight;
 - c. Maximum olefin content, expressed in the nearest 10th of a percent by volume;
 - d. Minimum and maximum oxygen content, expressed in the nearest 10th of a percent by weight;
 - e. Maximum T50, expressed in the nearest degree Fahrenheit;
 - f. Maximum T90, expressed in the nearest degree Fahrenheit; and
 - g. Maximum aromatic hydrocarbon content, expressed in the nearest 10th of a percent by volume.
7. "PM flat limit" means a PM alternative specification that is subject to the PM flat limit compliance option.
8. "PM flat limit compliance option" means, with reference to a specific fuel property, the compliance option that each gallon of gasoline must meet for that specified fuel property as contained in the PM alternative specifications.
9. "Produce" means:
 - a. Except as otherwise provided, to convert a liquid compound that is not Arizona CBG or AZRBOB into Arizona CBG or AZRBOB.
 - b. If a person blends a blendstock that is not Arizona CBG or AZRBOB with Arizona CBG or AZRBOB acquired from another person, and the resulting blend is Arizona CBG or AZRBOB, the person conducting the blending produces only the portion of the blend not previously Arizona CBG or AZRBOB. If a person blends Arizona CBG or AZRBOB with other Arizona CBG or AZRBOB in accordance with this Article, without the addition of a blendstock that

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- is not Arizona CBG or AZRBOB, that person is not a producer of Arizona CBG or AZRBOB.
- c. If a person supplies Arizona CBG or AZRBOB to a refiner that agrees in writing to further process the Arizona CBG or AZRBOB at the refiner's refinery and be treated as the producer of Arizona CBG or AZRBOB, the refiner is the producer of the Arizona CBG or AZRBOB.
 - d. If an oxygenate blender blends oxygenates or ethanol flex fuel into Arizona CBG or AZRBOB, and nothing further is added to the AZRBOB or the resulting Arizona CBG except for the addition of a deposit-control or similar additive, the producer or importer of the AZRBOB, rather than the oxygenate blender, is considered the producer or importer of the resulting Arizona CBG.
10. "Registered supplier" means a producer or importer that supplies Arizona CBG or AZRBOB and is registered with the associate director under R3-7-750.
 11. "Third-party terminal" means an owner or operator of a gasoline storage tank facility that accepts custody, but not ownership, of Arizona CBG or AZRBOB from a registered supplier, oxygenate blender, pipeline, or other third-party terminal and relinquishes custody of the Arizona CBG or AZRBOB to a transporter or other terminal.
 12. "Type 1 Arizona CBG" means a gasoline that meets the standards contained in R3-7-751(A) and R3-7-751(D)(1).
 13. "Type 2 Arizona CBG" means a gasoline that meets the standards contained in R3-7-751(D)(2), and meets the requirements in:
 - a. R3-7-751(A) beginning April 1 through October 31 of each year, and
 - b. R3-7-751(B) beginning November 1 through March 31 of each year.
 14. "Winter" means November 1 through March 31.

Historical Note

New Section R3-7-749 recodified from Section R20-2-749 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2666, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-750. Registration Relating to Arizona CBG or AZRBOB

- A. For each physical location, the following shall register with the associate director before producing, importing, or obtaining custody of Arizona CBG or AZRBOB:
 1. A refiner or CBG blender that produces Arizona CBG or AZRBOB;
 2. An importer that imports Arizona CBG or AZRBOB;
 3. An oxygenate blender that blends oxygenate with AZRBOB to produce Arizona CBG;
 4. An oxygenate blender that recertifies Arizona CBG under R3-7-755(F); or
 5. A pipeline or third-party terminal that has custody of Arizona CBG or AZRBOB.
- B. A person listed in subsection (A) shall register on a form prescribed by the associate director and include the following information:
 1. Business name, business address, and contact name or position title and telephone number;

2. The facility name, physical location, contact name or position title and telephone number, and type of facility;
 3. The location of the records required under this Article; and if records are kept off-site, the primary off-site storage facility name, physical location, and contact name or position title and telephone number; and
 4. If an independent laboratory is used to meet the requirements of R3-7-752(F), the name and address of the independent laboratory, and contact name or position title and telephone number;
 5. If required under 40 CFR § 1090.800, the EPA registration number; and
 6. A statement of consent permitting the Division or its authorized agent to collect samples and access records as provided in R3-7-716.
- C. A person registered under subsection (B) shall notify the associate director within 10 days after the effective date of a change in any of the information provided under subsection (B).
 - D. If a refiner, CBG blender, oxygenate blender, or importer fails to register under this Section, all Arizona CBG or AZRBOB, which is produced by the refiner, CBG blender, or oxygenate blender, or imported by the importer, and which is transported to the CBG-covered area, is presumed to be noncompliant from the date that registration should have occurred.
 - E. The Division shall maintain a list of all registered suppliers.

Historical Note

New Section R3-7-750 recodified from Section R20-2-750 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-751. Arizona CBG Requirements

- A. General fuel property and performance requirements. In addition to the other requirements of this Article and except as provided in subsection (B), all Arizona CBG shall meet the following requirements and for any fuel property not specified, shall meet the requirements in ASTM D4814. The dates in this Section are compliance dates for the owner or operator of a motor fuel dispensing site or a fleet vehicle fueling facility.
 1. Sulfur: 95 ppm by weight (max).
 2. Aromatics: 50% by volume (max).
 3. Olefins: 25% by volume (max).
 4. E200: 70-30% volume.
 5. E300: 100-70% volume.
 6. Maximum vapor pressure:
 - a. October: 9.0 psi.
 - b. November 1 - March 31: 9.0 psi.
 - c. April: 10.0 psi.
 - d. May: 9.0 psi.
 - e. June 1 - September 30: 7.0 psi.
 - f. A gasoline-ethanol blend in the CBG-covered area is subject to the 1 psi vapor pressure waiver, as described in R3-7-708(D)(2), during April only.
 7. Oxygen and oxygenates:
 - a. Minimum content:
 - i. November 1 - March 31: 10% ethanol by volume or 12.5% isobutanol by volume. If a petition under A.R.S. § 3-3493(C) is in effect: 2.7% oxygen by weight as approved by the associate director.

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- ii. April 1 - October 31: 0% by weight (any oxygenate).
 - b. The maximum oxygen content shall not exceed 5.8% by weight for ethanol and shall not exceed the amount allowed by EPA waivers under Section 211(f) of the Clean Air Act for other oxygenates. Additionally, the oxygen content shall comply with the requirements of A.R.S. § 3-3491 and § 3-3492.
 - c. Arizona CBG shall not contain more than 0.3 volume percent MTBE nor more than 0.1 weight percent oxygen from all other ethers or alcohols listed in A.R.S. § 3-3491.
- 8. Arizona CBG shall meet the Federal Complex Model VOC emissions reduction percentage May 1 through September 15: 27.5% (Federal Complex Model settings: Summer, Area Class B, Phase 2).
- B.** Winter requirements. In addition to the other requirements of this Article, the owner or operator of a motor fuel dispensing site or a fleet vehicle fueling facility shall ensure that beginning November 1 through March 31 of each year, all Arizona CBG meets the following fuel property requirements.
 - 1. Sulfur: 80 ppm by weight (max),
 - 2. Aromatics: 30% by volume (max),
 - 3. Olefins: 10% by volume (max),
 - 4. 90% Distillation Temp. (T90): 330° F (max),
 - 5. 50% Distillation Temp. (T50): 220° F (max),
 - 6. Vapor Pressure: 9.0 psi (max), and
 - 7. Oxygenate:
 - a. Minimum oxygenate content - 10% ethanol by volume or 12.5% isobutanol by volume;
 - b. Maximum oxygen content - 5.8% oxygen by weight, and shall comply with the requirements of A.R.S. § 3-3492; and
 - c. Alternative minimum ethanol or isobutanol content may be used if approved by the associate director under A.R.S. § 3-3493(C).
- C.** Certification as Type 1 Arizona CBG or Type 2 Arizona CBG. A registered supplier shall certify Arizona CBG or AZRBOB under R3-7-752, using the test methods specified in R3-7-759. Type 1 Arizona CBG or Type 2 Arizona CBG shall be certified with the addition of 10 volume percent ethanol or an oxygen content of 2.7% by weight for other oxygenates. A PM alternative gasoline formulation shall be certified with an oxygen content of 1.8 to 2.2% by weight as outlined in subsection (I).
- D.** In addition to the standards in subsections (A) and (B), Type 1 Arizona CBG and Type 2 Arizona CBG shall be certified meeting the following standards:
 - 1. Type 1 standards. For each fuel property, Type 1 Arizona CBG shall comply with the following per gallon standards, and shall be certified using the Federal Complex Model:
 - a. VOC Emission Reduction: 27.5% (min) May 1 through September 15.
 - b. NOx Emission Reduction: 5.5% (min) May 1 through September 15.
 - c. NOx Emission Reduction: 0.0% (min) September 16 through October 31 and February 1 through April 30.
 - 2. Type 2 standards. For each fuel property, Type 2 Arizona CBG shall comply with the following maximum per gallon standards or a PM alternative gasoline formulation:
 - a. Maximum per gallon standards.
 - i. Sulfur: 40 ppm by weight (max).
 - ii. Aromatics: 25.0% by volume (max).
 - iii. Olefins: 6.0% by volume (max).
 - iv. 90% distillation temperature (T90): 300 °F (max).
 - v. 50% distillation temperature (T50): 210 °F (max).
 - b. PM alternative gasoline formulation. The PM alternative gasoline formulation shall meet the requirements of subsections (G) through (I), and the per gallon standards in R3-7-751(A) beginning April 1 through October 31 of each year, and R3-7-751(B) beginning November 1 through March 31 of each year.
- E.** A registered supplier may produce Type 1 Arizona CBG from December 1 through March 31 but the registered supplier shall not distribute the Arizona CBG to a motor fuel dispensing site within the CBG-covered area before April 1. A registered supplier may produce and distribute Type 2 Arizona CBG year-round.
- F.** November 1 through March 31 of each year, a registered supplier shall ensure that all Arizona CBG or AZRBOB complies with Type 2 Arizona CBG requirements or the PM alternative gasoline formulation requirements.
- G.** Certification and use of the Predictive Model Procedures for PM alternative gasoline formulations.
 - 1. Except as provided in subsection (I), a registered supplier shall use the PM as provided in the Predictive Model Procedures.
 - 2. A registered supplier shall certify a PM alternative gasoline formulation with the associate director on a form prescribed by, or in a format acceptable to, the associate director, of:
 - a. The PM alternative specifications that apply to the final blend; and
 - b. The numerical values for percent change in emissions for oxides of nitrogen and hydrocarbons determined in accordance with the Predictive Model Procedures.
 - 3. A registered supplier shall deliver the certification required under subsection (G)(2) to the associate director within 3 business days of transporting the PM alternative gasoline formulation. The registered supplier shall have a written process that is followed to verify the PM alternative gasoline formulation meets the applicable PM alternative specifications prior to transport.
 - 4. If a registered supplier notifies the associate director under subsection (G)(3) that a final blend of Arizona CBG is sold or supplied from a production or import facility as a PM alternative gasoline formulation, all final blends of Arizona CBG or AZRBOB subsequently sold or supplied from that production or import facility are subject to the same PM alternative specifications until the registered supplier either:
 - a. Designates a final blend at that facility as a PM alternative gasoline formulation subject to different PM alternative specifications; or
 - b. Chooses to certify a final blend at that facility subject to a flat limit compliance option.
- H.** Prohibited activities regarding PM alternative gasoline formulations. A registered supplier shall not sell, offer for sale, supply, or offer to supply from the registered supplier's production or import facility Arizona CBG that is reported as a PM alternative gasoline formulation under R3-7-752 if any of the following occur:

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1. The PM alternative specifications do not meet the criteria for approval in the Predictive Model Procedures, or
 2. The gasoline fails to conform to any PM flat limit in the PM alternative specifications. A registered supplier may not use an average compliance option in the PM alternative specifications.
- I.** Oxygen content requirements for PM alternative gasoline formulations. A registered supplier shall ensure that from November 1 through March 31, all alternative PM gasoline formulations comply with oxygen content requirements for the CBG-covered area. Regardless of the oxygen content, a registered supplier shall certify the final alternative PM gasoline formulation using the PM with a minimum oxygen content of 1.8% by weight and a maximum oxygen content of 2.2% by weight. A registered supplier may use the CARBOB Model as a substitute for the preparation of a ethanol hand blend and use the fuel qualities calculated under the CARBOB Model for compliance and reporting purposes.
- J.** Rounding of values shall be conducted following 40 CFR 1090.50.

Historical Note

New Section R3-7-751 recodified from Section R20-2-751 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2666, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-751.01. Repealed**Historical Note**

Repealed Section R3-7-751.01 recodified from repealed Section R20-2-751.01 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-752. General Requirements for Registered Suppliers

- A.** A registered supplier shall certify that each batch of Arizona CBG or AZRBOB transported for sale or use in the CBG-covered area meets the standards in this Article.
- B.** A registered supplier shall make the certification on a form or in a format prescribed by the associate director. The registered supplier shall include in the certification information on shipment volumes, fuel properties as determined under R3-7-759, and performance standards for each batch of Arizona CBG or AZRBOB. The registered supplier shall submit the certification to the associate director on or before the 15th day of each month for each batch of Arizona CBG or AZRBOB transported during the previous month.
- C.** Recordkeeping and records retention.
1. A registered supplier that samples and analyzes a final blend or shipment of Arizona CBG or AZRBOB under this Section shall maintain, for five years from the date of each sampling, records of the following:
 - a. Sample date;
 - b. Identity of blend or product sampled;
 - c. Container or other vessel sampled;
 - d. The final blend or shipment volume; and
 - e. The test results for sulfur, aromatic hydrocarbon, olefin, oxygen, vapor pressure, and as applicable, T50, T90, E200, and E300 as determined under R3-7-759.
 2. If Arizona CBG or AZRBOB produced or imported by a registered supplier is not tested and documented as required by this Section, the associate director shall deem the Arizona CBG or AZRBOB to have a vapor pressure, sulfur, aromatic hydrocarbon, olefin, oxygen, T50, and T90 that exceeds the standards specified in R3-7-751 or the comparable PM limits, unless the registered supplier demonstrates to the associate director that the Arizona CBG or AZRBOB meets all applicable fuel property limits and performance standards.
- 3.** A registered supplier shall provide to the associate director any records maintained by the registered supplier under this Section within 15 days of a written request from the associate director. If a registered supplier fails to provide records for a blend or shipment of Arizona CBG or AZRBOB, the associate director shall deem the final blend or shipment of Arizona CBG or AZRBOB in violation of R3-7-751, unless the registered supplier demonstrates to the associate director that the Arizona CBG or AZRBOB meets all applicable fuel property limits and performance standards.
- D.** Notification requirement. A registered supplier shall notify the associate director by email before transporting Arizona CBG or AZRBOB into the CBG-covered area by a means other than a pipeline.
- E.** Quality Assurance and Quality Control ("QA/QC") Program. A registered supplier shall develop a QA/QC program to demonstrate the accuracy and effectiveness of the registered supplier's laboratory testing of Arizona CBG or AZRBOB. The registered supplier shall submit the QA/QC program to the associate director for approval at least three months before the registered supplier transports Arizona CBG or AZRBOB. The associate director shall approve a QA/QC program only if the associate director determines that the QA/QC program ensures that the registered supplier's laboratory testing procedures comply with R3-7-759 and the data generated by the registered supplier's laboratory are complete, accurate, and reproducible. If the registered supplier makes significant changes to the QA/QC program, the registered supplier shall resubmit the QA/QC program to the associate director for review and approval. Within 30 days of receiving the changed QA/QC program, the associate director shall determine whether the changed QA/QC program meets the original quality objectives. The associate director shall approve the changed QA/QC program if it meets the quality objectives. Instead of developing a QA/QC program, a registered supplier may comply with the independent testing requirements of subsection (F).
- F.** Independent testing.
1. A registered supplier of Arizona CBG or AZRBOB that does not develop a QA/QC program shall conduct a program of independent sample collection and analysis for the Arizona CBG or AZRBOB produced or imported, that complies with one of the following:
 - a. Option 1. A registered supplier shall, for each batch of Arizona CBG or AZRBOB produced or imported, have an independent laboratory collect and analyze a representative sample from the batch using the methodology specified in R3-7-759 for compliance with each fuel property and performance standard for which the Arizona CBG or AZRBOB is certified.
 - b. Option 2. A registered supplier shall have an independent testing program for all Arizona CBG or AZRBOB that the registered supplier produces or imports that consists of the following:

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- i. An independent laboratory shall collect a representative sample from each batch;
 - ii. The associate director or designee shall identify up to 10% of the samples collected under subsection (F)(1)(b)(i) for analysis; and
 - iii. The independent laboratory shall, for each sample identified by the associate director or designee, analyze the sample using the methodology specified in R3-7-759 for compliance with each fuel property and performance standard for which the Arizona CBG or AZRBOB is certified.
2. The associate director or designee may request in writing a duplicate of the batch sample collected under subsection (F)(1)(a) or (b) for analysis by a laboratory selected by the associate director or designee. The registered supplier shall submit a duplicate of the sample to the associate director within 24 hours of the written request.
3. Designation of independent laboratory.
 - a. A registered supplier that does not develop a QA/QC program shall designate one independent laboratory for each production or import facility at which the registered supplier produces or imports Arizona CBG or AZRBOB. The independent laboratory shall collect samples and perform analyses according to subsection (F).
 - b. A registered supplier shall identify the designated independent laboratory to the associate director under the registration requirements of R3-7-750.
 - c. A laboratory is considered independent if:
 - i. The laboratory is not operated by a registered supplier or the registered supplier's subsidiary or employee,
 - ii. The laboratory does not have any interest in any registered supplier, and
 - iii. The registered supplier does not have any interest in the designated laboratory.
 - d. Notwithstanding the restrictions in subsection (F)(3)(c), a laboratory owned or operated by a pipeline shall be considered independent if the pipeline is owned or operated by four or more registered suppliers.
 - e. A registered supplier shall not use a laboratory that is debarred, suspended, or proposed for debarment according to the Government-wide Debarment and Suspension regulations, 40 CFR 32, or the Debarment, Suspension and Ineligibility provisions of the Federal Acquisition Regulations, 48 CFR 9.4.
4. A registered supplier shall ensure that its designated independent laboratory:
 - a. Records the following at the time the designated independent laboratory collects a representative sample from a batch of Arizona CBG or AZRBOB:
 - i. The producer's or importer's assigned batch number for the batch sampled;
 - ii. The volume of the batch;
 - iii. The identification number of the gasoline storage tank in which the batch is stored at the time the sample is collected;
 - iv. The date and time the batch became Arizona CBG or AZRBOB;
 - v. The date and time the sample is collected;
 - vi. The grade of the batch (for example, unleaded premium, unleaded mid-grade, or unleaded); and
 - vii. For Arizona CBG or AZRBOB produced by computer-controlled in-line blending, the date and time the blending process began and the date and time the blending process ended, unless exempt under subsection (G);
 - b. Retains each sample collected under this subsection for at least 45 days, unless this time is extended by the associate director for up to 180 days;
 - c. Submits to the associate director a quarterly report on or before the 15th day of January, April, July, and October of each year that includes, for each sample of Arizona CBG or AZRBOB analyzed under subsection (F):
 - i. The results of the independent laboratory's analyses for each fuel property, and
 - ii. The information specified in subsection (F)(4)(a) for each sample; and
 - d. Supplies to the associate director, upon request, a duplicate of the sample.
- G. Exemptions to QA/QC and independent laboratory testing requirements. A registered supplier that produces or imports Arizona CBG or AZRBOB using computer-controlled in-line blending equipment and operates under an exemption from EPA under 40 CFR § 1090.1315, is exempt from the requirements of subsections (E) and (F), if reports of the results of the independent audit program of the registered supplier's computer-controlled in-line blending operation, which are submitted to EPA under 40 CFR § 1090.1315, are submitted to the associate director by March 1 of each year.
- H. Use of laboratory analysis for certification of Arizona CBG and AZRBOB.
 1. If both a registered supplier and an independent laboratory collect a sample from the same batch of Arizona CBG or AZRBOB and perform a laboratory analysis under subsection (F) to determine compliance of the sample with a fuel property, the registered supplier and independent laboratory shall use the same test methodology. The results of the analysis conducted by the registered supplier shall be used for certification of the Arizona CBG or AZRBOB under subsection (B), unless the absolute value of the difference between the two results is larger than one of the following:
 - a. Sulfur content: 25 ppm by weight,
 - b. Aromatics: 2.7% by volume,
 - c. Olefins: 2.5% by volume,
 - d. Ethanol: 0.4% by volume,
 - e. Isobutanol: 0.6% by volume,
 - f. Vapor pressure: 0.3 psi,
 - g. 50% distillation temperature: ASTM reproducibility for that sample using the slope from the registered supplier's results,
 - h. 90% distillation temperature: ASTM reproducibility for that sample using the slope from the registered supplier's results,
 - i. E200: 2.5% by volume,
 - j. E300: 3.5% by volume, or
 - k. API gravity: 0.3° API.
 2. If the absolute value of the difference between the results of the analyses conducted by the registered supplier and independent laboratory is larger than one of the values specified in subsection (H)(1), the registered supplier

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shall use one of the following for certification of the batch of Arizona CBG or AZRBOB under subsection (B):

- a. The larger of the two values for each fuel property, except the smaller of the two values shall be used for measures of oxygenates; or
- b. Have a second independent laboratory analyze the Arizona CBG or AZRBOB for each fuel property; and if the difference between the results obtained by the second independent laboratory and those obtained by the registered supplier are within the range listed in subsection (H)(1), the registered supplier's results shall be used for certifying the Arizona CBG or AZRBOB under subsection (B).

Historical Note

New Section R3-7-752 recodified from Section R20-2-752 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2666, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-753. General Requirements for Pipelines and Third-party Terminals

- A. A pipeline or third-party terminal shall not accept Arizona CBG or AZRBOB for transport unless:
 1. The Arizona CBG or AZRBOB is physically transferred from an importer, refiner, CBG blender, oxygenate blender, pipeline, or third-party terminal registered with the Division under R3-7-750; and
 2. The registered supplier provides written verification that the gasoline is Arizona CBG or AZRBOB and complies with the standards in R3-7-751(A) or (B), as applicable, without reproducibility or numerical rounding.
- B. A pipeline or third-party terminal that transports Arizona CBG or AZRBOB shall collect a sample of each incoming batch. The pipeline or third-party terminal shall retain the sample for at least 30 days unless this time is extended for an individual sample for up to 180 days by the associate director.
- C. A pipeline shall conduct quality control testing of Arizona CBG or AZRBOB at each input location. Testing shall consist of at least one sample for each registered supplier who completes a batch shipment at that input location on that day.
- D. A pipeline shall provide the associate director with a report summarizing the quality control testing results obtained under subsection (C) by the 15th day of each month, for all results obtained during the previous month. The report shall contain the quantity of Arizona CBG or AZRBOB, date tendered, whether the Arizona CBG or AZRBOB was transported by pipeline, present sample location, and laboratory analysis results.
- E. If a batch does not meet the standards in R3-7-751(A) or (B), as applicable, but is within reproducibility, the pipeline shall notify the associate director by email within 48 hours of the batch volume and date tendered, proposed shipment date, whether the batch was transported by the pipeline, present batch location, and laboratory analysis results.
- F. If a batch does not meet the standards in R3-7-751(A) or (B), as applicable, including reproducibility, the pipeline or third-party terminal shall notify the associate director by email within 24 hours of the batch quantity and date tendered, proposed shipment date, whether the batch was transported by the

pipeline, present batch location, and laboratory analysis results. If the batch is in the pipeline's or third-party terminal's control, the pipeline or third-party terminal shall prevent release of the batch from a distribution point until the batch is certified as meeting the standards in R3-7-751(A) or (B), as applicable.

- G. A pipeline or third-party terminal shall develop a QA/QC program to demonstrate the accuracy and effectiveness of the pipeline's or third-party terminal's laboratory testing. The QA/QC program for a pipeline or third-party terminal shall include a description of the laboratory testing protocol used to verify that Arizona CBG or AZRBOB transported to the CBG-covered area meets the standards in R3-7-751(A) or (B). A pipeline or third-party terminal shall submit the QA/QC program to the associate director for approval at least three months before the pipeline or third-party terminal begins to transport Arizona CBG or AZRBOB. The associate director shall approve a QA/QC program only if the associate director determines that the QA/QC program ensures that the pipeline's or third-party terminal's laboratory testing produces data that are complete, accurate, and reproducible. If a pipeline or third-party terminal makes significant changes to the QA/QC program, the pipeline or third-party terminal shall resubmit the QA/QC program to the associate director for review and approval. Within 30 days of receiving the changed QA/QC program, the associate director shall determine whether the changed QA/QC program meets the quality objectives originally approved by the Division. The associate director shall approve the changed QA/QC program if it meets the quality objectives.
- H. A portion of a facility that a third-party terminal uses for production, import, or oxygenate blending is exempt from this Section, but the third-party terminal shall operate the exempt portion of the facility in compliance with requirements for registered suppliers in R3-7-752 and oxygenate blenders in R3-7-755, as applicable.
- I. A pipeline is not liable under R3-7-761 if it follows all of the procedures in this Section.

Historical Note

New Section R3-7-753 recodified from Section R20-2-753 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-754. Downstream Blending Exceptions for Transmix

- A. A pipeline or third-party terminal may blend transmix into Arizona CBG or AZRBOB at a rate not to exceed 1/4 of one percent by volume. Each pipeline or third-party terminal shall document the transmix blending (recording each batch and volume of transmix blended) and maintain the records at the third-party terminal for two years from the date of blending.
- B. One of two methods shall be used to measure the transmix as it is blended into the product stream:
 1. Meters, calibrated at least twice each year; or
 2. Tank gauge as per the API Manual of Petroleum Measurement Standards.

Historical Note

New Section R3-7-754 recodified from Section R20-2-754 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final

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rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-755. Additional Requirements for AZRBOB and Oxygenate Blending

A. Application of Arizona CBG standards to AZRBOB. Determining whether AZRBOB complies with Arizona CBG standards.

1. If a registered supplier designates a final blend as AZRBOB and complies with the provisions of this Section, the fuel properties and performance standards of the AZRBOB, for purposes of compliance with R3-7-751(C), are determined by adding the specified type and amount of oxygenate to a representative sample of the AZRBOB and determining the fuel properties and performance standards of the resulting gasoline using the test methods in R3-7-759 or, in the case of ethanol blends, certifying the AZRBOB using the CARBOB Model, on a form or in a format prescribed by the associate director. If the registered supplier designates a range of amounts of oxygenate to be added to the AZRBOB, the minimum designated amount of oxygenate shall be added to the AZRBOB to determine the fuel properties and performance standards of the resulting Arizona CBG. If a registered supplier does not comply with this subsection, the Division shall determine whether the AZRBOB complies with applicable fuel properties and performance standards, excluding requirements for vapor pressure, without adding oxygenate to the AZRBOB.
2. In determining whether AZRBOB complies with the Arizona CBG standards, the registered supplier shall ensure that the oxygenate added to the representative sample under subsection (A)(1) is representative of the oxygenate the registered supplier reasonably expects will be subsequently added to the AZRBOB.
3. The representative sample under subsection (A)(1) shall be prepared in accordance with ASTM D7717 or another test method approved by EPA or CARB.
4. Calculating the volume of AZRBOB. If a registered supplier designates a final blend as AZRBOB and complies with this Section, the volume of AZRBOB is calculated for compliance purposes under R3-7-751 by adding the minimum amount of oxygenate designated by the registered supplier. If a registered supplier fails to comply with this subsection, the Division shall calculate the volume of AZRBOB for purposes of compliance with applicable fuel properties and performance standards without adding the amount of oxygenate to the AZRBOB.

B. Restrictions on transferring AZRBOB.

1. A person shall not transfer ownership or custody of AZRBOB to any other person unless the transferee notifies the transferor in writing that:
 - a. The transferee is a registered oxygenate blender and will add oxygenate in the type and amount (or within the range of amounts) designated in R3-7-757, or will recertify the AZRBOB under R3-7-755(F), before the AZRBOB is transferred from a final distribution facility; or
 - b. The transferee will take all reasonably prudent steps necessary to ensure that the AZRBOB is transferred to a registered oxygenate blender that adds the type and amount (or within the range of amounts) of oxygenate designated in R3-7-757 to the AZRBOB, or recertifies the AZRBOB under R3-7-755(F), before

the AZRBOB is transferred from a final distribution facility.

2. A person shall not sell or supply Arizona CBG from a final distribution facility if the type and amount or range of amounts of oxygenate designated in R3-7-757 have not been added to the AZRBOB, unless the final distribution facility recertifies the AZRBOB under R3-7-755(F).
- C.** Restrictions on blending AZRBOB with other products. A person shall not combine AZRBOB supplied from the facility at which the AZRBOB is produced or imported with any other AZRBOB, gasoline, blendstock, or oxygenate, except for:
 1. Oxygenate in the type and amount (or within the range of amounts) specified by the registered supplier at the time the AZRBOB is supplied from the production or import facility unless the AZRBOB is recertified by an oxygenate blender under R3-7-755(F); or
 2. Other AZRBOB for which the same oxygenate type and amount (or range of amounts) is specified by the registered supplier at the time the AZRBOB is supplied from the production or import facility, except that AZRBOB certified for the addition of 10% ethanol may be combined with AZRBOB certified for the addition of more than 10 but no more than 15 volume percent ethanol.
- D.** Survey for oxygenate blending during the winter. A registered supplier supplying AZRBOB from a production or import facility shall conduct an oxygenate blending survey program that meets the requirements of R3-7-760(A) or use an independent third-party to conduct an oxygenate blending survey program that meets the requirements in R3-7-760(B).
- E.** Requirements for oxygenate blenders.
 1. Requirement to add oxygenate to AZRBOB. If an oxygenate blender receives AZRBOB from a transferor to whom the oxygenate blender represents that oxygenate will be added to the AZRBOB, the oxygenate blender shall add oxygenate to the AZRBOB in the type and amount (or within the range of amounts) identified in the documentation accompanying the AZRBOB except as provided under R3-7-755(F).
 2. Additional requirements for oxygenate blending at terminals. An oxygenate blender that makes Arizona CBG by blending oxygenate with AZRBOB in a motor fuel storage tank, other than a truck used to deliver motor fuel to a retail outlet or bulk-purchaser consumer facility, shall determine the oxygen content and volume of the Arizona CBG before shipping, by collecting and analyzing a representative sample of the Arizona CBG, using the methodology in R3-7-759.
 3. Additional requirements for oxygenate blending in trucks. An oxygenate blender that blends AZRBOB in a motor fuel delivery truck shall conduct a quality assurance sampling and testing program to determine whether the proper type and amount of oxygenate is added to AZRBOB. The program shall be conducted as follows:
 - a. All samples shall be collected subsequent to the addition of oxygenate and prior to combining the resulting gasoline with any other gasoline;
 - b. Sampling and testing shall be done at one of the following rates:
 - i. In the case computer-controlled in-line blending is used, a rate of not less than one sample per each five hundred occasions AZRBOB and oxygenate are loaded into a truck by that oxygenate blender, or one sample every three months, whichever is more frequent; or

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- ii. In the case computer-controlled in-line blending is not used, a rate of not less than one sample per each one hundred occasions AZRBOB and oxygenate are blended in a truck by that oxygenate blender, or one sample per month, whichever is more frequent.
 - c. Sampling and testing shall be of the Arizona CBG produced by that oxygenate blender;
 - d. Samples shall be analyzed for oxygenate type and oxygen content using the testing methodology specified in R3-7-759, including reproducibility; and
 - e. In the event the testing results for any sample indicate the gasoline does not contain the specified type and amount of oxygenate (within the ranges of the applicable test methods, including reproducibility), the oxygenate blender shall:
 - i. Immediately stop selling (or where possible, to stop any transferee of the gasoline from selling) the gasoline which was sampled;
 - ii. Take steps to determine and correct the cause of the noncompliance; and
 - iii. Increase the rate of sampling and testing to double the required frequency outlined in subsection (E)(3)(b).
 - f. The increased frequency in subsection (E)(3)(e)(iii) shall continue until the results of ten consecutive samples and tests indicate the gasoline complies with applicable standards, at which time the sampling and testing frequency may revert to the original frequency.
4. Additional requirements for in-line oxygenate blending in pipelines using computer-controlled blending.
- a. An oxygenate blender that produces Arizona CBG by blending oxygenate with AZRBOB into a pipeline using computer-controlled in-line blending shall, for each batch of Arizona CBG produced:
 - i. Obtain a flow proportional composite sample after the addition of oxygenate and before combining the resulting Arizona CBG with any other Arizona CBG;
 - ii. Determine the oxygen content of the Arizona CBG by analyzing the composite sample within 24 hours of blending using the methodology in R3-7-759; and
 - iii. Determine the volume of the resulting Arizona CBG.
 - b. If the test results for the Arizona CBG indicate that it does not contain the amount of oxygenate specified by the ranges of the applicable test methods, the oxygenate blender shall:
 - i. Notify the pipeline to downgrade the Arizona CBG to conventional gasoline or transmix upon arrival in Arizona;
 - ii. Begin an investigation to determine the cause of the noncompliance;
 - iii. Collect a representative sample every two hours during each in-line blend of AZRBOB and oxygenate, and analyze the samples within 12 hours of collection, until the cause of the noncompliance is determined and corrected; and
 - iv. Notify the associate director in writing within one business day that the Arizona CBG does not comply with the requirements of this Article.
5. Additional requirements for oxygenate blending at motor fuel dispensing sites. An oxygenate blender that blends AZRBOB or Arizona CBG with oxygenates at a motor fuel dispensing site shall conduct a quality assurance sampling and testing program to determine whether the proper type and amount of oxygenate is added as follows:
- a. The samples shall be collected subsequent to the addition of oxygenate at least once every six months.
 - b. Samples shall be analyzed for oxygenate type and oxygen content using the testing methodology in R3-7-759, including reproducibility.
 - c. In the event testing results for any sample indicate the gasoline does not contain the specified type and amount of oxygenate (within the ranges of the applicable test methods), the oxygenate blender shall:
 - i. Immediately stop selling the gasoline which was sampled and take steps to determine and correct the cause of the noncompliance; and
 - ii. Increase the rate of sampling and testing to quarterly, and continue quarterly testing until two consecutive tests indicate the gasoline complies with the applicable standards.
6. Recordkeeping and records retention.
- a. An oxygenate blender shall maintain, for five years from the date of each sampling, records of the following:
 - i. Sample date;
 - ii. Identity of blend or product sampled;
 - iii. Container or other vessel sampled;
 - iv. Volume of final blend or shipment;
 - v. Oxygen content as determined under R3-7-759; and
 - vi. Results from all testing.
 - b. The associate director shall deem that Arizona CBG blended by an oxygenate blender and not tested and documented as required by this Section has an oxygen content that does not comply with the standards specified in R3-7-751 unless the oxygenate blender demonstrates to the associate director that the Arizona CBG meets the standards in R3-7-751.
 - c. Within 15 days of the associate director's written request, an oxygenate blender shall provide any records maintained by the oxygenate blender under this Section. If the oxygenate blender fails to provide records requested for a blend or shipment of Arizona CBG, the associate director shall deem that the blend or shipment of Arizona CBG violates R3-7-751 unless the oxygenate blender demonstrates to the associate director that the Arizona CBG meets the standards and limits under R3-7-751.
7. Notification requirement. An oxygenate blender shall notify the associate director by email before transporting Arizona CBG or AZRBOB into the CBG-covered area by a means other than a pipeline.
8. Quality assurance and quality control ("QA/QC") program. An oxygenate blender that conducts sampling and testing under subsection (E) in the oxygenate blender's

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own laboratory shall develop a QA/QC program to demonstrate the accuracy and effectiveness of the oxygenate blender's sampling and testing of Arizona CBG or AZRBOB. The oxygenate blender shall submit the QA/QC program to the associate director for approval before transporting Arizona CBG. The associate director shall approve a QA/QC program only if the associate director determines that the QA/QC program ensures that the oxygenate blender's sampling and testing produces data that are complete, accurate, and reproducible. Instead of developing a QA/QC program, an oxygenate blender may comply with the independent testing requirements of R3-7-752(F), except that, for sampling and testing conducted under subsection (E)(3), the minimum number of samples collected and tested by the independent laboratory shall be 10% of the number of samples required to be collected and tested under subsection (E).

9. An oxygenate blender that does not conduct laboratory sampling and testing required under subsection (E) in its own laboratory shall designate an independent laboratory, as described in R3-7-752(F), to conduct the sampling and testing required under subsection (E)(8).
 10. Within 24 hours of the associate director's or designee's written request, an oxygenate blender shall submit a duplicate of any sample collected under subsection (E)(8).
- F. Downstream AZRBOB or Arizona CBG Recertification.** If a registered supplier has specified blending instructions for oxygenate(s) under R3-7-752 and R3-7-755(A), an oxygenate blender may recertify AZRBOB for a different type or amount of oxygenate. The oxygenate blender is exempt from the requirements to register as a registered supplier and certify the finished Arizona CBG under R3-7-751(C) and (D), and R3-7-752, if the recertifying oxygenate blender:
1. Only recertifies AZRBOB to contain a greater amount of a specified oxygenate (e.g. the oxygenate blender adds 15 volume percent ethanol to a batch certified for the addition of 10 volume percent ethanol) or a different oxygenate at an equal or greater amount (e.g. the oxygenate blender adds 16 volume percent isobutanol to a batch certified for 10 volume percent ethanol);
 2. Issues product transfer documentation that includes the information for the recertified gasoline contained in R3-7-757, unless the recertified gasoline is blended and dispensed at a motor fuel dispensing site or fleet vehicle fueling facility;
 3. Meets the requirements applicable to oxygenate blenders in R3-7-755(E); and
 4. Uses oxygenates meeting the requirements of R3-7-708(B) or (C), or ethanol flex fuel that meets the requirements of R3-7-708(E) to blend with AZRBOB or Arizona CBG.
- G.** Upon request, on a form or in a format prescribed by the associate director, an oxygenate blender shall report to the Division the volume of Arizona CBG recertified, including the types and amounts of oxygenate added. The report shall be submitted to the Division within 15 days of the request.

Historical Note

New Section R3-7-755 recodified from Section R20-2-755 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2666, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 29

A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-756. Downstream Blending of Arizona CBG with Nonoxygenate Blendstocks

- A.** A person shall not combine Arizona CBG supplied from a production or import facility with any nonoxygenate blendstock, other than vapor recovery condensate, unless the resulting gasoline blend meets the requirements in ASTM D4814 and is not used within the CBG-covered area.
- B.** Notwithstanding subsection (A), a person may add nonoxygenate blendstock to a previously certified batch or mixture of certified batches of Arizona CBG that does not comply with one or more of the applicable per-gallon standards contained in R3-7-751(A) or (B) if the person obtains prior written approval from the associate director based on a demonstration that adding the blendstock will bring the previously certified Arizona CBG into compliance with the applicable per-gallon standards for Arizona CBG. The oxygenate blender or registered supplier shall certify the re-blended Arizona CBG to the Division, on a form or in a format prescribed by the associate director.

Historical Note

New Section R3-7-756 recodified from Section R20-2-756 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-757. Product Transfer Documentation; Records Retention

- A.** If a person transfers custody or title to Arizona CBG or AZRBOB, other than when Arizona CBG is sold or dispensed at a motor fuel dispensing site or fleet vehicle fueling facility, the transferor shall provide to the transferee documents that include the following:
 1. Volume of Arizona CBG or AZRBOB being transferred;
 2. Location of the Arizona CBG or AZRBOB at the time of transfer;
 3. Date of the transfer;
 4. Product transfer document number;
 5. Identification of the gasoline as Arizona CBG or AZRBOB;
 6. Minimum octane rating of the Arizona CBG or AZRBOB;
 7. For Arizona CBG that contains an oxygenate, a legible and conspicuous statement that the gasoline being transferred contains an oxygenate and lists the type and percentage concentration of the oxygenate;
 8. If the product transferred is AZRBOB for which oxygenate blending is intended:
 - a. Identification of the fuel as AZRBOB and a statement that the "AZRBOB does not comply with the standards for Arizona CBG without the addition of oxygenate";
 - b. Oxygenate type or types and amount or range of amounts that the AZRBOB requires to meet the fuel properties or performance standards claimed by the registered supplier of the AZRBOB, and the applicable specifications for volume percent of oxygenate and weight percent oxygen content; and
 - c. Instructions to the transferee that the AZRBOB may not be combined with any other AZRBOB unless the other AZRBOB has the same requirements for oxy-

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genate type or types and amount or range of amounts; and

9. The final destination:

- a. When a terminal is the transferor, the owner or the operator shall include on the product transfer document the terminal name and address and the transporter name and address;
- b. When a transporter is the transferor, the transporter shall include on the product transfer document the name and address of the transporter and the final destination, which is the location at which the motor fuel will be delivered and off loaded from the truck; and
- c. When a jobber or marketer is the transferor, the jobber or marketer shall include on the product transfer document the name and address of the jobber or marketer and the final destination, which may be a final distribution facility or a motor fuel dispensing site.

- B. To enable a transferor to comply fully with the requirement in subsection (A)(9), the transferee shall supply to the transferor information regarding the final destination.
- C. A registered supplier, third-party terminal, or pipeline may comply with subsection (A) by using standardized product codes on pipeline tickets if the codes are specified in a manual distributed by the pipeline to transferees of the Arizona CBG or AZRBOB, and the manual includes all required information for the Arizona CBG or AZRBOB.
- D. Any transferee in subsection (A), other than a registered supplier, oxygenate blender, third-party terminal, pipeline, motor fuel dispensing site, or fleet vehicle fueling facility shall retain product transfer documents for each shipment of Arizona CBG or AZRBOB transferred during the 24 months before the most recent transfer. The transferee shall maintain product transfer documents for the 30 days before the most recent transfer at the business address listed on the product transfer document. The transferee may maintain all remaining product transfer documents for the preceding 24 months elsewhere.
- E. A motor fuel dispensing site or fleet vehicle fueling facility shall retain product transfer documents for each shipment of Arizona CBG transferred during the 12 months before the most recent transfer. The motor fuel dispensing site or fleet vehicle fueling facility shall maintain product transfer documents for the three most recent transfers on the premises. The motor fuel dispensing site or fleet vehicle fueling facility may maintain the remaining product transfer documents for the preceding 12 months elsewhere.
- F. A registered supplier, oxygenate blender, third-party terminal, or pipeline shall retain product transfer documents for each shipment of Arizona CBG or AZRBOB transferred during the 60 months before the most recent transfer. The transferee shall maintain product transfer documents for each shipment of Arizona CBG or AZRBOB transferred during the 30 days preceding the most recent transfer at the business address listed on the product transfer document. The transferee may maintain all remaining product transfer documents for the preceding 60 months elsewhere.
- G. Upon request by the associate director or designee, a person shall present product transfer documents to the Division within

two business days of the request. Legible photocopies or electronic copies of the product transfer documents are acceptable.

Historical Note

New Section R3-7-757 recodified from Section R20-2-757 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2666, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-758. Repealed

Historical Note

Repealed Section R3-7-758 recodified Section R20-2-758 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

R3-7-759. Testing Methodologies

- A. Except as provided in subsection (C), a registered supplier certifying Arizona CBG or AZRBOB as meeting the requirements of this Article shall use one of the EPA- or CARB-approved ASTM methods listed in Table A, a copy of which may be obtained at: ASTM International, 100 Bar Harbor Drive, West Conshohocken, PA 19428-2959 or www.astm.org. A copy of the CARB methods may be obtained at: California Air Resources Board, P.O. Box 2815, Sacramento, CA 95812 or www.arb.ca.gov.
- B. An oxygenate blender or third-party terminal certifying Arizona CBG or AZRBOB before transport to the CBG-covered area shall measure the oxygenate content in accordance with the oxygenate blender's or third-party terminal's approved QA/QC program or in accordance with one of the methods listed in Table A.
- C. Rather than using a method listed in Table A to certify Arizona CBG or AZRBOB, a registered supplier may use the CARBOB Model and use the fuel-quality measures calculated using the CARBOB Model for compliance and reporting purposes.
- D. A test method that the Division determines is equivalent to those listed in Table A may be used to certify Arizona CBG or AZRBOB. The Division has determined that test methods approved by either EPA methodology described in 40 CFR 1090.1360 or CARB are equivalent test methods. EPA referee methods from 40 CFR 80.47 as it existed December 31, 2020, may be used if the tested property is not listed in 40 CFR 1090.1360. If a correlation equation is required by EPA, CARB, or the ASTM test method, the correlation equation shall be used to align the test methods, and becomes part of the equivalent test method.

Historical Note

New Section R3-7-759 recodified from Section R20-2-759 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2666, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

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Table A. Arizona Weights and Measures Services Division Test Methods for Arizona CBG and AZRBOB

Fuel Parameter	Units	Approved Test Methods
Aromatics	V%	D1319-20a, D5769-20, D5580-02 (2007)
Benzene	V%	D3606-21, D5580-02 (2007)
Olefins	V%	D1319-20a, D6550-10 (2010)Footnote 1, D8071-21
Oxygenates	W%	D4815-09 (2009), D4815-15b (2019), D5599-18
Vapor Pressure (Correlation Equation)	psi	D5191-20Footnote 2, 13 CCR Section 2297
Sulfur	wppm	D2622-21, D5453-93 (1993)
Distillation T50	°F	D86-99a ϵ 1, D86-20b
Distillation T90	°F	D86-99a ϵ 1, D86-20b

Footnotes:

1. Replace the last sentence in ASTM D6550-00 (2010) Section 1.1 with the following: "The application range is from 0.3 to 25 mass percent total olefin, as defined in Section 2263(b), Title 13, California Code of Regulations. If olefin concentrations are not detected, substitute one-half of the detection limit."
2. When determining vapor pressure, the only correlation equation to be used is equation 1 in ASTM D5191-20, Section 14.2, ASTM equation ((.965X)-A).

Historical Note

New Article 7, Table A recodified from 20 A.A.C. 2, Article 7, Table A at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Table A repealed; new Table A made by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-760. Compliance Surveys

- A.** A registered supplier shall conduct surveys for oxygenate blending during the winter and a compliance survey during the summer. The winter survey shall be conducted following the requirements in subsection (A), or using an independent third-party surveyor following the requirements in subsections (B) and (D). The summer survey shall be conducted following the requirements in subsection (C), or using an independent third-party surveyor following the requirements in subsections (C) and (D). Surveys for oxygenate blending during the winter: A registered supplier supplying AZRBOB from a production or import facility shall conduct an oxygenate blending survey program to be carried out at the facilities of each oxygenate blender who blends any AZRBOB produced or imported by the refiner or importer with any oxygenate, to determine whether the Arizona CBG, which has been produced through blending, complies with the applicable standards using the methodology specified in R3-7-759. The sampling and testing program shall be conducted as follows:
1. Samples shall be collected in accordance with ASTM D4057 and be analyzed for oxygenates. All samples shall be collected subsequent to the addition of oxygenate and prior to combining the resulting gasoline with any other gasoline.
 2. Sampling and testing shall be at one of the following rates, regardless of the amount of oxygenate added:
 - a. In the case of AZRBOB which is blended with oxygenate in a gasoline storage tank, a rate of not less than one sample for every 400,000 barrels of AZRBOB produced or imported by that refiner or importer that is blended by that oxygenate blender, or one sample every month, whichever is more frequent;
 - b. In the case of AZRBOB which is blended with oxygenate in gasoline delivery trucks through the use of computer-controlled in-line blending equipment, a rate of not less than one sample for every 200,000 barrels of AZRBOB produced or imported by that refiner or importer that is blended by that oxygenate blender, or one sample every three months, whichever is more frequent; or
 3. In the event that the test results for any sample indicate the gasoline does not comply with applicable standards, including reproducibility, the refiner or importer shall:
 - a. Immediately take steps to stop the sale of the gasoline that was sampled;
 - b. Take steps which are reasonably calculated to determine and correct the cause of the noncompliance;
 - c. Increase the rate of sampling and testing to double the required frequency outlined in subsection (A)(2); and
 - d. Continue the increased frequency of sampling and testing until the results of ten consecutive samples and tests indicate the gasoline complies with applicable standards, at which time the sampling and testing may be conducted at the original frequency.
 4. This survey program conducted by a registered supplier shall be conducted in addition to any survey requirements carried out under this subsection by other registered suppliers.
- B.** Instead of conducting the oxygenate blending survey program in subsection (A), the registered supplier may use an independent third-party surveyor to conduct a winter oxygenate blending survey that meets the following requirements:
1. Designed and conducted by an independent third-party surveyor that meets the requirements of subsection (D)(2)(a);
 2. Conducted November 1 through March 31 on all samples collected under the program design approved by the associate director under subsection (D);

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3. Involves sampling and testing that is representative of all Arizona CBG dispensed in the CBG-covered area, including a representative number of E15 samples;
 4. Analyzes each sample for oxygenate according to the methodologies specified in R3-7-759;
 5. Collects samples of gasoline produced at blender pumps using "Method #1" of the E15 Sampling Procedure specified in Handbook 158;
 6. Verifies compliance of E15 labeling requirements at gasoline retail outlets that offer E15 for sale; and
 7. Includes a sufficient amount of samples to ensure that the average levels of oxygen is determined at a 95% confidence level with an error of 0.1% or less for oxygen by weight.
- C. Summer Compliance Surveys. A registered supplier shall ensure that compliance surveys are conducted in accordance with a compliance survey program plan approved by the associate director. A registered supplier may use an independent third-party surveyor as outlined in subsection (D) to conduct a summer compliance survey. The associate director shall approve a compliance survey program plan if the plan:
1. Consists of at least four VOC and NOx surveys conducted at least once per month between June 1 and September 30 of each year;
 2. Consists of all samples that are collected under an approved survey program plan during any consecutive seven days;
 3. Is representative of all Arizona CBG being dispensed in the CBG-covered area including a representative number of E15 samples;
 4. Includes enough samples to ensure that the average levels of oxygen, vapor pressure, aromatic hydrocarbons, olefins, T50, T90, and sulfur are determined at a 95% confidence level with an error of:
 - a. 0.1% or less for oxygen by weight;
 - b. 0.1 psi for vapor pressure;
 - c. 0.5% for aromatic hydrocarbons by volume;
 - d. 0.5% for olefins by volume;
 - e. 5° F for T50 and T90; and
 - f. 10 ppm for sulfur.
 5. Analyzes each sample included in the compliance survey for oxygenate type and content, olefins, sulfur, aromatic hydrocarbons, E200, E300, and vapor pressure according to the test methods in R3-7-759 (vapor pressure is required to be analyzed only from June 1 through September 30); and
 6. If a laboratory analyzes the compliance survey samples, the laboratory participates in a correlation program approved by the associate director to ensure the validity of analysis results.
 7. For each compliance survey sample, determine the VOC and NOx emissions reduction percentage based upon the tested fuel properties for that sample using the methodology for calculating VOC and NOx emissions reductions under the Federal Complex Model.
- D. An independent third-party surveyor may conduct the winter oxygenate blending survey outlined in subsection (B) and the summer compliance survey outlined in subsection (C), if the survey program:
1. Is approved by the associate director;
 2. Is designed and conducted by a third-party surveyor that is independent of the registered supplier. To be considered independent:
 - a. The surveyor shall not be an employee of any registered supplier;
 - b. The surveyor shall not have an obligation to, or interest in, any registered supplier; and
 - c. The registered supplier shall not have an obligation to or interest in the surveyor.
 3. Requires that the surveyor not provide advance notice, except as provided in subsection (D)(8), of the date or location of any survey sampling;
 4. Provides a duplicate of any sample taken during the survey to the associate director, upon request of the associate director within 30 days following submission of the survey report required under subsection (D)(7), including:
 - a. Information regarding the name and address of the facility from where the sample was collected, and
 - b. The date of collection;
 5. Requires that the surveyor permit a Division official to monitor sample collection, transportation, storage, and analysis at any time;
 6. Requires the laboratory to participate in a correlation program approved by the associate director to ensure the validity of analysis results;
 7. Requires the surveyor to submit a report of each survey to the associate director within 30 days after sampling is completed, including the following information:
 - a. Name of the person conducting the survey;
 - b. Attestation by an officer of the surveyor that the sampling and testing was conducted according to the compliance survey program plan and the results are accurate;
 - c. Identification of the registered supplier for whom the compliance survey was conducted if the compliance survey was conducted for only one registered supplier;
 - d. Identification of the area from which survey samples were selected;
 - e. Dates on which the survey was conducted;
 - f. Address of each facility at which a sample was collected, and the date of collection;
 - g. Name and address of each laboratory at which samples were analyzed;
 - h. Description of the method used to select the facilities from which a sample was collected;
 - i. Number of samples collected from each facility;
 - j. Justification for excluding a collected sample from the survey, if one was excluded; and
 - k. For a survey conducted under subsection (A), analyzes each sample for oxygenate according to the methodologies specified in R3-7-759; or
 - l. For a survey conducted under subsection (C), results of the sample analysis for oxygenate type, oxygen weight percent, aromatic hydrocarbons, olefin content, E200, E300, vapor pressure, and the calculated VOC or NOx emissions reduction percentage, as applicable, for each survey conducted during the period identified in subsection (C)(1);
 8. Begins each survey on a date selected by the associate director, or as approved in the survey program. The associate director shall notify the surveyor of the date selected at least 10 days before the survey is to begin.
- E. To obtain the associate director's approval of a survey program plan, the person seeking approval shall:
1. Submit the plan to the associate director no later than January 1 to cover the survey period of November 1 through

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March 31 or June 1 through September 15 of each year, as applicable; and

2. Have the plan signed by a corporate officer of the registered supplier or by an officer of the independent third-party surveyor.
- F. If the associate director determines that a sample used in a compliance survey does not comply with R3-7-751 or another requirement under this Article, the associate director may take enforcement action against the registered supplier, oxygenate blender, and/or retail location.
- G. If a registered supplier fails to ensure that an approved compliance survey program is conducted, the associate director may consider all batches delivered into the CBG-covered area during the survey period as non-compliant.
- H. No later than April 1 of each year, a registered supplier that intends to meet the requirements in subsections (A) and (C) by contracting with an independent third-party surveyor to conduct the compliance survey plan for the next summer and winter season shall enter into the contract and pay all of the money necessary to conduct the compliance survey plan. The registered supplier may pay the money necessary to conduct the compliance survey plan to the independent third-party surveyor or to an escrow account with instructions to the escrow agent to release the money to the independent third-party surveyor as the compliance survey plan is implemented. No later than April 15, the registered supplier shall submit to the associate director a copy of the contract with the independent third-party surveyor, proof that the money necessary to conduct the compliance survey plan has been paid, and, if applicable, a copy of the escrow agreement.
- I. A registered supplier is exempt from the survey requirements of this Section if they supply less than 1,000,000 gallons of Arizona CBG or AZRBOB within a calendar year.

Historical Note

New Section R3-7-760 recodified from Section R20-2-760 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-761. Liability for Noncompliant Arizona CBG or AZRBOB

- A. Persons liable. If motor fuel designated as Arizona CBG or AZRBOB does not comply with R3-7-751, the following are liable for the violation:
 1. Each person who owns, leases, operates, controls, or supervises a facility where the noncompliant Arizona CBG or AZRBOB is found;
 2. Each registered supplier whose corporate, trade, or brand name, or whose marketing subsidiary's corporate, trade, or brand name, appears at a facility where the noncompliant Arizona CBG or AZRBOB is found; and
 3. Each person who manufactured, imported, sold, offered for sale, dispensed, supplied, offered for supply, stored, transported, or caused the transportation of any gasoline in a storage tank containing Arizona CBG or AZRBOB found to be noncompliant.
- B. Defenses.
 1. A person who is otherwise liable under subsection (A) is not liable if that person demonstrates:
 - a. That the violation was not caused by the person or person's employee or agent;

- b. That product transfer documents account for all of the noncompliant Arizona CBG or AZRBOB and indicate that the Arizona CBG or AZRBOB complied with this Article; and
 - c. That the person had a quality assurance sampling and testing program, as described in subsection (C) in effect at the time of the violation; except that any person who transfers Arizona CBG or AZRBOB, but does not assume title, may rely on the quality assurance program carried out by another person, including the person who owns the noncompliant Arizona CBG or AZRBOB, provided the quality assurance program is properly administered.
2. If a violation is found at a facility that operates under the corporate, trade, or brand name of a registered supplier, that registered supplier must show, in addition to the defense elements in subsection (B)(1), that the violation was caused by:
 - a. A violation of law other than A.R.S. Title 3, Chapter 19, Article 6, this Article, or an act of sabotage or vandalism;
 - b. A violation of a contract obligation imposed by the registered supplier designed to prevent noncompliance, despite periodic compliance sampling and testing by the registered supplier; or
 - c. The action of any person having custody of Arizona CBG or AZRBOB not subject to a contract with the registered supplier but engaged by the registered supplier for transportation of Arizona CBG or AZRBOB, despite specification or inspection of procedures and equipment by the registered supplier designed to prevent violations.
3. To show that the violation was caused by any of the actions in subsection (B)(2), the person must demonstrate by a preponderance of the evidence, that the violation was caused or must have been caused by another person.
- C. Quality assurance sampling and testing program. To demonstrate an acceptable quality assurance program for Arizona CBG or AZRBOB, at all points in the gasoline distribution network, other than at a motor fuel dispensing site or fleet vehicle fueling facility, a person shall present evidence:

1. Of a periodic sampling and testing program to determine compliance with the maximum or minimum standards in R3-7-751; and
2. That each time Arizona CBG or AZRBOB is noncompliant with one of the requirements in R3-7-751:
 - a. The person immediately ceases selling, offering for sale, dispensing, supplying, offering for supply, storing, transporting, or causing the transportation of the noncompliant Arizona CBG or AZRBOB; and
 - b. The person remedies the violation as soon as practicable.

Historical Note

New Section R3-7-761 recodified from Section R20-2-761 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-762. Penalties

Any person who violates any provision of this Article is subject to the following:

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1. Prosecution for a Class 2 misdemeanor under A.R.S. § 3-3473(B)(4);
2. Civil penalties under A.R.S. §§ 3-3473 and 3-3475; and
3. Stop-use, stop-sale, hold, and removal orders under A.R.S. § 3-3415(A)(2).

Historical Note

New Section R3-7-762 recodified from Section R20-2-762 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3).

Table 1. Repealed**Historical Note**

New Article 7, Table 1 recodified from 20 A.A.C. 2, Article 7, Table 1 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Table 1 amended by final rulemaking at 24 A.A.R. 2666, effective November 10, 2018 (Supp. 18-3). Table 1 repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

Table 2. Repealed**Historical Note**

New Article 7, Table 2 recodified from 20 A.A.C. 2, Article 7, Table 2 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Table 2 amended by final rulemaking at 24 A.A.R. 2666, effective November 10, 2018 (Supp. 18-3). Table 2 repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

Table 3. Repealed**Historical Note**

Repealed Table 3 recodified from repealed Table 3 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).

ARTICLE 8. RESERVED**ARTICLE 9. REPEALED****R3-7-901. Repealed****Historical Note**

New Section R3-7-901 recodified from Section R20-2-901 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-902. Repealed**Historical Note**

New Section R3-7-902 recodified from Section R20-2-902 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-903. Repealed**Historical Note**

New Section R3-7-903 recodified from Section R20-2-903 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280,

effective October 2, 2017 (Supp. 17-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-904. Repealed**Historical Note**

New Section R3-7-904 recodified from Section R20-2-904 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-905. Repealed**Historical Note**

New Section R3-7-905 recodified from Section R20-2-905 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-906. Repealed**Historical Note**

New Section R3-7-906 recodified from Section R20-2-906 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-907. Repealed**Historical Note**

New Section R3-7-907 recodified from Section R20-2-907 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-908. Repealed**Historical Note**

New Section R3-7-908 recodified from Section R20-2-908 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-909. Repealed**Historical Note**

New Section R3-7-909 recodified from Section R20-2-909 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-910. Repealed**Historical Note**

New Section R3-7-910 recodified from Section R20-2-910 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Repealed by final

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rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-911. Repealed**Historical Note**

New Section R3-7-911 recodified from Section R20-2-911 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-912. Repealed**Historical Note**

New Section R3-7-912 recodified from Section R20-2-912 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-913. Repealed**Historical Note**

New Section R3-7-913 recodified from Section R20-2-913 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Repealed by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

ARTICLE 10. STAGE I VAPOR RECOVERY**R3-7-1001. Material Incorporated by Reference**

The following documents are incorporated by reference and on file with the Division. The documents incorporated by reference contain no later amendments or editions:

1. California Environmental Protection Agency, Air Resources Board, Vapor Recovery Test Procedure TP-201.1B, Static Torque of Rotatable Phase 1 Adaptors, October 8, 2003 edition, California Air Resources Board, P.O. Box 2815, 2020 L. Street, Sacramento, California 95812-2815 (herein referred to as "CARB TP-201.1B").
2. California Environmental Protection Agency, Air Resources Board, Vapor Recovery Test Procedure TP-201.1E, Leak Rate and Cracking Pressure of Pressure/Vacuum Vent Valves, October 8, 2003 edition, California Air Resources Board, P.O. Box 2815, 2020 L. Street, Sacramento, California 95812-2815 (herein referred to as "CARB TP-201.1E").
3. California Environmental Protection Agency, Air Resources Board, Vapor Recovery Test Procedure TP-201.3, Determination of 2 Inch WC Static Pressure Performance of Vapor Recovery Systems of Dispensing Facilities, July 26, 2012 edition, California Air Resources Board, P.O. Box 2815, 2020 L. Street, Sacramento, California 95812-2815 (herein referred to as "CARB TP-201.3").
4. California Environmental Protection Agency, Air Resources Board, Vapor Recovery Test Procedure TP-201.3C, Determination of Vapor Piping Connections to Underground Gasoline Storage Tanks (Tie-Tank Test), March 17, 1999 edition, California Air Resources Board, P.O. Box 2815, 2020 L. Street, Sacramento, California 95812-2815 (herein referred to as "CARB TP-201.3C").

Historical Note

New Section R3-7-1001 recodified from Section R20-2-1001 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-1002. Exemptions

An owner or operator of a gasoline dispensing site with a gasoline throughput that does not exceed that specified in A.R.S. § 3-3512(B) may file for an exemption from this Article. To obtain an exemption, the owner or operator of the gasoline dispensing site shall submit an annual throughput report to the Division, using a form prescribed by the Division, no later than March 30 of each year and attest to the throughput during each month of the previous calendar year. If the owner or operator fails to file an annual throughput report timely or if the annual throughput report indicates the exemption limit specified in A.R.S. § 3-3512(B) was exceeded, the Division shall deem the exemption void.

Historical Note

New Section R3-7-1002 recodified from Section R20-2-1002 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-1003. Equipment and Installation

- A. The Division shall reject a stage I vapor recovery system or component from future installation if:
 1. Federal regulations prohibit its use;
 2. The vapor recovery system or component does not meet the manufacturer's specifications as certified by CARB using test methods approved in R3-7-1001; or
 3. The vapor recovery system or component fails greater than 20% of Division inspections for that system or component or the Division receives equivalent failure results from a vapor recovery registered service agency, as defined and regulated by Article 6, or from another jurisdiction's vapor recovery program, and the Division provides at least 30 days public notice of its proposed rejection.
- B. The piping of a stage I vapor recovery system shall be designed and constructed as certified by CARB for that specific vapor recovery system. A person shall not alter a stage I vapor recovery system or component from the CARB-certified configuration without obtaining Division approval under R3-7-1004. All components installed with the stage I vapor recovery system shall be certified by CARB or approved by the Division as required under A.R.S. § 3-3512.
- C. If Division inspection or test data reveal a deficiency in a fitting, assembly, or component that cannot be permanently corrected, the deficient fitting, assembly, or component shall not be used in Arizona.
- D. A stage I liquid or vapor spill containment bucket may have a plugged drain rather than a drain valve if a hand-operated pump is kept onsite for draining entrapped liquid.
- E. A stage I vapor recovery system shall have pressure/vacuum (P/V) threaded valves on top of the vent lines for gasoline storage tanks.

Historical Note

New Section R3-7-1003 recodified from Section R20-2-1003 at 22 A.A.R. 2786, effective August 15, 2016

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(Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-1004. Application Requirements and Process for Authority to Construct Plan Approval

- A.** A person shall not begin to construct a stage I vapor recovery system or to make a modification of an existing stage I vapor recovery system before applying for and obtaining an Authority to Construct permit. A modification is:
 1. Adding or replacing a gasoline storage tank that is equipped with a stage I vapor recovery system;
 2. Modifying, adding, or replacing vent piping; or
 3. Conducting construction at the tank top that exposes stage I or stage II vapor recovery piping.
- B.** A person shall file with the Division a written change order, using a form provided by the Division, to obtain a modification of the approved vapor recovery system or component if a modification is needed after the Division issues an Authority to Construct permit. The person shall not make any modification until the Division approves the change order.
- C.** To obtain an Authority to Construct permit, a person shall submit to the Division, on a form provided by the Division, the following:
 1. The name, address, and telephone number of any owner, operator, and proposed contractor, if known;
 2. The name of the stage I vapor recovery system or component to be installed along with the CARB certification for that system or component;
 3. The street address of the site where construction or modification will take place with an estimated timetable for construction or modification;
 4. A copy of a blueprint or scaled site plan for the vapor recovery system or component including all stage I vapor recovery equipment and stage I vapor recovery piping detail; and
 5. The application fee specified under R3-7-1006.
- D.** A person shall ensure that an installed or modified stage I vapor recovery system meets the following requirements:
 1. Has CARB-certified product and vapor adaptors that prevent loosening or over-tightening of the stage I product and vapor adaptors;
 2. Consists of a two-point stage I system with separate fill and vapor connection points. Coaxial stage I vapor recovery systems shall not be used;
 3. Has a submerged fill pipe that has the fill pipe's highest point of discharge no more than six inches from the tank bottom;
 4. Has no tank containing motor fuel other than gasoline connected to the vapor piping;
 5. Has vapor piping with a minimum 1/8 inch slope per foot from the vent riser to the tank;
 6. Uses cement that is resistant to deterioration from exposure to water, hydrocarbons, and alcohol to join all pipes;
 7. Has tank vent pipes that extend at least 12 feet above the elevation of the stage I fill points;
 8. Has tank vent pipes with a minimum inside diameter of:
 - a. Two inches if the pipe is not manifolded, or
 - b. Three inches from the point of manifold for a single vent line;
 9. Has pressure vacuum vent valves that are attached to the tank vent pipes by a threaded connection;
10. If a gasoline tank is installed in an enclosed vault, has an emergency vent in addition to the pressure vacuum vent valve required under subsection (D)(9);
11. Has risers into gasoline storage tanks that are covered with caps approved by Underwriters Laboratories;
12. Has lead wires for instrumentation that pass through a leak-tight grommet with a compression fitting suitable for exposure to gasoline vapors;
13. Has storage tank vent pipes and fill and vapor manhole tops that are painted a color that minimizes solar gain and has a Light Reflectance Value ("LRV") of at least 55%, according to the following principles:
 - a. Reflectivity shall be determined by visually comparing the paint with paint-color cards obtained from a paint manufacturer that uses either the Master Palette system to specify the paint color (e.g. 58YY 88/180, where "88" represents the paint reflectivity percentage), or notes the LRV for a specific color;
 - b. Examples of colors have a LRV of at least 55% include, but are not limited to, yellow, light gray, aluminum, tan, red iron oxide, cream or pale blue, light green, glossy gray, light blue, light pink, light cream, white, silver, beige, tin plate, and mirrored finish;
 - c. A manhole cover that is color coded for product identification is exempt from this subsection; and
14. Complies with other requirements outlined in the Authority to Construct permit.
- E.** After review and approval of the Authority to Construct application, the Division shall issue the Authority to Construct permit and mail or email the permit to the address indicated on the application.
 1. A copy of the Authority to Construct permit shall be maintained at the facility during construction so that it is accessible for Division review.
 2. Construction of a stage I vapor recovery system or component at a site not having an Authority to Construct permit, shall be stopped and no further installation work done until an Authority to Construct permit is obtained.
 3. An Authority to Construct permit is not transferable.
- F.** The Division shall deny an Authority to Construct application for any of the following reasons:
 1. Providing incomplete, false, or misleading information; or
 2. Failing to meet the requirements stated in this Chapter.
- G.** If excavation is involved, the Division may visually inspect the stage I underground piping of a gasoline dispensing site before the piping is buried for compliance with the Authority to Construct permit. The owner or operator of a vapor recovery system or component shall give the Division notice by email at least two business days before the underground piping is complete to schedule the inspection. The Division may require the owner or operator to excavate all piping not inspected before burial if the owner or operator does not give the required two business days' notice.
- H.** After construction is complete, a person who has a valid Authority to Construct permit may dispense gasoline for up to 90 days before final approval if an initial inspection is scheduled according to R3-7-1005.
- I.** An Authority to Construct permit expires one year from the date of issue or when a gasoline dispensing site is placed into service following installation or modification of an approved vapor recovery system, whichever is sooner.

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Historical Note

New Section R3-7-1004 recodified from Section R20-2-1004 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-1005. Initial Inspection and Testing

- A. Within 10 days after beginning the dispensing of gasoline at a site that requires an Authority to Construct permit, a person shall provide the Division with a written certification of completion by the contractor and schedule an inspection that includes tests and acceptance criteria specified in the Authority to Construct permit and this subsection. The inspection shall be witnessed by the Division at a time approved by the Division and include the following tests:
1. A pressure decay test for each vapor control system including underground storage tanks and tank vents using CARB TP-201.3 test procedures, as follows:
 - a. All test procedures pertaining to stage I vapor recovery systems shall be followed except the post-test procedures in section 8 and the calculations in section 9 of the CARB TP-201.3 test procedures;
 - b. The compliance status of the site shall be determined by comparing the final five-minute pressure with the minimum allowable final pressure in Table 1; and
 - c. A calculated ullage exceeding that listed in Table 1 shall be rounded up to the next higher ullage volume in the table;
 2. A test of each pressure vacuum vent valve using CARB TP-201.1E test procedures;
 3. A Tie-Tank test using CARB TP-201.3C test procedure;
 4. A Static Torque test for each rotatable stage I adaptor using CARB TP-201.1B test procedures; and
 5. Procedures specified by a manufacturer or CARB for testing the vapor recovery system.
- B. If there is a difference between a testing contractor's test results and the Division's test results, the Division's test results prevail.
- C. If a site fails to pass any of the tests required by subsection (A), the affected vapor recovery system or component shall remain out of service until the vapor recovery system and component pass all the appropriate tests in subsection (A).
- D. A person who cancels an initial inspection shall notify the Division by calling the Division's designated telephone number at least one hour before the scheduled inspection and shall reschedule the inspection within 10 business days after this notification. The Division shall take enforcement action if a person fails to comply with this Section.
- E. A person shall notify the Division when a vapor recovery system or component is repaired after failing an initial inspection. A registered service representative shall not proceed with a reinspection until the Division approves the reinspection date and time.
- F. If a registered service representative does not start an initial inspection pressure decay test within 30 minutes of the scheduled start time, the Division shall fail the initial inspection of that site.
- G. If a person cancels an initial inspection, the person shall reschedule the inspection within 90 days from the date gasoline was first dispensed.
 1. The Division shall take enforcement action if the person fails to timely reschedule the inspection.

2. The registered service agency shall notify the Division in writing at least 10 business days before the inspection of the time, date, and location of the inspection.
3. The Division shall notify the registered service agency within five business days, by email, whether it approves the inspection date and time.

Historical Note

New Section R3-7-1005 recodified from Section R20-2-1005 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-1006. Fee

The Authority to Construct permit fee is \$250.

Historical Note

New Section R3-7-1006 recodified from Section R20-2-1006 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-1007. Operation

- A. The owner or operator of a gasoline dispensing site with stage I vapor recovery shall not transfer or permit the transfer of gasoline into any gasoline storage tank subject to this Article unless stage I vapor recovery equipment is installed, maintained, operating, and being used according to the requirements of A.R.S. Title 3, Chapter 19, Article 7, and this Article.
- B. The owner or operator of a gasoline dispensing site with stage I vapor recovery shall operate the stage I vapor recovery system and associated components in compliance with the CARB certification or Division approval under A.R.S. § 3-3512 for that system and these rules.
- C. The owner or operator of a gasoline dispensing site with stage I vapor recovery located in area A shall inspect the system and its components at least once every seven days. The inspections shall include all stage I fittings and spill containment.
- D. The owner or operator of a gasoline dispensing site shall immediately stop using a stage I vapor recovery system or component if one or more of the following system or component defects occur:
 1. Tank vent pipes are not the proper height or are not properly capped with approved pressure and vacuum vent valves;
 2. Vent pipes do not meet the CARB-specified paint color code specified in R3-7-1004(D)(13);
 3. The stage I vapor recovery system is not properly installed or maintained as evidenced by the following:
 - a. Spill containment buckets are cracked, rusted, or not clean and empty of liquid; sidewalls are not attached or are otherwise improperly installed; and drain valves are non-functioning or do not seal;
 - b. A fill adaptor collar or vapor poppet (drybreak) is loose, damaged, or has a fill or vapor cap that is not installed or is missing, broken, not securely attached, or missing gaskets;
 - c. Coaxial stage I is not equipped with a functioning CARB-approved poppeted fill tube or the coaxial cap is not installed or is missing, broken, not securely attached, or missing gaskets; or
 - d. A fill tube is missing, broken, or not sealed; has holes or damaged overfill prevention; or the high

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point of the bottom opening is more than six inches above the tank bottom;

4. The tank rise cap with instrument lead wire for an electronic monitoring system is not installed tightly or any other tank riser is not sealed and capped securely;
 5. An above-ground storage tank does not display a permanently attached UL approval plaque; or
 6. Any other component identified in the diagrams, exhibits, attachments, or other documents and certified by CARB or required by the Authority to Construct permit for that system is missing, disconnected, or malfunctioning.
- E. For proper operation of a stage I vapor recovery system or component under A.R.S. § 3-3512(C)(4), the owner or operator of a gasoline dispensing site shall recover vapors during pump-out from a gasoline storage tank to a mobile transporter.
- F. The owner or operator of a gasoline dispensing site shall ensure that any underground tightness test is conducted in a manner that prevents gasoline vapors being emitted to the atmosphere.

Historical Note

New Section R3-7-1007 recodified from Section R20-2-1007 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-1008. Training and Public Education

Each owner or operator of a gasoline dispensing site using a stage I vapor recovery system or component shall obtain adequate training and written instructions to enable the system to be installed, operated, and maintained properly in accordance with the manufacturer's specifications and CARB certification. The owner or operator shall maintain documentation of this training onsite and make the documentation available to the Division within two business days of a request.

Historical Note

New Section R3-7-1008 recodified from Section R20-2-1008 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-1009. Recordkeeping and Reporting

- A. The owner or operator of a gasoline dispensing site employing a stage I vapor recovery system or component in area A shall maintain records of the inspections done under R3-7-1007.
- B. The owner or operator of a gasoline dispensing site employing a stage I vapor recovery system or component in area A shall maintain a log and related records of all regularly scheduled maintenance and any repairs that have been made to stage I equipment.
- C. The owner or operator of a gasoline dispensing site that is exempt under A.R.S. § 3-3512(B) from requirements to install and operate a stage I vapor recovery system or component shall maintain a log at the site showing monthly throughputs. The owner or operator shall make the log available to the Division within two business days after request. The owner or operator shall submit to the Division the throughput information required under R3-7-1002(B). If any throughput requirement provided in A.R.S. § 3-3512(B) and this Article is exceeded for any month, the owner or operator shall notify the Division in writing within 30 days. The owner or operator

shall, within six months after the end of the month the throughput is exceeded, install and operate a stage I vapor recovery system or component conforming to this Article. If a stage I vapor recovery system is already installed, the owner or operator shall have the system tested under R3-7-1010 within 30 days after the end of the month in which the throughput was exceeded.

- D. The owner or operator of a gasoline dispensing site shall keep all records required by this Article at the gasoline dispensing site for at least one year and shall make these records available to the Division upon request.

Historical Note

New Section R3-7-1009 recodified from Section R20-2-1009 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-1010. Annual Testing and Inspection

- A. A person shall ensure that an annual inspection is conducted by a registered service representative on or before the annual inspection date. The annual inspection date is the last day of the month in which the last scheduled annual inspection was performed. A registered service agency shall notify the Division in writing at least 10 business days before an annual inspection of the time, date, and location of the inspection. The Division shall notify the registered service agency within five business days, by email, whether it approves the annual inspection date and time. The registered service agency shall not perform the annual inspection unless the Division approves the inspection date and time.
- B. The annual inspection shall include the tests defined in R3-7-1005(A)(1) through (4) that pertain to the specific vapor recovery system installed.
- C. To verify proper operation of a vapor recovery system, the Division may perform or may require registered service representatives to perform additional tests under R3-7-1005(A)(5) during the annual inspection and testing. The Division shall provide registered service agencies with six months' notice before requiring additional annual testing under R3-7-1005(A)(5).
- D. If there is a difference between a testing contractor's test results and the Division's test results, the Division's test results prevail.
- E. If a site fails to pass any of the tests required under subsection (B), the affected vapor recovery system or component shall remain out of service until the vapor recovery system and component pass all tests required under subsection (B).
- F. After an annual inspection begins, a person shall not make a repair to the vapor recovery system or component until the results of the inspection are recorded.
- G. A person shall notify the Division when a stage I vapor recovery system or component is repaired after failing an annual inspection. A registered service representative shall not conduct a reinspection until the Division approves the reinspection date and time.
- H. A registered service representative shall perform all tests according to this Article and any other vapor recovery procedure the Division issues to registered service agencies.
- I. A person that cancels an annual inspection shall notify the Division by calling the Division's designated telephone number at least one hour before the scheduled inspection and shall reschedule the test to be completed by the annual inspection

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date. A registered service agency shall notify the Division in writing at least 10 business days before an annual inspection of the time, date, and location of the inspection. The Division shall notify the registered service agency within five business days, by email, of its approval of the inspection date and time. The Division shall take enforcement action if a person does not comply with this subsection.

- J. Gasoline dispensing sites located in area B are exempt from the annual inspection and testing requirements of this Section.

Historical Note

New Section R3-7-1010 recodified from Section R20-2-1010 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-1011. Compliance Inspections and Additional Test Methods

The Division shall not announce when it plans to conduct a compliance inspection of a stage I vapor recovery system or component. If results of a compliance inspection reveal a violation of A.R.S. Title 3, Chapter 19, or this Article, the Division shall require the vapor recovery system or component to undergo an appropriate test as specified in R3-7-1010.

Historical Note

New Section R3-7-1011 recodified from Section R20-2-1011 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3).

R3-7-1012. Enforcement

If the Division finds that a stage I vapor recovery system or component is defective or non-compliant with one or more of the provisions of this Chapter or A.R.S. Title 3, Chapter 19, the Division shall issue to the owner or operator an administrative order and place a Stop-Sale, Stop-Use tag on the non-compliant vapor recovery system or component. The owner or operator may be required to schedule an inspection for a stage I vapor recovery system or component to ensure that it meets all requirements of A.R.S. Title 3, Chapter 19 and this Chapter before the vapor recovery system or component is placed in service.

Historical Note

New Section R3-7-1012 recodified from Section R20-2-1012 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

R3-7-1013. Stage II Vapor Recovery

If the Division identifies a gasoline dispensing site operating a stage II vapor recovery system within an ozone nonattainment area designated as moderate, serious, severe, or extreme by the EPA under section 107(d) of the Clean Air Act or in area A after September 30, 2018, the Division shall issue an administrative order to require that the stage II vapor recovery system be decommissioned within three months after identification, and may impose a civil penalty under A.R.S. §§ 3-3473 and 3-3475.

Historical Note

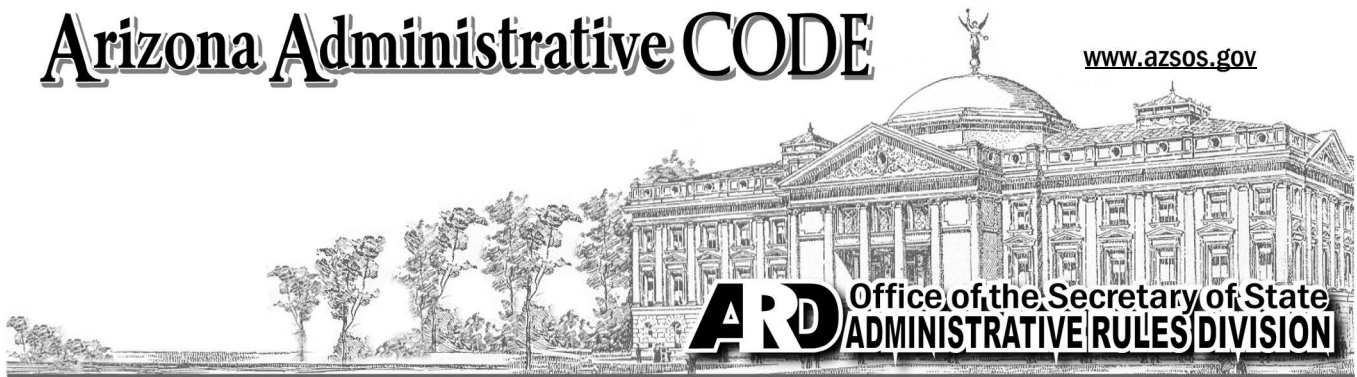
New Section R3-7-1013 recodified from Section R20-2-1013 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 2280, effective October 2, 2017 (Supp. 17-3). Amended by final rulemaking at 29 A.A.R. 441 (February 3, 2023), effective March 5, 2023 (Supp. 23-1).

Table 1. Acceptability of Final System Pressure Results for Systems Tested Using TP-201.3

Ullage (gallons)	Minimum Pressure after Five Minutes (Inches Water Column)
500	0.73
550	0.80
600	0.87
650	0.93
700	0.98
750	1.03
800	1.07
850	1.11
900	1.15
950	1.18
1000	1.21
1200	1.32
1400	1.40
1600	1.46
1800	1.51
2000	1.56
2400	1.62
2600	1.65
2800	1.67
3000	1.69
3500	1.73
4000	1.76
4500	1.79
5000	1.81
6000	1.84
7000	1.86
8000	1.88
9000	1.89
10000	1.90
15000	1.93
20000	1.95
25000	1.96

Historical Note

Article 10, New Table 1 recodified from 20 A.A.C. 2, Article 10, Table 1 at 22 A.A.R. 2786, effective August 15, 2016 (Supp. 16-3).



3 A.A.C. 8

Supp. 23-1

TITLE 3. AGRICULTURE

CHAPTER 8. DEPARTMENT OF AGRICULTURE - PEST MANAGEMENT DIVISION

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of
January 1, 2023 through March 31, 2023

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Questions about these rules? Contact:

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The release of this Chapter in Supp. 23-1 replaces Supp. 21-2, 1-27 pages.

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, www.azsos.gov under Services-> Legislative Filings.

EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.

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Administrative Rules Division

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TITLE 3. AGRICULTURE

CHAPTER 8. DEPARTMENT OF AGRICULTURE - PEST MANAGEMENT DIVISION

Authority: A.R.S. §§ 3-107 and 3-3603(A)(1)

Supp. 23-1

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ARTICLE 1. GENERAL AND ADMINISTRATIVE PROVISIONS

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ARTICLE 1. GENERAL AND ADMINISTRATIVE PROVISIONS**R3-8-101. Definitions**

In addition to the definitions provided in A.R.S. § 3-3601, the following terms apply to this Chapter:

“Administratively complete” means the application contains all components required by statute or this Chapter to be submitted to the PMD to enable the PMD to determine whether to grant a license or approval.

“Advertisement” means a written or oral notice, including a business card, website, or telephone directory listing, which is intended, directly or indirectly, to induce a person to enter into an agreement for pest management services.

“Applicator” means an individual who provides pest management services. Applicator does not include a laborer.

“Applicator certification” means a certified applicator license.

“Broadening” means to add another category of work to an existing certification.

“Certified applicator” means an individual who is licensed by the PMD to provide pest management services, including a QA.

“CEU” means continuing education unit.

“Continuing education unit” means 50 minutes of participation in continuing education.

“Control” or “manage” means, with respect to pests, to exterminate, eradicate, destroy, kill, repel, attract, sterilize, mitigate, remove, or a combination of these activities.

“Department” means the Arizona Department of Agriculture.

“Disassociate” means to die, become disabled, resign, retire, be ill or take leave for more than 14 days, be terminated, or be called to active military duty.

“Entire structure” means all critical areas as defined in this Chapter and as specified on product labeling for both the interior and exterior of a structure.

“EPA” means the U.S. Environmental Protection Agency.

“EPA registration number” means the actual EPA registration number of a product or the federal provision exempting the product from EPA registration.

“Faulty grade” means the top of the foundation is even with or below the adjacent earth. The existing earth level shall be considered grade. Specific exceptions are basement construction and sunken room construction when the surrounding foundation is at least 3 inches above the exterior grade level.

“Fog or fogging” means applying a pesticide by a flammable, aerosolizing thermal or other generator that forms particles less than 10 microns in diameter.

“Food-handling establishment” means a place, other than a private residence, in which food is received, served, stored, packaged, prepared, or processed.

“Fumigant” means a chemical substance with a vapor pressure greater than five millimeters of mercury at 25 degrees Centigrade that is used to destroy plant or animal life.

“Fumigation” means a method of pest management that completely fills an area with a fumigant to suffocate or poison pests within the area.

“Fungi” means saprophytic and parasitic organisms that lack chlorophyll such as molds, rusts, mildews, smuts, and yeast, except those on or in living people or animals or processed foods, beverages, or pharmaceuticals.

“Health care institution” means a health care institution licensed pursuant to title 36, chapter 4 and includes doctor and dental offices.

“Label” means a written, printed, electronic or graphic document that is approved by the EPA and on or attached to a pesticide container, the wrapper of a pesticide container, or a device.

“Labeling” means a written, printed, electronic or graphic document that is authorized by the manufacturer or a state or federal agency to accompany a pesticide or device, or is referred to on the label or in literature accompanying the pesticide or device.

“Laborer” means an individual who performs physical labor necessary for an applicator to provide pest management services, including drilling and trenching, but who does not handle any pesticide container that has ever been opened, identify infestations, make inspections, make inspection reports or recommendations with respect to infestations, or use any device for the purpose of eliminating, exterminating, controlling or preventing infestations, except that laborer includes an individual who assists with the use of a tarp on a structure for a fumigation performed by an applicator.

“Pest” means a vertebrate or invertebrate insect, bird, mammal, or other animal or organism, or a weed or plant pathogen that is in an undesirable location.

“Pesticide,” as defined in A.R.S. § 3-3601, includes an insecticide, fungicide, rodenticide, termiticide, fumigant, larvicide, piscicide, adulticide, herbicide, nematocide, avicide, or molluscicide.

“PMD” means Pest Management Division.

“Primary service,” as used in A.R.S. § 3-3613(B)(3), means applying an herbicide as the only or predominant service under a verbal or written contract to maintain a property.

“Project” means an individual address or a privately owned or individually owned dwelling.

“QA” means certified qualified applicator.

“QP” means qualifying party.

“Qualified applicator certification” means a certified qualified applicator license.

“SDS” means safety data sheet, which is a written communication regarding a hazardous chemical that meets the standards at 29 CFR 1910.1200(g).

“Service container” means a receptacle that is used to hold, store, or transport a pesticide concentrate or use-dilution preparation other than the original labeled receptacle provided by the manufacturer, a measuring instrument, or application equipment.

“Signal word” means a word printed on a label that indicates the toxicity level of the pesticide in the container to which the label is affixed.

“Special Local Need registration” means an authorization from the Department to use a pesticide, which meets an Ari-

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zona-specific need, in Arizona according to the terms of the registration.

“Specimen label” means a label other than the label attached to a pesticide container that contains the same information as the labeling; including an electronic label.

“Structure” means all parts of a building, whether vacant or occupied, in all stages of construction.

“Subterranean termites” means the several species of termites that usually maintain contact with the soil, including those in the families Rhinotermitidae and Termitidae.

“Supplemental wood-destroying insect inspection” means a re-examination made by an applicator of the business licensee that conducted a previous wood-destroying insect inspection and within 30 days of the previous examination to determine whether corrective treatment has been performed or conditions conducive to wood-destroying insects have been corrected.

“Tag” means a written document that is required under this Chapter to be posted conspicuously at a pretreatment or new-construction treatment site.

“TARF” means termite action report form.

“Termiticide” means a chemical registered by the EPA and the Department and used for control of termites.

“Water-retention basin” means an area to temporarily hold water run-off until the water dissipates.

“WDIIR” means wood-destroying insect inspection report.

“Wood-destroying insect inspection” means an inspection for the presence or absence of wood-destroying insects.

Historical Note

New Section recodified from R4-29-101 at 23 A.A.R.

1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-102. Certification Categories; Scope

The name and scope of each certification category are as follows and as prescribed in 40 CFR § 171.101(c), (e) through (h) (82 FR 1029, January 4, 2017), and (n). This material is incorporated by reference, is on file with the Department, and does not include any later amendments or editions:

1. The categories shall be as follows, and as prescribed in 40 CFR § 171.101(c), (e) through (h), and (n) (82 FR 1029, January 4, 2017). This material is incorporated by reference, is on file with the Department, and does not include any later amendments or editions; and,
2. The competency standards shall be as follows, and as prescribed in 40 CFR § 171.103(d)(3), (5) through (8), and (14) (82 FR 1029, January 4, 2017). This material is incorporated by reference, is on file with the Department, and does not include any later amendments or editions.
3. State-only categories.
 - a. Wood-destroying organism management.
 - i. Wood-destroying organism treatment: inspecting for the presence or absence of wood-destroying organisms and treating for wood-destroying organisms in or about a residential or other structure by a means other than use of a fumigant.
 - ii. Wood-destroying insect inspection: inspecting for the presence or absence of wood-destroying

insects only and excluding preparing treatment proposals.

- b. Wood preservation: application of pesticides, labeled for use on utility poles or railroad ties, directly to structural components of wood or wood products, to prevent or manage wood degradation by wood destroying organisms including fungi and bacteria, which are not part of an existing structure. This includes drilling a cavity into a structural timber, inserting a methylisothiocyanate or other similar product into the cavity, and sealing the cavity.
4. Competency standards for state-only categories.
 - a. Wood-destroying organism treatment certification applicants must be able to do the following:
 - i. Demonstrate practical knowledge of inspection of structures for the presence or absence of wood-destroying organisms, including recognition of wood-destroying organisms and signs of their presence, and understanding their life cycle, biology, and affect on building structural components;
 - ii. Demonstrate practical knowledge of treatment of structures to control the wood-destroying organisms;
 - iii. Demonstrate practical knowledge of the formulations appropriate for control of wood-destroying organisms;
 - iv. Demonstrate practical knowledge of methods of application that avoid contamination of sensitive areas, minimize damage and contamination to treated areas, minimize exposure to people and pets, and minimize environmental impacts;
 - v. Read and understand pesticide labels, labeling and safety data sheets for pesticides, and apply pesticides according to label and labeling instructions; and
 - vi. Complete a treatment proposal, TARF and WDIIR.
 - b. Wood-destroying insect inspection involves no use of pesticides, and certification applicants must be able to do the following:
 - i. Demonstrate practical knowledge of inspection of structures for the presence or absence of wood-destroying insects, including recognition of wood-destroying insects and signs of their presence, and understanding their life cycle, biology, and affect on building structural members; and
 - ii. Complete a WDIIR.
 - c. Wood preservation certification applicants must be able to do the following:
 - i. Demonstrate practical knowledge of inspection of wood for the presence or absence of wood-destroying organisms, including recognition of wood-destroying organisms and signs of their presence, and understanding their life cycle, biology, and affect on wood;
 - ii. Demonstrate practical knowledge of treatment of wood to control the wood-destroying organisms;
 - iii. Demonstrate practical knowledge of the formulations appropriate for control of wood-destroying organisms;

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- iv. Demonstrate practical knowledge of methods of application that avoid contamination of sensitive areas, minimize damage and contamination to treated areas, minimize exposure to people and pets, and minimize environmental impacts; and
- v. Read and understand pesticide labels, labeling and safety data sheets for pesticides, and apply pesticides according to label and labeling instructions.

Historical Note

New Section recodified from R4-29-102 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-103. Fees; Charges; Exemption

- A.** A person shall pay the following application and renewal fees for licensure, certification, and registration:
 - 1. For an applicator:
 - a. Applicator certification, \$55.
 - b. Applicator certification broadening application, \$0.
 - c. QA certification, \$75.
 - d. QA certification broadening application, \$15.
 - 2. For a qualifying party:
 - a. Registration at same time as application for or renewal of the business license, \$0.
 - b. Registration at a different time than application for or renewal of the business license, \$35.
 - c. Registration broadening, \$15.
 - d. Temporary qualifying party registration, \$75.
 - 3. For a business:
 - a. Business license, \$185.
 - b. Business license for federal entity, \$0.
 - c. Applicator registration, \$0 per applicator.
 - 4. For a branch:
 - a. Branch office registration, \$35 per branch.
 - b. Branch supervisor registration at same time as branch office registration, \$0.
 - c. Branch supervisor registration at a different time than branch office registration, \$15.
- B.** A person renewing an applicator certification, QA certification, business license, branch office registration, or branch supervisor registration shall receive a 10 percent reduction in the renewal fee for renewals submitted for a two year renewal period.
- C.** In addition to the fees listed in subsection (A), a person shall pay a \$10 handling fee for each application or renewal form not submitted electronically when PMD allows electronic submission.
- D.** A person shall pay a late fee equal to ten percent of the renewal fee for any license, certification, or registration that is not renewed timely.
 - 1. If a business license remains expired for more than 30 days, to renew the license, a person shall also pay an additional late fee of \$15 per month that the license remains expired, not to exceed \$165. Late fees are in addition to the renewal fee.
 - 2. If a certification remains expired for more than 30 days, to renew the certification, a person shall also pay an additional late fee of \$10 per month the certification remains

expired, not to exceed \$110. Late fees are in addition to the renewal fee.

- E.** A business licensee shall pay the following TARF fees:
 - 1. Electronic submissions, \$2;
 - 2. Electronic final grade treatment TARF submissions, \$0;
 - 3. Electronic TARF submissions for a pretreatment or new-construction treatment of an addition that abuts the slab of an originally treated structure, \$0, if the business licensee:
 - a. Performed the pretreatment or new-construction treatment of the main structure,
 - b. Filed a TARF regarding the pretreatment or new-construction treatment,
 - c. Has the structure under warranty, and
 - d. Treats the abutting addition under the terms of the site warranty;
 - 4. All paper submissions, \$8; and
 - 5. Late fee equal to the original TARF fee for any TARF submission more than 30 days after the due date, except that the late fee for an electronic final grade treatment TARF submission more than 30 days after the due date shall be \$2.
- F.** If the PMD administers a certification examination, an applicant shall pay \$50 to take the examination. If an examination service or testing vendor administers a certification examination, an applicant shall pay the examination service or testing vendor the examination cost established in the vendor's contract with the PMD.
- G.** PMD employees are exempt from the applicator and examination fees listed in this Section.
- H.** An applicant who makes a payment for a fee due under this Section that is rejected by a financial institution will be subject to all of the following:
 - 1. The PMD shall void any approval of the application or renewal.
 - 2. The applicant shall pay any financial institution fee incurred by the PMD.
 - 3. The PMD may require the applicant to pay all fees due using a method other than a personal or business check.
 - 4. An application for renewal will be considered untimely if the substitute payment is not received by the PMD by the original due date, and the applicant will be subject to a late fee based on the date of receipt of the substitute payment.
- I.** The PMD may reject an application or request for service that is submitted with the incorrect fee and not process the application or provide the service. An application for renewal will be considered untimely if the substitute payment is not received by the PMD by the original due date, and the applicant will be subject to a late fee based on the date of receipt of the substitute payment.

Historical Note

New Section recodified from R4-29-103 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2). Section amended by final expedited rulemaking at 25 A.A.R. 720, effective February 25, 2019 (Supp. 19-1). Section amended by final expedited rulemaking at 27 A.A.R. 1007, with an immediate effective date of June 8, 2021 (Supp. 21-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-104. Pest Management Division Council

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- A.** A five-member Pest Management Division Council is established to assist and make recommendations to the Director regarding the administration and implementation of A.R.S. Title 3, Chapter 20.
- B.** The members shall meet the following qualifications:
- Three members shall be business licensees or qualifying parties and shall each have a minimum of five years of pest management experience.
 - At least one of these three members shall be a business licensee who has five or fewer applicators.
 - For one of these three members, first priority shall be given to a business licensee or QP based outside of Maricopa and Pima Counties and secondary priority shall be given to a business licensee or QP who is not based outside of those counties but is associated with a business that has an office in Arizona outside of those counties. If there are no qualified first or secondary priority applicants, the Director may appoint any business licensee or QP with a minimum of five years of pest management experience.
 - One member shall be a representative of a political subdivision.
 - One member shall be a public member who does not provide pest management services or work for a business licensee.
- C.** Members shall serve three year staggered terms. Members shall not serve consecutive terms, except that a member who is appointed to fill a vacancy may serve the unexpired term that fills the vacancy plus one regular term. A member shall be ineligible for reappointment for three years.
- D.** The office of a member shall be deemed vacant under any of the following circumstances:
- The member no longer satisfies the qualification in subsection (B).
 - The member is unable to perform the duties of the office.
 - The absence of the member from three consecutive Committee meetings if the absences have not been excused by the Committee.
- E.** The Committee shall annually select a chairman and vice-chairman from among its members.
- Historical Note**
New Section recodified from R4-29-104 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).
- R3-8-105. Reserved**
- Historical Note**
New reserved Section recodified from R4-29-105 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).
- R3-8-106. Reserved**
- Historical Note**
New reserved Section recodified from R4-29-106 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).
- R3-8-107. Licensing Time-frames**
- A.** Overall time-frame. The PMD shall issue or deny a license within the overall time-frames listed in Table 1. The overall time-frame, which is the total number of days provided for both the administrative completeness and substantive review time-frames, begins when the PMD receives an application.
- B.** Administrative completeness review time-frame.
- During the administrative completeness review time-frame, the PMD shall notify the applicant in writing whether the application is complete or incomplete. If the application is incomplete, the PMD shall specify in the notice what information is missing. If the PMD does not provide notice to the applicant within the administrative completeness review time-frame, the PMD shall deem the application complete.
 - An applicant with an incomplete license application shall supply the missing information within the completion request period listed in Table 1. The administrative completeness review and overall time-frames are suspended from the postmark date of the notice of missing information until the date the PMD receives the information.
 - If an applicant fails to submit the missing information before expiration of the completion request period, the PMD shall consider the application withdrawn and close the file. An applicant whose file is closed may apply for a license by submitting a new application and application fee.
- C.** Substantive review time-frame.
- The substantive review time-frame listed in Table 1 begins when an application is administratively complete or at the end of the administrative completeness review time-frame in Table 1, whichever occurs first. If the PMD determines during the substantive review that additional information is needed, the PMD shall send the applicant a comprehensive written request for additional information.
 - Both the substantive review and overall time-frames are suspended from the date of the PMD request until the date that the PMD receives the additional information. The applicant shall submit the additional information within the additional information period listed in Table 1.
 - If the applicant fails to provide the additional information within the additional information period in Table 1, the PMD shall consider the application withdrawn and close the application. An applicant whose file is closed may apply for a license by submitting a new application and application fee.
- D.** Within the overall time-frame listed in Table 1, the PMD shall:
- Deny a license or approval to an applicant if the PMD determines that the applicant does not meet all the substantive criteria required by the PMD's statutes and this Chapter; or
 - Grant a license or approval to an applicant if the PMD determines that the applicant meets all the substantive criteria required by the PMD's statutes and this Chapter.
- E.** If the PMD denies a license or approval under subsection (D)(1), the PMD shall provide a written notice of denial to the applicant that explains:
- The reason for the denial, with citations to supporting statutes or rules;
 - The applicant's right to seek a fair hearing to challenge the denial; and
 - The time for appealing the denial.
- Historical Note**
New Section recodified from R4-29-107 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an

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immediate effective date of March 10, 2023 (Supp. 23-1).

Table 1. Time-frames (Calendar Days)

License	Authority	Administrative Completeness Review	Applicant Response to Completion Request	Substantive Completeness Review	Applicant Response to Additional Information Request	Overall Time-frame
Applicator	A.R.S. § 3-3614					
New	R3-8-203	30	45	60	360	90
Renewal	R3-8-208	30	45	60	15	90
Broaden	R3-8-210	30	45	60	360/ ∞*	90
Qualified applicator (QA)	A.R.S. § 3-3614					
New	R3-8-204	30	45	60	360	90
Renewal	R3-8-208	30	45	60	15	90
Broaden	R3-8-210	30	45	60	360	90
Qualifying party (QP)	A.R.S. § 3-3616					
New	R3-8-205	30	45	60	90	90
Renewal	R3-8-208	30	45	60	15	90
Broaden	R3-8-210	30	45	60	90	90
Temporary	R3-8-205	10	10	10	15	20
Business	A.R.S. § 3-3615; R3-8-202; R3-8-208; R3-8-209	30	45	60	15	90
Branch Office	A.R.S. § 3-3617; R3-8-206	30	45	60	15	90
Branch supervisor	A.R.S. § 3-3617					
New	R3-8-206	30	45	60	90	90
Renewal	R3-8-208	30	45	60	15	90
Continuing Education Approval	R3-8-216	20	20	55	15	75

* ∞ (Infinity) response refers to examination scores for current applications only.

Historical Note

New Article 1, Table 1 recodified from 4 A.A.C. 29, Article 1, Table 1, at 23 A.A.R. 1976, effective June 30, 2017; Table 1 amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-108. Reserved**Historical Note**

New reserved Section recodified from R4-29-108 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

ARTICLE 2. CERTIFICATION, REGISTRATION AND LICENSURE; CONTINUING EDUCATION**R3-8-201. Activities that Require a License; Exemptions**

- A. Business license. A person doing an activity defined as the business of pest management shall first possess a valid business license, unless the person is:
 1. A political subdivision;
 2. Acting on behalf of a business licensee or political subdivision; or
 3. Otherwise exempt by this Chapter or the PMD's statutes.
- B. Qualifying party registration. A business licensee or school district shall only do an activity defined as the business of pest management if the business licensee or school district has a registered qualifying party. The business licensee or school district shall only provide pest management services in a certification category if the qualifying party is registered in that certification category.
- C. Applicator licensure.
 1. An individual who provides pest management services shall be a certified applicator and only provide pest management services in a certification category for which the

applicator is currently certified except as provided under subsections (C)(2) and (C)(3) or as otherwise exempt by this Chapter or the PMD's statutes.

2. A certified applicator desiring to work in a category for which the applicator is not certified shall become certified in the category within 30 calendar days after beginning work in that category and shall be supervised as provided in subsection (C)(3)(c) while working in that category.
3. An individual may provide pest management services on behalf of a business licensee without being a certified applicator if the individual:
 - a. Is registered as an applicator of the business licensee under R3-8-207;
 - b. Has been registered as an applicator of the business licensee for not more than 90 calendar days out of the last 365 days; and
 - c. Is supervised by a certified applicator who:
 - i. Is certified in the category for which supervision is provided;
 - ii. Provides immediate supervision when the individual performs pest management services in the wood-destroying organism treatment, aquatic, or fumigation category, uses a restricted use pesticide, or uses a pesticide under an experimental use permit; and

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- iii. Provides direct supervision when the individual performs pest management services not covered by subsection (C)(3)(c)(ii).
- 4. An individual may not provide pest management services at a school, child care facility, health care institution, or food-handling establishment unless the individual is a certified applicator in the certification category for which services are being provided.
- 5. An individual using an animal to assist with identifying infestations or making inspections for the purpose of identifying or attempting to identify infestations shall be a certified applicator in the certification category for which services are being provided.
- D.** Applicator registration. An applicator may not provide pest management services on behalf of a business licensee or political subdivision unless the applicator is registered as an applicator of the business licensee or political subdivision pursuant to R3-8-207.
- E.** Exemptions. A person is not required to be licensed who:
 - 1. Provides general information about a label or labeling, the identification or management of a pest, integrated pest management or the use of a registered pesticide; does not directly or indirectly charge for the information; and does not make an on-site recommendation.
 - 2. Performs sales work that does not include:
 - a. Identifying on-site infestations or making inspections for the purpose of identifying or attempting to identify infestations;
 - b. Making written or oral inspection reports or on-site recommendations with respect to infestations; or
 - c. The application of pesticides or the use of devices for the purpose of eliminating, exterminating, controlling or preventing infestations.
 - 3. Is an authorized representative of any educational institution engaged in research in the study of pest management and does not provide pest management services for hire.
 - 4. Is a certified home inspector and documents evidence of wood-destroying organisms on a home inspection, but does not prepare a WDIIR, prepare a treatment proposal, make treatment estimates, bids, or recommendations, apply pesticides, or use devices.
 - 5. Only uses, applies or installs home improvement articles, such as insulation, caulk and paint, that are pre-incorporated with a pesticide.
- v. Person authorized to make decisions for the business if any other type of business form;
 - vi. Names of all principals of the business including all individuals or other corporations or partnerships that own at least ten percent interest of the business.
 - d. Telephone number;
 - e. Physical address;
 - f. Mailing address, if different from physical address;
 - g. Email address; and
 - h. Chemical storage address.
- 2. Daytime telephone number of individuals identified under subsection (A)(1)(c);
- 3. Name of the qualifying party; and
- 4. The dated signature and title of an authorized representative of the business affirming that the information provided is true and correct.
- B.** In addition to the form required under subsection (A), an applicant shall submit:
 - 1. The fee specified in R3-8-103;
 - 2. The proof of financial security required by A.R.S. § 3-3615;
 - 3. The name and physical address of the statutory agent of the business; and
 - 4. A copy of the Articles of Incorporation or Organization, Certificate of Limited Partnership, trust, trade name certificate, partnership agreement, or other evidence of the form of business organization.
- C.** A business cannot be licensed without a registered qualifying party.
- D.** If the PMD determines there may be cause to deny a license to an applicant, the PMD may send a written notice to the applicant requiring the applicant to appear at a specific location, date and time to answer questions.
- E.** A business license expires on May 31, and is:
 - 1. Issued with an expiration in the following calendar year as an initial licensure; and
 - 2. Renewable for one or two years, depending on the renewal period selected by the applicant.
- F.** A business license may not be transferred except in accordance with R3-8-209 and may not be renewed beyond the expiration of the registration for the business's qualifying party.
- G.** If an applicant's proof of financial security includes an insurance policy which provides for a deductible in excess of one percent of the total financial security for each occurrence, the applicant shall provide other evidence of financial security for the excess deductible amount as required by A.R.S. § 3-3615. Financial security in the following forms will be acceptable, provided that the nature of the security provides adequate protection for persons who may suffer bodily injury or property damage as a result of the operations of the applicant:
 - 1. Liability insurance, self-insured retention or surety bond issued by an insurer that holds a valid certificate of authority or that is permitted to transact surplus lines insurance in this state;
 - 2. Bank statement evidencing a deposit of money in an amount equal to, or greater than, the excess deductible amount; or
 - 3. Certified Check in an amount equal to, or greater than, the excess deductible amount.

Historical Note

New Section recodified from R4-29-201 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-202. Business License

- A.** An applicant for a business license shall submit the following information on a form obtained from the PMD:
 - 1. About the business:
 - a. Business name;
 - b. Name and form of business organization;
 - c. Names of the following persons authorized to act on behalf of the business:
 - i. Owner if a sole proprietorship;
 - ii. Managing or general partner if a partnership;
 - iii. President and other authorized officers if a corporation;
 - iv. All the managers or members if a limited liability company; or

Historical Note

New Section recodified from R4-29-202 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August

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29, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-203. Applicator Certification

A. Application. An applicant for applicator certification shall submit the fee specified in R3-8-103 and the following information on a form obtained from the PMD:

1. Full name;
2. Applicator certification number, if any;
3. Home address;
4. Mailing address, if different from the home address;
5. Telephone number;
6. Email address;
7. Date of birth;
8. Social Security number;
9. A statement whether the applicant has ever had a license or permit to practice pest management denied, revoked, or suspended and if the answer is yes, the date, jurisdiction taking the action, nature of the action, and explanation of the circumstances;
10. Name of employer, if any;
11. Employer's business license number, if applicable;
12. Employer's telephone number, if applicable; and
13. The applicant's dated signature affirming that the information provided is true and correct.
14. Information and documentation concerning lawful presence required by A.R.S. § 41-1080.

B. Examination. An applicant shall take and pass the certification examinations as provided in R3-8-211 in order to become certified.

C. An applicant for initial certification shall be at least 18 years of age.

D. If the PMD determines there may be cause to deny certification to an applicant, the PMD may send a written notice to the applicant requiring the applicant to appear at a specific location, date and time to answer questions.

E. Certification. Applicator certification is not transferable, expires on May 31, and is:

1. Issued with an expiration in the following calendar year as an initial certification,
2. Renewable for one or two years, depending on the renewal period selected by the applicant, and
3. Renewed for all certification categories for the same renewal period, and
4. The responsibility of the individual to whom it is issued.

Historical Note

New Section recodified from R4-29-203 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-204. Qualified Applicator Certification

A. Before applying for QA certification, an applicant shall fulfill the experience requirement for each category.

B. Application. An applicant for QA certification shall submit the fee specified in R3-8-103 and the following information on a form obtained from the PMD:

1. Full name;
2. Applicator certification number, if any;
3. QA certification number, if any;
4. Home address;
5. Mailing address, if different from the home address;

6. Telephone number;
7. Email address;
8. Date of birth;
9. Social Security number;
10. A statement whether the applicant has ever had a license or permit to practice pest management denied, revoked, or suspended and if the answer is yes, date, jurisdiction taking the action, nature of the action, and explanation of the circumstances;
11. Name of employer, if any;
12. Employer's business license number, if applicable;
13. Employer's telephone number, if applicable;
14. Certification categories for which application is made; and
15. The applicant's dated signature affirming that the information provided is true and correct.
16. Information and documentation concerning lawful presence required by A.R.S. § 41-1080, if not on file.

C. Experience. An applicant shall possess one of the following qualifications:

1. Certification as an applicator for 24 months within the ten years preceding the application in the category applied for.
2. Certification as an applicator for 12 months within the ten years preceding the application and either:
 - a. Successful completion of 12 semester hours or its equivalent within the 10 years preceding the application in pest management courses directly related to each category applied for; or
 - b. A Bachelor's degree in agricultural sciences, biological sciences, or pest management with 12 semester hours or its equivalent in pest management courses directly related to each category applied for.
3. Twenty four months of verifiable experience in the business of pest management, in another State where licensure was not required, within the ten years preceding application directly related to the category applied for.

D. For an individual who applies for QA certification within one year of honorable separation from active military duty, the time periods "preceding the application" in subsection (C) are tolled during the term of active military duty.

E. PMD review.

1. After notification by the PMD that the applicant is eligible for certification, the applicant may schedule and take the certification examinations described under R3-8-211.
2. If the PMD determines there may be cause to deny certification to an applicant, the PMD may send a written notice to the applicant requiring the applicant to appear at a specific location, date and time to answer questions.

F. Examination. An applicant shall take and pass the certification examinations as provided in R3-8-211 in order to become certified.

G. Certification. QA certification is not transferable, expires on May 31, and is:

1. Issued with an expiration in the following calendar year as an initial certification,
2. Renewable for one or two years, depending on the renewal period selected by the applicant,
3. Renewed for all certification categories for the same renewal period, and
4. The responsibility of the individual to whom it is issued.

H. For the purposes of this Section, pest management courses means courses in entomology, zoology, vertebrate management, plant pathology, agronomy, general horticulture, plant

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biology or botany, biochemistry, organic or inorganic chemistry, the eradication or management of weeds, toxicology, the environmental impact of pesticides, or any combination thereof.

Historical Note

New Section recodified from R4-29-204 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-205. Qualifying Party Registration; Temporary Qualifying Party Registration

- A. An applicant for registration as a QP shall submit the fee specified in R3-8-103 and the following information on a form obtained from the PMD:
 1. Full Name;
 2. QA certification number;
 3. Certification categories to be registered;
 4. Name, and license number if applicable, of the business or school district for which the applicant will act as the QP; and
 5. Dated signature of the applicant affirming that the information provided is true and correct;
- B. An individual may only register as a QP in categories for which the individual possesses QA certification.
- C. A certified applicator who is the representative of a business licensee or school district may register as a temporary QP if the QP has become disassociated with the business licensee or school district within the last 45 days. A certified applicator may only register as a temporary QP in the categories for which both the former QP was registered and the certified applicator is certified.
- D. An applicant for registration as a temporary QP shall submit the fee specified in R3-8-103 and:
 1. The information required in subsection (A), except subsection (A)(2);
 2. The applicant's applicator certification number;
 3. Written confirmation signed by the business licensee, school district, or former QP indicating that the former QP has become disassociated with the business licensee or school district; and
 4. A written statement signed by the business licensee or school district that:
 - a. The business licensee or school district has not operated in the business of pest management for more than five business days since the disassociation in the categories for which the disassociated QP was registered; and
 - b. The business licensee or school district wants the certified applicator to act as a temporary QP.
- E. A business licensee or school district shall not use a temporary QP to qualify the business or school district in a category for more than 180 days in any 12 month period.
- F. Registration.
 1. QP registration is not transferable, expires on May 31, and is:
 - a. Issued with an expiration in the following calendar year as an initial registration,
 - b. Renewable for one or two years, depending on the renewal period selected by the applicant, and
 - c. Renewed for all registration categories for the same renewal period.

2. Temporary QP registration is not transferable, is valid for 90 calendar days and may be renewed once for the business license.
3. A QP or temporary QP may only register to qualify one business licensee or school district except as provided in subsection (F)(4).
4. A QP for school districts shall separately register as a QP for each school district served, but may not register as a QP for more than one school district without approval from the Director pursuant to R3-8-402(C).

Historical Note

New Section recodified from R4-29-205 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-206. Branch Office Registration; Branch Supervisor Registration

- A. A business licensee may not do business from a branch office unless the branch office and a branch supervisor are registered with the PMD.
- B. To register a branch office, the business licensee shall submit the fee specified in R3-8-103 and the following information on a form obtained from the PMD:
 1. The business licensee's name and licensee number.
 2. About the branch office:
 - a. Full name of branch supervisor;
 - b. Branch supervisor's applicator certification number;
 - c. Telephone and fax numbers;
 - d. Physical address;
 - e. Mailing address, if different from physical address;
 - f. Email address; and
 - g. Chemical storage address; and
 3. The dated signature of an authorized representative of the business licensee.
- C. A branch office shall do business in the name of the business licensee only.
- D. To register as a branch supervisor, the applicant shall submit the fee specified in R3-8-103 and the following information on a form obtained from the PMD:
 1. Full name,
 2. Applicator certification number,
 3. Business name and license number,
 4. Physical and mailing address of branch office where the applicant will be the supervisor,
 5. Branch office telephone and fax numbers,
 6. Dated signature of the applicant affirming that the information provided is true and correct, and
 7. Dated signature of an authorized representative of the business licensee.
- E. A branch supervisor may only register to supervise a branch office at one physical location.
- F. Registration. Registration as a branch office or branch supervisor is not transferable, expires on May 31, and is:
 1. Issued with an expiration in the following calendar year as an initial registration, and
 2. Renewable for one or two years, depending on the renewal period selected by the applicant.

Historical Note

New Section recodified from R4-29-206 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August

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29, 2017 (Supp. 17-2).

R3-8-207. Applicator Registration

- A.** Every applicator of a business licensee or political subdivision shall be registered with the PMD as an applicator for that business licensee or political subdivision before providing pest management services for the business licensee or political subdivision. This requirement is in addition to applicator certification requirements.
- B.** To register an applicator, a person shall submit the fee specified in R3-8-103 and the following information about the applicator on a form obtained from the PMD:
 - 1. Full name;
 - 2. Name, and license number if applicable, of the business licensee or political subdivision;
 - 3. For an applicator of a business licensee, identification of the primary or branch office where the applicator's pest management records will be kept;
 - 4. For a certified applicator, the applicator's certification number;
 - 5. For an uncertified applicator, the applicator's:
 - a. Home address;
 - b. Mailing address, if different from the home address;
 - c. Email address;
 - d. Telephone number;
 - e. Date of birth;
 - f. Social Security number; and
 - 6. Dated signature of the applicant affirming that the information provided is true and correct.
- C.** An uncertified applicator shall be at least 18 years of age.
- D.** Applicator registration is valid from the date the PMD receives all the information required under subsection (B) and the registration fee.
- E.** Applicator registration is non-transferable and expires on May 31.
- F.** A business licensee and QP are jointly responsible for ensuring compliance with this Section.
- G.** The Director shall assess a business licensee with a \$150 civil penalty for each unregistered applicator.

Historical Note

New Section recodified from R4-29-207 at 23 A.A.R.

1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-208. License, Certification and Registration Renewal

- A.** An application to renew a business license, applicator or QA certification, or qualifying party, branch office, branch supervisor, or applicator registration is due May 1 of the year the license, certification, or registration expires. Failure to receive a renewal application does not justify a failure to timely renew.
- B.** An applicant for renewal shall submit the following information on a form obtained from the PMD:
 - 1. All renewals:
 - a. A change in physical address and mailing address, if any;
 - b. Email address;
 - c. Telephone number;
 - d. Dated signature of the applicant affirming that the information provided is true and correct; and
 - e. License specific information described in this subsection, if applicable.
 - 2. Business license:
 - a. Full name of the qualifying party in each category for which the business provides pest management services, and
 - b. Proof that the licensee still meets the financial security requirement in A.R.S. § 3-3615; and
 - c. A change in the chemical storage address, if any.

- 3. Applicator and QA certification:
 - a. Name of employer, if any;
 - b. A statement whether the applicant has had a license or permit to practice pest management denied, revoked, or suspended during the last 12 months and if the answer is yes, the date, jurisdiction taking the action, nature of the action, and explanation of the circumstances; and
- 4. Applicator registration: The names and if applicable certification numbers of all of the business licensee's current applicators.
- C.** An applicant for renewal shall select a one or two year renewal period and shall pay the renewal fee listed in R3-8-103 for each year of renewal.
- D.** CEU requirements. The Director shall not renew a certification unless, prior to the expiration of the current certification, the applicator obtains the CEUs required by R3-8-215.
- E.** Expired license, certification, or registration.
 - 1. An applicant who submits a complete renewal application, including the renewal fee, after the expiration of the license, certification, or registration shall pay the late fee listed under R3-8-103 as a penalty in addition to the renewal fee.
 - 2. An applicant may renew an expired applicator or QA certification without retaking the written examinations provided the applicant has satisfied the CEU requirements, during their most recent certification period.
 - 3. A certification that has been expired for more than 11 months may not be renewed. The former certificate holder may apply as a new applicant and shall retake and pass the applicable certification examinations.
 - 4. A business license that has been expired for more than one year may not be renewed. The former licensee may apply as a new applicant.
 - 5. Notwithstanding subsections (E)(1) through (4), an applicant who fails to renew because the applicant is on active military duty may obtain the continuing education required under R3-8-215 and apply for renewal within one year of honorable separation from active military duty without paying a late fee.
- F.** Renewal effective date.
 - 1. If an applicant submits a complete application for renewal, including the renewal fee, before the expiration of the license, certification, or registration, then the license certification, or registration does not expire until:
 - a. The renewal has been approved; or
 - b. In the case of denial or new limits on the license, certification, or registration, the last day for seeking review of the PMD order or later date fixed by a court.
 - 2. If an applicant fails to submit a complete application for renewal, including the renewal fee, before the expiration of the license, certification, or registration, then the license, certification, or registration expires as provided in this Article and is not valid until the PMD has approved the renewal application. A business, branch office, or applicator with an expired license, registration, or certification may not provide pest management ser-

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vices or otherwise engage in the business of pest management. A qualifying party with an expired registration may not qualify a business licensee or school district. A branch supervisor with an expired registration may not supervise a branch office.

G. Surrendering a certification or license.

1. An applicator or business licensee may surrender their certification or license at any time, except for the following situations:
 - a. The applicator or business licensee is currently the subject of an investigation; or
 - b. The applicator or business licensee owes civil penalties or termite action registration form fees.
2. An applicator or business licensee that has surrendered their certification or license is not absolved of any termite action registration form fees or civil penalties based on actions or omissions that occurred prior to surrendering their certification or license.
3. The Office shall not refund any certification or licensing fees paid prior to the applicator or business license surrendering their certification or license.

Historical Note

New Section recodified from R4-29-208 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-209. Change in Business Licensee

- A.** Transfer to spouse. A business license may be transferred to the licensee's spouse without a fee by submission of a Business License Entity Change Application if the licensee's spouse submits evidence of marriage to the licensee, keeps the same business name for the remainder of the licensee period and agrees to honor all of the licensee's customer contracts and warranties.
- B.** Transfer to new entity. A person may request a transfer of a business license to a new entity without a fee by submitting a Business License Entity Change Application if:
 1. The owners of the current business licensee own a majority of the new entity,
 2. The new entity keeps the same business name as the current business licensee for the remainder of the licensing period,
 3. The new entity agrees to honor all customer contracts and warranties provided by the current business licensee, and
 4. The current business licensee and the new entity are not the same form of entity.
- C.** When a business license is transferred under subsection (A) or (B), the new licensee shall be responsible for any outstanding fees or penalties owed to the PMD and for any disciplinary action taken by the PMD as a result of violations of this Chapter or the PMD's statutes by the former licensee.
- D.** Except as provided in subsections (A) and (B), a change in ownership of a licensed sole proprietorship requires a new business license.
- E.** If, through a change in ownership, a licensed business's office becomes a branch office of another licensed business, the new owner shall notify the PMD and comply with R3-8-206.
- F.** A business licensee shall report any change in the principals of the business to the PMD within 30 days. Principal means a person who owns at least a 10 percent interest in a business. Principal includes an owner that is itself a business as well as owners of a principal.

G. If a business licensee changes the name of the business, the licensee shall provide the following information on a Business Name Change Application submitted to the PMD prior to the change:

1. Name of business entity;
2. Current business name;
3. Business license number;
4. New business name requested;
5. Copy of the Registered Trade Name Certificate, amended Articles of Organization or Incorporation, amended Certificate of Limited Partnership, or amended Statement of Partnership Authority or Qualification showing the new name; and
6. Dated signature of the authorized representative of the business licensee affirming that the information provided is true and correct.

H. If a business licensee changes the form of the business, the licensee shall provide the following information on a Business Entity Change Application submitted to the PMD within 30 days of the change:

1. Name of licensed business entity;
2. Business name and license number;
3. Name and form of new business entity;
4. Names of the following persons authorized to act on behalf of the new business entity:
 - a. Owner if a sole proprietorship,
 - b. Managing or general partner if a partnership,
 - c. President and other authorized officers if a corporation,
 - d. All the managers or members if a limited liability company, or
 - e. Person authorized to make decisions for the business if any other type of business form;
5. Copy of the new business entity's Articles of Organization or Incorporation, Certificate of Limited Partnership, trust, trade name certificate, partnership agreement, or other evidence of the form of business organization;
6. As applicable, the Articles of Merger or Consolidation, Statement of Merger, or approved partnership conversion; and
7. Dated signature of the authorized representative of the business licensee affirming that the information provided is true and correct.

Historical Note

New Section recodified from R4-29-209 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-210. Certification Broadening

- A.** To broaden an applicator certification, the applicant shall:
 1. Submit the application described in R3-8-203,
 2. Submit the fee required under R3-8-103, and
 3. Take and pass the certification examination for the specific category in which broadening is sought.
- B.** A QA is eligible to broaden a QA certification only if, in the category in which broadening is sought, the QA has a valid applicator certification or a qualification listed in R3-8-204(C).
- C.** To broaden a QA certification, the QA shall:
 1. Submit the application described in R3-8-204 and indicate on the application the category in which broadening is sought,
 2. Submit the fee required under R3-8-103,

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3. Submit the evidence of experience required under R3-8-204(C) for the category in which broadening is sought except as provided in subsection (D), and
 4. Take and pass the certification examination for the specific category in which broadening is sought.
- D.** Experience exemptions. A QA may become certified without meeting the experience requirement of R3-8-204(C) in the categories of:
1. Right-of-way or ornamental and turf if the individual has QA certification in the category of industrial and institutional, wood-destroying organism treatment, ornamental and turf, or right-of-way.
 2. Wood-destroying organism management if the individual has QA certification in the industrial and institutional category.
 3. Wood preservation if the individual has QA certification in the wood-destroying organism treatment category.

Historical Note

New Section recodified from R4-29-210 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-211. Certification Examination

- A.** An applicant for applicator certification or QA certification shall make arrangements to take the certification examinations by contacting the PMD or the examination service or testing vendor with which the PMD has contracted. An individual may apply for applicator certification in any of the categories found in R3-8-102.
- B.** The Department shall ensure that the core examination tests the knowledge and understanding of 40 CFR 171.103(c) (82 FR 1029, January 4, 2017). This material is incorporated by reference, is on file with the Department, and does not contain any later amendments or additions.
- C.** The category competency standards shall be as prescribed in 40 CFR § 171.103(d)(3), (5) through (8), and (14) (82 FR 1029, January 4, 2017). This material is incorporated by reference, is on file with the Department, and does not contain any later amendments or additions.
- D.** To be certified, an applicant shall score at least 75 percent on the general standards ("core") examination and on the category-specific examination in each category for which the applicant seeks certification.
- E.** An applicant who fails an examination may not retake the examination for at least seven days or more than two times in a 6-month period.
- F.** An examination score is only valid for the earlier of 12 months from the date of application for certification or 12 months from the examination date.
- G.** The PMD shall void the examination score and deny the application of an applicant that the PMD determines cheated on an examination. The applicant may not reapply for one year.

Historical Note

New Section recodified from R4-29-211 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-212. Reciprocity

The Director may waive the examination requirements in whole or in part for an individual who is certified as an applicator by another state, federal, or tribal agency under an approved EPA certification plan. In order to qualify for reciprocity:

1. An applicant must apply for Arizona reciprocal certification. In that application, the candidate shall:
 - a. Provide information as in R3-8-203 or R3-3-204, as applicable.
 - b. Submit the Department required form to their state, federal or tribal agency for verification of certification.
2. Upon verification of like competency standards for each category of certification requested, the Department shall issue an Arizona certification.
3. In addition to reasons for revocation under A.R.S. Title 3, Chapter 20, Articles 1 through 5, and the rules adopted thereunder, the Department can terminate an applicator's certification upon notification that the applicator's original certification has been terminated for any reason.

Historical Note

New Section recodified from R4-29-212 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-213. Political Subdivision Responsible Individual

- A.** A political subdivision that uses pesticides to conduct pest management on property that is owned, leased or managed by the political subdivision, including easements, shall designate an individual or individuals responsible for the following:
 1. Responding to inquiries or concerns by the Director or the Director's designee regarding compliance with A.R.S. Title 3, Chapter 20.
 2. Identifying for the Director or the Director's designee where records required by this Chapter are maintained, where personal protection equipment is located, and where pesticides are stored.
 3. Demonstrating that all applicators are properly certified.
- B.** The political subdivision shall annually submit the following information about the responsible individual(s) during the month of May on a form obtained from the Director or the Director's designee:
 1. Full name;
 2. Physical address;
 3. Mailing address, if different from the physical address;
 4. Email address;
 5. Telephone number;
 6. Dated signature of the responsible individual(s) affirming that the information provided is true and correct.
- C.** If the political subdivision changes its responsible individual(s), the political subdivision shall provide the information about the new responsible individual(s) listed in subsection (B) to the Director within 30 days.
- D.** School districts are exempt from this Section.

Historical Note

New Section recodified from R4-29-213 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-214. Reserved**Historical Note**

New reserved Section recodified from R4-29-214 at 23

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A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-215. Continuing Education

- A. A certified applicator who is not a QA shall, during the current certification period, obtain six CEUs in order to renew the certification for one year or 12 CEUs in order to renew for two years.
- B. A QA shall, during the current certification period, obtain 12 CEUs in order to renew the certification for one year or 24 CEUs in order to renew for two years.
- C. For an individual who holds both a certified applicator license and a QA license, obtaining the units required in subsection (B) satisfies the requirement in subsection (A).
- D. CEUs earned during a certification period that are in excess of the requirements in this Section do not carry forward for use in a subsequent certification period.
- E. An applicator who teaches a continuing education course may earn one unit of continuing education for each hour taught, not more than once during a calendar year.
- F. No CEU credit will be earned by an attendee of a continuing education course who does not complete the course.
- G. No CEU credit will be earned by an attendee of a continuing education course who had previously attended the same course during the same licensing period.

Historical Note

New Section recodified from R4-29-215 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-216. Continuing Education Approval

- A. Only continuing education courses approved by the PMD may be used to satisfy the continuing education requirement in R3-8-215. The PMD shall approve a continuing education course only if the course addresses what is found in R3-8-211(B) and (C).
- B. A person who wishes to have the PMD determine whether a course qualifies for CEU credit shall submit the following information to the PMD:
 1. Type of continuing education listed under subsection (A);
 2. Name of continuing education provider;
 3. Address and telephone number of continuing education provider;
 4. Course outline, listing the subjects and indicating the amount of time allocated for each subject;
 5. Brief description of the information covered within each subject;
 6. Brief biography of the presenter, demonstrating the presenter's qualifications;
 7. Whether a fee is charged for attending the course;
 8. Date and location of each session;
 9. Whether the course is open to the public;
 10. Number of continuing education units sought;
 11. Previous continuing education number, if any; and
 12. Dated signature of applicant;
- C. The provider of an approved continuing education course shall:
 1. Enter attendance information using the PMD's on-line continuing education reporting tool within 10 days after the date of the continuing education course, and
 2. Maintain a copy of the verification of attendance and original sign-in sheet that lists the attendees' names and certification numbers for two years.
 3. Allow PMD and Department employees to attend the course and review course materials without charge,

except that the provider has no obligation to provide food to the employees that is made available for paying attendees.

4. Notify PMD in writing of the date, time and place of each continuing education course at least two weeks before each course. In-house and online courses are exempt from this requirement.
- D. Unless otherwise indicated in the notice of approval, the PMD's approval of a continuing education course is valid for two years.
- E. Approval of a continuing education course is not renewable. To reapply for approval of a continuing education course, a person shall comply with the requirements of subsection (B).
- F. The provider of an approved continuing education course shall provide notice and updated information to the PMD within 10 days after the subject matter or instructor of the course changes.
- G. To evaluate the effectiveness of a continuing education course, the PMD may monitor an approved continuing education course at no cost.
- H. The PMD shall revoke its approval of a continuing education course if the PMD determines that the course fails to meet the standards for approval listed in this Section, the continuing education provider provided false information on its application or false information pertaining to attendance, or the continuing education provider fails to comply with the PMD's statutes and this Chapter.
- I. The PMD may modify the number of CEUs earned for a CEU course if the CEU course varies significantly in content or length from the approved curriculum. If the PMD modifies the number of CEUs earned, the PMD shall send a letter of modification to the course organizer, who shall be required to inform all individuals who attended the course.

Historical Note

New Section recodified from R4-29-216 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

ARTICLE 3. PEST MANAGEMENT**R3-8-301. Using Pesticides and Devices**

- A. An applicator shall use only a pesticide that is currently registered for use by the Department or was registered by the Department and does not have a passed EPA end use date.
- B. An applicator shall not misuse a pesticide or device. It is misuse of a pesticide or device if an applicator:
 1. Applies, handles, stores, or disposes of a pesticide or device in a manner that is inconsistent with the label or labeling;
 2. Provides a pest management service or handles a pesticide without wearing clothing and using the personal protective equipment required by the label or labeling to protect the applicator from pesticide exposure;
 3. Uses a pesticide in a manner that causes the pesticide to come into contact with a person, other than the applicator, animal, or property, other than the property receiving the pest management service, unless the contact results from an accident beyond the reasonable control of the applicator;
 4. Uses a pesticide in a food-handling establishment that is not labeled for food-handling establishment; and

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5. Uses a pesticide in a manner that contaminates food, feed, or drugs or equipment used to prepare or serve food, feed, or drugs.
- C. While mixing a pesticide with water, an applicator shall protect the water supply from back-siphoning of the pesticide mixture. An applicator shall not add water to a tank in which a pesticide is mixed or from which a pesticide is dispensed by protruding a fill-pipe or hose connection into the tank. An applicator shall ensure that a fill-pipe or hose connection terminates at least two inches above the tank fill opening or is equipped with an effective anti-siphoning device.
- D. An applicator shall ensure that all equipment, including auxiliary equipment such as a hose or metering device, used for mixing or applying a pesticide is in good repair and operating properly.
- E. An applicator shall apply, store, or dispose of a pesticide designated by the EPA as restricted use only if the applicator is certified or working under the immediate supervision of an applicator certified in the category for which the restricted-use pesticide is applicable.
- F. An applicator shall clean a pesticide spill in accordance with the pesticide label and labeling directions and in a manner that minimizes exposure to humans and other non-target organisms. If a pesticide spill may endanger humans, an applicator shall clean the pesticide spill in accordance with recommendations by health and medical personnel and local authorities.
- G. An applicator shall apply a pesticide at a rate provided by a Special Local Need registration issued by the Department and the pesticide labeling. The applicator shall have in the applicator's possession at the time of the application both the Special Local Need labeling and the EPA section 3 label and labeling.
- H. If information regarding provision of a particular pest management service is not available on the pesticide label or labeling or addressed in the PMD's statutes or this Chapter, an applicator shall comply with the pesticide manufacturer's recommendation and the general industry practice prevailing in the community at the time the pest management service is provided.
- I. If there is a conflict between any provision in this Section and labeling instructions, an applicator shall follow the more specific instruction.
4. The strength of the concentrate or dilution expressed as a percentage of active ingredients;
5. Any signal word required on the label; and
6. The phrase "KEEP OUT OF REACH OF CHILDREN."
- D. An applicator shall not place words or markings on a service container or on the label affixed to the service container that are unrelated to the pesticide in the service container, except for markings related to a method of tracking the product.
- E. If the label affixed to a pesticide container becomes lost or damaged, an applicator shall attach a specimen label to the pesticide container.
- F. An applicator shall replace a damaged container, other than a fumigant container, with an identically labeled container or a properly labeled service container.
- G. Application equipment from which a pesticide is directly discharged and in which the pesticide is not stored is not subject to the labeling requirements of this Section.
- H. An applicator shall not store a pesticide in a manner which food, beverage, feed, drugs, cosmetics, eating utensils, or tobacco products can be contaminated.
- I. An applicator shall not store a pesticide in a container that was used for food, beverage, feed, drugs, or cosmetics, or which by size, shape, or marking could be confused as being a food, beverage, feed, drug, or cosmetic.
- J. An applicator shall not store a fumigant within a residence, office or cab of a vehicle.
- K. An applicator shall ensure that a pesticide in an original or service container, an empty pesticide container that has not been prepared for disposal in accordance with its label, or a returnable or reusable pesticide container is kept in a locked storage space when on an unattended service vehicle or is within view and under the supervision of the applicator responsible for the service vehicle.
- L. An applicator shall ensure that a pesticide in portable application equipment is kept locked when on an unattended service vehicle or is within view and under the supervision of the applicator responsible for the service vehicle.
- M. To prevent damage during transit, an applicator shall ensure that a pesticide container is secured in a locked storage space while the pesticide container is transported on a service vehicle.

Historical Note

New Section recodified from R4-29-301 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-302. Storing and Disposing of Pesticides and Devices

- A. An applicator shall store and dispose of a pesticide or device in a manner consistent with its label and labeling.
- B. An applicator shall store a pesticide in a closed container that is free from corrosion, leakage, or pesticide contamination on the outside of the container and properly labeled.
- C. An applicator shall ensure that a service container bears a durable and legible specimen label with the following information:
 1. The name, address, and telephone number of the business licensee or political subdivision;
 2. The common chemical or trade name of the principal active ingredients;
 3. The EPA registration number;

Historical Note

New Section recodified from R4-29-302 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-303. Pesticide and Device Storage Area

- A. A business licensee or political subdivision shall provide a pesticide and device storage area that complies with all federal, state, and local laws. The storage area may include an area on a service vehicle.
- B. A business licensee or political subdivision shall secure the storage area required under subsection (A) from unauthorized entry by equipping its entrance or access with a lock.
- C. Immediately after storing a pesticide, a business licensee or political subdivision shall conspicuously post a sign at the entrance or access to a non-vehicle storage area and on a vehicle storage area indicating there is a pesticide, chemical, or poison stored inside.
- D. A business licensee or political subdivision shall provide sufficient ventilation to the outside of the storage area required under subsection (A) to prevent build-up of odors and preclude chemical injury to an individual or animal.
- E. A business licensee or political subdivision shall provide the following in or immediately adjacent to the storage area

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required under subsection (A), including a storage area on a service vehicle:

1. Electric or battery-powered lighting that is sufficient to read a pesticide label;
2. Fully charged and operational fire extinguisher or fire suppression system appropriate to each pesticide stored in the area;
3. Emergency medical information including the telephone number of the state or local poison control center;
4. Material capable of absorbing a spill or leak of at least one gallon;
5. Specimen label and SDS for each pesticide stored in the area; and
6. Washing facilities that include at least one gallon of fresh water, soap, and towels.

Historical Note

New Section recodified from R4-29-303 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-304. Devices Exempt from Licensure and Registration; Advertising

- A.** The following devices are not subject to the licensure and registration requirements of this Chapter or the PMD's statutes:
1. Physical barriers used to remove or prevent infestation by pests;
 2. Equipment used for the physical removal of pests or the habitat of pests;
 3. Mechanical equipment used for the physical removal of weeds and other vegetation;
 4. Mechanical traps used without a pesticide;
 5. Installation equipment used for home improvement or modifications;
 6. Raptors used to control or relocate other birds; and
 7. Fire arms.
- B.** An unlicensed person who engages in the business of pest management, but is exempt from licensure and registration because the person does not apply any pesticides and only uses devices listed in subsection (A) shall prominently display or include the phrase "Not licensed to apply pesticides" in all written and oral advertisements.

Historical Note

New Section recodified from R4-29-304 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-305. Equipping a Service Vehicle

A business licensee or political subdivision shall provide each service vehicle with the following:

1. All equipment and supplies required by the label and labeling to apply properly the pesticides on the service vehicle;
2. A measuring and pouring device compatible with the pesticides on the service vehicle;
3. Protective clothing and safety equipment suitable for use when handling, mixing, or applying the pesticides on the service vehicle;
4. Material capable of absorbing a spill or leak of at least one gallon;
5. A storage container large enough to hold material contaminated by absorbing a spill or leak of pesticides;
6. At least one gallon of clean, drinkable water for each individual using the service vehicle at one time;
7. Uncontaminated change of clothing;

8. Specimen label and SDS for each pesticide on the service vehicle; and
9. A locking storage space designed to prevent a pesticide container from being damaged while in transit.

Historical Note

New Section recodified from R4-29-305 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-306. Providing Notice to Customers

- A.** Immediately following an application, the applicator shall provide a written notice to a customer for whom the applicator provides a pest management service that contains the:
1. Name and address of the customer;
 2. Specific site to which a pesticide was applied;
 3. Date of service;
 4. Target pest or purpose of service;
 5. Trade name of pesticide applied;
 6. EPA registration number of restricted use pesticide applied;
 7. Amount of pesticide applied, in terms of percent active ingredient and volume of diluted mixture or in terms of total amount of liquid concentrate, ready-to-use product, granular material, or bait stations;
 8. Name and certification number of the applicator or if the applicator is uncertified, the name of the uncertified applicator and the name and certification number of the applicator providing supervision; and
 9. Following statement printed in at least an eight-point font: "Warning—Pesticides can be harmful. Keep children and pets away from pesticide applications until dry, dissipated, or aerated. For more information, contact [business licensee's name and business license number issued by the PMD] at [business licensee's telephone number]."
- B.** The applicator may provide the notice required by subsection (A) electronically.
- C.** An applicator who provides a pest management service at a school shall comply with the notification requirements in A.R.S. § 3-3606.

Historical Note

New Section recodified from R4-29-306 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-307. Performing a Wood-destroying Insect Inspection; WDIIRs

- A.** Only an applicator certified in the category of wood-destroying organism management, who works under the direct employment of a business license and who has received the training required under A.R.S. § 3-3633 may complete a WDIIR.
- B.** An applicator completing a WDIIR shall inspect all areas of a structure including crawlspaces that are visible or accessible at the time of the inspection. The applicator may use techniques such as non-destructive probing and sounding.
- C.** An applicator completing a WDIIR may exclude from inspection an area that is permanently covered by a floor covering, wall covering, or built-in appurtenance such as a bookcase, cabinet, appliance, equipment, or furniture or that would require removing or marring finish work or moving furniture, appliances, or equipment. The applicator shall note on the WDIIR all areas that are not inspected and the reason the areas are not inspected.

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- D.** An applicator completing a WDIIR shall inspect all areas where there is evidence of current or previous infestation and where a condition conducive to infestation exists. A condition conducive to infestation includes:
1. Faulty grade level. If a structure contains a slab or floor that is at or below grade, the existing earth level is considered grade level;
 2. Inaccessible sub-area such as an area with less than 24 inches of clear space between the bottom of a floor joist and grade level;
 3. Excessive cellulose debris. Cellulose debris is excessive when:
 - a. The debris can be raked into a pile of at least one cubic foot,
 - b. A stump or wood imbedded in a footing of the structure is in contact with earth, or
 - c. Firewood or a lumber pile is within six inches of the structure;
 4. Earth-to-wood contact, which involves wood that is part of a structure or that is attached to or securely abuts the structure and is in contact with the ground; or
 5. Excessive moisture or evidence of a moisture condition in or around a structure.
- E.** To verify whether a corrective treatment was performed or a condition conducive to infestation was corrected, an applicator may conduct a supplemental inspection within 30 days after an original inspection. An inspection conducted more than 30 days after an original inspection is not a supplemental inspection.
- F.** An applicator completing a WDIIR may exclude from inspection other structures at the site. The applicator shall note on the WDIIR all structures at the site that are not inspected and the reason the structures are not inspected.
- G.** WDIIRs shall be prepared in accordance with R3-8-501(E).

Historical Note

New Section recodified from R4-29-307 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-308. Performing Wood-destroying Insect Management

- A.** An applicator shall not perform wood-destroying insect management or fumigation unless the applicator is certified in the category of wood-destroying organism treatment or fumigation, respectively, or working under the immediate supervision of an applicator who is certified in the category of wood-destroying organism treatment or fumigation respectively.
- B.** An applicator shall not perform wood-destroying insect management, issue a treatment proposal, or quote a fee for service until the business licensee that employs the applicator ensures that:
1. An on-site inspection of the property is performed by a certified applicator meeting the training requirement under A.R.S. § 3-3632(E),
 2. A treatment proposal is prepared, based upon the on-site inspection, on a form approved by the PMD and contains the information required under A.R.S. § 3-3632(B) and (C), and
 3. The treatment proposal is delivered to the person requesting the proposal or treatment, prior to the treatment.
- C.** An applicator shall apply a termiticide only in the quantity, strength, dosage, and manner prescribed on the termiticide label unless otherwise specified by this Chapter or a PMD order.
- D.** Pretreatment for commercial or residential construction.
1. Unless a contract between the business licensee and customer specifies additional requirements, an applicator performing a pretreatment shall:
 - a. Establish a horizontal barrier of termiticide before any concrete slab under roof is poured or in conjunction with establishing the footings and supports for a raised foundation; and
 - b. Establish a vertical barrier of termiticide in all critical areas visible during the time of pretreatment. An area is critical at the time of pretreatment if the area is identified as critical by the termiticide label or if there is soil in the immediate vicinity of:
 - i. A penetration or protrusion through the slab;
 - ii. An observable preset for crack or joint control;
 - iii. A formed-up change of grade level;
 - iv. Abutting slabs;
 - v. A bath trap or tear-out;
 - vi. The interior of a foundation or stem wall; or
 - vii. A pier, pillar, pipe, or other object that extends from the soil to the structure.
 2. Except as specified on the termiticide label, an applicator shall treat all critical areas during a pretreatment at a rate allowed by the product label, for each foot of depth from grade level to the footer. If there is no adjacent footer, the applicator shall treat to a depth of one foot or as specified by labeling instructions.
 3. Unless the termiticide label requires more, an applicator is not required to treat a critical area during a pretreatment beyond a depth of four feet if:
 - a. Treating beyond a depth of four feet will, or reasonably may, cause an off-site application;
 - b. Access to the footer is not possible because of its distance below grade; or
 - c. Treating beyond a depth of four feet will, or reasonably may cause an environmental contamination.
 4. If an applicator does not treat a critical area during a pretreatment beyond a depth of four feet because the applicator determines that one of the exceptions in subsection (D)(3) is applicable, the applicator shall:
 - a. Apply the amount of termiticide possible without causing an off-site application or environmental contamination, and
 - b. Include evidence of the exception in the treatment record. Evidence of the exception may include:
 - i. A photograph of the interior grade and adjacent location that would or reasonably might be contaminated by treating beyond a depth of four feet,
 - ii. A photograph of the site after the pretreatment but before concrete placement,
 - iii. A written statement from the general contractor concerning the fill material and compaction rating,
 - iv. A written statement from the concrete subcontractor describing the depth of the footer as greater than four feet, or
 - v. A written compaction rating statement from the engineering subcontractor.
 5. If an applicator is advised before concrete is poured that a treated area is disturbed and the continuous horizontal or vertical chemical barrier established under subsection

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- (D)(1) is broken, and if the applicator is provided an opportunity to re-treat the disturbed area, the applicator shall re-treat the disturbed area and re-establish a continuous horizontal and vertical chemical barrier.
6. Immediately after completing a pretreatment, an applicator shall securely affix a tag to the pretreatment site. The applicator shall ensure that the tag is visible, readily available for inspection, and unlikely to be covered with concrete or soil. If there is a contractor's permit or inspection board at the pretreatment site, the applicator may affix the tag to the board. The applicator shall ensure that the tag contains the following information about the pretreatment:
 - a. Name of business licensee;
 - b. Address of business licensee;
 - c. Telephone number of business licensee;
 - d. License number of business licensee;
 - e. Location or address of project;
 - f. Date of pretreatment application;
 - g. Time that application was started (not time that applicator arrived at the site);
 - h. Time that application ended (not time that applicator left the site);
 - i. Trade name of pesticide used;
 - j. Percentage of active ingredient in the pesticide used;
 - k. Number of gallons of chemical preparation applied;
 - l. Square footage of area treated;
 - m. Linear footage of area treated;
 - n. Type of slab construction;
 - o. Name of applicator; and
 - p. Certification number of applicator or, if not certified, the name and certification number of the applicator providing immediate supervision.
 7. If it is necessary for an applicator to abandon a pretreatment site before completing the treatment, the applicator shall complete and affix the tag described in subsection (D)(6), representing the work completed, and after marking the tag "TREATMENT IN-COMPLETE."
 8. If a contractor requires a copy of the tag described in subsection (D)(6) for the customer's file, an applicator shall prepare and provide the contractor with a duplicate tag that is clearly marked "DUPLICATE."
- E.** New-construction treatment for commercial or residential construction.
1. Unless specifically precluded by the termiticide label, an applicator performing a new-construction treatment shall treat all critical areas visible at the time of the treatment. An area is critical at the time of a new-construction treatment if the area is identified as critical by the termiticide label or if there is soil in the immediate vicinity of:
 - a. A penetration or protrusion through the slab;
 - b. An observable crack or joint;
 - c. Abutting slabs;
 - d. A bath trap or tear-out;
 - e. The interior of a foundation or stem wall; or
 - f. A pier, pillar, pipe, or other object that extends from the soil to the structure.
 2. An applicator shall comply with subsections (D)(2) through (D)(4) when treating a critical area during a new-construction treatment except that the treatment shall be at the labeled rate rather than at a rate of four gallons of chemical preparation per 10 linear feet for each foot of depth.
 3. If an applicator is advised that a treated area is disturbed, the applicator shall re-treat the disturbed area.
 4. Immediately after completing a new-construction treatment, an applicator shall securely affix a tag to the new-construction site in the manner described in subsection (D)(6). The applicator shall ensure that the tag contains the information listed in subsection (D)(6).
 5. An applicator shall comply with subsections (D)(7) and (D)(8) when performing a new-construction treatment.
- F.** Final grade treatment for commercial or residential construction.
1. A business licensee that performs a pretreatment or new-construction treatment shall perform a final grade treatment. The final grade treatment must occur after all grading and other construction-related soil disturbance is complete, but within 18 months of the original pretreatment or new construction treatment. The business licensee shall keep a written or electronic record as to why the final grade has not been completed and an estimated time for completion. This record shall be available upon written requests for inspection by the Agency.
 2. Except as specified on the termiticide label, an applicator shall treat all critical areas during a pretreatment at a rate allowed by the product label.
 3. An applicator shall leave a record of the final grade treatment in an unlocked electrical or circuit-breaker box, if available. Otherwise, the applicator shall conspicuously post or leave the record with the property agent. The applicator shall ensure that the record of the final grade treatment contains the information listed in subsection (D)(6), except the information required under subsections (D)(6)(l) and (D)(6)(n) is not required.
- G.** An applicator who performs a pretreatment, new-construction treatment or final grade treatment shall ensure that a copy of the information recorded on a tag required under subsection (D) or (E) or the final grade treatment record required under subsection (F) is provided to the business licensee for inclusion in the business licensee's service records.
- H.** A warranty regarding subterranean termite treatment shall only be issued to a builder if the structure received a pretreatment or a new-construction treatment.
- I.** Post-construction treatment for commercial or residential construction.
1. If an applicator uses a drilling and injecting application method for a post-construction treatment, the applicator shall space the treatment holes in each treated area no more than 24 inches apart or in accordance with the termiticide label, whichever is more restrictive. If an applicator determines that a structural feature makes it necessary to space treatment holes more than 24 inches apart, the applicator may space the treatment holes more than 24 inches apart if the greater distance is within the limits on the termiticide label.
 2. After completing a post-construction treatment using a drilling and injection application method, an applicator shall securely patch all treatment holes, including those in an un-finished basement, enclosed porch, garage, or workshop, with a material that is non-porous and non-cellulose.
 3. Unless precluded by label directions, any application to treat the soil along the exterior of foundation walls shall be made at an effective treatment rate of four gallons of chemical preparation per ten linear feet in a trench six

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inches wide or other method of treatment prescribed by the label to achieve the effective treatment rate.

4. All post construction treatments shall be made in accordance with the treatment proposal delivered as required under subsection (B). Any deviations to the original proposal shall be redelivered in writing in a revised treatment proposal and shall be approved prior to performing the treatment by the person who requested the original proposal or their authorized agent.

Historical Note

New Section recodified from R4-29-308 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-309. Termite Warranties and Retreatments

- A. If a business licensee or an employee of a business licensee is advised before concrete is poured that a pretreatment area is disturbed and the continuous chemical barrier is broken and if an opportunity is provided to re-treat the disturbed area or is advised that a new-construction treatment area is disturbed, the business licensee shall ensure that the disturbed area is retreated.
- B. A business licensee that provides a subterranean termite treatment warranty shall ensure that the effective date of the warranty is the date on which treatment begins.
- C. If subterranean termites occur in or on a residential or commercial structure within three years after a business licensee first performs a pretreatment or new-construction treatment of the structure, the business licensee shall re-treat the affected area of the structure free of charge in accordance with the label specifications of a termiticide available for use. If subterranean termites occur in or on an addition that does not abut the slab of a residential or commercial structure within three years after a business licensee first performs a pretreatment or new-construction treatment of the non-abutting addition, the business licensee shall re-treat the non-abutting addition free of charge in accordance with the label specifications of a termiticide available for use. For the purpose of this subsection, the business licensee is the business licensee who performed the pretreatment or new-construction treatment or a successor that acquired the business assets pertaining to wood-destroying insect treatment.
- D. If subterranean termites occur a third time on the exterior of a one or two unit residential structure within three years after a business licensee first performs a pretreatment or new-construction treatment, the business licensee shall re-treat the entire exterior perimeter of the structure free of charge.
 1. As used in this subsection, exterior means a portion of a residential structure where termite activity originates and that is not livable and not a garage;
 2. For the purpose of this subsection and subsection (E):
 - a. A first occurrence means the first time evidence of subterranean termites exists after a pretreatment or new-construction treatment;
 - b. A second occurrence means evidence of subterranean termites exists at least 25 feet away from the site of the first occurrence and at least 45 days after the date of re-treatment for the first occurrence; and
 - c. A third occurrence means evidence of subterranean termites exists at least 25 feet away from the sites of both the first and second occurrences and at least 45

days after the date of re-treatment for the second occurrence.

- E. If subterranean termites occur a third time on the interior of a one or two unit residential structure within three years after a business licensee first performs a pretreatment or new-construction treatment, the business licensee shall perform a post-construction treatment of the entire structure free of charge. As used in this subsection, interior means a portion of a residential structure where termite activity originates and that is livable or a garage.
- F. A business licensee that performs a re-treatment under subsection (C) or (D) or a post-construction treatment under subsection (E) shall not charge the consumer for any expense incurred in providing the re-treatment or post-construction treatment to which the consumer is entitled under this Chapter.
- G. If a business licensee goes to a structure to perform a re-treatment under subsection (C) or (D) or a post-construction treatment under subsection (E) and determines there is no evidence of subterranean termites, the business licensee may charge the consumer a reasonable amount for the expenses incurred in making the trip.
- H. If a business licensee determines that a re-treatment or post-construction treatment is necessary because the continuous chemical barrier is disturbed, the business licensee may charge the reasonable cost of reestablishing the barrier.
- I. If a customer refuses a re-treatment or post-construction treatment as described in this Section, access to the customer's property, or to allow drilling in an area where drilling is necessary, the business licensee shall obtain the customer's printed name and dated signature on a document evidencing that the business licensee:
 1. Informed the customer of the right to a re-treatment or post-construction treatment at no charge,
 2. Provided the customer with a copy of this Section and the termiticide label requirements,
 3. Provided the customer with the PMD's telephone number, and
 4. Explained to the customer the benefits of having and the detriments of not having a re-treatment or post-construction treatment.

Historical Note

New Section recodified from R4-29-309 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-310. Business Management

- A. Financial responsibility.
 1. A business licensee shall maintain the financial responsibility required by A.R.S. § 3-3615 and this Chapter.
 2. A business licensee shall ensure that the required financial responsibility covers all pest management activities provided from the primary business office and each branch office.
 3. If there is an interruption in the financial responsibility of a business licensee, the business licensee shall immediately stop providing pest management services.
- B. Use of business name and license number.
 1. A business licensee shall prominently display the license issued by the PMD at the primary business office and each branch office.
 2. A business licensee shall prominently display the business name and license number, as recorded on the license issued by the PMD, on:

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- a. Customer proposals or contracts for pest management services;
- b. Service records;
- c. Inspection reports;
- d. Written materials provided to customers or potential customers;
- e. Correspondence;
- f. Advertisements; and
- g. Service vehicles and trailers used in providing pest management services. The business licensee shall ensure that the business name and license number display on a service vehicle or trailer used in providing pest management services conforms to the following:
 - i. Is affixed to the service vehicle or trailer used in providing pest management services within 30 days after the PMD issues the license or issues a business license change or after the service vehicle or trailer is acquired, whichever is sooner;
 - ii. Is in a color that contrasts with the color of the service vehicle and trailer;
 - iii. Is on both sides of the service vehicle and trailer;
3. A business licensee that always uses a service vehicle and trailer together is required to mark only the service vehicle or trailer as described in subsection (B)(2)(g). A business licensee that uses a vehicle only for sales, solicitations, or solely for inspections and does not carry a pesticide, and does not otherwise use the vehicle to provide a pest management service, is not required to mark the vehicle as described in subsection (B)(2)(g).
4. When complying with subsection (B)(2), a business licensee may use a slogan, trade name, or trade mark in addition to the business name and license number. When complying with subsection (B)(2), a business licensee may use a word or phrase to indicate its former licensed business name if it had a previously licensed business name.

Historical Note

New Section recodified from R4-29-310 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-311. Reserved**Historical Note**

New reserved Section recodified from R4-29-311 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-312. Reserved**Historical Note**

New reserved Section recodified from R4-29-312 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-313. Reserved**Historical Note**

New reserved Section recodified from R4-29-313 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-314. Reserved**Historical Note**

New reserved Section recodified from R4-29-314 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-315. Reserved**Historical Note**

New reserved Section recodified from R4-29-315 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-316. Reserved**Historical Note**

New reserved Section recodified from R4-29-316 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-317. Reserved**Historical Note**

New reserved Section recodified from R4-29-317 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-318. Reserved**Historical Note**

New reserved Section recodified from R4-29-318 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-319. Reserved**Historical Note**

New reserved Section recodified from R4-29-319 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-320. Reserved**Historical Note**

New reserved Section recodified from R4-29-320 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

ARTICLE 4. SUPERVISION**R3-8-401. Supervising an Applicator**

- A. A QP and business licensee shall ensure that an applicator receives the training, equipment, and supervision that the applicator requires to comply fully with the PMD's statutes, this Chapter, and label and labeling directions.
- B. A QP shall be readily available to an applicator while the applicator provides pest management services.
- C. A QP shall ensure that the use, application, storage, or disposal of a pesticide is performed or supervised by an individual certified in a category applicable to the pesticide being used, applied, stored, or disposed.
- D. A QP shall ensure that immediate supervision, which requires supervision by a certified applicator who is physically present, is provided when an uncertified applicator performs pest management services in the wood-destroying organism management, aquatic, or fumigation category, uses a restricted use pesticide, or uses a pesticide under an experimental use permit. A QP shall ensure that a certified applicator provides immediate supervision to not more than two uncertified applicators at a time.
- E. In circumstances other than those described in subsection (D), a QP shall ensure that direct supervision, which does not require a supervising certified applicator to be physically present, is provided. A QP shall ensure that a certified applicator providing direct supervision considers the potential danger to the public or environment if the uncertified applicator misuses a pesticide. A QP shall ensure that a certified applicator providing direct supervision instructs the uncertified applicator in

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the following areas and has written evidence that the instruction was provided and understood:

1. Proper loading, mixing, applying, storing, and disposing of the pesticide;
2. Use of required safety equipment; and
3. Method and means by which to contact the supervisor immediately.

- F.** A QP shall ensure that an applicator has the protective clothing, safety supplies, and equipment specified by the label or labeling of each product used by the applicator and by the PMD's statutes and this Chapter. The QP shall ensure that the applicator is instructed regarding how to use, maintain, clean, and store the protective clothing, safety supplies, and equipment.
- G.** A QP, business licensee, and political subdivision shall not allow an uncertified applicator to apply a pesticide for more than 120 days after the applicator is registered.
- H.** Direct Supervision Requirements For Restricted Use Pesticides. When a restricted use pesticide is applied by a non-certified applicator, the certified applicator providing direct or immediate supervision shall meet the requirements of 40 CFR § 171.201(a) through (d) (82 FR 1040, January 4, 2018). This material is incorporated by reference, is on file with the Department, and does not contain any later amendments or additions.

Historical Note

New Section recodified from R4-29-401 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-402. Qualifying a Business or School District

- A.** A business licensee or school district shall employ a QP in each category of pest management in which the business licensee or school district provides pest management services. A business licensee or school district may employ multiple QPs.
- B.** A QP may not qualify more than one business licensee or school district at a time.
- C.** Notwithstanding subsection (B), the Director may allow a QP to qualify more than one school district if the Director believes that the number of applicators, pest management needs, and distance of the school districts will not hinder the QP's ability to comply with R3-8-403.
- D.** A QP may only qualify a business licensee or school district in the categories of pest management in which the QP is registered.

Historical Note

New Section recodified from R4-29-402 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-403. Qualifying Party Management

- A.** A QP shall be physically present at the primary business office at least once every 14 days and at each branch office at least once every 120 days and ensure that all of the following are done:
1. Determine pesticide use by reviewing records of pesticide acquisitions, storage, disposal, and current inventory;

2. Review the pesticide inventory, including pesticides stored on a service vehicle, to determine compliance with labels, labeling, and the PMD's statutes and rules;
3. Review the training, supervision, and equipping of applicators employed by the business licensee or school district to determine whether the training, supervision, and equipping is sufficient to enable the applicators to comply with labels, labeling, and the PMD's statutes and rules;
4. Review personnel records to determine whether an applicator employed by the business licensee or school district is registered and certified in all applicable categories within the time-frames specified by R3-8-201;
5. Review office records and recordkeeping procedures to determine compliance with required recordkeeping and reporting; and
6. Ensure that any deficiency noted when the responsibilities listed in subsections (A)(1) through (A)(5) are performed is corrected.

- B.** A QP shall develop a written plan that specifies how the duties and responsibilities of the QP are to be fulfilled if the QP is absent or unavailable for any reason. The QP shall ensure that the plan is implemented when the QP is absent or unavailable.

- C.** A QP shall not delegate the responsibility to be physically present at least every 14 days at the primary business office and at least every 120 days at branch offices unless the QP submits written documentation to the PMD from a licensed medical or mental health care professional that indicates the licensed medical or mental health care professional is treating the QP and is of the opinion that the QP is unable to fulfill the responsibility to be physically present as required.

- D.** A QP shall:

1. Be active in the management of all pest management related activities of the business licensee or school district.
2. During normal business hours, be readily available to the applicators of the business licensee or school district.
3. Ensure that a business licensee maintains current proof of financial security.

- E.** A temporary QP has the same duties and responsibilities as a regular QP.

Historical Note

New Section recodified from R4-29-403 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-404. Branch Supervisors

With respect to a branch office, the branch supervisor shall fulfill all the duties and responsibilities of a QP in this Article, except as follows:

1. The branch supervisor shall be present at the branch office at a minimum of once every 14 days to review pesticide use, storage and disposal and by ensuring the training, equipping, and supervision of the applicators.
2. The branch office may operate in each category of pest management in which the QP is registered even if the branch supervisor is not a certified applicator in the category, though R3-8-201(C) still applies.
3. The branch supervisor is not responsible for ensuring that the business licensee maintains current proof of financial security.

Historical Note

New Section recodified from R4-29-404 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2). Section

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amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-405. Supervision of Qualifying Party

A business licensee or school district shall ensure that a QP of the business licensee or school district receives the training, equipment, and supervision that the QP requires to comply fully with the PMD's statutes and rules and label and labeling directions.

Historical Note

New Section recodified from R4-29-405 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-406. Responsible Individuals

A responsible individual for a political subdivision shall

1. Respond to inquiries or concerns by the Director or the Director's designee regarding compliance with A.R.S. Title 3, Chapter 20.
2. Identify for the Director or the Director's designee where records required by this Chapter are maintained, where personal protection equipment is located, and where pesticides are stored.
3. Demonstrate that all applicators are properly certified.

Historical Note

New Section recodified from R4-29-406 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-407. Joint Responsibility

- A. An applicator, qualifying party, branch supervisor, or business licensee who supervises another person shall ensure that the supervised person is properly trained and equipped and receives the supervision necessary for the supervised person to provide pest management services in accordance with the pesticide label and labeling, this Chapter and the PMD statutes.
- B. An applicator, qualifying party, branch supervisor, or business licensee who supervises another person may be held jointly responsible for the acts or omissions of the supervised person.
- C. It is an affirmative defense to joint responsibility as described in subsection (B) if an applicator, qualifying party, branch supervisor, or business licensee complied with subsection (A) and can demonstrate that compliance with contemporaneously maintained records.
- D. A QP and business licensee shall comply with every provision in this Chapter regarding applicator duties and responsibilities.

Historical Note

New Section recodified from R4-29-407 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-408. Reserved**Historical Note**

New reserved Section recodified from R4-29-408 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-409. Reserved**Historical Note**

New reserved Section recodified from R4-29-409 at 23

A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-410. Reserved**Historical Note**

New reserved Section recodified from R4-29-410 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-411. Reserved**Historical Note**

New reserved Section recodified from R4-29-411 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-412. Reserved**Historical Note**

New reserved Section recodified from R4-29-412 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-413. Reserved**Historical Note**

New reserved Section recodified from R4-29-413 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-414. Reserved**Historical Note**

New reserved Section recodified from R4-29-414 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-415. Reserved**Historical Note**

New reserved Section recodified from R4-29-415 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-416. Reserved**Historical Note**

New reserved Section recodified from R4-29-416 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-417. Reserved**Historical Note**

New reserved Section recodified from R4-29-417 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-418. Reserved**Historical Note**

New reserved Section recodified from R4-29-418 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

ARTICLE 5. RECORDKEEPING AND REPORTING**R3-8-501. Applicator Recordkeeping**

- A. An applicator shall make all records required by law and provide the records to the business licensee or political subdivision that supervises, directs, or employs the applicator within five business days.
- B. Service records. An applicator shall make a record of each pest management service provided. The applicator shall include the following information in the service record:
 1. Name and address of the customer;
 2. Specific site at which a pesticide was applied;
 3. Date and time of service;
 4. Target pest or purpose of service;
 5. Trade name of pesticide applied;
 6. EPA registration number of any restricted use pesticide applied;

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7. Amount of pesticide applied, in terms of percent active ingredient and volume of diluted mixture or in terms of total amount of liquid concentrate, ready-to-use product, granular material, or bait stations; and
 8. Name and certification number of the applicator or if the applicator is uncertified, name of the uncertified applicator and the name and certification number of the applicator providing supervision.
- C.** Pesticide purchase records. An applicator shall make a record of each restricted-use pesticide purchased or otherwise acquired. The applicator shall include the following information in the pesticide purchase record:
1. Date of purchase or acquisition;
 2. Trade name of pesticide;
 3. EPA registration number of pesticide;
 4. Quantity of pesticide purchased or acquired; and
 5. Name and license number of the applicator making the pesticide purchase record or name of the business licensee.
- D.** Pesticide disposal records. An applicator shall make a record of each pesticide disposed, sold, lost, or otherwise relinquished. The applicator shall include the following information in the pesticide disposal record:
1. Date of disposal;
 2. Trade name of pesticide;
 3. EPA registration number of pesticide;
 4. Quantity of pesticide disposed;
 5. Percent active ingredient in the pesticide disposed;
 6. Method of disposal;
 7. Location and type of disposal site or service; and
 8. Name and license number of the applicator making the pesticide disposal record or name of the business licensee.
- E.** WDIIR. An applicator who completes a WDIIR shall:
1. Complete the WDIIR using the most current form approved by the PMD. A trademark or logo may be placed on the WDIIR if it does not alter the format or substance of the PMD approved form;
 2. Submit an original WDIIR to the QP or branch supervisor within seven days after completing the wood-destroying insect inspection;
 3. Submit a supplemental WDIIR to the QP or branch supervisor within seven days after completing a supplemental wood-destroying insect inspection to verify that a corrective treatment was performed or a condition conducive to the pest was corrected. The applicator shall include the original inspection number on the supplemental WDIIR;
 4. If required by a federal agency, complete another inspection form in addition to but not instead of the PMD - approved WDIIR; and
 5. Ensure that the following information is included on the WDIIR:
 - a. Name, address, telephone number, and license number of business licensee. This information may be pre-printed on the WDIIR;
 - b. Time and date of wood-destroying insect inspection, and the WDIIR number;
 - c. Purpose of the inspection report;
 - d. Whether the report is from an original or supplemental inspection;
 - e. Name of property owner or seller;
 - f. Address of inspected property;
 - g. Inspected and un-inspected structures at the site and the reason why structures are un-inspected;
 - h. Areas of the structure not inspected because they were obstructed or inaccessible and the cause of the obstruction or inaccessibility;
 - i. Whether visible evidence of wood-destroying insects is observed;
 - j. Whether visible evidence of infestation from wood-destroying insects is observed and if so, the date on which a proper management measure is performed, if applicable;
 - k. Whether visible damage from wood-destroying insects is observed and if so, the insect causing the damage and the areas in which the damage is observed;
 - l. Whether visible evidence of previous treatment is observed and if so, the nature of the evidence;
 - m. If damage from wood-destroying insects is observed, whether or when the damage will be corrected and whether the damage will be corrected by the business licensee or another company;
 - n. Visible conditions conducive to infestation by wood-destroying insects;
 - o. Diagram or graph of the structure clearly indicating wood-destroying insects, damage, conducive conditions observed, and areas where further inspection is recommended, and a statement or indication on the diagram or graph clearly identifying inaccessible areas; and
 - p. Dated signature and certification number of the individual making the inspection. The individual making the inspection shall sign the WDIIR by hand or electronically and shall not use a signature stamp or allow another individual to affix the signature.
- F.** Wood-destroying organism treatment proposal. An applicator who is qualified under A.R.S. § 3-3632(B) and (E) shall complete a wood-destroying organism treatment proposal using a form approved by the PMD and provide a copy of the proposal to the person requesting the proposal or treatment and the QP.
- G.** Non-certified applicator records: When supervising an applicator of a restricted use pesticide, records shall be kept as required in 40 CFR § 171.201(e) (82 FR 1040, January 4, 2018). This material is incorporated by reference, is on file with the Department, and does not contain any later amendments or additions.

Historical Note

New Section recodified from R4-29-501 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-502. Qualifying Party Recordkeeping

- A.** In addition to ensuring that the records required under R3-8-501 are made, a QP shall ensure that complete records are made and maintained of the training, supervision, and equipping provided to an applicator.
- B.** At a minimum, QP training records must consist of the following information:
1. Date of the training,
 2. Printed name and signature of the trainee,
 3. Printed name and signature of the trainer,
 4. Brief description of the topic or topics covered, and
 5. Copies of labels and any other pertinent material used in training.

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- C. A QP shall maintain the records described in this Section for three years, including after the applicator's employment ending date.
- D. Non-certified applicator records: When supervising an applicator of a restricted use pesticide, records shall be kept as required in 40 CFR § 171.201(e) (82 FR 1040, January 4, 2018). This material is incorporated by reference, is on file with the Department, and does not contain any later amendments or editions.

Historical Note

New Section recodified from R4-29-502 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-503. Business Licensee and Political Subdivision Recordkeeping and Retention

- A. In addition to ensuring that the records required under R3-8-501 and R3-8-502 are made and maintained, a business licensee and political subdivision shall make and maintain records of the following:
 - 1. The specimen label and SDS for each registered pesticide currently used by an applicator supervised, directed or employed by the business licensee or political subdivision;
 - 2. The financial responsibility required under R3-8-310(A), if applicable;
 - 3. Purchase records of each pesticide purchased or otherwise acquired that include the following information:
 - a. Date of purchase or acquisition;
 - b. Trade name of pesticide;
 - c. Quantity of pesticide purchased or acquired; and
 - d. Name of the business licensee;
 - 4. Date on which a service vehicle or trailer is acquired;
 - 5. Incident reports submitted to the PMD as required under R3-8-504;
 - 6. A pest management service provided, including a service provided under a warranty;
 - 7. The evidence of customer refusal of a re-treatment or post-construction treatment required under R3-8-309(J);
 - 8. Written inspection reports;
 - 9. Business licensee contracts for pest management services; and
 - 10. Personnel records including for each applicator supervised, directed or employed by the business licensee or political subdivision:
 - a. Date of hire or beginning of relationship;
 - b. Date on which pest management services are first performed;
 - c. Training and continuing education received;
 - d. Supervision received;
 - e. Protective clothing, safety supplies, and equipment issued to employee;
 - f. Name of supervisor; and
 - g. Employment or relationship ending date.
- B. A business licensee or political subdivision shall maintain the records as follows:
 - 1. Records under subsection (A)(1), as long as the registered pesticide is used by the business licensee or political subdivision. The business licensee shall maintain the records required under subsection (A)(1) at the primary business office or branch office from which the registered pesticide is used or at which the registered pesticide is stored;
 - 2. Records under subsection (A)(2), current;
 - 3. Records under subsection (A)(3) or R3-8-501(C) and (D), three years from the date of purchase or disposal;
 - 4. Records under subsection (A)(4), as long as the service vehicle or trailer is owned by the business licensee or political subdivision;
 - 5. Records under subsection (A)(5), until the statute of limitation for possible legal action resulting from the incident is expired or until resulting legal action is completed;
 - 6. Records under subsections (A)(6) and (A)(7), three years;
 - 7. Records under subsections (A)(8) and (A)(9), three years from the date on the inspection report or customer contract;
 - 8. Records under subsection (A)(10), three years, including after the employment ending date;
 - 9. WDIIRs completed under subsection (C), three years; and
 - 10. Records under subsections (A)(5) and (A)(6) that pertain to the use of a restricted-use pesticide shall be maintained separate from other records.
- C. When an applicator supervised, directed or employed by a business licensee submits a WDIIR, the business licensee shall record the following on the WDIIR:
 - 1. TARF number,
 - 2. If the business licensee has the property under warranty:
 - a. Account number,
 - b. Target pest,
 - c. Date of initial treatment,
 - d. Date of warranty expiration, and
 - 3. The TARF number of each TARF completed regarding the property after the WDIIR is completed.
- D. TARF. A business licensee or political subdivision shall:
 - 1. Submit to the PMD a TARF, using a form approved by the PMD, within 30 days of completing an action specified under subsection (D)(3). For the purpose of reporting, a pretreatment or new-construction treatment is complete when no further preventative treatment is necessary until the final grade treatment unless it is necessary to re-treat a disturbed continuous chemical barrier. In a multiple-unit project, a pretreatment or new-construction treatment is complete when no further preventative treatment is necessary for the last unit at the project until the final grade treatment unless it is necessary to re-treat a disturbed continuous chemical barrier;
 - 2. Include the fee with each TARF and, if applicable, the penalty required under R3-8-103;
 - 3. Unless exempt under subsection (D)(4), submit a TARF after completing each of the following:
 - a. Pretreatment, including pretreatment of an addition that does not abut the slab of a previously pretreated structure;
 - b. New-construction treatment, including new-construction treatment of an addition that does not abut the slab of a previously new-construction treated structure;
 - c. Final grade treatment;
 - d. Initial corrective termite treatment at a site; and
 - e. WDIIR.
 - 4. Not submit a TARF after completing:
 - a. A supplemental WDIIR; or
 - b. The first initial corrective insect termite treatment at a site if the business licensee:
 - i. Performed a pretreatment or new-construction treatment at the site,

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- ii. Filed a TARF regarding the pretreatment or new-construction treatment, and
 - iii. Performs the initial corrective termite treatment under R3-8-309(D) or under a warranty.
- 5. Include the information required under A.R.S. § 3-3631 and the following on a TARF:
 - a. License number of the licensed business that performed the work;
 - b. Name of the QP;
 - c. For a WDIIR, indicate whether:
 - i. There was evidence of infestation, conditions conducive to infestation, or damage present;
 - ii. Previous treatment was performed for an infestation; and
 - iii. Corrective actions were taken for conditions conducive or damage present;
 - d. For a pretreatment, new-construction treatment, or final grade treatment to establish an exterior vertical barrier, indicate:
 - i. Chemical used and its EPA registration number,
 - ii. Amount of chemical used,
 - iii. Percentage of active ingredient in the chemical used, and
 - iv. Square and linear footage treated; and
 - e. For a post-construction corrective termite treatment, indicate:
 - i. Type of treatment,
 - ii. Target organism,
 - iii. Chemical used and its EPA registration number,
 - iv. Amount of chemical used, and
 - v. Percentage of active ingredient in the chemical used.

Historical Note

New Section recodified from R4-29-503 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).

R3-8-504. Reporting Incidents and Bulk Releases

- A. Notice to PMD of an incident.
 - 1. A business licensee and political subdivision shall provide written notice to the PMD within one business day after one of the following incidents is confirmed by medical personnel or an applicable regulatory agency to be caused by a pesticide applied by the business licensee or political subdivision:
 - a. Death or illness of an individual;
 - b. Contamination of food, feed, drugs, or water supply;
 - c. Contamination of a structure that results in the hospitalization of an occupant or evacuation of the structure; or
 - d. Contamination of the environment that results in evacuation of the area.
 - 2. A QP shall determine if the business licensee or school district has complied with subsection (A)(1). If compliance has not occurred, the QP shall provide the written notice required by subsection (A)(1) to the PMD within the time-frame specified in subsection (A)(1).
- B. Notice to PMD of a bulk release.
 - 1. A business licensee or political subdivision shall notify the PMD at the Pesticide Hotline, 1-800-423-8876, as soon as practical after a bulk release, but no later than

three hours after the bulk release. If the bulk release is on a public highway or railway, or results in the death of an individual, the person shall immediately report the release to the Arizona Department of Public Safety Duty Office.

- 2. A QP shall determine if the business licensee or school district has complied with subsection (B)(1). If compliance has not occurred, the QP shall provide the notices specified in subsection (B)(1) within one business day after the release.

Historical Note

New Section recodified from R4-29-504 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-505. Groundwater Protection List Reporting

- A. For each application of a soil-applied pesticide containing an active ingredient that appears on the Arizona Department of Environmental Quality groundwater protection list and has been detected in Arizona groundwater within the last five years, the QP shall submit the following information on a quarterly basis on a form approved by the PMD:
 - 1. The county of use,
 - 2. The name of product used and the EPA registration number,
 - 3. The amount applied,
 - 4. The dates covered by the report, and
 - 5. Business license number.
- B. For the purposes of this Section, "soil-applied pesticide" means a pesticide intended for application to or injection into the soil or for which the label requires or recommends that the application be followed within seventy-two hours by irrigation. Soil-applied pesticides include pesticides applied for final grade treatment, post-construction exterior trench or rod treatment, or pre-emergent weed control, but exclude pesticides applied within the stem wall or footer of a structure or to soil that will be promptly covered with concrete.

Historical Note

New Section recodified from R4-29-505 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

Appendix A. Reserved**Historical Note**

Reserved Article 5, Appendix A recodified from Article 5, Appendix A at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

ARTICLE 6. INSPECTIONS; DISCIPLINARY PROCEDURES**R3-8-601. Inspection of Licensee Records**

- A. Upon written request by the PMD for the production of records, an applicator, QP, branch supervisor, business licensee, or political subdivision shall:
 - 1. Make the records required under this Chapter available for review by the PMD within 24 hours or by a later date specified by the PMD.
 - 2. Make the records available at the PMD unless another location is agreed upon.
 - 3. Be available to interpret the submitted records if requested by the PMD.

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- B. If a person cannot timely comply with a request made under subsection (A), the person shall immediately provide written notice to the PMD, indicate the reason for noncompliance, and request greater specificity regarding the information to be made available or additional time in which to comply.
- C. If the PMD requests a record from a business licensee or political subdivision when there may be an immediate risk to the health or safety of an individual, non-target animal, or the environment, the business licensee or political subdivision shall provide the record to the PMD within one hour.
- D. An applicator or branch supervisor is only responsible for producing records within the applicator's or branch supervisor's control.

Historical Note

New Section recodified from R4-29-601 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-602. Compliance with PMD Monitoring

- A. If the PMD makes a written request of an applicator for a list of the time and location of pest management services that the applicator is scheduled to provide on a specified date, the applicator shall make the information available within 24 hours. The applicator may make the information available in a manner prescribed by the PMD.
- B. If an applicator cannot timely comply with a request made under subsection (A), the applicator shall immediately provide written notice to the PMD, indicate the reason for noncompliance, and request greater specificity regarding the information to be made available or additional time in which to comply.

Historical Note

New Section recodified from R4-29-602 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-603. Corrective Work Orders

- A. If the PMD issues a corrective work order requiring a licensee to remedy deficiencies in treatment or to comply with this Chapter or the PMD's statutes, the licensee shall notify the PMD in writing by the date specified in the order that the corrective work is complete.
- B. The Director may consider a licensee's compliance with a corrective work order or lack thereof in imposing appropriate disciplinary action.
- C. Failure to timely complete the corrective action or notify the PMD of the completion is a separate ground for disciplinary action.
- D. A corrective work order issued by the PMD is not subject to A.R.S. § 41-1009(E)-(F) unless the PMD indicates in the order that timely compliance with the order will result in no disciplinary action being taken for a deficiency or violation.

Historical Note

New Section recodified from R4-29-603 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-604. Disciplinary Action

To determine the disciplinary action that is appropriate, the Director may consider the following:

- 1. Prior violations,
- 2. Dishonest or self-serving motive,

- 3. Amount of experience as a licensee,
- 4. Submission of false evidence or statements or other deceptive practices during the investigative or disciplinary process,
- 5. Acknowledgement of wrongful nature of violation,
- 6. Practices put in place to prevent a similar violation from occurring again,
- 7. Compliance with a corrective work order,
- 8. Degree of harm resulting from the violation, and
- 9. Whether harm resulting from the violation was cured.

Historical Note

New Section recodified from R4-29-604 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-605. Consent Agreements

- A. A consent agreement shall include the following:
 - 1. General nature of violations,
 - 2. Citation to statutes and rules alleged to be violated,
 - 3. Disciplinary action to be taken,
 - 4. Effective date of the disciplinary action if different from the date of the consent agreement,
 - 5. Corrective action to be taken, and
 - 6. Date to complete any corrective action.
- B. A person entering into a consent agreement with the PMD shall waive the right to a formal hearing, rehearing, or judicial review of the matters contained in the consent agreement.

Historical Note

New Section recodified from R4-29-605 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2).

R3-8-606. Penalties

- A. When assessing a civil penalty for a violation, the Director shall assess a civil penalty for each violation based on the violation's total point value set out in this Section. To calculate the total point value, the Director shall sum the points for each aggravating factor and may subtract the points for each mitigating factor. The Director, in his sole discretion, may treat multiple violations as a single violation for the purpose of calculating the civil penalty.
- B. Aggravating factors.

1. Pesticide type.	
a. General use.	2
b. Experimental use or special local need.	3
c. Restricted use or unregistered.	5
2. Harm to humans and non-target animals.	
a. None or unverified potential harm.	0
b. Potential harm.	3
c. Actual, verifiable harm.	5
3. Harm to environment and economic loss.	
a. None or unverified potential harm.	0
b. Potential harm or loss.	3
c. Actual, verifiable loss of \$10,000 or less.	4
d. Actual, verifiable loss exceeding \$10,000.	5
e. Actual, verifiable environmental harm.	5
4. Non-pesticide violations.	
a. Negligent violations.	4
b. Knowing or willful violations.	8
5. Prior similar violations.	
a. None.	0
b. Warning letter within 12 months.	1
c. One or more within 36 months, but none within 12 months.	2

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- d. One within 12 months. 3
- e. More than one within 24 months, but none within 12 months. 4
- f. More than one within 12 months. 5
6. Culpability.
- a. Negligent violations. 2
- b. Knowing or willful violations. 4
- C. Mitigating factors. In considering whether to subtract points for mitigating factors, the Director may consider whether the mitigating act occurred before, during, or after PMD's investigation.
1. Good will.
- a. Admission of fault or cooperation 1
- b. Admission and cooperation 2
- c. Admission, cooperation, and corrective action prior to request. 3
2. Environmental benefit.
- a. Clean up. 1
- b. Move toward less toxic methods. 2
- c. Develop IPM program. 3
3. Consumer benefit.
- a. Consumer education. 1
- b. Make consumer whole. 2
- c. Extend warranty. 3
4. Other benefits.
- a. Training (CEU). 1
- b. Equipment (modification or new). 2
- c. Purchase and use of computer for TARFs. 3
- D. Civil penalty. To calculate the civil penalty, the Director shall:
1. For total point values of 6-10, multiply the value by \$100 and then subtract \$500.
2. For total point values of 11-15, multiply the value by \$100 and then subtract \$600.
3. For total point values of more than 16, assess the maximum penalty of \$1000.
- E. Other penalties. In addition to assessing a civil penalty, the Director:
1. For any total point value, may require extra continuing education.
2. For total point values of 6-11, may impose probation requirements.
3. For total point values of 12-17, shall impose probation requirements and may suspend the license, certification, or registration.
4. For total point values of 18 or more, shall suspend or revoke the license, certification, or registration.
5. May take any other action permitted by law, including imposing probation requirements after a suspension ends.
- F. In addition to the civil penalties prescribed by this Section, the Director may charge a person who knowingly or willfully commits a violation of this Article which causes:
1. Harm to the environment or economic loss of \$10,000 or less with a class 1 misdemeanor.
2. Harm to humans or animals, or the environment or an economic loss exceeding \$10,000 with a class 6 felony.
- G. In addition, the Director may deny, suspend or revoke applicator certification for:
1. Misuse of a pesticide.
2. Falsifying records required to be kept by a certified applicator.
3. A criminal conviction under section 14(b) of FIFRA (7 U.S.C. § 136l) (June 25, 1947, ch. 125, § 14, as added Pub. L. 92-516, § 2, Oct. 21, 1972, 86 Stat. 992; amended Pub. L. 95-396, § 17, Sept. 30, 1978, 92 Stat. 832; Pub. L. 100-532, title VI, § 604, Oct. 25, 1988, 102 Stat. 2678; Pub. L. 102-237, title X, § 1006(a)(8), Dec. 13, 1991, 105 Stat. 1895.). This material is incorporated by reference, is on file with the Department, and includes no later amendments or editions.
4. A final order imposing civil penalty under section 14(a) of FIFRA (7 U.S.C. § 136l) (June 25, 1947, ch. 125, § 14, as added Pub. L. 92-516, § 2, Oct. 21, 1972, 86 Stat. 992; amended Pub. L. 95-396, § 17, Sept. 30, 1978, 92 Stat. 832; Pub. L. 100-532, title VI, § 604, Oct. 25, 1988, 102 Stat. 2678; Pub. L. 102-237, title X, § 1006(a)(8), Dec. 13, 1991, 105 Stat. 1895.). This material is incorporated by reference, is on file with the Department, and includes no later amendments or editions.
5. A violation of State laws or regulations relevant to the State certification plan.
- Historical Note**
New Section recodified from R4-29-606 at 23 A.A.R. 1976, effective June 30, 2017; Section amended by exempt rulemaking at 23 A.A.R. 1949, effective August 29, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 757 (March 24, 2023), with an immediate effective date of March 10, 2023 (Supp. 23-1).
- R3-8-607. Reserved**
- Historical Note**
New reserved Section recodified from R4-29-607 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).
- R3-8-608. Reserved**
- Historical Note**
New reserved Section recodified from R4-29-608 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).
- R3-8-609. Reserved**
- Historical Note**
New reserved Section recodified from R4-29-609 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).
- ARTICLE 7. RESERVED**
- R3-8-701. Reserved**
- Historical Note**
New reserved Section recodified from R4-29-701 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).
- R3-8-702. Reserved**
- Historical Note**
New reserved Section recodified from R4-29-702 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).
- R3-8-703. Reserved**
- Historical Note**
New reserved Section recodified from R4-29-703 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).
- R3-8-704. Reserved**
- Historical Note**
New reserved Section recodified from R4-29-704 at 23 A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).
- R3-8-705. Reserved**
- Historical Note**
New reserved Section recodified from R4-29-705 at 23

TITLE 3. AGRICULTURE

CHAPTER 8. DEPARTMENT OF AGRICULTURE - PEST MANAGEMENT DIVISION

A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-706. Reserved**Historical Note**

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A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-707. Reserved**Historical Note**

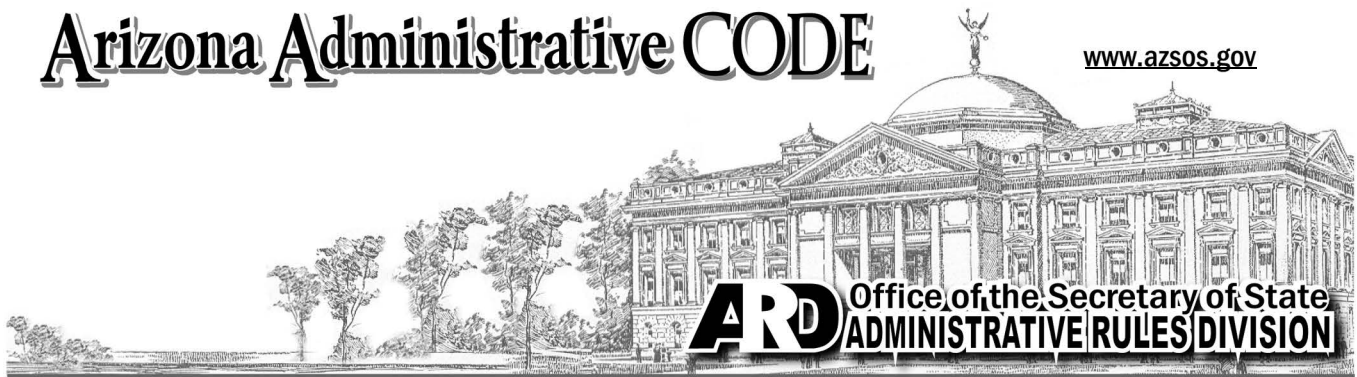
New reserved Section recodified from R4-29-707 at 23

A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).

R3-8-708. Reserved**Historical Note**

New reserved Section recodified from R4-29-708 at 23

A.A.R. 1976, effective June 30, 2017 (Supp. 17-2).



4 A.A.C. 33

Supp. 23-1

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 33. BOARD OF EXAMINERS OF NURSING CARE INSTITUTION ADMINISTRATORS AND ASSISTED LIVING FACILITY MANAGERS

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of
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Questions about these rules? Contact:

Board: Board of Examiners for Nursing Care
Administrators and Assisted Living Facility
Managers

Address: 1740 W. Adams St., Suite 2490
Phoenix, AZ 85007

[Website:](#) nciaboard.az.gov

Name: John Confer, Executive Director

Telephone: (602) 364-2374

[Email:](#) john.confer@aznciaboard.us

The release of this Chapter in Supp. 23-1 replaces Supp. 21-1, 1-39 pages.

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, www.azsos.gov under Services-> Legislative Filings.

EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

PERSONAL USE/COMMERCIAL USE

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Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.

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Administrative Rules Division

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TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 33. BOARD OF EXAMINERS OF NURSING CARE INSTITUTION ADMINISTRATORS AND ASSISTED LIVING FACILITY MANAGERS

Authority: A.R.S. § 36-446.03(A)

Supp. 23-1

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Chapter heading amended from “Board of Examiners for Nursing Care Institution Administrators and Assisted Living Facility Managers” to “Board of Examiners of Nursing Care Institution Administrators and Assisted Living Facility Managers” to be consistent with A.R.S. § 36-446.02 (Supp. 11-4).

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Article 2, consisting of Sections R4-33-201 through R4-33-216, renumbered by emergency action from R4-33-115 through R4-33-130 effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3).

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Article 3, consisting of Sections R4-33-301 through R4-33-312, adopted permanently effective November 25, 1992 (Supp. 92-4).

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311, adopted by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3).

Article 3, consisting of Sections R4-33-301 through R4-33-311, adopted by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2).

Article 3, consisting of Sections R4-33-301 through R4-33-311, adopted by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1).

Article 3, consisting of Sections R4-33-301 through R4-33-311, adopted by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4).

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TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 33. BOARD OF EXAMINERS OF NURSING CARE INSTITUTION ADMINISTRATORS AND ASSISTED LIVING

ARTICLE 1. GENERAL**R4-33-101. Definitions**

The definitions in A.R.S. § 36-446 apply to this Chapter. Additionally, in this Chapter, unless otherwise specified:

“Accredited” means approved by the North Central Association of Colleges and Secondary Schools, New England Association of Schools and Colleges, Middle States Association of Colleges and Secondary Schools, North-west Association of Schools and Colleges, Southern Association of Colleges and Schools, or Western Association of Schools and Colleges.

“ACHCA” means the American College of Health Care Administrators.

“Administrator” has the meaning prescribed at A.R.S. § 36-446 and means an individual licensed under this Chapter.

“Administrator in training” or “AIT” means an individual who is taking an AIT program to be licensed as an administrator for a nursing care institution.

“AIT program” means a training that the Board approves after determining that the training meets the standards at R4-33-302.

“Applicant” means an individual who applies to the Board to be licensed as an administrator of a nursing care institution, to be certified as a manager of an assisted living facility, or for approval of a continuing education.

“Application package” means the forms, documents, and fees that the Board requires an applicant to submit or have submitted on the applicant’s behalf.

“Arizona examination” means a measure of an applicant’s knowledge of Arizona statutes and rules regarding nursing care institution administration or assisted living facility management.

“Biennial period” means:

For an administrator, the period until 30 days after the licensee’s birthday in an even-numbered year; and

For a manager, the period until 30 days after the certificate holder’s birthday in an odd-numbered year.

“Contact hour” means an hour during which an administrator or manager is physically present at a continuing education or a manager is physically present at a required initial training.

“Continuing education” means a planned educational course or program that the Board approves under R4-33-502.

“Good standing” means an individual licensed by the state is not subject to any disciplinary action or consent order, and not currently under investigation for alleged unprofessional conduct.

“Health care institution” means every place, institution, building or agency, whether organized for profit or not, that provides facilities with medical services, nursing services, behavioral health services, health screening services, other health-related services, supervisory care services, personal care services or directed care services and includes home health agencies as defined in A.R.S. §

36-151, outdoor behavioral health care programs and hospice services agencies. A.R.S. § 36-401.

“Manager” means an assisted living facility manager, as defined at A.R.S. § 36-446, who is certified under this Chapter.

“NAB” means the National Association of Long Term Care Administrator Boards.

“Party” has the same meaning as prescribed in A.R.S. § 41-1001.

“Preceptor” means a practicing nursing care institution administrator who helps to develop a new professional in the field of long-term care administration by tutoring the new professional.

“Qualified instructor” means a person who meets one or more of the following criteria:

A registered nurse, licensed under A.R.S. Title 32, Chapter 15;

An instructor employed by an accredited college or university, or health care institution to teach a health-care related course; or

A person or entity that has sufficient education and training to be qualified to teach a health-care related course.

“Work experience in a health-related field” means employment in a health care institution or in the professional fields of medicine, nursing, social work, gerontology, or other closely related field.

Historical Note

Section R4-33-101 renumbered from R4-33-112 and amended by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1). Amended by final rulemaking at 21 A.A.R. 543, effective June 6, 2015 (Supp. 15-2). Amended by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 29 A.A.R. 642 (March 3, 2023), with an immediate effective date of February 13, 2023 (Supp. 23-1).

R4-33-102. Board Officers

- A. At its first annual meeting, the Board shall elect a president and vice-president.
- B. The functions, duties, and limitations of these officers are as follows:
 1. President. The president shall call and preside at all Board meetings. The president shall act as chief officer of the Board, appoint committees, and delegate authority to other members of the Board as needed.
 2. Vice-president. The vice-president shall preside at Board meetings in the absence of the president and may exercise all the powers and duties of the president in the absence of the president.
- C. Board officers serve for one year. A Board officer shall not serve more than two consecutive years in the same position.

Historical Note

Section R4-33-102 renumbered from R4-33-113 and amended by final rulemaking at 5 A.A.R. 423, effective

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 33. BOARD OF EXAMINERS OF NURSING CARE INSTITUTION ADMINISTRATORS AND ASSISTED LIVING

January 15, 1999 (Supp. 99-1). Amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1).

R4-33-103. Time Frames for Licenses, Certifications, and Approvals

- A.** For each type of license, certification, or approval issued by the Board, the overall time frame described in A.R.S. § 41-1072(2) is listed in Table 1.
- B.** For each type of license, certification, or approval issued by the Board, the administrative completeness review time frame described in A.R.S. § 41-1072(1) is listed in Table 1 and begins on the date the Board receives an application package.
1. If an application package is not administratively complete, the Board shall send a deficiency notice to the applicant that specifies each piece of information or document needed to complete the application package. Within the time provided in Table 1 for response to a deficiency notice, beginning on the mailing date of the deficiency notice, the applicant shall submit to the Board the missing information or document specified in the deficiency notice. The time frame for the Board to finish the administrative completeness review is suspended from the date the Board mails the deficiency notice to the applicant until the date the Board receives the missing information or document.
 2. If an application package is administratively complete, the Board shall send a written notice of administrative completeness to the applicant.
 3. If an application package is not completed within the time provided to respond to the deficiency notice, the Board shall send a written notice to the applicant informing the applicant that the application is deemed withdrawn.
- C.** For each type of license, certification, or approval issued by the Board, the substantive review time frame described in A.R.S. § 41-1072(3) is listed in Table 1 and begins on the date the Board sends written notice of administrative completeness to the applicant.
1. During the substantive review time frame, the Board may make one comprehensive written request for additional information. Within the time provided in Table 1 for response to a comprehensive written request for additional information, beginning on the mailing date of the comprehensive written request for additional information, the applicant shall submit to the Board the requested additional information. The time frame for the Board to finish the substantive review is suspended from the date the Board mails the comprehensive written request for additional information to the applicant until the Board receives the requested additional information.
 2. The Board shall issue a written notice informing the applicant that the application is deemed withdrawn if the applicant does not submit the requested additional information within the time provided in Table 1.
- D.** Within the overall time frame listed in Table 1, the Board shall:
1. Deny a license, certificate, or approval to an applicant if the Board determines the applicant does not meet all of the substantive criteria required by statute and this Chapter; or
 2. Grant a license, certificate, or approval to an applicant if the Board determines the applicant meets all of the substantive criteria required by statute and this Chapter.
- E.** If the Board denies a license, certificate, or approval under subsection (D)(1), the Board shall provide a written notice of denial to the applicant that explains:
1. The reason for the denial, with citations to supporting statutes or rules;
 2. The applicant's right to seek a fair hearing to challenge the denial; and
 3. The time for appealing the denial.
- F.** In computing any period of time prescribed in this Section, the day of the act, event, or default after which the designated period of time begins to run is not included. The last day of the period is included unless it is Saturday, Sunday, or a state holiday, in which event the period runs until the end of the next day that is not Saturday, Sunday, or a state holiday. The computation includes intermediate Saturdays, Sundays, and state holidays. The time begins on the date of personal service, date shown as received on a certified mail receipt, or postmark date.

Historical Note

Section R4-33-103 adopted by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3).

Table 1. Time Frames (in days)

Type of License	Overall Time Frame	Administrative Review Time Frame	Time to Respond to Deficiency Notice	Substantive Review Time Frame	Time to Respond to Request for Additional Information
Initial License R4-33-201 and R4-33-202 A.R.S. §§ 36-446.04(A) and 36-446.05	135	30	90	105	60
Renewal of License R4-33-206 A.R.S. § 36-446.07(E)	75	30	15	45	15
Temporary License R4-33-203 A.R.S. § 36-446.06	135	30	90	105	60

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Type of License	Overall Time Frame	Administrative Review Time Frame	Time to Respond to Deficiency Notice	Substantive Review Time Frame	Time to Respond to Request for Additional Information
Continuing Education Program Approval R4-33-502 A.R.S. § 36-446.07(E) and (F)	60	15	30	45	15
Administrator-in-Training Program Approval R4-33-301 A.R.S. § 36-446.04	60	15	30	45	15
Initial Certification R4-33-401 A.R.S. § 36-446.04(B)	135	30	90	105	60
Renewal of Certification R4-33-405 A.R.S. § 36-446.07(F)	75	30	15	45	15
Temporary Certification R4-33-402 A.R.S. § 36-446.06	135	30	90	105	60
Initial Approval of an Assisted Living Facility Manager or Caregiver Training Program R4-33-604, R4-33-704, R4-33-704.1, A.R.S. § 36-446.03(O)	120	60	60	60	60
Renewal Approval of an Assisted Living Facility Manager or Caregiver Training Program R4-33-605, R4-33-705, R4-33-705.1, A.R.S. § 36-446.03(O)	120	60	30	60	30

Historical Note

Table 1 adopted by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 19 A.A.R. 1619, effective August 4, 2013 (Supp. 13-2). Amended by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3).

R4-33-104. Fees

A. Under the authority provided at A.R.S. § 36-446.12(A), the Board establishes and shall collect the following fees related to nursing care institution administrators. The fees are nonrefundable unless A.R.S. § 41-1077 applies:

1. Initial application, \$150;
2. Arizona examination, \$500;
3. Re-administer Arizona examination, \$150;
4. Issuance of a license, \$400 or \$17 for each month remaining in the biennial period, whichever is less;
5. Duplicate license, \$75;
6. Biennial active license renewal, \$400;
7. Biennial inactive license renewal, \$200;
8. Late renewal, \$100;
9. Temporary license, \$300;
10. Certify licensure status, \$15;
11. Review sponsorship of a continuing education, \$10 per credit hour;
12. Review a licensed administrator's request for continuing education credit, \$5 per credit hour.

B. Under the authority provided at A.R.S. § 36-446.03(B), the Board establishes and shall collect the following fees related to assisted living facility managers. The fees are nonrefundable unless A.R.S. § 41-1077 applies:

1. Initial application, \$150;
2. Arizona examination, \$150;
3. Re-administer Arizona examination, \$150;
4. Issuance of a certificate, \$150 or \$7 for each month remaining in the biennial period, whichever is less;

5. Duplicate certificate, \$75;
6. Biennial active certificate renewal, \$150;
7. Biennial inactive certificate renewal, \$100;
8. Late renewal, \$75;
9. Temporary certificate, \$100;
10. Review sponsorship of a continuing education, \$10 per credit hour;
11. Review a certified manager's request for continuing education credit, \$5 per credit hour.

C. Under the authority provided at A.R.S. § 36-446.03(B), the Board establishes and shall collect the following fees related to approval of an assisted living facility manager training program. The fees are nonrefundable unless A.R.S. § 41-1077 applies:

1. Initial approval, \$1,000; and
2. Renewal approval, \$600.

D. Under the authority provided at A.R.S. § 36-446.03(B), the Board establishes and shall collect the following fees related to approval of an assisted living facility caregiver training program. The fees are nonrefundable unless A.R.S. § 41-1077 applies:

1. Initial approval, \$1,500; and
2. Renewal approval, \$1,300.

E. Under the authority provided at A.R.S. § 36-446.03(B), the Board establishes and shall collect the following fees related to approval of an assisted living facility caregiver medication management training program. The fees are nonrefundable unless A.R.S. § 41-1077 applies:

1. Initial approval, \$300; and

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2. Renewal approval, \$250.

- F. The Board shall ensure that fees established under this subsection are not increased by more than 25 percent above the amounts previously prescribed by the Board.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 805, effective April 13, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 15 A.A.R. 1975, effective November 3, 2009 (Supp. 09-4). Amended by final rulemaking at 19 A.A.R. 1619, effective August 4, 2013 (Supp. 13-2). Amended by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3).

R4-33-105. Repealed**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Repealed by final rulemaking at 27 A.A.R. 233, effective April 4, 2021 (Supp. 21-1).

R4-33-106. Rehearing or Review of Decision

- A. The Board shall provide for a rehearing and review of its decisions under A.R.S. Title 41, Chapter 6, Article 10 and the rules established by the Office of Administrative Hearings.
- B. Except as provided in subsection (I), a party is required to file a motion for rehearing or review of a decision of the Board to exhaust the party's administrative remedies.
- C. A party may amend a motion for rehearing or review at any time before the Board rules on the motion.
- D. The Board may grant a rehearing or review for any of the following reasons materially affecting a party's rights:
1. Irregularity in the proceedings of the Board or any order or abuse of discretion that deprived the moving party of a fair hearing;
 2. Misconduct of the Board, its staff, or an administrative law judge;
 3. Accident or surprise that could not have been prevented by ordinary prudence;
 4. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
 5. Excessive or insufficient penalty;
 6. Error in the admission or rejection of evidence or other errors of law occurring at the hearing or during the progress of the proceedings; and
 7. The findings of fact or decision is not justified by the evidence or is contrary to law.
- E. The Board may affirm or modify a decision or grant a rehearing or review to all or some of the parties on all or some of the issues for any of the reasons listed in subsection (D). An order modifying a decision or granting a rehearing or review shall specify with particularity the grounds for the order. If a rehearing or review is granted, the rehearing or review shall cover only the matters specified in the order.
- F. Not later than 30 days after the date of a decision and after giving the parties notice and an opportunity to be heard, the Board may, on its own initiative, order a rehearing or review of its decision for any reason it might have granted a rehearing or review on motion of a party. The Board may grant a motion for rehearing or review, timely served, for a reason not stated in the motion. An order granting a rehearing or review shall spec-

ify with particularity the grounds on which the rehearing or review is granted.

- G. When a motion for rehearing is based upon affidavits, they shall be served with the motion. An opposing party may, within 15 days after service, serve opposing affidavits. This period may be extended by the Board for a maximum of 20 days for good cause as described in subsection (H) or by written stipulation of the parties. Reply affidavits may be permitted.
- H. The Board may extend all time limits listed in this Section upon a showing of good cause. A party demonstrates good cause by showing that the grounds for the party's motion or other action could not have been known in time, using reasonable diligence, and a ruling on the motion will:
1. Further administrative convenience, expedition, or economy; or
 2. Avoid undue prejudice to any party.
- I. If, in a particular decision, the Board makes a specific finding that the immediate effectiveness of the decision is necessary for immediate preservation of the public health, safety, or welfare and that a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the decision may be issued as a final decision without an opportunity for a rehearing or review. If an application for judicial review of the decision is made, it shall be made under A.R.S. § 12-901 et seq.

Historical Note

Section R4-33-106 renumbered from R4-33-209 and amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4).

R4-33-107. Change of Name or Address

- A. The Board shall communicate with an administrator or manager using the name and address in the Board's records. To ensure timely communication from the Board, an administrator or manager shall inform the Board in writing of any change in name or address.
- B. An administrator or manager shall include in a notice of change in name or address either the new and former name or new and former address.
- C. An administrator or manager shall attach to a notice of change in name a copy of the legal document changing the name.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4).

R4-33-108. Display of License or Certificate

- A. An administrator shall display the administrator's original license and current renewal receipt in a conspicuous place in the nursing care institution at which the administrator is appointed.
- B. A manager shall display the manager's original certificate and current renewal receipt in a conspicuous place in the assisted care facility at which the manager is appointed.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 21 A.A.R. 543, effective June 6, 2015 (Supp. 15-2).

R4-33-109. Fingerprint Clearance Card Requirement

Under A.R.S. § 36-446.04, an administrator or manager is required to maintain a valid fingerprint clearance card during the biennial

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period. Within 10 days after the referenced action, an administrator or manager shall:

1. Submit to the Board a photocopy of the front and back of a new fingerprint clearance card issued to the administrator or manager during the biennial period, or
2. Provide written notice to the Board if:
 - a. The fingerprint clearance card of the administrator or manager is suspended or revoked, or
 - b. The administrator or manager is denied a new fingerprint clearance card.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1).

R4-33-110. Reserved**R4-33-111. Repealed****Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-11 renumbered as Section R4-33-111 (Supp. 82-1). Emergency amendment effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-1). Emergency expired. Emergency repeal adopted effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency repeal adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency repeal adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency repeal adopted again effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Emergency expired. Section repealed by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1).

R4-33-112. Renumbered**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Amended effective July 24, 1978 (Supp. 78-4). Former Section R4-33-12 renumbered and amended as Section R4-33-112 (Supp. 82-1). Emergency amendments effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-1). Emergency expired. Amended effective August 6, 1991 (Supp. 91-3). Emergency amendments effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency amendments adopted again with changes effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency amendments adopted again with changes effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency amendments adopted again with changes effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Amended with changes effective November 25, 1992 (Supp. 92-4). Final Section R4-33-112 renumbered to R4-33-101 at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1).

R4-33-113. Renumbered**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Former Section R4-33-13 renumbered as Section R4-33-113

(Supp. 82-1). Final Section R4-33-113 renumbered to R4-33-102 at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1).

R4-33-114. Repealed**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-14 renumbered and amended as Section R4-33-114 (Supp. 82-1). Section R4-33-114 renumbered by emergency action to R4-33-201 effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Repealed effective August 6, 1991 (Supp. 91-3).

R4-33-115. Renumbered**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-15 renumbered and amended as Section R4-33-115 (Supp. 82-1). Section R4-33-115 renumbered to R4-33-202 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-3). Amended effective August 6, 1991 (Supp. 91-3). Emergency expired. Section R4-33-115 renumbered to R4-33-201 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-115 renumbered to R4-33-201 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-115 renumbered to R4-33-201 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-115 renumbered to R4-33-201 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-115 renumbered to R4-33-201 effective November 25, 1992 (Supp. 92-4).

R4-33-116. Renumbered**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-16 renumbered as Section R4-33-116 (Supp. 82-1). Section R4-33-116 renumbered to R4-33-203 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Amended effective August 6, 1991 (Supp. 91-3). Emergency expired. Section R4-33-116 renumbered to R4-33-202 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-116 renumbered to R4-33-202 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-116 renumbered to R4-33-202 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-116 renumbered to R4-33-202 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-116 renumbered to R4-33-202 effective November 25, 1992 (Supp. 92-4).

R4-33-117. Renumbered**Historical Note**

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Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-17 renumbered and amended as Section R4-33-117 (Supp. 82-1). Section R4-33-117 renumbered to R4-33-204 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Amended effective August 6, 1991 (Supp. 91-3). Emergency expired. Section R4-33-117 renumbered to R4-33-203 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-117 renumbered to R4-33-203 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-117 renumbered to R4-33-203 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-117 renumbered to R4-33-203 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-117 renumbered to R4-33-203 effective November 25, 1992 (Supp. 92-4).

R4-33-118. Renumbered**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-18 renumbered as Section R4-33-118 and repealed effective February 10, 1982 (Supp. 82-1). Section R4-33-118 renumbered to R4-33-205 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). New Section R4-33-118 adopted effective August 6, 1991 (Supp. 91-3). Emergency expired. Section R4-33-118 renumbered to R4-33-205 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Section R4-33-118 renumbered to R4-33-204 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-118 renumbered to R4-33-204 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-118 renumbered to R4-33-204 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-118 renumbered to R4-33-204 effective November 25, 1992 (Supp. 92-4).

R4-33-119. Renumbered**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Amended effective July 24, 1978 (Supp. 78-4). Former Section R4-33-19 renumbered as Section R4-33-119 and repealed, new Section R4-33-119 adopted effective February 10, 1982 (Supp. 82-1). Amended effective May 2, 1984 (Supp. 84-3). Amended as an emergency effective October 2, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency expired. Emergency amendments readopted without change effective January 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-1). Emergency amendments readopted without change effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days; amended effective June 14, 1990 (Supp. 90-2). Section R4-33-119 renumbered to R4-33-206 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for

only 90 days (Supp. 91-2). Amended effective August 6, 1991 (Supp. 91-3). Emergency expired. Section R4-33-119 renumbered to R4-33-206 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-119 renumbered to R4-33-205 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-119 renumbered to R4-33-205 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-119 renumbered to R4-33-205 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-119 renumbered to R4-33-205 effective November 25, 1992 (Supp. 92-4).

R4-33-120. Renumbered**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Amended effective July 24, 1978 (Supp. 78-4). Former Section R4-33-20 renumbered and amended as Section R4-33-120 (Supp. 82-1). Amended effective August 6, 1991 (Supp. 91-3). Section R4-33-120 renumbered to R4-33-207 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Amended effective August 6, 1991 (Supp. 91-3). Section R4-33-120 renumbered to R4-33-207 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-120 renumbered to R4-33-206 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-120 renumbered to R4-33-206 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-120 renumbered to R4-33-206 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-120 renumbered to R4-33-206 effective November 25, 1992 (Supp. 92-4).

R4-33-121. Renumbered**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-21 renumbered and amended as Section R4-33-121 (Supp. 82-1). Section R4-33-121 renumbered to R4-33-208 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Section R4-33-121 renumbered to R4-33-208 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-121 renumbered to R4-33-207 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-121 renumbered to R4-33-207 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-121 renumbered to R4-33-207 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-121 renumbered to R4-33-207 effective November 25, 1992 (Supp. 92-4).

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R4-33-122. Renumbered**Historical Note**

Adopted effective July 24, 1978 (Supp. 78-4). Former Section R4-33-22 renumbered as Section R4-33-122 (Supp. 82-1). Section R4-33-122 renumbered to R4-33-209 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Section R4-33-122 renumbered to R4-33-209 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-122 renumbered to R4-33-208 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-122 renumbered to R4-33-208 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-122 renumbered to R4-33-208 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-122 renumbered to R4-33-208 effective November 25, 1992 (Supp. 92-4).

R4-33-123. Renumbered**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-23 renumbered as Section R4-33-123 (Supp. 82-1). Section R4-33-123 renumbered to R4-33-210 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Section R4-33-123 renumbered to R4-33-210 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-123 renumbered to R4-33-209 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-123 renumbered to R4-33-209 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-123 renumbered to R4-33-209 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-123 renumbered to R4-33-209 effective November 25, 1992 (Supp. 92-4).

R4-33-124. Renumbered**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-24 renumbered as Section R4-33-124 (Supp. 82-1). Section R4-33-124 renumbered to R4-33-211 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Section R4-33-124 renumbered to R4-33-211 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-124 renumbered to R4-33-210 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-124 renumbered to R4-33-210 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-124 renumbered to R4-33-210 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90

days (Supp. 92-3). Section R4-33-124 renumbered to R4-33-210 effective November 25, 1992 (Supp. 92-4).

R4-33-125. Renumbered**Historical Note**

Section R4-33-125 renumbered to R4-33-211 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-125 renumbered to R4-33-211 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-125 renumbered to R4-33-211 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-125 renumbered to R4-33-211 effective November 25, 1992 (Supp. 92-4).

R4-33-126. Renumbered**Historical Note**

Adopted effective August 6, 1991 (Supp. 91-3). Former Section R4-33-126 renumbered to R4-33-212 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-126 renumbered to R4-33-212 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-126 renumbered to R4-33-212 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-126 renumbered to R4-33-212 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-126 renumbered to R4-33-212 effective November 25, 1992 (Supp. 92-4).

R4-33-127. Renumbered**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-27 renumbered and amended as Section R4-33-127 (Supp. 82-1). Section R4-33-127 renumbered to R4-33-212 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Repealed effective August 6, 1991 (Supp. 91-3). Emergency expired. Section R4-33-127 renumbered to R4-33-213 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-127 renumbered to R4-33-213 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-127 renumbered to R4-33-213 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-127 renumbered to R4-33-213 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-127 renumbered to R4-33-213 effective November 25, 1992 (Supp. 92-4).

R4-33-128. Renumbered**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-28 renumbered as Section R4-33-128 (Supp. 82-1). Section R4-33-128 renumbered to R4-33-

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213 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Section R4-33-128 renumbered to R4-33-214 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-128 renumbered to R4-33-214 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-128 renumbered to R4-33-214 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-128 renumbered to R4-33-214 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-128 renumbered to R4-33-214 effective November 25, 1992 (Supp. 92-4).

R4-33-129. Renumbered**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-29 renumbered as Section R4-33-129 and repealed effective February 10, 1982 (Supp. 82-1). Section R4-33-129 renumbered to R4-33-214 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Section R4-33-129 renumbered to R4-33-215 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-129 renumbered to R4-33-215 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-129 renumbered to R4-33-215 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-129 renumbered to R4-33-215 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-129 renumbered to R4-33-215 effective November 25, 1992 (Supp. 92-4).

R4-33-130. Renumbered**Historical Note**

Adopted effective July 24, 1989 (Supp. 78-4). Former Section R4-33-30 renumbered as Section R4-33-130 and repealed, new Section R4-33-130 adopted effective February 10, 1982 (Supp. 82-1). Amended effective August 6, 1991 (Supp. 91-3). Section R4-33-130 renumbered to R4-33-215 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Amended effective August 6, 1991 (Supp. 91-3). Emergency expired. Section R4-33-130 renumbered to R4-33-216 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-130 renumbered to R4-33-216 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-130 renumbered to R4-33-216 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-130 renumbered to R4-33-216 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-130 renum-

bered to R4-33-216 effective November 25, 1992 (Supp. 92-4).

ARTICLE 2. NURSING CARE INSTITUTION ADMINISTRATOR LICENSING

Article 2, consisting of Sections R4-33-201 through R4-33-207 and R4-33-209 through R4-33-215, renumbered from R4-33-115 through R4-33-124 and R4-33-127 through R4-33-130 effective November 25, 1992 (Supp. 92-3).

Article 2, consisting of Sections R4-33-201 through R4-33-207 and R4-33-209 through R4-33-215, renumbered by emergency action from R4-33-115 through R4-33-124 and R4-33-127 through R4-33-130 effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2).

Article 2, consisting of Sections R4-33-201 through R4-33-215, renumbered by emergency action from R4-33-114 through R4-33-124 and R4-33-127 through R4-33-130 effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2).

R4-33-201. Requirements for Initial License by Examination

To be eligible to receive an initial license by examination as a nursing care institution administrator, an individual shall:

1. Education and training.
 - a. Hold a minimum of a baccalaureate degree from an accredited college or university and successfully complete an AIT program;
 - b. Hold a minimum of a master's degree in either a health-related field or business administration from an accredited college or university; or
 - c. Hold a minimum of an associate of arts degree in nursing from an accredited college or university and:
 - i. Be currently licensed as a registered nurse under A.R.S. § 32-1632,
 - ii. Have worked as a registered nurse for five of the last seven years, and
 - iii. Successfully complete an AIT program.
2. Examination.
 - a. Obtain the scaled passing scores on both the NAB core of knowledge and line of service examinations or qualify with NAB as a Health Services Executive, and
 - b. Obtain a score of at least 80 percent on the Arizona examination; and
3. Application. Submit all applicable information required under R4-33-204.

Historical Note

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-15 renumbered and amended as Section R4-33-115 (Supp. 82-1). Section R4-33-202 renumbered from R4-33-115 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Amended effective August 6, 1991 (Supp. 91-3). Emergency expired. New Section R4-33-201 renumbered from R4-33-115 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). New Section R4-33-201 renumbered from R4-33-115 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). New Section R4-33-201 renumbered from R4-33-115 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. New Section R4-33-201 renumbered from

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R4-33-115 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-201 renumbered from R4-33-115 effective November 25, 1992 (Supp. 92-4). Text corrected to include amendments adopted effective August 6, 1991, which were inadvertently omitted (Supp. 95-2). Amended by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Former R4-33-201 renumbered to R4-33-204; new R4-33-201 renumbered from R4-33-204 and amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1). Amended by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 29 A.A.R. 642 (March 3, 2023), with an immediate effective date of February 13, 2023 (Supp. 23-1).

R4-33-202. Requirements for Initial License by Reciprocity

To be eligible for an initial license by reciprocity as a nursing care institution administrator, an individual shall:

1. Substantially equivalent educational requirement.
 - a. Hold a minimum of a baccalaureate degree from an accredited college or university, or
 - b. Hold ACHCA certification;
2. Substantially equivalent examination requirement.
 - a. Hold a valid and current license as a nursing care institution administrator:
 - i. Issued at least two years ago,
 - ii. Issued by a state or territory, and
 - iii. Obtained by passing the NAB examination; or
 - b. Have evidence of qualification by NAB as a Health Services Executive; and
 - c. Obtain a score of at least 80 percent on the Arizona examination;
3. Never have had a nursing care administrator license suspended, revoked, or otherwise restricted by any state or territory; and
4. Application.
 - a. Submit all applicable information required under R4-33-204,
 - b. Have submitted directly to the Board a certified copy of the valid and current license issued by a state or territory, and
 - c. Have submitted directly to the Board by NAB:
 - i. The examination score referenced under subsection (2)(a), or
 - ii. Evidence of qualification as a Health Services Executive.

Historical Note

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-16 renumbered as Section R4-33-116 (Supp. 82-1). Section R4-33-203 renumbered from R4-33-116 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Amended as Section R4-33-116 effective August 6, 1991 (Supp. 91-3). Section R4-33-202 renumbered from R4-33-116 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-202 renumbered from R4-33-116 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-202 renumbered from R4-33-116 by emergency action

effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-202 renumbered from R4-33-116 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-202 renumbered from R4-33-116 effective November 25, 1992 (Supp. 92-4). Text corrected to include amendments adopted effective August 6, 1991, which were inadvertently omitted (Supp. 95-2). Amended by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Former R4-33-202 renumbered to R4-33-205; new R4-33-202 renumbered from R4-33-203 and amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1). Amended by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3709, effective February 1, 2020 (Supp. 19-4). Amended by final rulemaking at 29 A.A.R. 642 (March 3, 2023), with an immediate effective date of February 13, 2023 (Supp. 23-1).

R4-33-203. Requirements for Temporary License

A. To be eligible for a temporary license as a nursing care institution administrator, an individual shall:

1. Meet the requirements specified in R4-33-201 or R4-33-202 except for the requirement at R4-33-201(2) or R4-33-202(2)(c);
2. Have the owner of a nursing care institution that intends to appoint the applicant as administrator if the applicant is successful in obtaining a temporary license submit to the Board a Letter of Intent to Appoint on a form that is available from the Board. The owner of the nursing care institution shall include the following in the Letter of Intent to Appoint:
 - a. Name of the owner of the nursing care institution,
 - b. Name and address of the nursing care institution,
 - c. Name of the applicant,
 - d. An affirmation of intent to appoint the applicant,
 - e. Reason for requesting a temporary license for the applicant,
 - f. License number of the nursing care institution, and
 - g. Signature of the owner of the nursing care institution affirming the information provided is true and complete;
3. Not have held an Arizona temporary license as a nursing care institution administrator within the past three years; and
4. Not have failed the Arizona or NAB examination before applying for a temporary license.

B. At the Board's request, an applicant for a temporary license shall appear or be available by telephone for an interview with the Board.

C. A temporary license is valid for 150 days and is not renewable. Before expiration of the temporary license, the temporary licensee shall become licensed under A.R.S. § 36-446.04 and this Article or discontinue as administrator of the nursing care institution.

D. If a temporary licensee fails the Arizona or NAB examination during the term of the temporary license, the temporary license is automatically revoked and the former licensee shall discontinue as administrator of the nursing care institution.

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Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-17 renumbered and amended as Section R4-33-117 (Supp. 82-1). Section R4-33-204 renumbered from R4-33-117 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Amended as Section R4-33-117 effective August 6, 1991 (Supp. 91-3). Section R4-33-203 renumbered from R4-33-117 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-203 renumbered from R4-33-117 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-203 renumbered from R4-33-117 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-203 renumbered from R4-33-117 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-203 renumbered from R4-33-117 effective November 25, 1992 (Supp. 92-4). Text corrected to include amendments adopted effective August 6, 1991, which were inadvertently omitted (Supp. 95-2). Amended by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Former R4-33-203 renumbered to R4-33-202; new R4-33-203 renumbered from R4-33-212 and amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 21 A.A.R. 543, effective June 6, 2015 (Supp. 15-2). Amended by final rulemaking at 25 A.A.R. 3709, effective February 1, 2020 (Supp. 19-4).

R4-33-204. Initial Application

A. An individual who desires to be licensed as a nursing care institution administrator shall submit the following information to the Board on an application form, which is available from the Board:

1. Full name of the applicant;
2. Other names that the applicant has used;
3. Mailing address of the applicant;
4. Email address of the applicant;
5. Home, work, and mobile telephone numbers of the applicant;
6. Applicant's date and place of birth;
7. Applicant's Social Security number;
8. Address of every residence at which the applicant has lived in the last five years;
9. Name and address of every accredited college or university attended, dates of attendance, date of graduation, and degree or certificate received;
10. Information regarding professional licenses or certifications currently or previously held by the applicant, including:
 - a. Name of issuing agency;
 - b. License or certificate number;
 - c. Issuing jurisdiction;
 - d. Date on which the license or certificate was first issued;
 - e. Whether the license or certificate is current; and
 - f. Whether the license or certificate is in good standing and if not, an explanation;
11. Information regarding the applicant's employment record for the last five years, including:

- a. Name, address, and telephone number of each employer;
 - b. Title of position held by the applicant;
 - c. Name of applicant's supervisor;
 - d. Dates of employment; and
 - e. Reason for employment termination;
12. Whether the applicant was ever denied a professional license or certificate and if so, the kind of license or certificate denied, licensing authority making the denial, and date;
 13. Whether the applicant ever voluntarily surrendered a professional license or certificate and if so, the kind of license or certificate surrendered, licensing authority, date, and reason for the surrender;
 14. Whether the applicant ever allowed a professional license or certificate to lapse and if so, the kind of license or certificate that lapsed, licensing authority, date, reason for lapse, and whether the license or certificate was reinstated;
 15. Whether the applicant ever had a limitation imposed on a professional license or certificate and if so, the kind of license or certificate limited, licensing authority, date, nature of limitation, reason for limitation, and whether the limitation was removed;
 16. Whether the applicant ever had a professional license or certificate suspended or revoked and if so, the kind of license or certificate suspended or revoked, licensing authority, date, and reason for the suspension or revocation;
 17. Whether the applicant ever was subject to disciplinary action with regard to a professional license or certificate and if so, the kind of license or certificate involved, licensing authority, date, and reason for and nature of the disciplinary action;
 18. Whether any unresolved complaint against the applicant is pending with a licensing authority, professional association, health care facility, or nursing care institution and if so, the nature of and where the complaint is pending;
 19. Whether the applicant ever was charged with or convicted of a felony or a misdemeanor, other than a minor traffic violation, in any court and if so, the nature of the offense, jurisdiction, and date of discharge; and
 20. Whether the applicant ever was pardoned from or had expunged the record of a felony conviction and if so, the nature of the offense, jurisdiction, and date of pardon or expunging.
- B.** In addition to the application form required under subsection (A), an applicant shall have the following submitted directly to the Board on the applicant's behalf:
1. Official transcript submitted by each accredited college or university attended by the applicant;
 2. Verification of license that is signed, authenticated by seal or notarization, and submitted by each agency that ever issued a professional license to the applicant;
 3. "Character Certification" form submitted by two individuals who have known the applicant for at least three years and are not related to, employed by, or employing the applicant; and
 4. If the applicant is certified by ACHCA, verification of certification submitted by ACHCA;
- C.** In addition to complying with subsections (A) and (B), an applicant shall submit:
1. If the applicant completed an AIT program, a photocopy of the certificate issued upon completion;

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2. For every felony or misdemeanor charge listed under subsection (A)(19), a copy of documents from the appropriate court showing the disposition of each charge;
 3. For every felony or misdemeanor conviction listed under subsection (A)(19), a copy of documents from the appropriate court showing whether the applicant met all judicially imposed sentencing terms;
 4. Full-face photograph of the applicant taken within the last six months;
 5. Fingerprint clearance card.
 - a. Photocopy of the front and back of the applicant's fingerprint clearance card and has not been convicted of a felony involving violence or financial fraud,
 - b. Proof of submission of an application for a fingerprint clearance card and has not been convicted of a felony involving violence or financial fraud, or
 - c. If denied a fingerprint clearance card, proof the applicant qualifies for a good-cause exception hearing under A.R.S. § 41-619.55 and has not been convicted of a felony involving violence or financial fraud;
 6. A full set of fingerprints taken by a law enforcement agency or other authority acceptable to the Board and in a format acceptable to the Arizona Department of Public Safety and the Federal Bureau of Investigation and the amount charged by the Arizona Department of Public Safety to process the fingerprints for a state and federal criminal history records check;
 7. Documentation, as described in A.R.S. § 41-1080(A), of U.S. citizenship or alien status indicating presence in the U.S. is authorized under federal law;
 8. Affirm the information provided in the application is true and complete and authorize others to release information regarding the applicant to the Board; and
 9. Fees required under R4-33-104(A)(1) and (A)(2).
- D.** If required by the Board under A.R.S. § 36-446.03(D), an applicant shall appear before the Board.
- E.** When the information required under subsections (A) through (C) is received and following an appearance before the Board required under subsection (D), the Board shall provide notice regarding whether the applicant may take the licensing examinations required under R4-33-201 or R4-33-202.
- F.** Because of the time required for the Board to perform an administrative completeness review under R4-33-103, an applicant shall ensure the information required under subsections (A) through (C) is submitted at least 30 days before the applicant expects to take the Arizona examination.

Historical Note

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-18 renumbered as Section R4-33-118 and repealed effective February 10, 1982 (Supp. 82-1). Section R4-33-205 renumbered from R4-33-118 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Section R4-33-204 renumbered from R4-33-118 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-204 renumbered from R4-33-118 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-204 renumbered from R4-33-118 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days

(Supp. 92-2). Emergency expired. Section R4-33-204 renumbered from R4-33-118 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-204 renumbered from R4-33-118 effective November 25, 1992 (Supp. 92-4). Final amendment at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Former R4-33-204 renumbered to R4-33-201; new R4-33-204 renumbered from R4-33-201 and amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1). Amended by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3709, effective February 1, 2020 (Supp. 19-4). Amended by final rulemaking at 29 A.A.R. 642 (March 3, 2023), with an immediate effective date of February 13, 2023 (Supp. 23-1).

R4-33-205. Administration of Examinations; License Issuance

- A.** The Board shall administer the Arizona examination at least twice each year at times and places specified by the Board.
- B.** An applicant shall make arrangements directly with NAB to take the NAB examination.
- C.** The Board shall provide written notice to an applicant regarding whether the applicant passed a required examination.
- D.** An applicant for licensure under R4-33-201 is not required to take or pass both examinations at the same time. An applicant who passes one of the examinations listed in R4-33-201(2) but fails the other is required to retake only the examination failed.
- E.** When an applicant passes the examinations required under R4-33-201 or R4-33-202, the Board shall send the applicant a written notice that the Board will issue a license to the applicant when the applicant submits to the Board the fee required under R4-33-104(A)(4). If the applicant fails to submit the fee within six months of the Board's notice, the Board shall administratively close the applicant's file. An individual whose file is administratively closed may receive further consideration only by submitting a new application under R4-33-201 or R4-33-202.

Historical Note

Adopted effective October 12, 1976 (Supp. 76-5). Amended effective July 24, 1978 (Supp. 78-4). Former Section R4-33-19 renumbered as Section R4-33-119 and repealed, new Section R4-33-119 adopted effective February 10, 1982 (Supp. 82-1). Amended effective May 2, 1984 (Supp. 84-3). Amended as an emergency effective October 2, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency expired. Emergency amendments readopted without change effective January 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-1). Emergency amendments adopted again without change effective April 3, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days; amended effective June 14, 1990 (Supp. 90-2). Section R4-33-206 renumbered from R4-33-119 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Amended as R4-33-119 effective August 6, 1991 (Supp. 91-3). Emergency expired. Section R4-33-206 renumbered from R4-33-119 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-205 renumbered from

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R4-33-119 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-205 renumbered from R4-33-119 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-205 renumbered from R4-33-119 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-205 renumbered from R4-33-119 effective November 25, 1992 (Supp. 92-4). Text corrected to include amendments adopted effective August 6, 1991, which were inadvertently omitted (Supp. 95-2). Amended by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section repealed by final rulemaking at 10 A.A.R. 805, effective April 13, 2004 (Supp. 04-1). Section R4-33-205 renumbered from R4-33-202 and amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4).

R4-33-206. Renewal Application

- A. The Board shall provide a licensee with notice of the need for license renewal. Failure to receive notice of the need for license renewal does not excuse a licensee's failure to renew timely.
- B. An administrator license expires at midnight 30 days after the administrator's birthday in each even-numbered year.
- C. To renew an administrator license, the licensee shall submit the following information to the Board, before expiration of the biennial period, on a renewal application, which is available from the Board:
 1. Current address;
 2. Current email address;
 3. Current home and business telephone numbers;
 4. Whether within the last 24 months the licensee was convicted of or pled guilty or no contest to a criminal offense, other than a minor traffic violation, in any court and if so, attach a copy of the original arrest record and final court judgment;
 5. Whether within the last 24 months the licensee was denied a professional license or had a professional license revoked, suspended, placed on probation, limited, or restricted in any way by a state or federal regulatory authority and if so, the kind of license, license number, issuing authority, nature of the regulatory action, and date;
 6. An affirmation that the number of hours of continuing education required under R4-33-501 has been completed; and
 7. The licensee's dated signature affirming the information provided is true and complete.
- D. In addition to the renewal application required under subsection (C), a licensee shall submit:
 1. A photocopy of the front and back of the licensee's fingerprint clearance card;
 2. Documentation described in A.R.S. § 41-1080(A) unless the documentation previously submitted under R4-33-204(C)(7) established U.S. citizenship or was a non-expiring work authorization issued by the federal government; and
 3. The license renewal fee required under R4-33-104.
- E. An individual whose license expires because of failure to renew timely may apply for renewal by complying with subsections (C) and (D) if:
 1. The individual pays the late renewal fee prescribed under R4-33-104,
 2. The individual affirms the individual has not acted as a nursing care institution administrator since the license expired, and
 3. The individual's license has not been surrendered, suspended, or revoked.
- F. An individual whose license expires because of failure to renew timely and who does not comply with subsection (E) may become licensed as a nursing care institution administrator only by complying with R4-33-201 or R4-33-202.

Historical Note

Adopted effective October 12, 1976 (Supp. 76-5). Amended effective July 24, 1978 (Supp. 78-4). Former Section R4-33-20 renumbered and amended as Section R4-33-120 (Supp. 82-1). Section R4-33-207 renumbered from R4-33-120 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Amended as R4-33-120 effective August 6, 1991 (Supp. 91-3). Section R4-33-207 renumbered from R4-33-120 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-207 renumbered from R4-33-120 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-207 renumbered from R4-33-120 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-207 renumbered from R4-33-120 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-206 renumbered from R4-33-120 effective November 25, 1992 (Supp. 92-4). Text corrected to include amendments adopted effective August 6, 1991, which were inadvertently omitted (Supp. 95-2). Amended by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1). Amended by final rulemaking at 15 A.A.R. 1975, effective November 3, 2009 (Supp. 09-4). Amended by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3709, effective February 1, 2020 (Supp. 19-4). Amended by final rulemaking at 29 A.A.R. 642 (March 3, 2023), with an immediate effective date of February 13, 2023 (Supp. 23-1).

R4-33-207. Inactive Status

- A. The Board shall place an administrator's license on inactive status if the administrator:
 1. Is in good standing in Arizona,
 2. Submits a written request to the Board to be placed on inactive status, and
 3. Submits evidence that complies with R4-33-501(D) showing that the administrator completed two hours of continuing education for each month in the current biennial period before the request to be placed on inactive status.
- B. Within seven days after receiving a request to be placed on inactive status, the Board shall provide the administrator written confirmation of inactive status.

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- C. An administrator whose license is on inactive status is not required to comply with R4-33-501.
- D. An inactive license expires under R4-33-206 unless the administrator timely submits a renewal application and the fee required under R4-33-104(A)(7).
- E. To resume active licensure status, an administrator shall:
 1. Submit evidence that complies with R4-33-501(D) showing that the administrator completed 25 hours of continuing education within the six months before requesting to resume active licensure status, and
 2. Submit a written request to the Board to resume active licensure status.
- F. The Board shall grant a request to resume active licensure status if the requirements of subsection (E) are met. Within seven days after receiving the written request to resume active licensure status, the Board shall send written notice to the administrator granting or denying active status.

Historical Note

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-21 renumbered and amended as Section R4-33-121 (Supp. 82-1). Section R4-33-208 renumbered from R4-33-121 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Section R4-33-208 renumbered from R4-33-121 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-208 renumbered from R4-33-121 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-208 renumbered from R4-33-121 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired.

Section R4-33-208 renumbered from R4-33-121 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-207 renumbered from R4-33-121 effective November 25, 1992 (Supp. 92-4). Section R4-33-207 renumbered to R4-33-208, new Section adopted by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4).

R4-33-208. Standards of Conduct; Disciplinary Action

- A. An administrator shall know and comply with all federal and state laws applicable to operation of a nursing care institution.
- B. An administrator shall not:
 1. Engage in unprofessional conduct as defined at A.R.S. § 36-446;
 2. Be addicted to or dependent on the use of narcotics or other drugs, including alcohol;
 3. Directly or indirectly permit an owner, officer, or employee of a nursing care institution to solicit, offer, or receive any premium, rebate, or other valuable consideration in connection with furnishing goods or services to patients of the institution unless the resulting economic benefit is directly passed to the patients;
 4. Directly or indirectly permit an owner, officer, or employee of a nursing care institution to solicit, offer, or receive any premium, rebate, or other valuable consideration for referring a patient to another person or place unless the resulting economic benefit is directly passed to the patient;

5. Willfully permit the unauthorized disclosure of information relating to a patient or a patient's records;
 6. Discriminate against a patient or employee on the basis of race, sex, age, religion, disability, or national origin;
 7. Misrepresent the administrator's qualifications, education, or experience;
 8. Aid or abet another person to misrepresent that person's qualifications, education, or experience;
 9. Defend, support, or ignore unethical conduct of an employee, owner, or other administrator;
 10. Engage in any conduct or practice contrary to recognized community standards or ethics of a nursing care institution administrator;
 11. Engage in any conduct or practice that is or might constitute incompetence, gross negligence, repeated negligence, or negligence that might constitute a danger to the health, welfare, or safety of a patient or the public;
 12. Procure or attempt to procure by fraud or misrepresentation a license or renewal of a license as a nursing care institution administrator;
 13. Violate a formal order, condition of probation, or stipulation issued by the Board;
 14. Commit an act of sexual abuse, misconduct, harassment, or exploitation;
 15. Retaliate against any person who reports in good faith to the Board alleged incompetence or illegal or unethical conduct of any administrator; or
 16. Accept an appointment as administrator of a nursing care institution in violation of R4-33-212.
- C. The Board shall consider a final judgment or conviction for a felony, an offense involving moral turpitude, or direct or indirect elder abuse as grounds for disciplinary action under A.R.S. § 36-446.07 including denial of a license or license renewal.
 - D. An administrator who violates any provision of A.R.S. Title 36, Chapter 4, Article 6 or this Chapter is subject to discipline under A.R.S. § 36-446.07.

Historical Note

Adopted effective July 24, 1978 (Supp. 78-4). Former Section R4-33-22 renumbered as Section R4-33-122 (Supp. 82-1). Section R4-33-209 renumbered from R4-33-122 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Section R4-33-209 renumbered from R4-33-122 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-209 renumbered from R4-33-122 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-209 renumbered from R4-33-122 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-209 renumbered from R4-33-122 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-208 renumbered from R4-33-122 effective November 25, 1992 (Supp. 92-4). Section R4-33-208 renumbered to R4-33-209, new Section R4-33-208 renumbered from R4-33-207 and amended by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 21 A.A.R. 543, effective June 6, 2015 (Supp. 15-2).

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R4-33-209. Renumbered**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-23 renumbered as Section R4-33-123 (Supp. 82-1). Section R4-33-210 renumbered from R4-33-123 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Section R4-33-210 renumbered from R4-33-123 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-210 renumbered from R4-33-123 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-210 renumbered from R4-33-123 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-210 renumbered from R4-33-123 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-209 renumbered from R4-33-123 effective November 25, 1992 (Supp. 92-4). Section R4-33-209 renumbered to R4-33-210, new Section R4-33-209 renumbered from R4-33-208 and amended by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section R4-33-209 renumbered to R4-33-106 by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4).

R4-33-210. Licensure Following Revocation

An individual who wishes to be licensed after the individual's license as a nursing care institution administrator is revoked shall:

1. Not apply for licensure until at least 12 months have passed since the revocation; and
2. Apply for licensure under R4-33-201 or R4-33-202.

Historical Note

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-24 renumbered as Section R4-33-124 (Supp. 82-1). Section R4-33-211 renumbered from R4-33-124 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Section R4-33-212 renumbered from R4-33-124 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-210 renumbered from R4-33-124 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-210 renumbered from R4-33-124 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-210 renumbered from R4-33-124 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-210 renumbered from R4-33-124 effective November 25, 1992 (Supp. 92-4). Section R4-33-210 renumbered to R4-33-211, new Section R4-33-210 renumbered from R4-33-209 and amended by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4).

R4-33-211. Notice of Appointment

- A. An administrator shall provide written notice to the Board, within 30 days, of being appointed administrator of a nursing care institution or terminating an appointment.
- B. An administrator shall include the following, as applicable, in a notice regarding the administrator's appointment:
 1. Administrator's name,
 2. Administrator's license number,
 3. Name and address of the nursing care institution to which the administrator is appointed,
 4. Date of appointment,
 5. Name and address of the nursing care institution at which the administrator's appointment is terminated, and
 6. Date of termination.

Historical Note

Section R4-33-211 renumbered from R4-33-125 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-211 renumbered from R4-33-125 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-211 renumbered from R4-33-125 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-211 renumbered from R4-33-125 effective November 25, 1992 (Supp. 92-4). New Section R4-33-211 renumbered from R4-33-210 and amended by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4).

R4-33-212. Appointment as Administrator of Multiple Nursing Care Institutions

- A. Except as provided in subsection (B), an individual licensed under R4-33-201 or R4-33-202 shall not be appointed as administrator of more than one nursing care institution.
- B. An individual licensed under R4-33-201 or R4-33-202 may be appointed as administrator of a second nursing care institution if:
 1. Neither nursing care institution is operating under a provisional license;
 2. The two nursing care institutions are no more than 25 miles apart; and
 3. The appointment at the second institution is for no more than 90 days.
- C. A licensed administrator who is appointed as administrator of a second nursing care institution under subsection (B) shall:
 1. For both nursing care institutions, designate in writing an individual who is on the nursing care institution premises and accountable for the services provided at the nursing care institution when the licensed administrator is not on the nursing care institution premises. The designated individual shall:
 - a. Be at least 21 years old;
 - b. Be qualified through education and experience to fulfill the responsibilities of a nursing care institution administrator; and
 - c. Never have had licensure or certification suspended or revoked by the Board;
 2. Ensure that the name of the designated individual is conspicuously displayed at all times in a manner that informs those seeking assistance who is accountable for the services provided;

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3. Place the written notice of designation required under subsection (C)(1) in the personnel file of the individual designated; and
4. Be available to the individual designated under subsection (C)(1) by telephone or electronically within 60 minutes.

Historical Note

Adopted effective August 6, 1991 (Supp. 91-3). Section R4-33-211 renumbered from R4-33-126 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-212 renumbered from R4-33-126 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-212 renumbered from R4-33-126 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-212 renumbered from R4-33-126 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-212 renumbered from R4-33-126 effective November 25, 1992 (Supp. 92-4). Section R4-33-212 amended by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section R4-33-212 renumbered to R4-33-203 by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). New Section made by final rulemaking at 21 A.A.R. 543, effective June 6, 2015 (Supp. 15-2).

R4-33-213. Repealed**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-27 renumbered and amended as Section R4-33-127 (Supp. 82-1). Section R4-33-212 renumbered from R4-33-127 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Repealed as R4-33-127 effective August 6, 1991 (Supp. 91-3). Emergency expired. Section R4-33-213 renumbered from R4-33-127 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-213 renumbered from R4-33-127 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-213 renumbered from R4-33-127 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-213 renumbered from R4-33-127 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-213 renumbered from R4-33-127 effective November 25, 1992 (Supp. 92-4). Section R4-33-213 renumbered from R4-33-214 and amended by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section repealed by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4).

R4-33-214. Repealed**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-28 renumbered as Section R4-33-128 (Supp. 82-1). Section R4-33-213 renumbered from R4-33-128 by emergency action effective June 19, 1991, pur-

suant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Section R4-33-214 renumbered from R4-33-128 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-214 renumbered from R4-33-128 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-214 renumbered from R4-33-128 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-214 renumbered from R4-33-128 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-214 renumbered from R4-33-128 effective November 25, 1992 (Supp. 92-4). Section R4-33-214 renumbered from R4-33-216 and amended by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section repealed by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4).

R4-33-215. Renumbered**Historical Note**

Adopted effective October 12, 1976 (Supp. 76-5). Former Section R4-33-29 renumbered as Section R4-33-129 and repealed effective February 10, 1982 (Supp. 82-1). Section R4-33-214 renumbered from R4-33-129 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Section R4-33-214 renumbered from R4-33-129 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-215 renumbered from R4-33-129 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-215 renumbered from R4-33-129 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Section R4-33-215 renumbered from R4-33-129 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-215 renumbered from R4-33-129 effective November 25, 1992 (Supp. 92-4).

R4-33-216. Renumbered**Historical Note**

Adopted effective July 24, 1989 (Supp. 78-4). Former Section R4-33-30 renumbered as Section R4-33-130 and repealed, new Section R4-33-130 adopted effective February 10, 1982 (Supp. 82-1). Section R4-33-215 renumbered from R4-33-130 by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Amended as R4-33-130 effective August 6, 1991 (Supp. 91-3). Emergency expired. Section R4-33-216 renumbered from R4-33-130 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Section R4-33-216 renumbered from R4-33-130 by emergency action effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Section R4-33-216 renumbered from R4-33-130 by emergency action effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2).

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Emergency expired. Section R4-33-216 renumbered from R4-33-130 by emergency action effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Section R4-33-216 renumbered from R4-33-130 effective November 25, 1992 (Supp. 92-4). Text corrected to include amendments adopted effective August 6, 1991, which were inadvertently omitted (Supp. 95-2). Section R4-33-216 renumbered to R4-33-214 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1).

ARTICLE 3. ADMINISTRATOR-IN-TRAINING PROGRAM**R4-33-301. Approval of an AIT Program**

- A. The Board approves an AIT internship provided at an educational institution with a NAB-accredited program.
- B. The provider of an AIT program that does not meet the standard in subsection (A) may apply to the Board for approval of the AIT program. To apply for approval of an AIT program, the provider of the program shall submit to the Board:
 1. A letter on official letterhead providing the following information:
 - a. Name, address, email address, and telephone and fax numbers of the provider; and
 - b. Name, telephone number, and email address of an individual who can be contacted regarding the information provided;
 2. A description of the procedure required under R4-33-302(2)(d) to measure the success of an AIT and a copy of any materials used to measure the success of an AIT,
 3. A copy of the AIT program monitoring procedure required under R4-33-302(3) and any forms that are used in the monitoring,
 4. A copy of the certificate of completion required under R4-33-302(2)(e),
 5. A detailed outline of the training course required under R4-33-302(4)(d),
 6. A copy of the policy and procedures manual required under R4-33-302(5), and
 7. The signature of an authorized representative of the provider:
 - a. Affirming that the information provided is true and complete, and
 - b. Authorizing the Board to monitor the program's compliance with the standards in R4-33-302.
- C. The Board shall approve an AIT program that the Board determines meets the standards in R4-33-302. The Board's approval of an AIT program is valid for one year if the program remains in compliance with the standards in R4-33-302.
- D. To maintain approval of an AIT program, the provider of the AIT program shall, before the approval expires, submit:
 1. The information required under subsection (B), or
 2. The letter required under subsection (B)(1) and the signature of an authorized representative of the provider affirming the materials previously submitted under subsections (B)(2) through (B)(6) continue to be true and complete and authorizing the Board to monitor the program's compliance with the standards in R4-33-302.

Historical Note

Emergency adoption effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Emergency rule adopted again with changes effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emer-

gency rule adopted again with changes effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Emergency rule R4-33-301 renumbered as a permanent rule to R4-33-302; new rule R4-33-301 adopted effective November 25, 1992 (Supp. 92-4). Former Section R4-33-301 renumbered to R4-33-401, new Section R4-33-301 adopted by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Amended by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1). Amended by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3).

R4-33-302. Standards for an AIT Program

For an AIT program to be approved by the Board, the provider of the AIT program:

1. Shall be:
 - a. An accredited college or university,
 - b. An institution licensed by the Board of Private Post-secondary Education under A.R.S. § 32-3001 et seq.,
 - c. ACHCA or the Arizona chapter of ACHCA, or
 - d. Another nationally recognized organization of long-term care administrators;
2. Shall ensure that the AIT program:
 - a. Provides at least 1,000 hours of full-time educational experience to the AIT in not less than six months and not more than 12 months in the following subject areas:
 - i. Federal and state law regarding nursing care institutions,
 - ii. Nursing care institution administration and policy,
 - iii. Health care quality assurance,
 - iv. Communications skills,
 - v. Health economics,
 - vi. Financial management of a nursing care institution,
 - vii. Personnel management,
 - viii. Resident care,
 - ix. Facility operation and management,
 - x. Safety and environmental management, and
 - xi. Community resources;
 - b. Allows the AIT to work only with a preceptor who meets the standards in subsection (4) and is responsible for supervising the AIT while the AIT participates in the program,
 - c. Is implemented at the nursing care institution of which the preceptor is administrator,
 - d. Measures the AIT's success in acquiring the knowledge and skills necessary to be a competent nursing care institution administrator, and
 - e. Provides the AIT with a certificate of completion that indicates:
 - i. The AIT's name,
 - ii. The preceptor's name and license number,
 - iii. The name and address of the facility at which the AIT program was implemented,
 - iv. The beginning and ending dates of the AIT program, and

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- v. The preceptor's signature affirming that the AIT successfully completed the AIT program;
- 3. Shall develop a procedure to monitor the AIT program, assess the AIT's progress through the AIT program, and make adjustments necessary to ensure that the AIT acquires the knowledge and skills necessary to be a competent nursing care institution administrator;
- 4. Shall ensure that an individual who serves as an AIT preceptor:
 - a. Has been licensed by the Board for at least two years,
 - b. Is appointed full-time as a nursing care institution administrator at a facility that the Department determines is in compliance with applicable standards,
 - c. Is in good standing and has no disciplinary actions against the individual's license in the last three years, and
 - d. Completes a training course regarding the role and responsibilities of a preceptor; and
- 5. Shall develop a written policy and procedures manual that includes at least the following:
 - a. Procedure and forms required to apply to be an AIT;
 - b. Procedure and forms required to apply to be a preceptor;
 - c. Procedure for matching an AIT applicant with a preceptor;
 - d. Goals of the AIT program related to each of the subject areas listed in subsection (2)(a);
 - e. Learning experiences to achieve each goal;
 - f. Estimated time to accomplish each goal;
 - g. Responsibilities of a preceptor;
 - h. Responsibilities of an AIT;
 - i. Procedures for deviating from the goals of the AIT program, changing the facility at which the AIT program is implemented, changing preceptor, and extending the AIT program; and
 - j. Procedure for evaluating the preceptor.

Historical Note

R4-33-302 adopted by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Emergency rule adopted again with changes effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again with changes effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Emergency rule R4-33-302 renumbered as a permanent rule to R4-33-303; new R4-33-302 renumbered from emergency rule R4-33-301 and adopted with changes effective November 25, 1992 (Supp. 92-4). Former Section R4-33-302 renumbered to R4-33-402, new Section R4-33-302 adopted by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1). Amended by final rulemaking at 21 A.A.R. 543, effective June 6, 2015 (Supp. 15-2).

R4-33-303. Repealed**Historical Note**

R4-33-303 adopted by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Emergency rule adopted again with changes effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again with changes effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Emergency rule R4-33-303 renumbered as a permanent rule to R4-33-304; new R4-33-303 renumbered from emergency rule R4-33-302 and adopted with changes effective November 25, 1992 (Supp. 92-4). Former Section R4-33-303 renumbered to R4-33-403, new Section R4-33-303 adopted by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section repealed by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1).

R4-33-304. Renumbered**Historical Note**

R4-33-304 adopted by emergency action effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Emergency rule adopted again with changes effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Emergency rule R4-33-304 renumbered as a permanent rule to R4-33-305, new rule R4-33-304 renumbered from emergency rule R4-33-303 and adopted with changes effective November 25, 1992 (Supp. 92-4). Section R4-33-304 renumbered to R4-33-404 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1).

R4-33-305. Renumbered**Historical Note**

Emergency adoption effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Emergency rule adopted again with changes effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again with changes effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Emergency rule R4-33-305 renumbered as a permanent rule to R4-33-306, new R4-33-305 renumbered from emergency rule R4-33-304 and adopted with changes effective November 25, 1992 (Supp. 92-4). Section R4-33-305 renumbered to R4-33-405 by final

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rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1).

R4-33-306. Renumbered**Historical Note**

Emergency adoption effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Emergency rule adopted again with changes effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again with changes effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Emergency rule R4-33-306 renumbered as a permanent rule to R4-33-307, new R4-33-306 renumbered from emergency rule R4-33-305 and adopted with changes effective November 25, 1992 (Supp. 92-4). Section R4-33-306 renumbered to R4-33-406 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1).

R4-33-307. Renumbered**Historical Note**

Emergency adoption effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Emergency rule adopted again with changes effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again with changes effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Emergency rule R4-33-307 renumbered as a permanent rule to R4-33-308, new R4-33-307 renumbered from emergency rule R4-33-306 and adopted with changes effective November 25, 1992 (Supp. 92-4). Amended effective February 6, 1995 (Supp. 95-1). Section R4-33-307 renumbered to R4-33-407 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1).

R4-33-308. Renumbered**Historical Note**

Emergency adoption effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Emergency rule adopted as R4-33-307 renumbered to R4-33-311 by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days; new emergency rule adopted as R4-33-307 renumbered from R4-33-312 and amended by emergency action effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again with changes effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2).

Emergency expired. Emergency rule adopted again effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Emergency rule R4-33-308 renumbered as a permanent rule to R4-33-309, new R4-33-308 renumbered from emergency rule R4-33-307 and adopted with changes effective November 25, 1992 (Supp. 92-4). Section R4-33-308 renumbered to R4-33-408 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1).

R4-33-309. Renumbered**Historical Note**

Emergency adoption effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. New emergency rule adopted as R4-33-308 renumbered from emergency rule R4-33-309 and amended effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Emergency rule R4-33-309 renumbered as a permanent rule to R4-33-310, new R4-33-309 renumbered from emergency rule R4-33-308 and adopted without change effective November 25, 1992 (Supp. 92-4). Section R4-33-309 renumbered to R4-33-409 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1).

R4-33-310. Renumbered**Historical Note**

Emergency adoption effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Emergency rule adopted as R4-33-309 renumbered to emergency rule R4-33-308; new emergency rule adopted as R4-33-309 renumbered from emergency rule R4-33-310 and amended effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again with changes effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Emergency rule R4-33-310 renumbered as a permanent rule to R4-33-311, new R4-33-310 renumbered from emergency rule R4-33-309 and adopted with changes effective November 25, 1992 (Supp. 92-4). Section R4-33-310 renumbered to R4-33-410 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1).

R4-33-311. Renumbered**Historical Note**

Emergency adoption effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Emergency rule adopted as R4-33-310 renumbered to R4-33-309; new emergency rule R4-33-310 renumbered from emergency rule R4-33-311 and

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amended effective November 29, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective February 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Emergency rule adopted again effective May 28, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-2). Emergency expired. Emergency rule adopted again effective September 10, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-3). Emergency rule R4-33-311 renumbered as a permanent rule to R4-33-312, new R4-33-311 renumbered from emergency rule R4-33-310 and adopted without change effective November 25, 1992 (Supp. 92-4). Section R4-33-311 renumbered to R4-33-411 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1).

R4-33-312. Renumbered**Historical Note**

Emergency adoption effective June 19, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. R4-33-312 renumbered from emergency rule R4-33-311 and adopted with changes effective November 25, 1992 (Supp. 92-4). Section R4-33-312 renumbered to R4-33-412 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1).

ARTICLE 4. ASSISTED LIVING FACILITY MANAGER CERTIFICATION**R4-33-401. Requirements for Initial Certification by Examination**

- A.** Except as provided in subsection (B), an individual who wishes to receive an initial certificate by examination as an assisted living facility manager shall:
1. Education:
 - a. Earn a high school diploma or G.E.D. or hold a license in good standing issued under A.R.S. Title 32, Chapters 13, 15, or 17 or 4 A.A.C. 33, Article 2;
 - b. Complete an assisted living facility caregiver training program that is approved by the Board under Article 7; and
 - c. Complete an assisted living facility manager training program that is approved by the Board under or Article 6;
 2. Work experience. Complete at least 2,080 hours of paid work experience in a health-related field within the five years before application;
 3. Examination. Obtain a score of at least 75 percent on the Arizona examination;
 4. Training. Complete an adult cardiopulmonary resuscitation and basic first-aid training program; and
 5. Submit all applicable information required under R4-33-403.
- B.** An individual who holds a license in good standing issued under A.R.S. Title 32, Chapter 13, 15, or 17 or 4 A.A.C. 33, Article 2 is exempt from the requirements specified in subsections (A)(1)(b) and (4).

Historical Note

Section R4-33-401 renumbered from R4-33-301 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section expired under A.R.S. § 41-1056(E) at 10 A.A.R. 3897, effective July 31, 2004 (Supp. 04-3). Section R4-33-401 renumbered from R4-33-402 and

amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1). Amended by final rulemaking at 21 A.A.R. 543, effective June 6, 2015 (Supp. 15-2). Amended by final rulemaking at 25 A.A.R. 3709, effective February 1, 2020 (Supp. 19-4). Amended by final rulemaking at 29 A.A.R. 642 (March 3, 2023), with an immediate effective date of February 13, 2023 (Supp. 23-1).

R4-33-402. Requirements for a Temporary Certificate

- A.** To be eligible for a temporary certificate as an assisted living facility manager, an individual shall:
1. Meet the requirements under R4-33-401 except for the requirement at R4-33-401(3);
 2. Have the owner of an assisted living facility that intends to appoint the applicant as manager if the applicant is successful in obtaining a temporary certificate submit to the Board a Letter of Intent to Appoint on a form that is available from the Board. The owner of the assisted living facility shall include the following in the Letter of Intent to Appoint:
 - a. Name of the owner of the assisted living facility;
 - b. Name and address of the assisted living facility;
 - c. Name of the applicant;
 - d. An affirmation of intent to appoint the applicant;
 - e. Reason for requesting a temporary certificate for the applicant;
 - f. License number of the assisted living facility; and
 - g. Signature of the owner of the assisted living facility affirming the information provided is true and complete;
 3. Not have held an Arizona temporary certificate as an assisted living facility manager within the past three years; and
 4. Not have failed the Arizona examination before applying for the temporary certificate.
- B.** At the Board's request, an applicant for a temporary certificate shall appear or be available by telephone for an interview with the Board.
- C.** A temporary certificate is valid for 150 days and is not renewable. Before expiration of the temporary certificate, the temporary certificate holder shall obtain a certificate under A.R.S. § 36-446.04 and this Article or discontinue as manager of the assisted living facility.
- D.** If a temporary certificate holder fails the Arizona examination during the term of the temporary certificate, the temporary certificate is automatically revoked and the former temporary certificate holder shall discontinue as manager of the assisted living facility.

Historical Note

Section R4-33-402 renumbered from R4-33-302 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Former R4-33-402 renumbered to R4-33-401; new R4-33-402 renumbered from R4-33-410 and amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). R4-33-402(A)(1) citation to R4-33-401(A)(3) corrected to R4-33-401(3) at the request of the Department, see Office File No. M10-416 filed October 18, 2010 (Supp. 09-4). Amended by final rulemaking at 21 A.A.R. 543, effective June 6, 2015 (Supp. 15-2). Amended by final rulemaking at 25 A.A.R. 3709, effective February 1, 2020 (Supp. 19-4).

R4-33-403. Initial Application

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- A.** An individual who desires to be certified as a manager of an assisted living facility shall submit the following information to the Board on an application form, which is available from the Board:
1. Full name of the applicant;
 2. Other names that the applicant has used;
 3. Mailing address of the applicant;
 4. Home, work, and mobile telephone numbers of the applicant;
 5. Applicant's date and place of birth;
 6. Applicant's Social Security number;
 7. Address of every residence at which the applicant has lived in the last five years;
 8. Education information regarding the applicant, including:
 - a. Name and location of last high school attended;
 - b. Date of high school graduation or date on which a G.E.D. was earned; and
 - c. Name and address of every accredited college or university attended, dates of attendance, date of graduation, and degree or certificate earned;
 9. Information regarding professional licenses or certifications currently or previously held by the applicant, including:
 - a. Name of issuing agency;
 - b. License or certificate number;
 - c. Issuing jurisdiction;
 - d. Date on which the license or certificate was first issued;
 - e. Whether the license or certificate is current; and
 - f. Whether the license or certificate is in good standing and if not, an explanation;
 10. Information regarding the applicant's employment record for the last five years, including:
 - a. Name, address, and telephone number of each employer;
 - b. Title of position held by the applicant;
 - c. Name of applicant's supervisor;
 - d. Dates of employment;
 - e. Number of hours worked each week;
 - f. Whether the employment was full or part time; and
 - g. Reason for termination;
 11. Whether the applicant was ever denied a professional license or certificate and if so, the kind of license or certificate denied; licensing authority making the denial, and date;
 12. Whether the applicant ever voluntarily surrendered a professional license or certificate and if so, the kind of license or certificate surrendered, licensing authority, date, and reason for the surrender;
 13. Whether the applicant ever allowed a professional license or certificate to lapse and if so, the kind of license or certificate that lapsed, licensing authority, date, reason for lapse, and whether the license or certificate was reinstated;
 14. Whether the applicant ever had a limitation imposed on a professional license or certificate and if so, the kind of license or certificate limited, licensing authority, date, nature of limitation, reason for limitation, and whether the limitation was removed;
 15. Whether the applicant ever had a professional license or certificate suspended or revoked and if so, the kind of license or certificate suspended or revoked, licensing authority, date, and reason for suspension or revocation;
 16. Whether the applicant ever was subject to disciplinary action with regard to a professional license or certificate and if so, the kind of license or certificate involved, licensing authority, date, and reason for and nature of the disciplinary action;
 17. Whether any unresolved complaint against the applicant is pending with a licensing authority, professional association, health care facility, or assisted living facility and if so, the nature of and where the complaint is pending;
 18. Whether the applicant ever was charged with or convicted of a felony or a misdemeanor, other than a minor traffic violation, in any court and if so, the nature of the offense, jurisdiction, and date of discharge; and
 19. Whether the applicant ever was pardoned from or had the record expunged of a felony conviction and if so, the nature of the offense, jurisdiction, and date of pardon or expunging.
- B.** In addition to the application form required under subsection (A), an applicant shall submit or have submitted on the applicant's behalf:
1. Education:
 - a. Copy of the applicant's high school diploma or G.E.D. and certificates of completion issued from the training courses described under R4-33-401(A)(1)(b) and (c); or
 - b. Copy of the applicant's license issued under A.R.S. Title 32, Chapter 13, 15, or 17 or 4 A.A.C. 33, Article 2, and certificate of completion issued from the training course described under R4-33-401(A)(1)(c);
 2. Documentation of 2,080 hours of paid work experience in a health-related field;
 3. Copy of current certification in adult cardiopulmonary resuscitation and first aid;
 4. Verification of license that is signed, authenticated by seal or notarization, and submitted directly to the Board by each agency that ever issued a professional license to the applicant;
 5. "Character Certification" form submitted directly to the Board by two individuals who have known the applicant for at least three years and are not related to, employed by, or employing the applicant;
 6. For every felony or misdemeanor charge listed under subsection (A)(18), a copy of documents from the appropriate court showing the disposition of each charge;
 7. For every felony or misdemeanor conviction listed under subsection (A)(18), a copy of documents from the appropriate court showing whether the applicant met all judicially imposed sentencing terms;
 8. Full-faced photograph of the applicant taken within the last six months;
 9. Fingerprint clearance card.
 - a. Photocopy of the front and back of the applicant's fingerprint clearance card and has not been convicted of a felony involving violence or financial fraud;
 - b. Proof of submission of an application for a fingerprint clearance card and has not been convicted of a felony involving violence or financial fraud; or
 - c. If denied a fingerprint clearance card, proof that the applicant qualifies for a good-cause exception hearing under A.R.S. § 41-619.55 and has not been convicted of a felony involving violence or financial fraud;

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10. A full set of fingerprints taken by a law enforcement agency or other authority acceptable to the Board and in a format acceptable to the Arizona Department of Public Safety and the Federal Bureau of Investigation and the amount charged by the Arizona Department of Public Safety to process the fingerprints for a state and federal criminal history records check;
 11. Documentation, as described in A.R.S. § 41-1080(A), of U.S. citizenship or alien status indicating presence in the U.S. is authorized under federal law;
 12. Affirm the information provided in the application is true and complete and authorize others to release information regarding the applicant to the Board; and
 13. Fees required under R4-33-104(B)(1) and (B)(2).
- C.** If required by the Board under A.R.S. § 36-446.03(D), an applicant shall appear before the Board.
- D.** When the information required under subsections (A) and (B) is received and following an appearance before the Board required under subsection (C), the Board shall provide notice regarding whether the applicant may take the Arizona examination required under R4-33-401(3).
- E.** Because of the time required for the Board to perform an administrative completeness review under R4-33-103, an applicant shall submit the information required under subsections (A) and (B) at least 30 days before the applicant expects to take the Arizona examination.

Historical Note

Section R4-33-403 renumbered from R4-33-303 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1). Amended by final rulemaking at 25 A.A.R. 3709, effective February 1, 2020 (Supp. 19-4). Amended by final rulemaking at 29 A.A.R. 642 (March 3, 2023), with an immediate effective date of February 13, 2023 (Supp. 23-1).

R4-33-404. Administration of Examination; Certificate Issuance

- A.** The Board shall administer the Arizona examination at least twice each year at times and places specified by the Board.
- B.** The Board shall provide written notice to an applicant regarding whether the applicant passed the Arizona examination.
- C.** When an applicant passes the Arizona examination, the Board shall send the applicant a written notice that the Board will issue a certificate to the applicant when the applicant submits to the Board the fee required under R4-33-104(B)(4). If the applicant fails to submit the fee within six months of the Board's notice, the Board shall administratively close the applicant's file. An individual whose file is administratively closed may receive further consideration only by submitting a new application under R4-33-401.

Historical Note

Section R4-33-404 renumbered from R4-33-304 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). R4-33-404 corrected by adding a subsection (C) at the request of the Department, Office File No. M10-416 filed October 18, 2010 (Supp. 09-4).

R4-33-405. Renewal Application

- A.** The Board shall provide a certificate holder with notice of the need for certificate renewal. Failure to receive notice of the need for certificate renewal does not excuse a certificate holder's failure to renew timely.
- B.** A manager certificate expires at midnight 30 days after the manager's birthday in each odd-numbered year.
- C.** To renew a manager certificate, the certificate holder shall submit the following information to the Board, on or before expiration of the biennial period, on a renewal application, which is available from the Board:
1. Current address;
 2. Current home and business telephone numbers;
 3. Whether within the last 24 months the certificate holder was convicted of or pled guilty or no contest to a criminal offense, other than a minor traffic violation, in any court and if so, attach a copy of the original arrest record and final court judgment;
 4. Whether within the last 24 months the certificate holder was denied a professional license or had a professional license revoked, suspended, placed on probation, limited, or restricted in any way by a state or federal regulatory authority and if so, the kind of license, license number, issuing authority, nature of the regulatory action, and date;
 5. An affirmation that the number of hours of continuing education required under R4-33-501 has been completed;
 6. An affirmation that the certificate holder complies with the disclosure requirements under R4-33-408; and
 7. The certificate holder's dated signature affirming the information provided is true and complete.
- D.** In addition to the renewal application required under subsection (C), a certificate holder shall submit:
1. A photocopy of the front and back of the certificate holder's fingerprint clearance card;
 2. Documentation described in A.R.S. § 41-1080(A) unless the documentation previously submitted under R4-33-403(B)(11) established U.S. citizenship or was a non-expiring work authorization issued by the federal government; and
 3. The renewal fee required under R4-33-104.
- E.** An individual whose certificate expires because of failure to renew timely may apply for renewal by complying with subsections (C) and (D) if:
1. The individual pays the late renewal fee prescribed under R4-33-104,
 2. The individual affirms that the individual has not acted as an assisted living facility manager since the certificate expired, and
 3. The individual's certificate has not been surrendered, suspended, or revoked.
- F.** An individual whose certificate expires because of failure to renew timely and who does not comply with subsection (E) may obtain a manager certificate only by complying with R4-33-401.

Historical Note

Section R4-33-405 renumbered from R4-33-305 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section repealed by final rulemaking at 10 A.A.R. 805, effective April 13, 2004 (Supp. 04-1). Section R4-33-405 renumbered from R4-33-406 and amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1). Amended by final rulemaking at 15 A.A.R.

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1975, effective November 3, 2009 (Supp. 09-4). Amended by final rulemaking at 25 A.A.R. 3709, effective February 1, 2020 (Supp. 19-4). Amended by final rulemaking at 29 A.A.R. 642 (March 3, 2023), with an immediate effective date of February 13, 2023 (Supp. 23-1).

R4-33-406. Inactive Status

- A. The Board shall place a manager's certificate on inactive status if the manager:
1. Is in good standing in Arizona,
 2. Submits a written request to the Board to be placed on inactive status, and
 3. Submits evidence that complies with R4-33-501(D) showing that the manager completed one hour of continuing education for each month in the current biennial period before the request to be placed on inactive status.
- B. Within seven days after receiving a request to be placed on inactive status, the Board shall provide the manager written confirmation of inactive status.
- C. A manager whose certificate is on inactive status is not required to comply with R4-33-501.
- D. An inactive certificate expires under R4-33-405 unless the manager timely submits a renewal application and the fee required under R4-33-104(B)(7).
- E. To resume active certificate status, a manager shall:
1. Submit evidence that complies with R4-33-501(D) showing that the manager completed 12 hours of continuing education within the six months before requesting to resume active certificate status,
 2. Submit a written request to the Board to resume active certificate status, and
 3. Submit the fee required under R4-33-104(B)(4).
- F. The Board shall grant a request to resume active certificate status if the requirements of subsection (E) are met. Within seven days after receiving the written request to resume active certificate status, the Board shall send written notice to the manager granting or denying active status.

Historical Note

New Section R4-33-406 renumbered from R4-33-306 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Former R4-33-406 renumbered to R4-33-405; new R4-33-406 made by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4).

R4-33-407. Standards of Conduct; Disciplinary Action

- A. A manager shall know and comply with all federal and state laws applicable to the operation of an assisted living facility.
- B. A manager shall not:
1. Engage in unprofessional conduct as defined at A.R.S. § 36-446;
 2. Be addicted to or dependent on the use of narcotics or other drugs, including alcohol;
 3. Directly or indirectly permit an owner, officer, or employee of an assisted living facility to solicit, offer, or receive any premium, rebate, or other valuable consideration in connection with furnishing goods or services to residents unless the resulting economic benefit is directly passed to the residents;
 4. Directly or indirectly permit an owner, officer, or employee of an assisted living facility to solicit, offer, or receive any premium, rebate, or other valuable consideration for referring a resident to another person or place unless the resulting economic benefit is directly passed to the resident;

5. Willfully permit the unauthorized disclosure of information relating to a resident or a resident's records;
 6. Discriminate against a resident or employee on the basis of race, sex, age, religion, disability, or national origin;
 7. Misrepresent the manager's qualifications, education, or experience;
 8. Aid or abet another person to misrepresent that person's qualifications, education, or experience;
 9. Defend, support, or ignore unethical conduct of an employee, owner, or other manager;
 10. Engage in any conduct or practice contrary to recognized community standards or ethics of an assisted living facility manager;
 11. Engage in any conduct or practice that is or might constitute incompetence, gross negligence, repeated negligence, or negligence that might constitute a danger to the health, welfare, or safety of a resident or the public;
 12. Procure or attempt to procure by fraud or misrepresentation a certificate or renewal of a certificate as an assisted living facility manager;
 13. Violate a formal order, condition of probation, or stipulation issued by the Board;
 14. Commit an act of sexual abuse, misconduct, harassment, or exploitation;
 15. Retaliate against any person who reports in good faith to the Board alleged incompetence or illegal or unethical conduct of any manager;
 16. Allow the manager's certificate to be displayed as required under R4-33-108(B) unless the manager has been appointed as specified in R4-33-410; or
 17. Manage an assisted living facility in violation of R4-33-411.
- C. The Board shall consider a final judgment or conviction for a felony, an offense involving moral turpitude, or direct or indirect elder abuse as grounds for disciplinary action under A.R.S. § 36-446.07, including denial of a certificate or certificate renewal.
- D. A manager who violates any provision of A.R.S. Title 36, Chapter 4, Article 6 or this Chapter is subject to discipline under A.R.S. § 36-446.07.

Historical Note

Section R4-33-407 renumbered from R4-33-307 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Amended by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 21 A.A.R. 543, effective June 6, 2015 (Supp. 15-2).

R4-33-408. Referral Requirements

- A. A manager who is appointed by an assisted living facility that pays a fee to an individual or entity for referral of a resident to the assisted living facility shall ensure that the assisted living facility:
1. Has on file a contract with the individual or entity making the referral;
 2. Maintains a file of the names of the residents referred by the individual or entity; and
 3. Obtains at the time of admission and maintains a statement, signed by the resident or the resident's representative or legal guardian, which discloses that:
 - a. A fee was paid for referring the resident to the assisted living facility;
 - b. The resident or the resident's representative or legal guardian was informed of the fee arrangement; and

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- c. The resident or the resident's representative or legal guardian was informed of any ownership interest between the assisted living facility and the individual or entity making the referral.
- B. A manager shall maintain the records required under subsection (A)(1) for five years and shall maintain the records required under subsections (A)(2) and (A)(3) for five years after the resident ceases to reside in the assisted living facility.
- C. A manager shall make the records required under this Section available for review upon request by the Board.

Historical Note

Section R4-33-408 renumbered from R4-33-308 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 21 A.A.R. 543, effective June 6, 2015 (Supp. 15-2).

R4-33-409. Certification Following Revocation

An individual who wishes to be certified after the individual's certificate as an assisted living facility manager is revoked shall:

- 1. Not apply for certification until at least 12 months have passed since the revocation, and
- 2. Apply for certification under R4-33-401.

Historical Note

Section R4-33-409 renumbered from R4-33-309 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section repealed by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). New Section made by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1).

R4-33-410. Notice of Appointment

- A. A manager shall provide written notice to the Board, within 30 days, of being appointed manager of an assisted living facility or terminating an appointment.
- B. A manager shall include the following, as applicable, in a notice regarding the manager's appointment:
 - 1. Manager's name,
 - 2. Manager's certificate number,
 - 3. Name and address of the assisted living facility to which the manager is appointed,
 - 4. Date of appointment,
 - 5. Name and address of the assisted living facility at which the manager's appointment is terminated, and
 - 6. Date of termination.

Historical Note

Section R4-33-410 renumbered from R4-33-310 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section R4-33-410 renumbered to R4-33-402 by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). New Section made by final rulemaking at 14 A.A.R. 516, effective April 5, 2008 (Supp. 08-1).

R4-33-411. Appointment as Manager of Multiple Assisted Living Facilities

- A. An individual certified under R4-33-401 shall not be appointed to manage more than two assisted living facilities at one time.
- B. A individual certified under R4-33-401 who is appointed to manage two assisted living facilities shall:
 - 1. Ensure that the two assisted living facilities are no more than 25 miles apart;

- 2. Designate in writing one or more individuals who are on the assisted living facility premises and accountable for the services provided at the assisted living facility when the appointed certified manager is not on the assisted living facility premises. A designated individual shall:
 - a. Be at least 21 years old;
 - b. Be a caregiver with at least three years' experience as a caregiver or hold a temporary certificate issued under R4-33-402; and
 - c. Never have had licensure or certification suspended or revoked by the Board;
- 3. Ensure that the name of the designated individual is conspicuously displayed at all times in a manner that informs those seeking assistance who is accountable for the services provided;
- 4. Place the written notice of designation required under subsection (B)(2) in the personnel file of the individual designated; and
- 5. Be available to the individual designated under subsection (B)(2) by telephone or electronically within 60 minutes.

Historical Note

Section R4-33-411 renumbered from R4-33-311 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section repealed by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). New Section made by final rulemaking at 21 A.A.R. 543, effective June 6, 2015 (Supp. 15-2).

R4-33-412. Repealed**Historical Note**

Section R4-33-412 renumbered from R4-33-312 by final rulemaking at 5 A.A.R. 423, effective January 15, 1999 (Supp. 99-1). Section repealed by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4).

ARTICLE 5. CONTINUING EDUCATION**R4-33-501. Continuing Education Requirement; Extension of Time**

- A. Continuing education is a prerequisite of license or certificate renewal.
 - 1. A licensed administrator shall obtain 50 credit hours of Board-approved continuing education during each biennial period. During the biennial period in which an administrator is initially licensed, the administrator shall obtain two credit hours of Board-approved continuing education for each month or part of a month remaining in the biennial period.
 - 2. A certified manager shall obtain 24 credit hours of Board-approved continuing education during each biennial period. During the biennial period in which a manager is initially certified, the manager shall obtain one credit hour of Board-approved continuing education for each month or part of a month remaining in the biennial period.
- B. The Board shall award credit hours in an approved continuing education as follows:
 - 1. Seminar or workshop. One credit hour of continuing education for each contact hour;
 - 2. Course at an accredited educational institution. Fifteen credit hours of continuing education for each course hour;
 - 3. Attendance at a business meeting of a national health care organization or of a state association affiliated with a

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national health care organization. One-half credit hour of continuing education for each business meeting attended;

4. Self-study, online, or correspondence course. Approved credit hours of continuing education requested by the course provider;
 5. Serving as a preceptor. Two credit hours of continuing education for each month that an administrator serves as an AIT preceptor; and
 6. Teaching a Board-approved continuing education. One credit hour of continuing education for each hour taught.
- C. The Board shall limit the number of credit hours of Board-approved continuing education awarded as follows:
1. No more than 40 percent of the required credit hours may be obtained using self-study, online, or correspondence courses;
 2. No more than 50 percent of the required credit hours may be obtained from serving as an AIT preceptor;
 3. Hours may be obtained for teaching a particular continuing education only once during each biennial period; and
 4. Hours that exceed the minimum required for a biennial period may not be carried over to a subsequent biennial period.
- D. An administrator or manager shall obtain a certificate or other evidence of attendance from the provider of each continuing education attended that includes the following:
1. Name of the administrator or manager;
 2. License or certificate number of the administrator or manager;
 3. Name of the continuing education;
 4. Name of the continuing education provider;
 5. Date, time, and location of the continuing education; and
 6. Number of credit hours in the continuing education.
- E. An administrator or manager shall maintain the evidence of attendance described in subsection (D) for three years and make the evidence available to the Board under R4-33-503 and as otherwise required under this Chapter.
- F. To obtain an extension of time under A.R.S. § 36-446.07(G) to complete the continuing education requirement, an administrator or manager shall submit to the Board a written request that includes the following:
1. Ending date of the requested extension,
 2. Continuing education completed during the current biennial period and the documentation required under subsection (D),
 3. Proof of registration for additional continuing education that is sufficient to enable the administrator or manager to fulfill the continuing education requirement before the end of the requested extension, and
 4. Administrator's or manager's attestation that the continuing education obtained under the extension will be reported only to fulfill the current renewal requirement and will not be reported on a subsequent renewal application.
- G. The Board shall grant an extension of time within seven days after receiving a request for an extension of time if the request:
1. Specifies an ending date no later than October 31,
 2. Includes the required documentation and attestation,
 3. Is submitted no sooner than April 30, and
 4. Will facilitate the safe and professional regulation of nursing care institutions or assisted living facilities in this state.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4).

Amended by final rulemaking at 15 A.A.R. 1975, effective November 3, 2009 (Supp. 09-4). Amended by final rulemaking at 27 A.A.R. 233, effective April 4, 2021 (Supp. 21-1).

R4-33-502. Approval of Continuing Education

- A. The Board shall approve any continuing education approved by NAB or the ACHCA.
- B. The Board shall approve a continuing education only if it is taught by a qualified instructor and addresses at least one of the following subject areas:
1. Laws regarding environmental health and safety,
 2. Principles of management,
 3. Psychology and principles of patient or resident care,
 4. Personal and social care,
 5. Therapeutic and supportive care and services in long-term or assisted care,
 6. Community health and social resources,
 7. Quality assurance,
 8. Ethics, and
 9. Recordkeeping.
- C. To obtain the Board's approval of a continuing education, an administrator, manager, or continuing education provider shall:
1. Submit a form, which is available from the Board, containing the following information:
 - a. Title of the continuing education;
 - b. Name and address of the continuing education provider;
 - c. Name, telephone and fax numbers, and email address of a contact person for the continuing education provider;
 - d. Date, time, and place at which the continuing education will be taught;
 - e. Whether the continuing education is intended for administrators or managers;
 - f. Subject matter of the continuing education;
 - g. Teaching methods and learning activities that will be used;
 - h. Learning objectives;
 - i. Description of how learning objectives will be evaluated;
 - j. Whether an examination will be given;
 - k. Number of continuing education hours requested; and
 - l. Signature of the person requesting approval of the continuing education.
 2. Submit the following documents:
 - a. Copy of any examination that will be given to those who attend the continuing education;
 - b. Curriculum vitae of each instructor;
 - c. Agenda of the continuing education showing the hours of instruction;
 - d. Certificate of attendance that meets the requirements in R4-33-501(D);
 - e. Copy of any brochure prepared regarding the continuing education; and
 - f. Fee required under R4-33-104.
- D. The Board's approval of a continuing education is valid for one year unless there is a change in subject matter, instructor, or hours of instruction. At the end of one year or when there is a change in subject matter, instructor, or hours of instruction, the continuing education provider shall apply again for approval.

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Historical Note

New Section made by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4).

R4-33-503. Audit of Compliance and Sanction for Noncompliance with Continuing Education Requirement

- A.** The Board may audit a licensee or certificate holder for compliance with the continuing education requirement at any time.
- B.** When notice of the need to renew a license or certificate is provided, the Board shall also provide notice of an audit of continuing education records to a random sample of administrators or managers. An administrator or manager subject to a continuing education audit shall submit the documentation required under R4-33-501(D) at the same time that the administrator or manager submits the renewal application required under R4-33-206 or R4-33-405. If an administrator or manager fails to submit the required documentation with the renewal application on or before June 30, the license or certificate expires unless the administrator or manager obtains an extension of time in which to complete the continuing education requirement.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4).
Amended by final rulemaking at 27 A.A.R. 233, effective April 4, 2021 (Supp. 21-1).

R4-33-504. Repealed**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 4075, effective December 4, 2006 (Supp. 06-4). Repealed by final rulemaking at 27 A.A.R. 233, effective April 4, 2021 (Supp. 21-1).

ARTICLE 6. ASSISTED LIVING FACILITY MANAGER TRAINING PROGRAMS**R4-33-601. Definitions**

“Owner” means the person responsible for ensuring that an assisted living facility training program complies with this Article.

“Resident” means an individual who lives in an assisted living facility.

“Student cohort” means a group of individuals who begin participation in an assisted living facility training program at the same time.

Historical Note

New Section made by final rulemaking at 19 A.A.R. 1619, effective August 4, 2013 (Supp. 13-2).

R4-33-602. Minimum Standards for Assisted Living Facility Manager Training Program

- A.** Organization and administration. The owner of an assisted living facility manager training program shall:
1. Provide the Board with a written description of the training program that includes:
 - a. Length of the training program in hours and days, and
 - b. Educational goals that demonstrate the training program is consistent with state requirements;
 2. Execute a written agreement with each assisted living facility at which students enrolled in the training program receive training that includes the following information:
 - a. The rights and responsibilities of both the facility and the training program,

- b. The role and authority of the governing bodies of both the facility and the training program, and
 - c. A termination clause that provides time for students enrolled in the training program to complete training at the facility upon termination of the agreement;
3. Develop and adhere to written policies and procedures regarding:
- a. Attendance. Ensure that a student receives at least 40 hours of instruction;
 - b. Grading. Require a student to attain at least 75 percent on each theoretical examination or 75 percent on a comprehensive theoretical examination;
 - c. Reexamination. Inform students that a reexamination:
 - i. Addresses the same competencies examined in the original examination,
 - ii. Contains items different from those on the original examination, and
 - iii. Is documented in the student’s record;
 - d. Student records. Include the following information:
 - i. Records maintained,
 - ii. Retention period for each record,
 - iii. Location of records,
 - iv. Documents required under subsections (E)(1) and (E)(2), and
 - v. Procedure for accessing records and who is authorized to access records;
 - e. Student fees and financial aid, if any;
 - f. Withdrawal and dismissal;
 - g. Student grievances including a chain of command for disputing a grade;
 - h. Admission requirements including any criminal background or drug testing required;
 - i. Criteria for training program completion; and
 - j. Procedure for documenting that before a student is enrolled, the student has received notice of Board requirements for certification, including:
 - i. The fingerprint clearance card requirement;
 - ii. The full set of fingerprints and state and federal criminal history records check requirement; and
 - iii. The disqualification of a conviction for a felony involving violence or financial fraud.
4. Date each policy and procedure developed under subsection (A)(3), review within one year from the date made and every year thereafter, update if necessary, and date the policy or procedure at the time of each review;
5. Provide each student who completes the training program with evidence of completion, within 15 days of completion, which includes the following:
- a. Name of the student;
 - b. Name and classroom location of the training program;
 - c. Number of classroom hours in the training program;
 - d. Date on which the training program was completed;
 - e. Board’s approval number of the training program; and
 - f. Signature of the training program owner, administrator, or instructor;
6. Provide the Board, within 15 days of completion, the following information regarding each student who completed the training program:
- a. Student’s name, date of birth, Social Security number, address, and telephone number;

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- b. Student's examination scores as provided by the examining entity;
 - c. Name and classroom location of the training program;
 - d. Number of classroom hours in the training program;
 - e. Date on which the training program was completed; and
 - f. Board's approval number of the training program; and
- 7. Execute and maintain under subsections (E)(1) and (E)(2) the following documents for each student:
 - a. A skills checklist containing documentation the student achieved competency in the assisted living facility manager skills listed in R4-33-603(C), and
 - b. An evaluation form containing the student's responses to questions about the quality of the classroom experiences provided by the training program.
- B.** Program administrator responsibilities. The owner of an assisted living facility manager training program shall ensure that a program administrator performs the following responsibilities:
 - 1. Supervises and evaluates the training program,
 - 2. Uses only instructors who are qualified under subsection (C), and
 - 3. Makes the written policies and procedures required under subsection (A)(3) available to each student on or before the first day of the training program;
- C.** The owner of an assisted living facility manager training program shall ensure that a program instructor:
 - 1. Is a certified assisted living facility manager who:
 - a. Holds an assisted living facility manager certificate that is in good standing and issued under A.R.S. Title 36, Chapter 4;
 - b. Has held the assisted living facility manager certificate referenced in subsection (C)(1)(a) for at least five years;
 - c. Has not been subject to any disciplinary action against the assisted living facility manager certificate during the last five years; and
 - d. Has at least three years' experience within the last five years as an assisted living facility manager of record immediately before becoming a training program instructor;
 - 2. Performs the following responsibilities:
 - a. Plans each learning experience,
 - b. Accomplishes educational goals of the training program and lesson objectives,
 - c. Enforces a grading policy that meets the requirement specified in subsection (A)(3)(b),
 - d. Requires satisfactory performance of all critical elements of each assisted living facility manager skill specified under R4-33-603(C),
 - e. Prevents a student from performing an activity unless the student has received instruction and been found able to perform the activity competently,
 - f. Is present in the classroom during all instruction,
 - g. Supervises health-care professionals who assist in providing training program instruction, and
 - h. Ensures that a health-care professional who assists in providing training program instruction:
 - i. Is licensed or certified as a health-care professional,
 - ii. Has at least one year of experience in the field of licensure or certification, and
- iii. Teaches only a learning activity that is within the scope of practice of the field of licensure or certification.
- D.** Instructional and educational resources. The owner of an assisted living facility manager training program shall provide or provide access to the following instructional and educational resources adequate to implement the training program for all students and staff:
 - 1. Current reference materials related to the level of the curriculum;
 - 2. Equipment, including computers, in good working condition to simulate facility management;
 - 3. Audio-visual equipment and media; and
 - 4. Designated space that provides a clean, distraction-free, learning environment for accomplishing educational goals of the training program;
- E.** The owner of an assisted living facility manager training program shall:
 - 1. Maintain the following training program records for three years:
 - a. Curriculum and course schedule for each student cohort;
 - b. Results of state-approved written and manual skills testing;
 - c. Evaluation forms completed by students, a summary of the evaluation forms for each student cohort, and measures taken, if any, to improve the training program based on student evaluations; and
 - d. Copy of all Board reports, applications, or correspondence related to the training program; and
 - 2. Maintain the following student records for three years:
 - a. Name, date of birth, and Social Security number;
 - b. Completed skills checklist;
 - c. Attendance record including a record of any make-up class sessions;
 - d. Score on each test, quiz, and examination and, if applicable, whether a test, quiz, or examination was retaken; and
 - e. Copy of the certificate of completion issued to the student as required under subsection (A)(5);
- F.** Examination and evaluation requirements. The owner of an assisted living facility manager training program shall ensure that each student in the training program:
 - 1. Takes an examination that covers each of the subjects listed in R4-33-603(C) and passes each examination using the standard specified in subsection (A)(3)(b);
 - 2. Is evaluated and determined to possess the practical skills listed in R4-33-603(C);
 - 3. Passes, using the standard specified in subsection (A)(3)(b), a final examination approved by the Board and given by a Board-approved provider; and
 - 4. Does not take the final examination referenced in subsection (F)(3) more than two times. If a student fails the final examination referenced in subsection (F)(3) two times, the student is able to obtain evidence of completion only by taking the assisted living facility manager training program again;
- G.** Periodic evaluation. The owner of an assisted living facility manager training program shall allow a representative of the Board or a state agency designated by the Board to conduct:
 - 1. An onsite scheduled evaluation:
 - a. Before initial approval of the training program as specified under R4-33-604(D),

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- b. Before renewal of the training program approval as specified under R4-33-605, and
 - c. During a time of correction as specified under R4-33-606(B); and
 - 2. An onsite unscheduled evaluation of the training program if the evaluation is in response to a complaint or reasonable cause, as determined by the Board; and
 - H.** Notice of change. The owner of an assisted living facility manager training program shall provide the documentation and information specified regarding the following changes within 10 days after making the change:
 - 1. New training program administrator. Name and license number;
 - 2. New instructor. Name, license number, and evidence of being qualified under subsection (C)(1);
 - 3. Decrease in number of training program hours. Description of and reason for the change, a revised curriculum outline, and revised course schedule;
 - 4. Change in classroom location. Address of new location and description of the new classroom; and
 - 5. For a training program that is based within an assisted living facility:
 - a. Change in name of the facility. Former and new name of the assisted living facility; and
 - b. Change in ownership of the facility. Names of the former and current owners of the assisted living facility.
- Historical Note**
- New Section made by final rulemaking at 19 A.A.R. 1619, effective August 4, 2013 (Supp. 13-2). Amended by final rulemaking at 29 A.A.R. 642 (March 3, 2023), with an immediate effective date of February 13, 2023 (Supp. 23-1).
- R4-33-603. Curriculum for Assisted Living Facility Manager Training Program**
- A.** The owner of an assisted living facility manager training program shall ensure that the training program consists of at least 40 hours of classroom instruction.
 - B.** The owner of an assisted living facility manager training program shall provide a written curriculum plan to each student that includes overall educational goals and for each required subject:
 - 1. Measurable learner-centered objectives,
 - 2. Outline of the material to be taught,
 - 3. Time allotted to each unit of instruction, and
 - 4. Learning activities or reading assignments.
 - C.** The owner of an assisted living facility manager training program shall ensure that the training program includes instruction regarding each of the following subjects:
 - 1. Resident services management. Developing policies and procedures regarding:
 - a. Resident rights and confidentiality;
 - b. Developing, implementing, and updating resident service plans;
 - c. Resident agreements;
 - d. Providing social and recreational services;
 - e. Maintaining resident records and managing documentation systems;
 - f. Managing ancillary services;
 - g. Responding to and reporting specific incidents, accidents, and emergencies involving residents;
 - h. Managing dining services to meet resident needs;
 - i. Preventing abuse, neglect, and exploitation;
 - j. Accepting and retaining residents; and
 - k. Developing systems for managing residents with dementia, Alzheimer's Disease, or difficult behaviors;
 - 2. Personnel management.
 - a. Complying with federal, state and local laws relating to hiring personnel;
 - b. Developing and implementing systems related to qualifying, orienting, training, and other recurring personnel requirements; and
 - c. Evaluating personnel;
 - 3. Medication management.
 - a. Developing and evaluating policies and procedures for:
 - i. Medication management including medical restraints; and
 - ii. Non-medication intervention; and
 - b. Developing systems for:
 - i. Receiving and documenting doctors' orders;
 - ii. Ordering, refilling, and storing medications; and
 - iii. Recordkeeping related to receipt and administration of medication; and
 - 4. Legal management.
 - a. Board-prescribed requirements for certification and re-certification,
 - b. Delegation,
 - c. Ethics,
 - d. Advanced directives and do-not-resuscitate orders,
 - e. Standards of conduct under R4-33-407,
 - f. Department of Health Services compliance and complaint inspections:
 - i. Statement of deficiencies,
 - ii. Plan for correction, and
 - iii. Enforcement action; and
 - g. Risk management and quality improvement;
 - 5. Financial management.
 - a. Developing and implementing policies, procedures, and practices that comply with:
 - i. State and local laws; and
 - ii. Generally accepted accounting principles regarding accounts receivable, accounts payable, payroll, resident funds, and refunds;
 - b. Developing, implementing, and evaluating facility budgeting including revenues, expenses, capital expenditures, and long-term projections; and
 - c. Maintaining appropriate insurance coverage; and
 - 6. Physical environment management.
 - a. Complying with federal, state, and local laws regarding:
 - i. Occupational Safety and Health Administration,
 - ii. Americans with Disabilities Act, and
 - iii. Fire and safety requirements for assisted living facilities;
 - b. Preparedness for and prevention of fire, emergencies, and disasters;
 - c. Resident safety and security including evacuation, relocation, and transportation; and
 - d. Daily and preventative maintenance plans for buildings, equipment, and grounds.
 - D.** The owner of an assisted living facility manager training program shall ensure that the training program provides a student with at least:

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1. Eight hours of classroom instruction and skills practice in each of the subjects identified in subsections (C)(1) through (C)(4), and
 2. Four hours of classroom instruction and skills practice in each of the subjects identified in subsections (C)(5) and (C)(6).
- E. The owner of an assisted living facility manager training program shall ensure that the training program uses textbooks that are relevant to the subjects being taught and have been published within the last five years.

Historical Note

New Section made by final rulemaking at 19 A.A.R. 1619, effective August 4, 2013 (Supp. 13-2).

R4-33-604. Application for Approval of an Assisted Living Facility Manager Training Program

- A. The owner of an assisted living facility manager training program shall ensure that no training is provided until the program is approved by the Board.
- B. To obtain approval of an assisted living facility manager training program, the owner of the training program shall submit to the Board an application packet that contains the following:
1. Name, address, telephone number, and email address of the owner;
 2. Name, address, telephone and fax numbers, and web site of the training program;
 3. Form of business organization under which the training program is operated and a copy of the establishing documents and organizational chart;
 4. A statement of whether the training program is based within an assisted living facility or other location;
 5. Name, telephone number, and license or certificate number of the program administrator required under R4-33-602(B);
 6. Name, telephone number, and certificate number of each program instructor and evidence that each program instructor is qualified under R4-33-602(C);
 7. A statement of whether the training program is accredited and if so, name of the accrediting body and date of last review;
 8. For all assisted living facilities at which the training program will provide classroom instruction:
 - a. Name, address, and telephone number of the assisted living facility;
 - b. Name and telephone number of a contact person at the assisted living facility;
 - c. License number of the assisted living facility issued by the Department of Health Services;
 - d. A statement of whether the license of the assisted living facility is in good standing; and
 - e. Date and results of the most recent compliance inspection conducted by the Department of Health Services;
 9. Evidence of compliance with R4-33-602 and R4-33-603, including the following:
 - a. Written training program description, consistent with R4-33-602(A)(1), and an implementation plan that includes timelines;
 - b. Description of classroom facilities, equipment, and instructional tools available, consistent with R4-33-602(D);
 - c. Written curriculum, consistent with R4-33-603(B);

- d. Skills checklist used to verify whether a student has acquired the necessary assisted living facility manager skills, consistent with R4-33-602(A)(7)(a);
- e. Evaluation form required under R4-33-602(A)(7)(b) to enable students to assess the quality of the classroom experience provided by the training program;
- f. Evidence of completion issued to a student under R4-33-602(A)(5);
- g. Name of textbook used, author, publication date, and publisher; and
- h. Copy of written policies and procedures required under R4-33-602(A)(3);

10. Signature of the owner of the training program; and
11. The fee prescribed under R4-33-104(C)(1).

- C. The owner of an assisted living facility manager training program shall ensure that the application materials submitted under subsection (B) are printed on only one side of white, letter-sized paper, and are not bound in any manner.
- D. After review of the materials submitted under subsection (B), the Board shall schedule an onsite evaluation of the training program and take one of the following actions:
1. If requirements are met, approve the training program for one year; or
 2. If requirements are not met, deny approval of the training program.
- E. The owner of an assisted living facility manager training program that is denied approval by the Board may request a hearing regarding the denial by filing a written request with the Board within 30 days after service of the Board's order denying approval of the training program. The Board shall conduct hearings under A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

New Section made by final rulemaking at 19 A.A.R. 1619, effective August 4, 2013 (Supp. 13-2).

R4-33-605. Renewal of Approval of an Assisted Living Facility Manager Training Program

- A. The approval of an assisted living facility manager training program expires one year from the date of approval. If the approval of an assisted living facility manager training program expires, the owner of the training program shall immediately stop all training program activity.
- B. To renew approval of an assisted living facility manager training program, the owner of the training program shall submit to the Board, no fewer than 60 and no more than 120 days before expiration of the current approval, an application packet that contains the following:
1. Name, address, email, and telephone number of the owner;
 2. Name, address, telephone and fax numbers, and web site of the training program;
 3. Name, telephone number, and license number of the program administrator required under R4-33-602(B);
 4. Name, telephone number, and license number of each program instructor and evidence that each program instructor is qualified under R4-33-602(C);
 5. Written training program description, consistent with R4-33-602(A)(1);
 6. Written curriculum, consistent with R4-33-603(B);
 7. Since the time the training program was last approved:
 - a. Number of student-cohort classes to which training was provided,
 - b. Number of students who completed the training program,

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- c. Results obtained on the Board-approved written and skills examinations for each student, and
 - d. Percentage of students who passed the examinations on the first attempt;
- 8. For an assisted living facility at which the training program has started to provide classroom instruction since the training program was last approved, the information required under R4-33-604(B)(8);
- 9. Evaluation form required under R4-33-602(A)(7)(b) to enable students to assess the quality of the classroom experience provided by the training program;
- 10. Summary of evaluations for each student cohort, required under R4-33-602(E)(1)(c), and measures taken, if any, to improve the training program based on student evaluations;
- 11. Evidence of completion issued to a student under R4-33-602(A)(5);
- 12. Name of textbook used, author, publication date, and publisher;
- 13. Copy of written policies and procedures required under R4-33-602(A)(3);
- 14. Signature of the owner of the program; and
- 15. The fee prescribed under R4-33-104(C)(2).
- C. After review of the materials submitted under subsection (B), the Board shall ensure that the training program is evaluated at either an onsite or telephonic meeting. The program owner shall ensure that the program owner, program administrator, and all instructors are available to participate in the evaluation meeting.
- D. The Board shall ensure that each training program receives an onsite evaluation at least every four years. An onsite evaluation includes visiting each assisted living facility at which the training program provides classroom instruction.
- E. If the Board approves a training program following an onsite evaluation, no deficiencies were identified during the onsite evaluation, and no complaints are filed with the Board, the Board shall evaluate the training program under subsection (C) using a telephonic meeting for at least two years.
- F. After conducting the evaluation required under subsection (C), the Board shall:
 - 1. Renew approval of a training program that the Board determines complies with R4-33-602 and R4-33-603, or
 - 2. Issue a notice of deficiency under R4-33-606 to the owner of a training program that the Board determines does not comply with R4-33-602 or R4-33-603.
- G. The owner of an assisted living facility manager training program that is issued a notice of deficiency by the Board under subsection (F)(2) may request a hearing regarding the deficiency notice by filing a written request with the Board within 30 days after service of the Board's order. The Board shall conduct hearings under A.R.S. Title 41, Chapter 6, Article 10.
 - 2. Citation to the requirement in this Article with which the training program is not in compliance; and
 - 3. The time, to a maximum of three months, allowed by the Board for correction of the deficiencies.
- B. Correction plan.
 - 1. Within 10 days after service of a notice of deficiency under subsection (A), the owner of the served training program shall submit to the Board a written plan to correct the identified deficiencies;
 - 2. The Board may conduct onsite or telephonic evaluations during the time for correction to assess progress towards compliance;
 - 3. The owner of a training program implementing a correction plan shall notify the Board when all corrections have been made; and
 - 4. After receiving notice under subsection (B)(3) or after the time provided under subsection (A)(3) has expired, the Board shall conduct an onsite evaluation to determine whether all deficiencies listed in the notice under subsection (A) have been corrected.
 - a. If the Board determines that all deficiencies have been corrected, the Board shall renew approval of the training program; or
 - b. If the Board determines that all deficiencies have not been corrected, the Board shall take disciplinary action under subsection (C).
- C. Disciplinary action.
 - 1. Under A.R.S. § 36-446.03(P), the Board shall issue a civil money penalty, suspend or revoke approval of an assisted living facility manager training program, or place the training program on probation if, following a hearing, the Board determines that the owner of the assisted living facility caregiver training program:
 - a. Failed to submit a plan of correction to the Board under R4-33-606(B) within 10 days after service of a notice of deficiency;
 - b. Failed to comply with R4-33-602 or R4-33-603 within the time set by the Board under R4-33-606(A)(3) for correction of deficiencies;
 - c. Failed to comply with a federal or state requirement;
 - d. Failed to allow the Board to conduct an evaluation under R4-33-602(G);
 - e. Failed to comply with R4-33-602(H);
 - f. Lent or transferred training program approval to another individual or entity or another training program, including one owned by the same owner;
 - g. Conducted an assisted living facility manager training program before obtaining Board approval;
 - h. Conducted an assisted living facility manager training program after expiration of program approval without submitting an application for renewal under R4-33-605;
 - i. Falsified an application for assisted living facility manager training program approval under R4-33-604 or R4-33-605;
 - j. Violated an order, condition of probation, or stipulation issued by the Board; or
 - k. Failed to respond to a complaint filed with the Board.
 - 2. The Board shall conduct hearings under A.R.S. Title 41, Chapter 6, Article 10.
 - 3. The Board shall include in an order suspending or revoking approval of an assisted living facility manager training program the time and circumstances under which the

Historical Note

New Section made by final rulemaking at 19 A.A.R. 1619, effective August 4, 2013 (Supp. 13-2).

R4-33-606. Notice of Deficiency; Correction Plan; Disciplinary Action; Voluntary Termination

- A. Notice of deficiency. If the Board determines that an assisted living facility manager training program does not comply with the requirements in this Article, the Board shall issue a written notice of deficiency to the owner of the training program. The Board shall include the following in the notice of deficiency:
 - 1. Description of each deficiency;

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owner of the suspended or revoked training program may apply again under R4-33-604 for training program approval.

- D. Voluntary termination.** If the owner of an approved assisted living facility manager training program decides to terminate the training program, the owner shall:
1. Provide written notice of the planned termination to the Board; and
 2. Ensure that the training program, including the instructors, is maintained according to this Article until the last student is transferred or completes the training program.

Historical Note

New Section made by final rulemaking at 19 A.A.R. 1619, effective August 4, 2013 (Supp. 13-2).

ARTICLE 7. ASSISTED LIVING FACILITY CAREGIVER TRAINING PROGRAMS

R4-33-701. Definitions

In addition to the definitions in R4-33-601, the following definitions apply in this Article:

1. "CMA" means certified medication assistant, an LNA certified by the Arizona Board of Nursing under A.R.S. § 32-1650.02.
2. "CNA" means certified nursing assistant, an individual licensed by the Arizona Board of Nursing under A.R.S. § 32-1645.
3. "DCW" means direct-care worker, an individual who meets the standards and requirements specified in Section 1240(A) of the Arizona Health Care Cost Containment System policy manual.
4. "Distance learning" means the use of technology to teach students who may or may not be physically present in a classroom.
5. "LNA" means licensed nursing assistant, an individual licensed by the Arizona Board of Nursing under A.R.S. § 32-1645.
6. "Skills training" means experiential learning focused on acquiring the ability to provide caregiving services to residents.

Historical Note

New Section made by final rulemaking at 19 A.A.R. 1619, effective August 4, 2013 (Supp. 13-2). Amended by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3).

R4-33-702. Minimum Standards for Assisted Living Facility Caregiver Training Program

- A. Organization and administration.** The owner of an assisted living facility caregiver training program shall:
1. Provide the Board with a written description of the training program that includes:
 - a. Length of the training program in hours:
 - i. Number of hours of classroom instruction,
 - ii. Number of hours of skills training, and
 - iii. Number of hours of distance learning, and
 - b. Educational goals that demonstrate the training program is consistent with state requirements;
 2. Develop and adhere to written policies and procedures regarding:
 - a. Attendance. Ensure that a student receives at least 62 hours of instruction;

- b. Grading. Require a student to attain at least 75 percent on each knowledge examination or 75 percent on a comprehensive knowledge examination;
- c. Reexamination. Inform students that a reexamination:
 - i. Addresses the same competencies examined in the original examination,
 - ii. Contains items different from those on the original examination, and
 - iii. Is documented in the student's record;
- d. Student records. Include the following information:
 - i. Records maintained,
 - ii. Retention period for each record,
 - iii. Location of records,
 - iv. Documents required under subsections (G)(1) and (G)(2), and
 - v. Procedure for accessing records and who is authorized to access records;
- e. Student fees and financial aid, if any;
- f. Withdrawal and dismissal;
- g. Student grievances including a chain of command for disputing a grade;
- h. Admission requirements including any criminal background or drug testing required;
- i. Criteria for training program completion; and
- j. Procedure for documenting that a student has received notice of the fingerprint clearance card requirement before the student is enrolled;
3. Date each policy and procedure developed under subsection (A)(2), review within one year from the date made and every year thereafter, update if necessary, and date the policy or procedure at the time of each review;
4. Provide each student who completes the training program with evidence of completion, within 15 days of completion, which includes the following:
 - a. Name of the student;
 - b. Name and classroom location of the training program;
 - c. Number of classroom, skills training, and distance learning hours in the training program;
 - d. Date on which the training program was completed;
 - e. Board's approval number of the training program; and
 - f. Signature of the training program owner, administrator, or instructor;
5. Provide the Board, within 15 days of completion, the following information regarding each student who completed the training program:
 - a. Student's name, date of birth, Social Security number, address, and telephone number;
 - b. Student's examination score as provided by a Board-approved provider;
 - c. Name and classroom location of the training program;
 - d. Number of classroom hours in the training program;
 - e. Number of distance learning hours in the training program;
 - f. Number of skills training hours in the training program;
 - g. Date on which the training program was completed; and
 - h. Board's approval number of the training program; and

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6. Execute and maintain under subsections (G)(1) and (G)(2) the following documents for each student:
 - a. A skills checklist containing documentation the student achieved competency in the assisted living facility caregiver skills listed in R4-33-703(C),
 - b. A copy of the current food-handler's card issued to the student by the county in which the student lives, and
 - c. An evaluation form containing the student's responses to questions about the quality of the instructional experiences provided by the training program.
- B.** Program administrator responsibilities. The owner of an assisted living facility caregiver training program shall ensure that a program administrator performs the following responsibilities:
 1. Supervises and evaluates the training program,
 2. Uses only instructors who are qualified under subsection (C), and
 3. Makes the written policies and procedures required under subsection (A)(2) available to each student on or before the first day of the training program;
- C.** The owner of an assisted living facility caregiver training program shall ensure that a program instructor is qualified under subsection (C)(1), (C)(2), or (C)(3):
 1. Is a certified assisted living facility manager:
 - a. Holds an assisted living facility manager certificate that is in good standing and issued under A.R.S. Title 36, Chapter 4;
 - b. Has held the assisted living facility manager certificate referenced in subsection (C)(1)(a) for at least two years;
 - c. Has not been subject to disciplinary action against the assisted living facility manager certificate during the last two years; and
 - d. Has at least two years' experience within the last five years as an assisted living facility manager of record immediately before becoming a training program instructor;
 2. Is a licensed health professional:
 - a. Holds a license that is in good standing and issued under A.R.S. Title 32, Chapter, 13, 15, 17, or 25;
 - b. Has held the health professional license referenced in subsection (C)(2)(a) for at least two years;
 - c. Has not been subject to disciplinary action against the health professional license during the last two years; and
 - d. Has at least two years' experience within the last five years in management, operation, or training in assisted living immediately before becoming a training program instructor; or
 3. Other qualified individual:
 - a. Holds at least a baccalaureate degree in a health-related field from an accredited college or university;
 - b. Has not been subject to disciplinary action against any professional or occupational license or certificate during the last two years; and
 - c. Has at least two years' experience within the last five years in management, operation, or training in assisted living immediately before becoming a training program instructor.
- D.** The owner of an assisted living facility caregiver training program shall ensure that a program instructor performs the following responsibilities:
 1. Plans each learning experience,
 2. Accomplishes educational goals of the training program and lesson objectives,
 3. Enforces a grading policy that meets the requirement specified in subsection (A)(2)(b),
 4. Requires satisfactory performance of all critical elements of each assisted living facility caregiver skill specified under R4-33-703(C),
 5. Prevents a student from performing an activity unless the student has received instruction and been found able to perform the activity competently,
 6. Is present in the classroom during all instruction,
 7. Uses a maximum of 20 hours of distance learning,
 8. Supervises health professionals who assist in providing training program instruction, and
 9. Ensures that a health professional who assists in providing training program instruction:
 - a. Is licensed or certified as a health professional,
 - b. Has at least one year of experience in the field of licensure or certification, and
 - c. Teaches only a learning activity that is within the scope of practice of the field of licensure or certification.
- E.** Skill training requirements. The owner of an assisted living facility caregiver training program shall:
 1. Provide each student with at least 12 hours of instructor-supervised skills training, and
 2. Ensure that each student develops skill proficiency in the subjects listed in R4-33-703(C).
- F.** Instructional and educational resources. The owner of an assisted living facility caregiver training program shall provide, or provide access to, the following instructional and educational resources adequate to implement the training program for all students and staff:
 1. Current reference materials related to the level of the curriculum;
 2. Equipment in functional condition for simulating resident care, including:
 - a. Patient bed, over-bed table, and nightstand;
 - b. Privacy curtain and call bell;
 - c. Thermometers, stethoscopes, including a teaching stethoscope, blood-pressure cuff, and balance scale;
 - d. Hygiene supplies, elimination equipment, drainage devices, and linens;
 - e. Hand-washing equipment and clean gloves; and
 - f. Wheelchair, gait belt, walker, anti-embolic hose, and cane;
 3. Computer in good working condition;
 4. Audio-visual equipment and media; and
 5. Designated space that provides a clean, distraction-free, learning environment for accomplishing educational goals of the training program;
- G.** Records. The owner of an assisted living facility caregiver training program shall:
 1. Maintain the following training program records for three years:
 - a. Curriculum and course schedule for each student cohort;
 - b. Results of state-approved written examination and skills checklist;

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- c. Evaluation forms completed by students, a summary of the evaluation forms for each student cohort, and measures taken, if any, to improve the training program based on student evaluations; and
 - d. Copy of all Board reports, applications, or correspondence related to the training program; and
 - 2. Maintain the following student records for three years:
 - a. Name, date of birth, and Social Security number;
 - b. Completed skills checklist;
 - c. Attendance record including a record of any make-up class sessions;
 - d. Score on each test, quiz, and examination and, if applicable, whether a test, quiz, or examination was retaken;
 - e. Documentation from the program instructor indicating the:
 - i. Number of skills training hours completed by the student,
 - ii. Student performance during the skills training, and
 - iii. Verification of distance learning hours completed by the student; and
 - f. Copy of the evidence of completion issued to the student as required under subsection (A)(4);
- H. Examination and evaluation requirements for students. The owner of an assisted living facility caregiver training program shall ensure each student in the training program:
 - 1. Takes an examination that covers each of the subjects listed in R4-33-703(C) and passes each examination using the standard specified in subsection (A)(2)(b);
 - 2. Is evaluated and determined to possess the practical skills listed in R4-33-703(C);
 - 3. Passes, using the standard specified in subsection (A)(2)(b), a final examination approved by the Board and given by a Board-approved provider; and
 - 4. Does not take the final examination referenced in subsection (H)(3) more than three times. If a student fails the final examination referenced in subsection (H)(3) three times, the student is able to obtain evidence of completion only by taking the assisted living facility caregiver training program again;
- I. Examination passing standard. The owner of an assisted living facility caregiver training program shall attain an annual first-time passing rate of 70 percent for all students who take the examination specified under subsection (H)(3). The Board may waive this requirement for a program if fewer than 10 students took the examination during the year.
- J. Periodic evaluation. The owner of an assisted living facility caregiver training program shall allow a representative of the Board or a state agency designated by the Board to conduct:
 - 1. A scheduled evaluation:
 - a. Before initial approval of the training program as specified under R4-33-704(D),
 - b. Before renewal of the training program approval as specified under R4-33-705(C), and
 - c. During a time of correction as specified under R4-33-706(B); and
 - 2. An onsite unscheduled evaluation of the training program if the evaluation is in response to a complaint or reasonable cause, as determined by the Board;
- K. Notice of change. The owner of an assisted living facility caregiver training program shall provide the documentation and information specified regarding the following changes within 10 days after making the change:
 - 1. New training program administrator. Name and license number;
 - 2. New instructor. Name, license number, and evidence of being qualified under subsection (C);
 - 3. Decrease in number of training program hours. Description of and reason for the change, a revised curriculum outline, and revised course schedule;
 - 4. Change in classroom location. Address of new location, if applicable, and description of the new classroom; and
 - 5. For a training program that is based within an assisted living facility:
 - a. Change in name of the facility. Former and new name of the assisted living facility; and
 - b. Change in ownership of the facility. Names of the former and current owners of the assisted living facility.
- L. Medication management training program. The owner of an assisted living facility caregiver training program may provide a medication management training program for a student who, at the time of admission, is in good standing and a CNA, LNA, or DCW. The owner shall ensure the medication management training program provides the classroom instruction listed in subsection R4-33-703(C)(14) and meets the standards in R4-33-703.1.

Historical Note

New Section made by final rulemaking at 19 A.A.R. 1619, effective August 4, 2013 (Supp. 13-2). Amended by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3). Amended Section R4-33-702 made by emergency rulemaking at 26 A.A.R. 1091, with an immediate effective date of May 5, 2020 as established under A.R.S. § 41-1032(A); effective for 180 days under A.R.S. § 41-1032(D). Before the emergency expired this Section was amended by final rulemaking at 26 A.A.R. 1465, effective September 5, 2020 (Supp. 20-3).

R4-33-703. Curriculum for Assisted Living Facility Caregiver Training Program

- A. The owner of an assisted living facility caregiver training program shall ensure that the training program consists of at least 62 hours of instruction including:
 - 1. Fifty hours of classroom instruction, of which a maximum of 20 hours may be provided by distance learning, and
 - 2. Twelve hours of instructor-supervised skills training.
- B. The owner of an assisted living facility caregiver training program shall provide a written curriculum plan to each student that includes overall educational goals and for each required subject:
 - 1. Measurable learner-centered objectives,
 - 2. Outline of the material to be taught,
 - 3. Time allotted to each unit of instruction, and
 - 4. Learning activities or reading assignments.
- C. The owner of an assisted living facility caregiver training program shall ensure the training program includes classroom instruction and skills training regarding each of the following subjects:
 - 1. Orientation to and overview of the assisted living facility caregiver training program (at least one classroom hour).
 - a. Levels of care within an assisted living facility, and
 - b. Impact of each level of care on residents;
 - 2. Legal and ethical issues and resident rights (at least two classroom hours).
 - a. Confidentiality (HIPAA);

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- b. Ethical principles;
 - c. Resident rights specified in R9-10-710;
 - d. Abuse, neglect, and exploitation;
 - e. Mandatory reporting; and
 - f. Do-not-resuscitate order and advanced directives;
- 3. Communication and interpersonal skills (at least two classroom hours).
 - a. Components of effective communication,
 - b. Styles of communication,
 - c. Attitude in communication,
 - d. Barriers to effective communication:
 - i. Culture,
 - ii. Language, and
 - iii. Physical and mental disabilities, and
 - e. Techniques of communication;
- 4. Job management skills (at least one classroom hour).
 - a. Stress management, and
 - b. Time management;
- 5. Service plans (at least two classroom hours). Developing, using, and maintaining resident service plans;
- 6. Infection control (at least three classroom hours).
 - a. Common types of infectious diseases,
 - b. Preventing infection,
 - c. Controlling infection:
 - i. Washing hands,
 - ii. Using gloves, and
 - iii. Disposing of sharps and other waste;
- 7. Nutrition and food preparation (at least two classroom hours).
 - a. Basic nutrition;
 - b. Menu planning and posting;
 - c. Procuring, handling, and storing food safely; and
 - d. Special diets;
- 8. Fire, safety, and emergency procedures (at least two classroom hours).
 - a. Emergency planning,
 - b. Medical emergencies,
 - c. Environmental emergencies,
 - d. Fire safety,
 - e. Fire drills and evacuations, and
 - f. Fire-code requirements;
- 9. Home environment and maintenance (at least two classroom hours).
 - a. Housekeeping,
 - b. Laundry, and
 - c. Physical plant;
- 10. Basic caregiver skills (at least eight classroom hours).
 - a. Taking vital signs and measuring height and weight;
 - b. Maintaining a resident's environment;
 - c. Observing and reporting pain;
 - d. Assisting with diagnostic tests;
 - e. Providing assistance to residents with drains and tubes;
 - f. Recognizing and reporting abnormal changes to a supervisor;
 - g. Applying clean bandages;
 - h. Providing peri-operative care;
 - i. Assisting ambulation of residents including transferring and using assistive devices;
 - j. Bathing, caring for skin, and dressing;
 - k. Caring for teeth and dentures;
 - l. Shampooing and caring for hair;
 - m. Caring for nails;
- n. Toileting, caring for perineum, and caring for ostomy;
 - o. Feeding and hydration including proper feeding techniques and use of assistive devices in feeding;
 - p. Preventing pressure sores; and
 - q. Maintaining and treating skin;
- 11. Mental health and social service needs (at least three classroom hours).
 - a. Modifying the caregiver's behavior in response to resident behavior,
 - b. Understanding the developmental tasks associated with the aging process,
 - c. Responding to resident behavior,
 - d. Promoting resident dignity,
 - e. Providing culturally sensitive care,
 - f. Caring for the dying resident, and
 - g. Interacting with the resident's family;
- 12. Care of the cognitively impaired resident (at least four classroom hours).
 - a. Anticipating and addressing the needs and behaviors of residents with dementia or Alzheimer's disease,
 - b. Communicating with cognitively impaired residents,
 - c. Understanding the behavior of cognitively impaired residents, and
 - d. Reducing the effects of cognitive impairment;
- 13. Skills for basic restorative services (at least two classroom hours).
 - a. Understanding body mechanics;
 - b. Assisting resident self-care;
 - c. Using assistive devices for transferring, walking, eating, and dressing;
 - d. Assisting with range-of-motion exercises;
 - e. Providing bowel and bladder training;
 - f. Assisting with care for and use of prosthetic and orthotic devices; and
 - g. Facilitating family and group activities; and
- 14. Medication management (at least 16 classroom hours).
 - a. Determining whether a resident needs assistance with medication administration and if so, the nature of the assistance;
 - b. Assisting a resident to self-administer medication;
 - c. Observing, documenting, and reporting changes in resident condition before and after medication is administered;
 - d. Knowing the rights of a resident regarding medication administration;
 - e. Knowing classifications of and responses to medications;
 - f. Taking, reading, and implementing a physician's medication and treatment orders;
 - g. Storing medication properly and securely;
 - h. Documenting medication and treatment services;
 - i. Maintaining records of medication and treatment services;
 - j. Using medication organizers properly;
 - k. Storing and documenting use of narcotic drugs and controlled substances;
 - l. Understanding how metabolism and physical conditions affect medication absorption;
 - m. Knowing the proper administration of all forms of medication;
 - n. Using drug-reference guides (Physician's Desk Reference); and

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- o. Preventing, identifying, documenting, reporting, and responding to medication errors.
- D. The owner of an assisted living facility caregiver training program shall ensure that the training program:
 - 1. Provides a student with at least the number of classroom hours specified in subsection (C);
 - 2. Subject to the limitations specified, uses distance learning for a maximum of 20 hours only for the classroom hours specified in subsections (C)(1) through (C)(9), (C)(11) and (C)(12):
 - a. Only one of the classroom hours specified in subsection (C)(6) may be taught by distance learning; and
 - b. Only two of the classroom hours specified in subsection (C)(12) may be taught by distance learning.
 - 3. Provides a student with at least the number of skills training hours specified in subsection (A)(2).
- E. The owner of an assisted living facility caregiver training program shall ensure that the training program uses textbooks that are relevant to the subjects being taught and have been published within the last five years.
- F. The owner of an assisted living facility caregiver training program shall ensure that any distance learning provided uses materials that are relevant to the subjects being taught and have been produced within the last five years.

Historical Note

New Section made by final rulemaking at 19 A.A.R. 1619, effective August 4, 2013 (Supp. 13-2). Amended by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3).

R4-33-703.1. Minimum Standards and Curriculum for an Assisted Living Facility Caregiver Medication Management Training Program

- A. An assisted living facility caregiver medication management training program may be established by:
 - 1. The owner or manager of an assisted living facility, or
 - 2. The owner of an assisted living facility caregiver training program.
- B. A person under subsection (A) may offer an assisted living facility caregiver medication management training program to:
 - 1. A CNA who is in good standing and whose certification by the Arizona Board of Nursing under A.R.S. § 32-1645 is verified;
 - 2. An LNA who is in good standing and whose licensure by the Arizona Board of Nursing under A.R.S. § 32-1645 is verified; and
 - 3. A DCW who is in good standing and whose training, including training about caregiving fundamentals and aging and physical disabilities, and testing record is verified through the AHCCCS online database.
- C. A person under subsection (A) that offers an assisted living facility caregiver medication management training program to individuals specified under subsection (B) shall ensure the assisted living facility caregiver medication management training program:
 - 1. Consists of at least the 16 classroom hours specified under R4-33-703(C)(14);
 - 2. Is not taught by distance learning;
 - 3. Is taught by a health professional who holds a license in good standing and issued under A.R.S. Title 32, Chapter 13, 15, 17, 18, or 25; and
 - 4. Requires passing an examination regarding assisted living facility caregiver medication management, using the standard specified in R4-33-702(A)(2)(b), that is

approved by the Board and given by a Board-approved provider. An individual under subsection (B) shall pass the required examination in no more than three attempts. After failing three times, the individual may take the assisted living facility caregiver medication management program again.

- D. In addition to complying with subsection (C), a person under subsection (A) shall ensure each individual under subsection (B) who participates in an assisted living facility caregiver medication management training program:
 - 1. Receives notice, before participating in the training program, of:
 - a. The fingerprint clearance card requirement, and
 - b. The need to obtain a food-handler's card from the county in which the individual lives.
 - 2. Provides written documentation, which is dated and signed, indicating the person under subsection (A) complied with subsection (D)(1). The person under subsection (A) shall maintain the written documentation under R4-33-702(G)(2).
- E. In addition to complying with subsection (C), a person under subsection (A) that offers an assisted living facility caregiver medication management training program to individuals specified under subsection (B) shall comply with the following subsections of R4-33-702:
 - 1. (A)(4)(a), (b), and (d) through (f);
 - 2. (A)(5)(a) through (d), (g), and (h);
 - 3. (A)(6)(b) and (c);
 - 4. (G)(1)(b) through (d);
 - 5. (G)(2)(a), (c), (d), and (f);
 - 6. (I) and
 - 7. (J).

Historical Note

New Section made by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3). Amended Section R4-33-703.1 made by emergency rulemaking at 26 A.A.R. 1091, with an immediate effective date of May 5, 2020 as established under A.R.S. § 41-1032(A); effective for 180 days under A.R.S. § 41-1032(D). Before the emergency expired this Section was amended by final rulemaking at 26 A.A.R. 1465, effective September 5, 2020 (Supp. 20-3).

R4-33-704. Application for Approval of an Assisted Living Facility Caregiver Training Program

- A. The owner of an assisted living facility caregiver training program shall ensure no training is provided until the program is approved by the Board.
- B. To obtain approval of an assisted living facility caregiver training program, the owner of the training program shall submit to the Board an application packet that contains the following:
 - 1. Name, address, telephone number, and email address of the owner;
 - 2. Name, address, telephone and fax numbers, and web site of the training program;
 - 3. Form of business organization under which the training program is operated and a copy of the establishing documents and organizational chart;
 - 4. A statement of whether the training program is based within an assisted living facility or other location;
 - 5. Name, telephone number, email address, and license or certificate number of the program administrator required under R4-33-702(B);

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6. Name, telephone number, email address, and license number of each program instructor and evidence each program instructor is qualified under R4-33-702(C);
 7. A statement of whether the training program is accredited and if so, name of the accrediting body and date of last review;
 8. For all assisted living facilities at which the training program will provide instruction:
 - a. Name, address, and telephone number of the assisted living facility;
 - b. Name, email address, and telephone number of a contact person at the assisted living facility;
 - c. License number of the assisted living facility issued by the Department of Health Services;
 - d. A statement of whether the license of the assisted living facility is in good standing; and
 - e. Date and results of the most recent compliance inspection conducted by the Department of Health Services;
 9. Evidence of compliance with R4-33-702 and R4-33-703, including the following:
 - a. Written training program description, consistent with R4-33-702(A)(1), and an implementation plan that includes timelines;
 - b. Description of classroom facilities, equipment, and instructional tools available, consistent with R4-33-702(F);
 - c. Written curriculum, consistent with R4-33-703(C);
 - d. Skills checklist used to verify whether a student has acquired the necessary assisted living facility caregiver skills, consistent with R4-33-702(A)(6)(a);
 - e. Evaluation form required under R4-33-702(A)(6)(c) to enable students to assess the quality of the instructional experience provided by the training program;
 - f. Evidence of completion issued to a student under R4-33-702(A)(4);
 - g. Name of textbook used, author, publication date, and publisher;
 - h. Name of any distance learning materials used, producer of the material, and date produced; and
 - i. Copy of written policies and procedures required under R4-33-702(A)(2);
 10. Signature of the owner of the training program; and
 11. The fee prescribed under R4-33-104(D)(1).
- C.** The owner of an assisted living facility caregiver training program shall ensure the application materials submitted under subsection (B) are printed on only one side of white, letter-sized paper, and are not bound in any manner.
- D.** After review of the materials submitted under subsection (B), the Board shall schedule an onsite evaluation of the training program and take one of the following actions:
1. If requirements are met, approve the training program for one year; or
 2. If requirements are not met, deny approval of the training program.
- E.** The owner of an assisted living facility caregiver training program denied approval by the Board may request a hearing regarding the denial by filing a written request with the Board within 30 days after service of the Board's order denying approval of the training program. The Board shall conduct hearings under A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

New Section made by final rulemaking at 19 A.A.R. 1619, effective August 4, 2013 (Supp. 13-2). Amended

by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3).

R4-33-704.1. Application for Approval of an Assisted Living Facility Caregiver Medication Management Training Program

- A.** A person described under R4-33-703.1(A) shall ensure no training is provided until the assisted living facility medication management training program is approved by the Board.
- B.** To obtain approval of an assisted living facility medication management training program, a person described under R4-33-703.1(A) shall submit to the Board an application packet that contains the following:
1. Name, address, telephone number, and email address of the person described under R4-33-703.1(A);
 2. A statement of whether the training program is based within an assisted living facility or other location and address of the location;
 3. Name, telephone number, email address, and license number of each program instructor and evidence each program instructor is qualified under R4-33-703.1(C)(3);
 4. The information required under R4-33-704(B)(8);
 5. The following evidence of compliance with R4-33-703.1(D):
 - a. Skills checklist used to verify whether a student has acquired the necessary assisted living facility caregiver skills, consistent with R4-33-702(A)(6)(a);
 - b. Evaluation form required under R4-33-702(A)(6)(c) to enable students to assess the quality of the instructional experience provided by the training program; and
 - c. Evidence of completion issued to a student under R4-33-702(A)(4);
 6. Signature of the person described under R4-33-703.1(A); and
 7. The fee prescribed under R4-33-104(E)(1) except a person that has an assisted living facility caregiver training program approved under R4-33-704 is not required to pay a fee for approval under this Section.
- C.** R4-33-704(C) through (E) applies to this Section.

Historical Note

New Section made by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3).

R4-33-705. Renewal of Approval of an Assisted Living Facility Caregiver Training Program

- A.** The approval of an assisted living facility caregiver training program expires one year from the date of approval. If the approval of the training program expires, the owner of the training program shall immediately stop all training program activity.
- B.** To renew approval of an assisted living facility caregiver training program, the owner of the training program shall submit to the Board, no fewer than 60 and no more than 120 days before expiration of the current approval, an application packet that contains the following:
1. Name, address, telephone number, and email address of the owner;
 2. Name, address, telephone and fax numbers, and web site of the training program;
 3. Name, telephone number, email address, and license number of the program administrator required under R4-33-702(B);
 4. Name, telephone number, email address, and license number of each program instructor and evidence each program instructor is qualified under R4-33-702(C);

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5. Written training program description, consistent with R4-33-702(A)(1);
 6. Written curriculum, consistent with R4-33-703(C);
 7. Since the time the training program was last approved:
 - a. Number of student-cohort classes to which training was provided;
 - b. Number of students who completed the training program;
 - c. Results obtained on the Board-approved written examination and skills checklist for each student, and
 - d. Percentage of students who passed the examination on the first attempt;
 8. For an assisted living facility at which the training program has started to provide instruction since the training program was last approved, the information required under R4-33-704(B)(8);
 9. Evaluation form required under R4-33-702(A)(6)(c) to enable students to assess the quality of the instructional experience provided by the training program;
 10. Summary of evaluations for each student cohort, required under R4-33-702(G)(1)(c), and measures taken, if any, to improve the training program based on student evaluations;
 11. Evidence of completion issued to a student under R4-33-702(A)(4);
 12. Name of textbook used, author, publication date, and publisher;
 13. Name of any distance learning materials used, producer of the material, and date produced;
 14. Copy of written policies and procedures required under R4-33-702(A)(2);
 15. Signature of the owner of the training program; and
 16. The fee prescribed under R4-33-104(D)(2).
- C.** After review of the materials submitted under subsection (B), the Board shall ensure the training program is evaluated at either an onsite or telephonic meeting. The program owner shall ensure the program owner, program administrator, and all instructors are available to participate in the evaluation meeting.
- D.** The Board shall ensure each training program receives an onsite evaluation at least every four years. An onsite evaluation includes visiting each assisted living facility at which the training program provides instruction.
- E.** If the Board approves a training program following an onsite evaluation, no deficiencies were identified during the onsite evaluation, and no complaints are filed with the Board, the Board shall evaluate the training program under subsection (C) using a telephonic meeting for at least two years.
- F.** After conducting the evaluation required under subsection (C), the Board shall:
1. Renew approval of a training program the Board determines complies with R4-33-702 and R4-33-703, or
 2. Issue a notice of deficiency under R4-33-706 to the owner of a training program the Board determines does not comply with R4-33-702 or R4-33-703.
- G.** The owner of an assisted living facility training program issued a notice of deficiency by the Board under subsection (F)(2) may request a hearing regarding the deficiency notice by filing a written request with the Board within 30 days after service of the Board's order. The Board shall conduct hearings under A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

New Section made by final rulemaking at 19 A.A.R. 1619, effective August 4, 2013 (Supp. 13-2). Amended by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3).

R4-33-705.1. Renewal of Approval of an Assisted Living Facility Caregiver Medication Management Training Program

- A.** The approval of an assisted living facility caregiver medication management training program expires one year from the date of approval. If the approval expires, the person described under R4-33-703.1(A) shall immediately stop all medication management training program activity.
- B.** To renew approval of an assisted living facility caregiver medication management training program, the person described under R4-33-703.1(A) shall submit to the Board, no fewer than 60 and no more than 120 days before expiration of the current approval, an application packet that contains the following:
1. Name, address, telephone number and email address of the person described under R4-33-703.1(A);
 2. Name, telephone number, email address, and license number of each program instructor and evidence each program instructor is qualified under R4-33-703.1(C)(3);
 3. The information required under R4-33-705(B)(7) through (11);
 4. Signature of the person described under R4-33-703.1(A); and
 5. The fee prescribed under R4-33-104(E)(2) except a person that has approval of an assisted living facility caregiver training program renewed under R4-33-705 is not required to pay a fee for approval under this Section.
- C.** R4-33-705(C) through (G) applies to this Section.

Historical Note

New Section made by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3).

R4-33-706. Notice of Deficiency; Correction Plan; Disciplinary Action; Voluntary Termination

- A.** Notice of deficiency. If the Board determines an assisted living facility caregiver or medication management training program does not comply with the requirements in this Article, the Board shall issue a written notice of deficiency to the program owner or person described under R4-33-703.1(A) of the training. The Board shall include the following in the notice of deficiency:
1. Description of each deficiency;
 2. Citation to the requirement in this Article with which the training program is not in compliance; and
 3. The time, to a maximum of three months, allowed by the Board for correction of the deficiencies.
- B.** Correction plan.
1. Within 10 days after service of a notice of deficiency under subsection (A), the owner or person described under R4-33-703.1(A) of the served training program shall submit to the Board a written plan to correct the identified deficiencies;
 2. The Board may conduct onsite or telephonic evaluations during the time for correction to assess progress towards compliance;
 3. The owner or person described under R4-33-703.1(A) of a training program implementing a correction plan shall notify the Board when all corrections have been made; and
 4. After receiving notice under subsection (B)(3) or after the time provided under subsection (A)(3) has expired, the

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Board shall conduct an onsite evaluation to determine whether all deficiencies listed in the notice under subsection (A) have been corrected.

- a. If the Board determines all deficiencies have been corrected, the Board shall renew approval of the training program; or
- b. If the Board determines all deficiencies have not been corrected, the Board shall take disciplinary action under subsection (C).

C. Disciplinary action.

1. Under A.R.S. § 36-446.03(P), the Board shall issue a civil money penalty, suspend or revoke approval of an assisted living facility caregiver or medication management training program, or place the training program on probation if, following a hearing, the Board determines that the owner or the person described under R4-33-703.1(A):
 - a. Failed to submit a plan of correction to the Board under R4-33-706(B) within 10 days after service of a notice of deficiency;
 - b. Failed to comply with R4-33-702, R4-33-703, or R4-33-703.1, as applicable, within the time set by the Board under R4-33-706(A)(3) for correction of deficiencies;
 - c. Failed to comply with a federal or state requirement;
 - d. Failed to allow the Board to conduct an evaluation under R4-33-702(J) or R4-33-703.1(D)(6);
 - e. Failed to comply with R4-33-702(K);
 - f. Lent or transferred training program approval to another individual or entity or another training program, including one owned by the same owner or person described under R4-33-703.1(A);
 - g. Conducted an assisted living facility caregiver or medication management training program before obtaining Board approval;
 - h. Conducted an assisted living facility caregiver or medication management training program after expiration of program approval without timely submitting an application for renewal under R4-33-705 or R4-33-705.1, as applicable;
 - i. Falsified an application for assisted living facility caregiver or medication management training program approval under R4-33-704, R4-33-704.1, R4-33-705, or R4-33-705.1;
 - j. Violated an order, condition of probation, or stipulation issued by the Board; or
 - k. Failed to respond to a complaint filed with the Board.
2. The Board shall conduct hearings under A.R.S. Title 41, Chapter 6, Article 10.
3. The Board shall include in an order suspending or revoking approval of an assisted living facility caregiver or medication management training program the time and circumstances under which the owner or person described under R4-33-703.1(A) of the suspended or revoked training program may apply again under R4-33-704 or R4-33-704.1 for training program approval.

D. Voluntary termination. If the owner or person described under R4-33-703.1(A) of an approved assisted living facility caregiver or medication management training program decides to terminate the training program, the owner or person described under R4-33-703.1(A) shall:

1. Provide written notice of the planned termination to the Board; and

2. Ensure that the training program, including the instructors, is maintained according to this Article until the last student is transferred or completes the training program.

Historical Note

New Section made by final rulemaking at 19 A.A.R. 1619, effective August 4, 2013 (Supp. 13-2). Amended by final rulemaking at 24 A.A.R. 2734, effective November 10, 2018 (Supp. 18-3).

R4-33-707. Minimum Standards for an Assisted Living Facility On-the-job Caregiver Training Program

A. In this Section:

1. "Direct supervision" has the same meaning as specified at A.R.S. § 36-446.16(C).
2. "Five years of experience," as used in A.R.S. § 36-446.16(A)(1)(a)(v), means a certified assisted living facility manager has been the manager of record for at least five years at an assisted living facility.
3. "Manager of record" means a certified assisted living facility manager for whom notice of appointment is provided under R4-33-410.
4. "OTJ" means on-the-job, a form of training that provides an employee with knowledge and skills essential to adequate job performance.

B. Before implementing an OTJ training program, the owner of the assisted living facility at which the OTJ training program will be implemented shall apply to the Board to have the OTJ training program approved.

C. To apply for Board approval under subsection (B), the owner of the assisted living facility shall submit an application packet that contains:

1. Name, address, telephone number, and email address of the owner of the assisted living facility;
2. Name, telephone number, email address, and certificate number of the assisted living facility manager of record;
3. A statement of who will be responsible for providing oversight of the OTJ training program. If oversight will be provided by someone other than the owner or manager of record, the name, telephone number, email address, and occupational license number of the individual who will be responsible;
4. License number of the assisted living facility at which the OTJ training program will be provided;
5. A written description of the OTJ training program that includes:
 - a. A statement of pre-requisites for being employed by the assisted living facility and becoming a participant in the OTJ training program including any criminal background or drug testing required;
 - b. An acknowledgment that the OTJ training program will be provided only to individuals who:
 - i. Are employed at the assisted living facility;
 - ii. Are being paid and receiving the same benefits as other caregivers employed at the assisted living facility;
 - iii. Have a valid fingerprint clearance card; and
 - iv. Have a current food-handler's card issued by the county in which the individual lives;
 - c. A statement of whether any hours of the OTJ training program will involve classroom instruction and if so, the number of hours and curriculum subjects, as specified in R4-33-703(C), that will be taught by classroom instruction;

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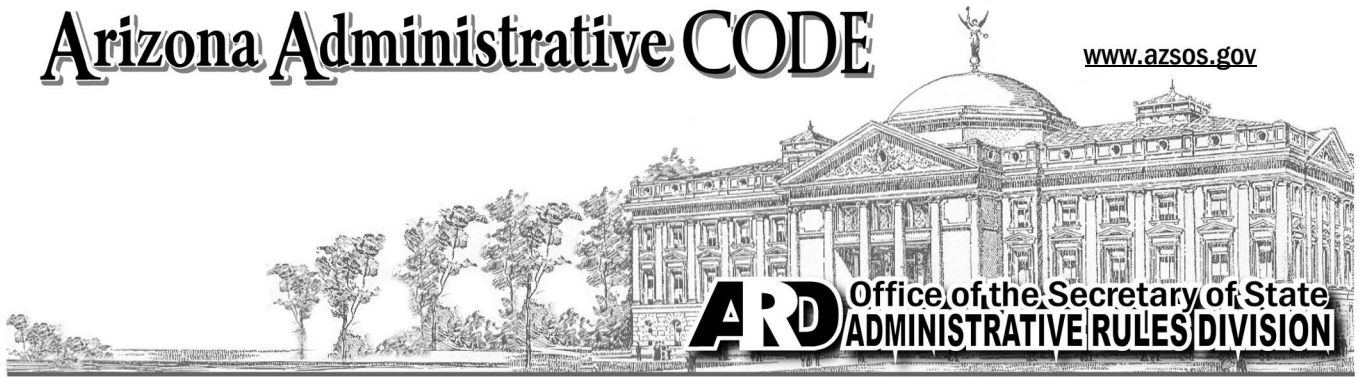
- d. An acknowledgment that none of the hours of the OTJ training program will be taught by distance learning;
 - e. An acknowledgment that the OTJ training program will consist of at least 62 hours of training covering all the curriculum subjects specified in R4-33-703(C); and
 - f. An acknowledgment that the OTJ training program complies with A.R.S. § 36-446.16(A)(1)(v) regarding direct supervision of the OTJ training program by the manager of record.
6. A copy of the license or certificate, as specified in A.R.S. § 36-446.16(A)(1), of each health professional who will provide direct supervision of the OTJ training program;
 7. A copy of written policies and procedures regarding:
 - a. Ensuring each individual in the OTJ training program receives at least 62 hours of training covering all the curriculum subjects specified in R4-33-703(C);
 - b. Examining and evaluating each individual as specified in R4-33-702(H);
 - c. Maintaining records of the OTJ training provided to each individual as specified in R4-33-702(A)(2)(d);
 - d. Termination of or quitting by an individual participating in the OTJ training program;
 - e. Criteria for completing the OTJ training program and procedure for ensuring each individual in the OTJ training program is informed of the criteria; and
 - f. Frequency and documentation of updating the written policies and procedures;
 8. A copy of a skills checklist used to verify that each individual in the OTJ training program acquires the skills listed in R4-33-703(C) and necessary to function competently as an assisted living facility caregiver;
 9. A copy of the evidence of completion provided within 15 days to each individual who completes the OTJ training program;
 10. A copy of the written information provided to each individual in the OTJ training program regarding how and to whom to submit a complaint regarding a grade, quality of training, failure to comply with this Section, discrimination, termination, or other issue;
 11. The fee specified at R4-33-104(D); and
 12. Signature of the owner of the assisted living facility at which the OTJ training program will be provided attesting that the information provided is complete and accurate.
- D. After receiving Board approval of the OTJ training program, the owner of the assisted living facility for which the approval was provided shall ensure the following responsibilities are performed:
 1. Within 15 days after an individual completes the OTJ training program, provide to the Board the information specified in R4-33-702(A)(5)(a), (b), (g), and (h); and
 2. Maintain the following records in the caregiver's permanent employee file:
 - a. A copy of the caregiver's fingerprint clearance card and food-handler's card required under subsection (C)(5);
 - b. Written documentation, signed by and with the license number of the health professional providing direct supervision, of each hour of OTJ training provided to the caregiver;
 - c. A copy of the caregiver's completed skills checklist required under subsection (C)(8);
 - d. Results of the state-approved written examination taken by the caregiver showing the caregiver achieved the grade specified in R4-33-702(A)(2)(b);
 - e. Copy of the evidence of completion issued to the caregiver with the caregiver's signed and dated acknowledgment of receipt; and
 - f. A copy of any complaint submitted by the caregiver and records showing how the complaint was resolved.
 - E. The owner of an assisted living facility with a Board-approved OTJ training program shall allow the Board to conduct periodic evaluation, as described in R4-33-702(J), of the OTJ training program.
 - F. The approval of an OTJ training program expires one year after the date of approval. If the approval expires, the owner of the assisted living facility shall ensure the OTJ training program ceases. To renew approval of the OTJ training program, the owner of the assisted living facility shall submit to the Board a renewal application packet, which is available on the Board's web site, and the fee specified under R4-33-104(D).
 - G. The provisions of R4-33-706 are applicable to an OTJ training program.

Historical Note

New Section made by final rulemaking at 27 A.A.R. 233, effective April 4, 2021 (Supp. 21-1).

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7 A.A.C. 1

Supp. 23-1

TITLE 7. EDUCATION

CHAPTER 1. DEPARTMENT OF ADMINISTRATION, DIVISION OF SCHOOL FACILITIES

The table of contents on page one contains links to the referenced page numbers in this Chapter.

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January 1, 2023 through March 31, 2023

[R7-1-101.](#) [Request for a Building Renewal Grant 2](#) [R7-1-201.](#) [Validation of Adjacent Ways Project 2](#)

Questions about these rules? Contact:

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Phoenix, AZ 85007
[Website:](#) <https://sfb.az.gov>
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Telephone: (602) 421-1882
[Email:](#) jack.smith@azdoa.gov

This Chapter released in Supp. 23-1 is new.

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ADMINISTRATIVE RULES DIVISION

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Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.

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Administrative Rules Division

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TITLE 7. EDUCATION

CHAPTER 1. DEPARTMENT OF ADMINISTRATION, DIVISION OF SCHOOL FACILITIES

Authority: A.R.S. §§ 41-5702(A)(10) and 41-5731(K)

Supp. 23-1

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Article 1, consisting of Section R7-1-101, made by final rulemaking at 29 A.A.R. 509 (February 3, 2023), effective March 10, 2023 (Supp. 23-1).

Section

R7-1-101. Request for a Building Renewal Grant 2

ARTICLE 2. VALIDATION OF ADJACENT WAYS PROJECT

Article 2, consisting of Section R7-1-201, made by final rulemaking at 29 A.A.R. 509 (February 3, 2023), effective March 10, 2023 (Supp. 23-1).

Section

R7-1-201. Validation of Adjacent Ways Project2

TITLE 7. EDUCATION

CHAPTER 1. DEPARTMENT OF ADMINISTRATION, DIVISION OF SCHOOL FACILITIES

ARTICLE 1. BUILDING RENEWAL GRANTS**R7-1-101. Request for a Building Renewal Grant**

- A.** A school district is eligible to request monies from the Building Renewal Grant Fund established under A.R.S. § 41-5731 if the building or part of a building for which monies are requested:
1. Is in the Division's database maintained under A.R.S. § 41-5702(A)(2);
 2. Is owned by the school district;
 3. Is used for student instruction or other academic purpose; and
 4. Has received routine preventative maintenance, as defined at A.R.S. § 41-5731(N), and the school district has submitted an annual preventative maintenance plan to the Division;
- B.** Grant request. To receive monies from the Building Renewal Grant Fund, a school district shall submit to the Division:
1. A complete and accurate request using a form that is available online. The school district shall ensure the following information is included in the request:
 - a. Identifying information.
 - i. Name of school district;
 - ii. Name and location of the building or part of a building for which monies are requested;
 - iii. Name, telephone number, and email address of the superintendent of the school district; and
 - iv. Name, telephone number, and email address of the school district contact person;
 - b. Project information.
 - i. A detailed description of the manner in which the building or part of a building referenced in subsection (B)(1)(a) fails to meet the Minimum School Facility Guidelines, established at 7 A.A.C. 6, Article 2;
 - ii. A summary of the conclusions from any completed professional study regarding the information provided under subsection (B)(1)(b)(i);
 - iii. Any citations by or reports from a governmental entity regarding the information provided under subsection (B)(1)(b)(i);
 - iv. Actions the school district proposes to take to address issues identified in subsection (B)(1)(b)(i) and that are consistent with A.R.S. § 41-5731(C);
 - v. Calculated cost of the actions proposed in subsection (B)(1)(b)(iv);
 - vi. A description of any local funding that will be used for the proposed project; and
 - vii. Amount of monies requested from the Building Renewal Grant Fund.
 2. The school district shall attach the following to the request:
 - a. A copy of any professional study referenced under subsection (B)(1)(b)(ii);
 - b. A copy of any citation or report referenced under subsection (B)(1)(b)(iii); and
 - c. A copy of any vendor bids, quotes, or proposals used to determine the cost under subsection (B)(1)(b)(v).
- C.** Technical assistance. As required under A.R.S. § 41-5702, the Division shall allow a school district to submit an incomplete request for monies from the Building Renewal Grant Fund and provide technical assistance to complete the request.
- D.** Division action on request for monies.

1. Within 15 days after receiving a request for monies submitted under subsection (B), the Division shall provide notice to the school district through the Division's grants management system of the Division's determination that the request:
 - a. Is complete or incomplete, or
 - b. The proposed project does not meet eligibility criteria. A school district may appeal a determination of ineligibility.
2. If the Division determines the submitted request is incomplete, the Division shall include in the notice provide under subsection (D)(1) a description the manner in which the request is incomplete, additional information needed, and the availability of technical assistance.
3. Except as provided under A.R.S. § 41-5702(A)(5)(h), the Division shall not act on a request for monies until the request is complete as described in subsection (B). If the school district fails to submit a complete request within 60 days after notice is provided under subsection (D)(2), the Division may deny the request.
4. When a request for monies is complete, the Division shall determine whether the need for monies is critical or non-critical as described in A.R.S. § 41-5731(G). The Division shall give priority to critical projects.
5. The Division shall distribute monies from the Building Renewal Grant Fund only after the Division and school district agree to the terms and conditions governing the grant of monies. Both the Division and school district shall comply with the agreed terms and conditions.
6. The Division shall distribute monies from the Building Renewal Grant Fund on a reimbursement basis. To be reimbursed for incurred expenses, a school district shall submit a complete and accurate financial report through the Division's grant management system. The Division shall reimburse the amount incurred within 20 days after a financial report is received in the Division's grants management system and accepted by the Division Administrator.
7. The Division shall provide status updates to the school district through the Division's grants management system.

Historical Note

New Section R7-1-101, made by final rulemaking at 29 A.A.R. 509 (February 3, 2023), effective March 10, 2023 (Supp. 23-1).

ARTICLE 2. VALIDATION OF ADJACENT WAYS PROJECT**R7-1-201. Validation of Adjacent Ways Project**

- A.** A school district that has monies from a special assessment on the taxable property in the school district for improvements necessary to ensure the safe ingress to and egress from school property to the public way may, as specified in A.R.S. § 15-995, use the monies for the following:
1. To construct, maintain, or improve a public way adjacent to a parcel of land owned or leased for school purposes by the school district;
 2. To construct sidewalks, sewers, utility lines, roadways, and other improvements along streets and intersections adjacent to a parcel of land owned or leased for school purposes by the school district;

TITLE 7. EDUCATION

CHAPTER 1. DEPARTMENT OF ADMINISTRATION, DIVISION OF SCHOOL FACILITIES

3. To ensure the safe ingress and egress of buses and fire equipment from the public way to a parcel of land owned or leased for school purposes by the school district; and
 4. To maintain fire and bus lanes, including signage and striping, on any parcel of land owned or leased for school purposes by the school district.
- B.** Before expending funds from the special assessment on an adjacent ways project, a school district shall file with the Division a complete and accurate description of the project using a form that is available online. The school district shall ensure the following information is included in the description:
1. Name and address of the school facility to be benefited by the project;
 2. Name of the school district;
 3. Name, telephone number, and email address of the school district superintendent;
 4. Name, telephone number, and email address of the school district contact person;
 5. A description of the proposed adjacent ways project including:
 - a. A designation of the category listed in subsection (A) applicable to the project; and
 - b. A summary of the conclusions from any completed professional study regarding need for the project; and
 6. Calculated cost of the proposed project.
- C.** A school district shall attach the following to the description filed under subsection (B):
1. A map showing the parcel of land owned or leased by the school district and the manner in which the proposed adjacent ways project will be placed on the parcel of land;
 2. A copy of any professional study referenced under subsection (B)(5); and
 3. A copy of any vendor bids, quotes, or proposals used to determine the cost provided under subsection (B)(6).
- D.** A school district that proposes an adjacent ways project with expenditures less than \$50,000 may begin the project after filing the complete and accurate description required under subsections (B) and (C).
- E.** Except as provided in subsection (D), the Division shall validate or invalidate a school district's proposed adjacent ways project within 60 days after receiving a complete filing under subsections (B) and (C). The Division shall validate a proposed adjacent ways project only if the Division determines the project:
1. Complies with all state laws relating to adjacent ways projects, and
 2. Does not contain work outside the scope of an adjacent ways project as described at A.R.S. § 15-995(A).

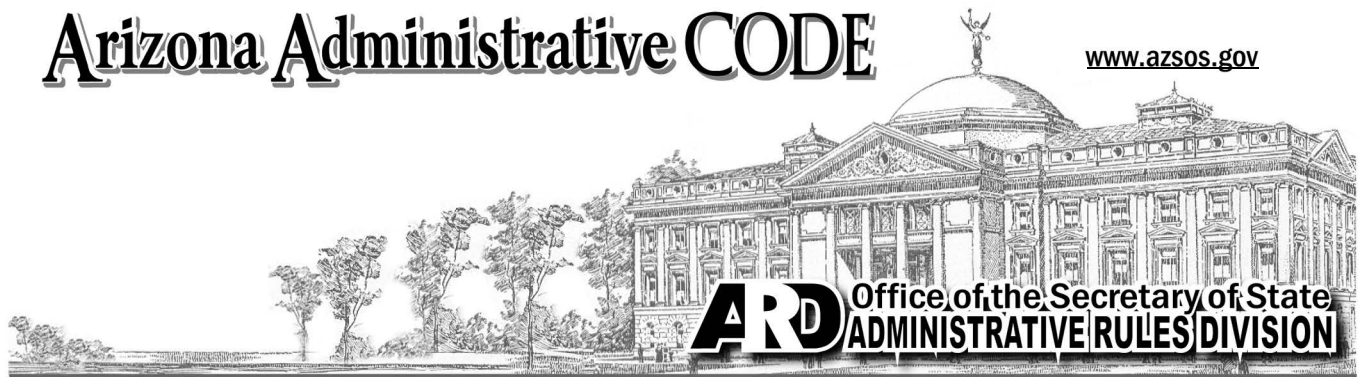
Historical Note

New Section R7-1-201, made by final rulemaking at 29 A.A.R. 509 (February 3, 2023), effective March 10, 2023 (Supp. 23-1).

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7 A.A.C. 2

Supp. 23-1

TITLE 7. EDUCATION CHAPTER 2. STATE BOARD OF EDUCATION

The table of contents on page one contains links to the referenced page numbers in this Chapter.
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

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Questions about these rules? Contact:

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Telephone: (602) 542-5057
Fax: (602) 542-3046
[Email:](mailto:inbox@azsbe.az.gov) inbox@azsbe.az.gov

The release of this Chapter in Supp. 23-1 replaces Supp. 22-4, 1-178 pages.

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ARTICLE 13. CONDUCT

Article 13, consisting of Sections R7-2-1301 through R7-2-1307, adopted effective December 3, 1998 (Supp. 98-4).

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Article 14, consisting of Sections R7-2-1401 through R7-2-1408, adopted by final rulemaking at 5 A.A.R. 3211, effective August 24, 1999 (Supp. 99-4).

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ARTICLE 1. STATE BOARD OF EDUCATION MEETINGS**R7-2-101. Governance****A. Officers**

1. The elective officers of the State Board of Education (Board) shall be a President and a Vice President.
2. The State Superintendent of Public Instruction shall serve as the Secretary and as the Executive Officer of the Board.
3. The President shall preside over all meetings of the Board, call meetings as herein provided and perform such other special duties as may be vested in him or her by the Board.
4. In the absence of the President, the Vice President shall preside over all meetings and shall perform such other special duties as may be vested in him or her by the Board.
5. The President shall appoint a nominating committee that will prepare a slate of candidates for presentation to the Board at the first regular meeting following January 1 of each year. Other candidates may be nominated from the floor. The two elected officers shall be elected by written ballot and shall serve for one year, or until their successors are elected.
6. If a vacancy occurs in the office of President, the Vice President shall immediately become the President. As soon as practicable, the Board shall elect a new Vice President.

B. Regular and special meetings

1. Unless otherwise agreed upon by a majority of the Board, meetings shall be held on the fourth Monday of each month.
2. The place of the meeting shall be designated by the President. In the absence of the President, the place of meeting shall be designated by the Vice President.

C. Public input to the Board

1. Requests for matters to be placed on the agenda.
 - a. When any person wishes to have a matter placed on the agenda, that person shall submit a written request to the President of the Board not less than 21 days prior to the Board meeting.
 - b. The President of the Board may choose not to place an item submitted by a person other than a Board member on the agenda.
2. Public comment on agenda items.
 - a. Any member of the public who wishes to address the Board regarding a matter on the agenda for Board action may submit a written request to be heard on forms provided by the Board.
 - b. The President of the Board or a majority of the Board may allot a reasonable time for members of the public to address the Board with respect to agenda items.

Historical Note

Former Section R7-2-101 repealed, new Section R7-2-101 adopted effective December 4, 1978 (Supp. 78-6). Amended effective February 27, 1980 (Supp. 80-1). Former Section R7-2-101 repealed, new Section R7-2-101 adopted effective June 17, 1985 (Supp. 85-3).

R7-2-102. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-103. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

ARTICLE 2. STATE BOARD OF EDUCATION COMMITTEES**R7-2-201. Advisory Committees**

- A.** The State Board of Education (Board) may create an advisory committee for the purpose of providing advice and recommendations as assigned by the Board. In this Section, unless the context otherwise requires, the following definitions shall apply:
1. "Ad Hoc Advisory Committee" means a committee, established by the Board, for a limited time and scope, for the purpose of providing advice and recommendations to the Board.
 2. "Executive Committee" means a committee, whose members consist of the President and Vice-President of the Board, established for the purpose of appointing ad hoc advisory committee members.
 3. "Standing Advisory Committee" means the Certification Advisory Committee, the Professional Practices Advisory Committee, or any other designated permanent committee, established by the Board, for the specific purpose of providing ongoing advice and recommendations as assigned by the Board.
- B.** Any advisory committee or similar body that has been created by either the Board or statute shall be appointed and conduct its business in accordance with this Section except as otherwise required by law.
- C.** The Board shall determine the structure, membership, and tasks of any standing advisory committee the Board has created.
- D.** The Board's Appointments Subcommittee, whose members are appointed by the President of the Board, shall review nominations submitted by the Board members for appointment to a standing advisory committee and shall provide a recommendation to the Board for consideration. A vacancy on a standing advisory committee shall be filled in the manner described in this Section.
- E.** The Board shall determine the structure and task of an ad hoc advisory committee it has created and may make suggestions as to members. The Executive Committee shall appoint the members of an ad hoc advisory committee. An ad hoc advisory committee shall exist for the time necessary to accomplish its assigned task or for one year from the date it is created, whichever is less. An ad hoc advisory committee may continue to function beyond a one-year period only with the express approval of the Executive Committee. A vacancy on an ad hoc advisory committee shall be filled in the manner prescribed by the Executive Committee.
- F.** The Board may in its discretion remove any member from and dissolve any standing advisory committee that the Board has created. The Executive Committee may in its discretion remove any member from and dissolve any ad hoc advisory committee that the Executive Committee has created.
- G.** An advisory committee shall not conduct a meeting of its members without prior acknowledgment from the Executive Director of the Board that the notice and agenda for the meeting have been approved by the President of the Board and posted and that there are sufficient funds to meet all expenses that would be incurred in connection with such meeting. An advisory committee member shall not obligate the payment of Board funds.

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- H. The meetings of a committee shall be held at the offices of the Board or any other facility for which no charges would be incurred for use of the facility.
- I. Activities of an advisory committee are limited to preparation of advice and recommendations to be presented to the Board for issues which relate directly to the task assigned by the Board.
- J. Advisory committees are not authorized the use of Board letterhead stationery without the express approval of the President of the Board and are not authorized the use of Department of Education letterhead stationery without the express approval of the Superintendent of Public Instruction.
- K. An advisory committee shall:
 1. Annually select from its members a chair and vice chair;
 2. Request information, assistance, or opinions from the Department of Education necessary to accomplish its task. An advisory committee shall convey any such request through the Department liaison designated pursuant to this Section.
- L. A quorum of an advisory committee shall be a majority of the voting members of the advisory committee. Voting members shall be only those members specifically appointed by the Board or Executive Committee. A quorum of an advisory committee is necessary to conduct its business. An affirmative vote of the majority of voting members present is necessary for an advisory committee to take action.
- M. The Superintendent shall designate an employee of the Department of Education to serve as a liaison to each advisory committee. The President of the Board may appoint a member of the Board to serve as an additional liaison to each advisory committee as the President deems appropriate.

Historical Note

Amended effective July 1, 1977 (Supp. 77-4). Former Section R7-2-201 repealed, new Section R7-2-201 adopted effective December 4, 1978 (Supp. 78-6). Amended effective February 25, 1987 (Supp. 87-1). Section repealed, new Section adopted effective March 18, 1994 (Supp. 94-1). Amended by final exempt rulemaking at 22 A.A.R. 2239, effective August 1, 2016 (Supp. 16-3). Amended by final exempt rulemaking at 25 A.A.R. 98, effective December 17, 2018 (Supp. 18-4). The word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-202. Repealed**Historical Note**

Former Section R7-2-202 repealed, new Section R7-2-202 adopted effective December 4, 1978 (Supp. 78-6). Former Section R7-2-202 repealed, new Section R7-2-202 adopted effective June 21, 1979 (Supp. 79-3). Amended effective June 12, 1989 (Supp. 89-2). Amended effective December 12, 1990 (90-4). Amended effective August 28, 1992 (Supp. 92-3). Repealed effective March 18, 1994 (Supp. 94-1).

R7-2-203. Repealed**Historical Note**

Former Section R7-2-203 repealed, new Section R7-2-203 adopted effective April 9, 1984 (Supp. 84-2). Amended subsections (A) and (B) effective December 30, 1988 (Supp. 88-4). Repealed effective February 20, 1997 (Supp. 97-1).

R7-2-204. Repealed**Historical Note**

Adopted effective December 4, 1978 (Supp. 78-6). Former Section R7-2-204 repealed, new Section R7-2-204 adopted effective December 31, 1984 (Supp. 84-6). Amended effective August 28, 1992 (Supp. 92-3). Repealed effective February 20, 1997 (Supp. 97-1).

R7-2-205. Professional Practices Advisory Committee

- A. Professional Practices Advisory Committees (Committees) shall act in an advisory capacity to the State Board of Education (Board) in regard to certification or recertification matters related to immoral conduct, unprofessional conduct, unfitness to teach, revocation, suspension, censure, or surrender of certificates, and matters related to immoral or unprofessional conduct, unfitness to teach and the discipline of noncertificated individuals.
- B. Committees shall each consist of nine members comprised of the following:
 1. One elementary classroom teacher,
 2. One secondary classroom teacher,
 3. One principal,
 4. One superintendent or assistant/associate superintendent,
 5. Three lay members, one lay member who shall be a parent of a student currently attending public school in Arizona,
 6. One local governing board member, and
 7. One charter school teacher, principal, or administrator.
- C. Members appointed under subsections (B)(1) through (4) shall meet at least the following requirements:
 1. Certified to teach in Arizona.
 2. Currently employed in or retired from the education profession in the specific category of their appointment.
- D. Terms of the members
 1. All regular terms shall be for four years except as set forth in subsection (E).
 2. A member may be reappointed with Board approval.
- E. The Board may remove any member from the Committee. All vacancies shall be filled as prescribed in subsections (C)(1) and (2), and those persons appointed to fill vacancies shall serve to complete the term of the person replaced.
- F. The Committee shall:
 1. Select from its members a Chairman and Vice-Chairman,
 2. A quorum shall be a majority of members of the Committee. A quorum is necessary to conduct business. An affirmative vote of the majority of the members present is needed to take action.
 3. Hold meetings as needed to conduct hearings or other Committee business by call of the Chairman of the Committee. If the Chairman neglects or declines to call a meeting, then a majority of the Committee may call a meeting. The Board may call a meeting as required to conduct necessary business. Notice of any meeting shall be given to Committee members seven days prior to the meeting.
 4. Recommend the removal of any member who is absent from three consecutive meetings.
 5. Refer to R7-2-1308 to assist in determining whether the acts complained of constitute unprofessional conduct.
 6. Conduct its business pursuant to R7-2-1301 et seq. and hearings pursuant to R7-2-701 et seq.

Historical Note

Adopted effective December 4, 1978 (Supp. 78-6). Former Section R7-2-205 repealed, new Section R7-2-205 adopted effective February 24, 1982 (Supp. 82-1). For-

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mer Section R7-2-205 repealed, new Section R7-2-205 adopted effective August 30, 1984 (Supp. 84-4).

Amended effective February 21, 1986 (Supp. 86-1). Amended subsections (H), (I), and (J) effective February 3, 1987 (Supp. 87-1). Amended effective December 15, 1989 (Supp. 89-4). Amended effective May 31, 1991 (Supp. 91-2). Amended effective April 9, 1993 (Supp. 93-2). Amended effective December 3, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Amended by final exempt rulemaking at 21 A.A.R. 1775, effective May 20, 2013 (Supp. 15-3). Amended by final exempt rulemaking at 23 A.A.R. 725, effective January 23, 2017 (Supp. 17-1). The word “rule” has been changed to “Section,” the words “above” and “below” have been removed to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-206. Certification Denial Appeals Process for Applications for Certification that Do Not Involve Allegations of Immoral or Unprofessional Conduct

A. Request for hearing. A person who has had an application for certification denied by the Department of Education pursuant to A.R.S. § 15-534.01(B) may file a written request for a hearing with the Board within 15 days after being served notice of the denial pursuant to subsection (C). Intermediate Saturdays, Sundays and legal holidays shall be included in the computation of the 15 days. If the final day of the 15 day deadline falls on a Saturday, Sunday or legal holiday, the next business day is the final day of the deadline. Applications for certification that involve allegations of immoral or unprofessional conduct shall be reviewed by the Professional Practices Advisory Committee pursuant to R7-2-205.

B. Notice of hearing

1. If an applicant requests a hearing to appeal the denial of an application for certification, a notice of hearing shall be given at least 20 days prior to the date set for the hearing.
2. The notice shall include:
 - a. A statement of the time, place and nature of the hearing.
 - b. A statement of the legal authority and jurisdiction under which the hearing is to be held.
 - c. A reference to the particular sections of the statutes and rules involved.
 - d. A short and plain statement of the matters asserted. If a party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter upon application a more definite and detailed statement shall be furnished.

C. Service of documents; change of address notice requirement

1. Every notice or decision issued by the Board or the Department pertaining to the denial of an application for initial certification or renewal of a certificate shall be served by personal delivery, first class mail or certified mail, return receipt requested, to the applicant or certificated person's last address of record with the Department of Education or by any other method that is reasonably calculated to give actual notice to the applicant or the certificated person. A document is filed with the Board on the date it is received by the Board, as established by the

Board's date stamp on the face of the document. A document issued by the Board or the Department pursuant to this Section is served on a party as follows:

- a. On the date it is personally served.
- b. Five days after it is mailed by first class mail.
- c. On the date of the return receipt if it is mailed by certified mail.

2. Each applicant or certificated person shall inform the Department of Education and the Board of any change of address within 30 days of the change of address.

D. Hearing process

1. All hearings shall be conducted before the Board or a hearing officer pursuant to A.R.S. Title 41, Chapter 6, Article 6 and this Section.
2. Parties may participate in the hearing in person or through an attorney.
3. Upon request of either party, the hearing officer may schedule a prehearing conference. The purpose of a prehearing conference shall be to narrow issues, attempt settlement, address evidentiary issues or for any other purpose deemed necessary by the hearing officer.
4. Opportunity shall be afforded all parties to respond and present evidence and argument on the issues involved.
5. The Board may dispose of any certification appeal by decision or approved stipulation, agreed settlement, consent agreement or by default.
6. A hearing shall be recorded manually or by a recording device and shall be transcribed on request of any party, unless otherwise provided by law. The cost of such transcript shall be paid by the party making the request, unless otherwise provided by law or unless assessment of the cost is waived by the Board.
7. The hearing may be rescheduled, maintaining due regard for the interests of justice and the orderly and prompt conduct of the proceedings.
8. The record in an appeal of a certification denial shall include:
 - a. All pleadings, motions and interlocutory rulings;
 - b. Evidence received or considered;
 - c. A statement of matters officially noticed;
 - d. Objections and offers of proof and rulings thereon;
 - e. Proposed findings of fact and conclusions of law and exceptions thereto;
 - f. Any decision, opinion, recommendation or report of the hearing officer;
 - g. All staff memoranda, other than privileged communications, or data submitted to the hearing officer in connection with its consideration of the case.
9. Findings of fact shall be based exclusively on the evidence and on matters officially noticed.
10. A hearing may be conducted in an informal manner and without adherence to the rules of evidence required in judicial proceedings. Neither the manner of conducting the hearing nor the failure to adhere to the rules of evidence required in judicial proceedings shall be grounds for reversing any administrative decision or order, providing the evidence supporting such decision or order is substantial, reliable, and probative. Irrelevant, immaterial or unduly repetitious evidence shall be excluded. Every person who is a party to such proceedings shall have the right to be represented by counsel, to submit evidence in open hearing and shall have the right of cross-examination. Unless otherwise provided by law, hearings may be held at any place determined by the Board. At such hear-

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ing such applicant shall be the moving party and have the burden of proof.

11. Copies of documentary evidence may be received in the discretion of the hearing officer. Upon request, the parties shall be given an opportunity to compare the copy with the original.
12. Notice may be taken of judicially cognizable facts. In addition, notice may be taken of generally recognized technical or scientific facts within the specialized knowledge of the hearing officer. Parties shall be notified either before or during the hearing or by reference in preliminary reports or otherwise of the material noticed including any staff memoranda or data and they shall be afforded an opportunity to contest the material so noticed. The hearing officer's experience, technical competence and specialized knowledge may be utilized in the evaluation of the evidence.

E. Subpoenas

1. The hearing officer may issue subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence on the hearing officer's own volition or at the request of a party.
2. A request for a hearing subpoena shall be in writing and served on each party at least seven days prior to the date set for hearing and shall state:
 - a. The name of the case, the case number, and the date, time and place where the witness is expected to appear and testify;
 - b. The name and address of the witness subpoenaed;
 - c. The documents, if any, sought to be provided; and
 - d. A brief statement of the relevance of the testimony or documents.
3. On application of a party or the agency and for use as evidence, the hearing officer may permit a deposition to be taken, in the manner and upon the terms designated by the hearing officer, of a witness who cannot be subpoenaed or is unable to attend the hearing.
4. The individual to whom a subpoena is directed shall comply with its provisions unless, prior to the date set for appearance, the hearing officer grants a written request to quash or modify the subpoena. The request shall state the reasons why it should be granted. The hearing officer shall grant or deny such request by order.
5. The hearing officer shall quash or modify the subpoena if:
 - a. It is unreasonable or oppressive; or
 - b. The desired testimony or evidence may be obtained by an alternative method.
6. The party requesting the subpoena shall prepare it and cause it to be served upon the individual to whom it is directed in the same manner as provided for service of subpoenas in civil matters before the superior court. The return of service shall be filed with the Board.

F. Conduct of hearing

1. The hearing officer may conduct all or part of the hearing by telephone or other electronic means, as long as each party has an opportunity to participate in the entire proceeding as it takes place.
2. Except for those hearings which may involve presentation of evidence protected by law as confidential, or which are otherwise closed pursuant to an express provision of law, all hearings are open to public observation.

3. Conduct at any hearing that is disruptive or shows contempt for the proceedings shall be grounds for exclusion from further participation or observation.

G. Evidence

1. All witnesses shall testify under oath or affirmation.
2. The hearing officer shall have the power to administer oaths and affirmations.
3. All parties shall have the right to present such oral or documentary evidence and to conduct such cross-examination as may be required for a full and fair disclosure of the facts.
4. The hearing officer shall receive evidence, rule upon offers of proof, and exclude evidence the hearing officer has determined to be irrelevant, immaterial, or unduly repetitious.
5. Unless otherwise ordered by the hearing officer, documentary evidence shall be limited in size when folded to 8 1/2 by 11 inches. The submitting party shall identify documentary exhibits by number or letter and party and furnish a copy of each exhibit to each party present. One additional copy shall be furnished to the hearing officer unless the hearing officer otherwise directs. When evidence offered by any party appears in a larger work, containing other information, the party shall plainly designate the portion offered. If the evidence offered is so voluminous as would unnecessarily encumber the record, the book, paper, or document shall not be received in evidence but may be marked for identification and, if properly authenticated, the designated portion may be read into or photocopied for the record. All documentary evidence offered shall be subject to appropriate and timely objection.

- H. Stipulations.** Parties to an appeal of a certification denial may stipulate, in writing, agreement upon any matter involved in the proceeding. If approved by the hearing officer, agreement on matters of procedure shall be binding upon the parties to the stipulation. The hearing officer may require presentation of evidence for proof of stipulated facts for the hearing officer's consideration. No substantive matter agreed to by the parties shall be binding upon the Board unless incorporated into the decision of the Board.

I. Recommendations

1. A recommended decision shall be prepared for the Board by the hearing officer and shall include findings of fact and conclusions of law, separately stated.
2. Parties shall be notified either personally or by mail to their last known address of any decision or order.
3. A recommended decision shall be delivered to the Board within 30 days after the close of the hearing unless the Board extends the period for good cause.

J. Decisions and orders

1. Any final decision or order adverse to a party shall be in writing or stated in the record.
2. When the Board is the hearing body, the decision shall be rendered within 60 days following the final day of the hearing.
3. Within 30 days after receipt of any recommended decision from the hearing officer, the Board shall render a decision to affirm, reverse, adopt, modify, supplement, amend or reject the recommendation and may remand the matter to the hearing officer with instructions, or may convene itself as the hearing body.

K. Rehearing and review of decisions

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1. After a hearing is held, a party in an appeal of a certification denial who is aggrieved by a decision rendered by the Board may file with the Board, not later than 30 days after such decision has been made, a written motion for rehearing specifying the particular grounds therefor. A motion for rehearing under this Section may be amended at any time before it is ruled upon by the Board. A response may be filed within 15 days after service of such motion by any other party. The Board may require the filing of written briefs on the issues raised in the motion or response and may provide for oral argument.
2. A rehearing of a decision by the Board may be granted for any of the following causes materially affecting the moving party's rights:
 - a. Irregularity in the administrative proceedings of the hearing body, or abuse of discretion, whereby the moving party was deprived of a fair hearing.
 - b. Misconduct of the hearing body or the prevailing party.
 - c. Accident or surprise which could not have been prevented by ordinary prudence.
 - d. Newly discovered material evidence which could not with reasonable diligence have been discovered and produced at the hearing.
 - e. Excessive or insufficient penalties.
 - f. Error in the admission or rejection of evidence or other errors of law occurring at the administrative hearing.
 - g. That the decision is not justified by the evidence or is contrary to the law.
3. The Board may affirm or modify the decision or grant a rehearing to all or any of the parties, on all or part of the issues, for any of the reasons set forth in subsection (K)(2). An order granting a rehearing shall specify with particularity the ground or grounds on which the rehearing is granted, and the rehearing shall cover only those matters so specified.
4. After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Board may grant a motion for rehearing for a reason not stated in the motion. The order granting such a rehearing shall specify the grounds therefor.
5. Not later than 20 days after a decision is rendered, the Board may, on its own initiative, order a rehearing of its decision for any reasons for which it might have granted a rehearing on motion of a party. The order granting such a rehearing shall specify the grounds therefor.
6. When a motion for rehearing is based upon affidavits they shall be served with the motion. An opposing party may, within 10 days after service of such motion, serve opposing affidavits and this period may be extended for an additional period not exceeding 20 days, by the Board for good cause shown or by written stipulation of the parties. Reply affidavits may be permitted.
7. After a hearing has been held and a final administrative decision has been entered, a party is not required to file a motion for rehearing or review of the decision in order to exhaust the party's administrative remedies.
8. Any party in an appeal of a certification denial who is aggrieved by a decision rendered by the Board may file with the Board, not later than 20 days after such decision has been made, a written request for review of the decision. If a review of the decision is granted, the Board may affirm or modify the previous decision.

Historical Note

Former Section R7-2-206 adopted effective December 4, 1978 (Supp. 78-6). Repealed effective February 24, 1982. See R7-2-205 adopted effective February 24, 1982 (Supp. 82-1). New Section R7-2-206 adopted effective August 9, 1989 (Supp. 89-3). Repealed effective March 18, 1994 (Supp. 94-1). New Section made by exempt rulemaking at 16 A.A.R. 156, effective December 7, 2009 (Supp. 09-4). Amended by final exempt rulemaking at 25 A.A.R. 98, effective December 17, 2018 (Supp. 18-4).

R7-2-207. Repealed**Historical Note**

Adopted effective August 9, 1989 (Supp. 89-3). Repealed effective March 18, 1994 (Supp. 94-1).

ARTICLE 3. CURRICULUM REQUIREMENTS AND SPECIAL PROGRAMS**R7-2-300. Adoption of Assessments**

As required in A.R.S. § 15-741, the Board shall adopt statewide assessments in order to measure pupil achievement of the state board adopted academic standards as follows:

1. In English language arts and mathematics, annually in grades three through eight and at least once in high school.
2. In science, once in grades three through five and grades six through eight and at least once in high school.
3. In other subjects and for other students, at the direction of the Board.

Historical Note

New Section made by final exempt rulemaking at 22 A.A.R. 143, effective August 26, 2013; filed in the Office on January 15, 2016 (Supp. 16-2). Amended by final exempt rulemaking at 27 A.A.R. 2342 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-301. Minimum Course of Study and Competency Goals for Students in the Common Schools

- A. Students shall demonstrate competency as defined by the State Board-adopted academic standards, at the grade levels specified, in the following required subject areas. District and charter school instructional programs shall include an ongoing assessment of student progress toward meeting the competency requirements. These shall include the successful completion of the academic standards in at least reading, writing, mathematics, science and social studies, as determined by district and/or statewide assessments.
 1. English language arts;
 2. Mathematics;
 3. Science;
 4. Social Studies; including:
 - a. Civics; and
 - b. Instruction on the Holocaust and other genocides at least once in either grade seven or grade eight;
 5. The Arts, which may consist of two or more of the following: visual arts, dance, theatre, music or media arts;
 6. Health/Physical Education, including mental health. Mental health instruction may be included as part of other subject areas and shall comply with A.R.S. § 15-701.02.
- B. The local governing board or charter school may prescribe course of study and competency requirements for promotion that are in addition to or higher than the course of study and competency requirements the State Board of Education prescribes. Additional subjects may be offered by the local gov-

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erning board or charter school as options and may include, but are not limited to:

1. Career and Technical Education,
 2. Computer Science,
 3. Educational Technology,
 4. World and Native Languages.
- C. Prior to the issuance of a standard certificate of promotion from the eighth grade, each student shall demonstrate competency, as defined by the local governing board, of the State Board of Education adopted academic standards for grade eight in the subject areas listed in subsections (A)(1) through (6).
- D. Special education and promotion from the eighth grade.
1. The charter school or local governing board of each school district shall be responsible for developing a course of study and graduation requirements for all students placed in special education programs in accordance with R7-2-401 et seq.
 2. Students placed in special education classes in grades K through eight are eligible to receive the standard certificate of promotion without meeting State Board of Education competency requirements.
- E. Online and distance education courses may be offered by the local governing board or charter school if the course is provided through an Arizona Online Instruction Program established pursuant to A.R.S. § 15-808.
- F. Alternative Demonstration of Competency. Upon request of the student, the local school district governing board or charter school shall provide the opportunity for a student in grades seven and eight to demonstrate competency in the subject areas listed in subsections (A)(1) through (6) in lieu of classroom time.

Historical Note

Former Section R7-2-301 repealed, new Section R7-2-301 adopted effective December 4, 1978 (Supp. 78-6). Amended subsections (A) and (B) effective May 4, 1982 (Supp. 82-3). Amended subsection (B) by adding subsection (10) effective July 26, 1982 (Supp. 82-4). Section repealed, new Section adopted effective April 12, 1993 (Supp. 93-2). Amended effective May 3, 1993 (Supp. 93-2). Amended by final exempt rulemaking at 22 A.A.R. 143, effective August 26, 2013 (the making of subsection (F)); filed in the Office January 15, 2016, with historical note added for clarification as the Board adopted the same amendment June 23, 2014 (Supp. 16-2). Amended by final exempt rulemaking at 21 A.A.R. 1778, effective June 23, 2014; filed in the Office August 4, 2015 (Supp. 15-3). Amended by final exempt rulemaking at 22 A.A.R. 143, effective August 26, 2013; filed in the Office on January 15, 2016 (Supp. 16-2). Amended by final rulemaking at 24 A.A.R. 691, effective February 26, 2018 (Supp. 18-1). Amended by final exempt rulemaking at 26 A.A.R. 2897, effective October 26, 2020 (Supp. 20-4). The hyphen between “K-8” has been changed to the word “through,” the numeral “8” has been changed to “eight,” the ordinal “8th” was corrected to “eighth” for consistency in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 2694 (November 19, 2021), effective October 25, 2021 (Supp. 21-4).

R7-2-301.01. Repealed**Historical Note**

R7-2-301(A), (B), and (C) repeated and numbered as R7-2-301.01(A), (B), and (C); R7-2-301(D) and (E) repeated

and numbered as R7-2-301.01(D) and (E) and amended; the text of R7-2-301.01 as amended is effective January 1, 1989 (Supp. 86-2). Complete text printed and historical note added (Supp. 89-3). Repealed effective April 12, 1993 (Supp. 93-2).

R7-2-301.02. Repealed**Historical Note**

Adopted effective March 26, 1990 (Supp. 90-1). Amended effective December 18, 1991; amended effective December 20, 1991 (Supp. 91-4). Repealed effective March 18, 1994 (Supp. 94-1).

R7-2-302. Minimum Course of Study and Competency Requirements for Graduation from High School

The Board prescribes the minimum course of study and competency requirements as outlined in subsections (1) through (5) and, through the graduating class of 2025, receipt of a passing score of 60 correct answers out of one hundred questions on a civics test identical to the civics portion of the naturalization test used by the United States Citizenship and Immigration Services as prescribed in A.R.S. § 15-701.01. Beginning with the graduating class of 2026, students shall obtain a passing score of at least 70 correct answers out of one hundred questions on a civics test identical to the civics portion of the naturalization test used by the United States Citizenship and Immigration Services prescribed in A.R.S. § 15-701.01.

1. Subject area course requirements. The Board establishes 22 credits as the minimum number of credits necessary for high school graduation. Students shall obtain credits for required subject areas as specified in subsections (1)(a) through (e) based on completion of subject area course requirements or competency requirements. At the discretion of the local school district governing board or charter school, credits may be awarded for completion of elective subjects specified in subsection (1)(f) based on completion of subject area course requirements or competency requirements. The awarding of a credit toward the completion of high school graduation requirements shall be based on successful completion of the subject area requirements prescribed by the State Board and local school district governing board or charter school as follows:
 - a. Four credits of English or English as a Second Language, which shall include but not be limited to the following: reading American and other world literature, reading informational text, writing, research methods, speaking and listening skills, grammar, and vocabulary.
 - b. Three credits in social studies to minimally include the following:
 - i. One credit of American history, including Arizona history;
 - ii. One credit of world history/geography, to include instruction on the Holocaust and other genocides;
 - iii. One-half credit of American government, including civics and Arizona government; and
 - iv. One-half credit in economics.
 - c. Four credits of mathematics to minimally include:
 - i. Three credits containing course content in preparation for proficiency at the high school level on the statewide assessment and aligned to the Arizona Mathematics Standards for Algebra I, Geometry, and Algebra II. These three credits shall be taken beginning with the

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- ninth grade unless a student meets these requirements prior to the ninth grade pursuant to subsection (1)(c)(iii). The requirement for the third credit covering Algebra II, may be met by, but is not limited to the following: a math course comparable to Algebra II course content; computer science, career and technical education and vocational education, economics, science and arts courses as determined by the local school district governing board or charter school.
- ii. A fourth credit that includes significant mathematics content as determined by the local school district governing board or charter school.
 - iii. Courses successfully completed prior to the ninth grade that meet the high school mathematics credit requirements may be applied toward satisfying those requirements.
 - iv. The mathematics requirements may be modified for students using a Personal Curriculum pursuant to R7-2-302.03.
- d. Three credits of science in preparation for proficiency at the high school level on the statewide assessment.
 - e. One credit of the Arts or career and technical education and vocational education.
 - f. Seven credits of additional courses prescribed by the local school district governing board or charter school.
 - i. Health instruction, regardless of the course it is provided in, shall include instruction on mental health;
 - ii. Mental health instruction may be included in other courses; and
 - iii. All mental health instruction shall comply with A.R.S. § 15-701.03.
 - g. A credit or partial credit may apply toward more than one subject area but shall count only as one credit or partial credit toward satisfying the 22 required credits.
2. Credits earned through correspondence courses to meet graduation requirements shall be taken from an accredited institution as defined in R7-2-601. Credits earned thereby shall be limited to four, and only one credit may be earned in each of the following subject areas:
 - a. English as described in subsection (1)(a) of this Section,
 - b. Social Studies,
 - c. Mathematics, and
 - d. Science.
 3. Online and distance education courses may be offered by the local governing board or charter school if the course is provided through an Arizona Online Instruction Program established pursuant to A.R.S. § 15-808.
 4. Local school district governing boards or charter schools may grant to career and technical education and vocational education program completers a maximum of 5 1/2 credits to be used toward the Board English, mathematics, science, and economics credit requirements for graduation, subject to the following restrictions:
 - a. The Board has approved the career and technical education and vocational education program for equivalent credit to be used toward the Board English, mathematics, science, and economics credit requirements for graduation.
 - b. A credit or partial credit may apply toward more than one subject area but shall count only as one credit or partial credit toward satisfying the 22 required credits.
 - c. A student who satisfies any part of the Board English, mathematics, science, and economics requirements through the completion of a career and technical education and vocational education program shall still be required to earn 22 total credits to meet the graduation requirements prescribed in this Section.
 5. Competency requirements.
 - a. The awarding of a credit toward the completion of high school graduation requirements shall be based on the requirements outlined in A.R.S. § 15-701.01 and the successful completion of State Board-adopted academic standards for subject areas listed in subsections (1)(a) through (1)(e) and the successful completion of the competency requirements for the elective subjects specified in subsection (1)(f). Competency requirements for elective subjects as specified in subsection (1)(f) shall be the academic standards adopted by the State Board. If there are no adopted academic standards for an elective subject, the local school district governing board or charter school shall be responsible for developing and adopting competency requirements for the successful completion of the elective subject. The school district governing board or charter school shall be responsible for developing and adopting the method and manner in which to administer a test that is identical to the civics portion of the naturalization test used by the United States Citizenship and Immigration Services. School districts and charter schools shall document and report student outcome data on the test pursuant to A.R.S. § 15-701.01 and based on procedures adopted by the Arizona Department of Education. Schools may administer the test to students beginning in the seventh grade and any pupil who does not obtain a passing score on the test may retake the test until the pupil obtains a passing score.
 - b. The determination and verification of student accomplishment and performance shall be the responsibility of the subject area teacher.
 - c. Upon request of the student, the local school district governing board or charter school shall provide the opportunity for the student to demonstrate competency in the subject areas listed in subsections (1)(a) through (1)(f) in lieu of classroom time. In appropriate courses, a school district governing board or charter school shall include as a mechanism to demonstrate competency a score determined by the State Board as college and career ready on the appropriate assessment adopted by the State Board pursuant to A.R.S. §§ 15-741 or 15-741.01.
 6. The local school district governing board or charter school shall be responsible for developing a course of study and graduation requirements for all students placed in special education programs in accordance with A.R.S. Title 15, Chapter 7, Article 4 and R7-2-401 et seq. Students placed in special education classes, through 12, are

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eligible to receive a high school diploma upon completion of graduation requirements.

Historical Note

Former Section R7-2-302 repealed, new Section R7-2-302 adopted effective December 4, 1978 (Supp. 78-6). Amended effective July 8, 1983 (Supp. 83-4). Amended subsections (1) and (5) effective January 1, 1987 (Supp. 84-3). See R7-2-302.01 and R7-2-302.02 for minimum credits for graduating classes of 1987 forward (Supp. 86-5). Repealed effective August 28, 1992; Inadvertently omitted from Supp. 92-3; corrected Supp. 93-4. Amended effective November 17, 1994 (Supp. 94-4). Repealed effective February 20, 1997 (Supp. 97-1). New Section adopted by final rulemaking at 7 A.A.R. 1255, effective February 20, 2001 (Supp. 01-1). Amended by final rulemaking at 8 A.A.R. 3893, effective August 21, 2002 (Supp. 02-3). Amended by final exempt rulemaking at 22 A.A.R. 143, effective August 26, 2013; since the Board did not file the amendments until January 15, 2016, subsection (3)(a) through (b) was already repealed at the time of publishing the Section in Supp. 15-3; therefore, there is no record of the amendments in the Administrative Code; these amendments can be viewed at 21 A.A.R. 1778 (Supp. 16-2). Amended by final exempt rulemaking at 21 A.A.R. 1778, effective June 23, 2014; filed in the Office August 4, 2015 (Supp. 15-3). Amended by final exempt rulemaking at 22 A.A.R. 197, effective October 26, 2015; filed in the Office January 15, 2016 (Supp. 16-3). Amended by final rulemaking at 24 A.A.R. 691, effective February 26, 2018 (Supp. 18-1). Amended by final exempt rulemaking at 26 A.A.R. 2897, effective October 26, 2020 (Supp. 20-4). The word “sixty” has been changed to the numeral “60,” the hyphen between “9-12” was replaced with the word “through” and the numeral “9” has been changed to “nine,” the phrase “of this Section” was removed, and “one hundred” was changed to the numeral “100” to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 2694 (November 19, 2021), effective October 25, 2021 (Supp. 21-4). Amended by final exempt rulemaking at 29 A.A.R. 183 (January 13, 2023), effective December 9, 2022 (Supp. 22-4).

R7-2-302.01. Repealed**Historical Note**

Section R7-2-302 repeated and amended effective January 1, 1987, filed September 24, 1986 (Supp. 86-5). Amended as an emergency by adding a new subsection (B) effective May 3, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Filing date for January 1, 1987, amendments corrected to September 24, 1986 (Supp. 89-3). Emergency expired. Adopted as a permanent rule effective February 7, 1990 (Supp. 90-1). Repealed effective August 28, 1992; Inadvertently omitted from Supp. 92-3; corrected Supp. 93-4. New Section made by exempt rulemaking at 14 A.A.R. 195, effective December 10, 2007 (Supp. 08-1). Section repealed by final exempt rulemaking at 22 A.A.R. 143, effective August 26, 2013; filed in the Office on January 15, 2016 (Supp. 16-2).

R7-2-302.02. Repealed**Historical Note**

Adopted effective January 1, 1991, filed September 24, 1986 (Supp. 86-5). Amended effective May 9, 1988 (Supp. 88-2). Amended effective June 12, 1989 (Supp. 89-2). Amended effective March 26, 1990 (Supp. 90-1). Repealed effective March 18, 1994 (Supp. 94-1). New Section made by exempt rulemaking at 14 A.A.R. 195, effective December 10, 2007 (Supp. 08-1). Section repealed by final exempt rulemaking at 22 A.A.R. 143, effective August 26, 2013; filed in the Office on January 15, 2016 (Supp. 16-2).

R7-2-302.03. Personal Curriculum**A. Definitions.**

1. “Personal Curriculum” means a documented process that may be used to modify the high school graduation requirements for mathematics delineated in R7-2-302.02(1)(c). A student may use a personal curriculum to modify the Algebra II requirement delineated in R7-2-302.02(1)(c)(ii) and reduce the credit requirements for mathematics from four to three credits. A student who successfully completes the student’s personal curriculum meets the requirements for high school graduation.
2. “Development Team” means a team that develops a personal curriculum for a student and consists of the student, the parent or legal guardian of the student, and a school counselor or principal or their designee. A school principal may add additional members to the development team as the principal deems appropriate.

B. A student is eligible for a personal curriculum if the student meets the following criteria:

1. The student has successfully completed the mathematics requirements delineated in R7-2-302.02(1)(c)(i); and
2. Despite the student’s successful completion of the mathematics requirements delineated in R7-2-302.02(1)(c)(i), the development team determines that the student demonstrates a need to modify the requirement delineated in R7-2-302.02(1)(c)(ii) for Algebra II or its equivalent course content.

C. The requirements for a personal curriculum are as follows:

1. An eligible student may only modify the mathematics requirement delineated in R7-2-302.02(1)(c)(ii) for Algebra II or its equivalent course content;
2. In lieu of successfully completing Algebra II or its equivalent course content, an eligible student shall successfully complete at least one credit in mathematics that shall include significant mathematics content as determined by the local school district governing board or charter school; and
3. An eligible student shall successfully complete a course in mathematics in the student’s senior year.

D. The procedures for developing and implementing a personal curriculum are as follows:

1. The parent or legal guardian of a student, an emancipated student, or a student with permission from the student’s parent or legal guardian may request a personal curriculum in a manner prescribed by the local school district governing board or charter school.
2. Upon receipt of a request for a personal curriculum made pursuant to subsection (D)(1), the local school district or charter school shall verify that the student successfully completed the mathematics requirements delineated in R7-2-302.02(1)(c)(i) and, upon verification, shall convene a development team.
3. The development team shall:

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- a. Verify that the student demonstrates a need to modify the requirement delineated in R7-2-302.02(1)(c)(ii) for Algebra II or its equivalent course content,
 - b. Identify an appropriate alternative mathematics course or courses to modify the requirement for Algebra II or its equivalent course content,
 - c. Develop a written personal curriculum plan that includes the alternative mathematics course or courses identified in subsection (D)(3)(b) and a plan for monitoring student progress toward successfully completing the alternative mathematics course or courses. In developing the personal curriculum plan the development team shall consider how the proposed modifications maintain the integrity of the high school diploma and enable the student to achieve the student's post-secondary education and career goals.
4. The development team may modify the personal curriculum plan based upon the development team's evaluation of the student's progress.
- E. The Superintendent of Public Instruction shall monitor a school district or charter school if there is reason to believe that the school district or charter school is allowing modifications inconsistent with the requirements delineated in this Section.

Historical Note

Adopted effective November 1, 1989 (Supp. 89-4).
Amended effective December 12, 1990 (Supp. 90-4).
Repealed effective February 20, 1997 (Supp. 97-1). New Section made by exempt rulemaking at 14 A.A.R. 195, effective December 10, 2007 (Supp. 08-1).

R7-2-302.04. Repealed**Historical Note**

Adopted effective July 10, 1992 (Supp. 92-3). Amended effective May 3, 1993 (Supp. 93-2). Amended effective December 17, 1998 (Supp. 98-4). Section repealed by final exempt rulemaking at 22 A.A.R. 143, effective August 26, 2013; filed in the Office on January 15, 2016 (Supp. 16-2).

R7-2-302.05. Arizona Education and Career Action Plan for Students in Grades nine through 12

- A. Effective for the graduation class of 2013, schools shall complete for every student in grades nine through 12 an Arizona Education and Career Action Plan ("ECAP") prior to graduation. Schools shall develop an Education and Career Action Plan in consultation with the student, the student's parent or guardian and the appropriate school personnel as designated by the school principal or chief administrative officer. Schools shall monitor, review and update each Education and Career Action Plan at least annually. Completion of an Education and Career Action Plan shall be verified by appropriate school personnel.
- B. An Arizona Education and Career Action Plan shall at a minimum allow students to enter, track and update the following information:
1. Academic Goals that include identifying and planning the coursework necessary to achieve the high school graduation requirements and pursue postsecondary education and career options; analyzing assessment results to determine progress and identify needs for intervention and advisement; and documenting academic achievement;

2. Career Goals that include identifying career plans, options, interests and skills; exploring entry level opportunities; and evaluating educational requirements;
3. Postsecondary Education Goals that include identifying progress toward meeting admission requirements, completing application forms and creating financial assistance plans; and
4. Extracurricular Activity Goals that include documenting participation in clubs, organizations, athletics, fine arts, community service, recreational activities, volunteer activities, work-related activities, leadership opportunities, and other activities.

Historical Note

New Section made by exempt rulemaking at 12 A.A.R. 876, effective August 22, 2005 (Supp. 06-1). Section R7-2-302.05 renumbered to R7-2-302.06; new Section R7-2-302.05 made by final exempt rulemaking at 22 A.A.R. 111, effective February 25, 2008; filed in the Office January 6, 2016 (Supp. 16-1). The hyphen between "9-12" has been changed to the word "through" and the numeral 9 has been changed to "nine," to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-302.06. Repealed**Historical Note**

New Section made by exempt rulemaking at 12 A.A.R. 876, effective August 22, 2005 (Supp. 06-1). Amended by exempt rulemaking at 15 A.A.R. 1570, effective September 25, 2006 (Supp. 09-1). Amended by exempt rulemaking at 16 A.A.R. 2031, effective August 25, 2008 (Supp. 09-2). Amended by exempt rulemaking at 15 A.A.R. 1602, effective August 24, 2009 (Supp. 09-3). Section R7-2-302.06 renumbered to R7-2-302.07; new Section R7-2-302.06 renumbered from Section R7-2-302.05 by final exempt rulemaking at 22 A.A.R. 111, effective February 25, 2008; filed in the Office January 6, 2016 (Supp. 16-1). Section repealed by final exempt rulemaking at 22 A.A.R. 143, effective August 26, 2013; filed in the Office on January 15, 2016 (Supp. 16-2).

R7-2-302.07. Repealed**Historical Note**

New Section made by exempt rulemaking at 15 A.A.R. 1602, effective August 24, 2009 (Supp. 09-3). Section R7-2-302.07 renumbered to R7-2-302.08; new Section R7-2-302.07 renumbered from Section R7-2-302.06 by final exempt rulemaking at 22 A.A.R. 111, effective February 25, 2008; filed in the Office January 6, 2016 (Supp. 16-1). Section repealed by final exempt rulemaking at 22 A.A.R. 143, effective August 26, 2013; filed in the Office on January 15, 2016 (Supp. 16-2).

R7-2-302.08 Repealed**Historical Note**

New Section made by exempt rulemaking at 15 A.A.R. 1602, effective August 24, 2009 (Supp. 09-3). Section R7-2-302.08 renumbered to R7-2-302.09; new Section R7-2-302.08 renumbered from Section R7-2-302.07 by final exempt rulemaking at 22 A.A.R. 111, effective February 25, 2008; filed in the Office January 6, 2016 (Supp. 16-1). Section repealed by final exempt rulemaking at 22

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A.A.R. 143, effective August 26, 2013; filed in the Office on January 15, 2016 (Supp. 16-2).

R7-2-302.09 Repealed**Historical Note**

New Section made by exempt rulemaking at 15 A.A.R. 1602, effective August 24, 2009 (Supp. 09-3). R7-2-302.09 renumbered to R7-2-302.10; new Section R7-2-302.09 renumbered from Section R7-2-302.08 by final exempt rulemaking at 22 A.A.R. 111, effective February 25, 2008; filed in the Office January 6, 2016 (Supp. 16-1). Section repealed by final exempt rulemaking at 22 A.A.R. 143, effective August 26, 2013; filed in the Office on January 15, 2016 (Supp. 16-2).

R7-2-302.10. Repealed**Historical Note**

New Section R7-2-302.10 renumbered from Section R7-2-302.09 by final exempt rulemaking at 22 A.A.R. 111, effective February 25, 2008; filed in the Office January 6, 2016 (Supp. 16-1). Section amended by final exempt rulemaking at 22 A.A.R. 143, effective August 26, 2013; filed in the Office on January 15, 2016 (Supp. 16-2). Repealed by final exempt rulemaking at 22 A.A.R. 197, effective October 26, 2015; filed in the Office January 15, 2016 (Supp. 16-3).

R7-2-302.11. Minimum Course of Study and Competency Requirements During Public Health Emergency in the 2019-2020 School Year

- A. Notwithstanding any other rule, local education agencies shall not refuse to withhold academic credit or a diploma from a student solely because the student missed instructional time due to a school closure issued by the governor.
- B. Local education agencies may issue academic credit and a diploma to a student if the student meets competency requirements pursuant to Article 3. When determining if a student meets competency requirements in a school year during which the governor issues a school closure, local education agencies may consider the educational opportunities provided to the student during the school closure. Educational opportunities, as determined by the local education agency, may include, but are not limited to the following:
 - 1. Independent study provided online or through printed materials; and
 - 2. Online instruction.
- C. If a local education agency is unable to consider or unable to provide the educational opportunities pursuant to subsection (B), the local education agency may award academic credit or a diploma if the student was on track to earn the academic credit or diploma prior to the school closure. Evidence that a student was on track to earn academic credit or a diploma, as determined by the local education agency, may include, but is not limited to, passing grades issued by the student's teacher or passing scores on locally or nationally administered assessments. It is the intent of the Board that all schools attempt, to the extent possible, to provide educational opportunities to students during a school closure issued by the governor.
- D. Local education agencies that issue academic credit and a diploma to a student pursuant to subsections (B) and (C) shall issue transcripts and diplomas to students in the same manner as the local education agency would for students that did not miss instructional time due to a school closure caused issued by the governor.

- E. This Section applies only to the 2019-2020 school year and the graduating class of 2020.

Historical Note

New Section made by final exempt rulemaking at 26 A.A.R. 966, effective March 31, 2020 (Supp. 19-2).

R7-2-303. Sex Education

- A. Instruction in sex education in the public schools of Arizona, including instruction provided after hours, shall be offered only in conformity with the following requirements. Nothing in this Section shall be construed to require a school district or charter school provide sex education instruction to pupils.
 - 1. Common schools: Nature of instruction; approval; format.
 - a. Supplemental/elective nature of instruction. The common schools of Arizona may provide a specific elective lesson or lessons concerning sex education as a supplement to the health course of study.
 - i. This supplement may only be taken by the student at the written request of the student's parent or guardian. When the school district or charter school seeks consent pursuant to this subsection, the school district or charter school shall inform the parent or guardian of their right to review the instructional materials and activities.
 - ii. Alternative elective lessons from the state-adopted optional subjects shall be provided for students who do not enroll in elective sex education.
 - iii. School districts and charter schools may not provide sex education lessons or instruction before grade five.
 - iv. Elective sex education lessons shall not exceed the equivalent of one class period per day for 1/4 of the school year for grades five through eight.
 - b. Local governing board approval. All elective sex education lessons to be offered shall first be approved by the local governing board.
 - i. Each local governing board contemplating the offering of elective sex education shall establish an advisory committee with membership representative of district size and the racial and ethnic composition of the community to assist in the development of lessons and advise the local governing board on an ongoing basis. All meetings of committees that are authorized for the purposes of reviewing and selecting the sex education course of study shall be publicly noticed at least two weeks before occurring and be open to the public according to A.R.S. Title 38, Chapter 3, Article 3.1.
 - ii. The local governing board shall review the total instructional materials and approve all lessons and curricula in the course of study to be offered in sex education.
 - iii. The local governing board shall make any proposed sex education course of study available and accessible for review and public comment for at least 60 days before the governing board or governing body decides whether to approve that course of study. The local governing board shall publicize and hold at least two public

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- hearings within the 60-day period for the purpose of receiving public input at least one week prior to the local governing board meeting at which the elective sex education lessons will be considered for approval. Public input may include written comments, oral comments and comments submitted electronically.
- iv. The local governing board shall maintain for viewing by the public, both online and in-person according to A.R.S. § 15-102(A)(2), the total instructional materials to be used in approved elective sex education lessons within the school district or charter school at least two weeks before any instruction is offered.
 - c. Format of instruction.
 - i. Lessons shall be taught to boys and girls separately.
 - ii. Lessons shall be ungraded, require no homework, and any evaluation administered for the purpose of self-analysis shall not be retained or recorded by the school or the teacher in any form.
 - iii. Lessons shall not include tests, psychological inventories, surveys, or examinations containing any questions about the student's or the student's parents' personal beliefs or practices in sex, family life, morality, values or religion.
 2. High schools: Course offering; approval; format.
 - a. A course in sex education may be provided in the high schools of Arizona.
 - b. This course may only be taken by the student at the written request of the student's parent or guardian.
 - c. Alternative elective lessons from the state-adopted optional subjects shall be provided for students who do not enroll in elective sex education.
 - d. All meetings of committees that are authorized for the purposes of reviewing and selecting the sex education course of study shall be publicly noticed at least two weeks before occurring and be open to the public according to A.R.S. Title 38, Chapter 3, Article 3.1.
 - e. The local governing board shall review the total instructional materials and approve all lessons and curricula in the course of study to be offered in sex education.
 - f. The local governing board shall make any proposed sex education course of study available and accessible for review and public comment for at least sixty days before the governing board or governing body decides whether to approve that course of study. The local governing board shall publicize and hold at least two public hearings within the sixty-day period for the purpose of receiving public input at least one week prior to the local governing board meeting at which the elective sex education lessons will be considered for approval. Public input may include written comments, oral comments and comments submitted electronically.
 - g. Lessons shall not include tests, psychological inventories, surveys, or examinations containing any questions about the student's or the student's parents' personal beliefs or practices in sex, family life, morality, values or religion.
 - h. Local governing boards shall maintain for viewing by the public, both online and in-person according to A.R.S. § 15-102(A)(2), the total instructional materials to be used in all sex education courses to be offered in high schools within the school district or charter school at least two weeks before any instruction is offered.
 3. Content of instruction: Common schools and high schools.
 - a. All sex education materials and instruction shall be age appropriate, recognize the needs of exceptional students, meet the needs of the district, recognize local community standards and sensitivities, shall not include the teaching of abnormal, deviate, or unusual sexual acts and practices, and shall include the following:
 - i. Emphasis upon the power of individuals to control their own personal behavior. Pupils shall be encouraged to base their actions on reasoning, self-discipline, sense of responsibility, self-control and ethical considerations such as respect for self and others; and
 - ii. Instruction on how to say "no" to unwanted sexual advances and to resist negative peer pressure. Pupils shall be taught that it is wrong to take advantage of, or to exploit, another person.
 - b. All sex education materials and instruction which discuss sexual intercourse shall:
 - i. Stress that pupils should abstain from sexual intercourse until they are mature adults;
 - ii. Emphasize that abstinence from sexual intercourse is the only method for avoiding pregnancy that is 100 percent effective;
 - iii. Stress that sexually transmitted diseases have severe consequences and constitute a serious and widespread public health problem;
 - iv. Include a discussion of the possible emotional and psychological consequences of preadolescent and adolescent sexual intercourse and the consequences of preadolescent and adolescent pregnancy;
 - v. Advise pupils of Arizona law pertaining to the financial responsibilities of parenting, and legal liabilities related to sexual intercourse with a minor.
 - B. Certification of compliance. All districts and charter schools offering a local governing board-approved sex education course or lesson shall certify, under the notarized signature of both the president of the local governing board and the chief administrator of the school district or charter school, compliance with this Section except as specified in subsection (C). Acknowledgment of receipt of the compliance certification from the State Board of Education is required as a prerequisite to the initiation of instruction. Certification of compliance shall be in a format and with such particulars as shall be specified by the Department of Education.
 - C. School districts and charter schools shall make any existing sex education course of study available and accessible for review both online and in person by June 30, 2021.

Historical Note

Former Section R7-2-303 repealed, new Section R7-2-303 adopted effective December 4, 1978 (Supp. 78-6).
 Former Section R7-2-303 repealed, new Section R7-2-

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303 adopted effective June 12, 1989 (Supp. 89-2). Amended by final exempt rulemaking at 25 A.A.R. 1551, effective May 20, 2019 (Supp. 19-2). The hyphens between grades in this Section have been replaced with the word “through,” the word “rule” was corrected to “Section,” the numeral “4” was corrected to “four,” the numeral “5” was corrected to “five,” and the numeral “8” was corrected to “eight” to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 1107, effective June 28, 2021 (Supp. 21-3). Amended by final exempt rulemaking at 27 A.A.R. 2340 (October 22, 2021) effective September 27, 2021 (Supp. 21-4).

R7-2-304. Extended School Year

The governing board of a common high school considering the adoption of an extended school year shall:

1. Prepare a comparative cost analysis of the extended school year program versus the cost of new facilities and sites.
2. Hold at least one public hearing, publicized a week in advance, to present the alternatives, including the results of the comparative cost analysis.
3. Determine faculty, community, and parental support prior to making a final determination.

Historical Note

Former Section R7-2-304 repealed, new Section R7-2-304 adopted effective December 4, 1978 (Supp. 78-6). The Section heading has been updated to title case to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-305. Declaration of Independence

The governing board of each common school district shall adopt policies that:

1. Require pupils to recite the following passage from the Declaration of Independence for pupils in grades four through six at the commencement of the first class of the day in the schools: “We hold these truths to be self-evident, that all men are created equal, that they are endowed by their creator with certain unalienable rights, that among these are life, liberty, and the pursuit of happiness. That to secure these rights, governments are instituted among men, deriving their just powers from the consent of the governed.”; and
2. Enable the pupil or the parent or legal guardian of the pupil to object to reciting the passage of the Declaration of Independence, and that specify that a pupil shall not be required to participate if the pupil or the pupil’s parent or guardian objects.

Historical Note

Repealed effective December 4, 1978 (Supp. 78-6). Adopted effective February 15, 1979 (Supp. 79-1). Repealed effective February 20, 1997 (Supp. 97-1). New Section made by final rulemaking at 7 A.A.R. 5363, effective November 7, 2001 (Supp. 01-4). The numeral “4” was corrected to “four,” the numeral “6” was corrected to “six” to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-306. English Language Learner Programs

A. Definitions. All terms defined in A.R.S. § 15-751 are applicable, with the following additions:

1. “Statewide assessment” means the test prescribed by A.R.S. § 15-741 or an assessment approved by the Board

pursuant to A.R.S. § 15-741.02 to administer to students instead of the statewide assessment.

2. “Arizona Academic Standards” means the standards adopted by the State Board of Education pursuant to A.R.S. §§ 15-203, 15-701, and 15-701.01.
3. “Board” means the State Board of Education.
4. “Compensatory instruction” means instruction given in addition to regular classroom instruction, such as individual or small group instruction, extended day classes, summer school or intersession school.
5. “Department” means the Department of Education.
6. “EL” means English learner.
7. “FEP” means fluent English language proficient, a student who has met the requirements for exit from an English language learner program.
8. “Federal EL grant monies” means federal grants or funds awarded to an LEA to educate ELs or to improve the LEA’s capacity to educate ELs, including but not limited to grants awarded under Title III of the Every Student Succeeds Act of 2015.
9. “IEP” means individualized education program, a written statement specifying special education services to be provided to a child with a disability.
10. “LEA” means local education agency, the school district or charter school that provides educational services.
11. “PHLOTE” means primary or home language other than English.
12. “Reassessment for reclassification” means the process of determining whether an English language learner may be reclassified as fluent English proficient (FEP).
13. “Superintendent” means the State Superintendent of Public Instruction.
14. “WICP” means written individualized compensatory plan that documents the scope and type of services provided to an EL to overcome the identified language and academic deficiencies.

B. Identification of students to be assessed.

1. The primary or home language of all students shall be identified by the students’ parent or legal guardian on the home language survey. These documents shall inform parents that the responses to these questions will determine whether their student will be assessed for English language proficiency.
2. A student shall be considered as a PHLOTE student if the home language survey indicates that one or more of the following are true:
 - a. The primary language used in the home is a language other than English, regardless of the language spoken by the student.
 - b. The language most often spoken by the student is a language other than English.
 - c. The student’s first acquired language is a language other than English.
3. The English language proficiency of all PHLOTE students shall be assessed as provided in subsection (C).

C. English language proficiency assessment.

1. PHLOTE students in kindergarten shall be administered an English language proficiency test. Students in grades one through 12 shall be administered an English language proficiency test. Students who score below the designated score for fluent English language proficiency, adopted by the Department and based on the test publishers’ designated scores, shall be classified as ELs.

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2. English language proficiency assessments shall be conducted by individuals who are proficient in English and trained in language proficiency testing to administer and, when applicable, score the tests.
 3. The LEA shall assess the English language proficiency of all new PHLOTE students as prescribed above within 60 days of the beginning of the school year or within 30 school days of a student's enrollment in school, whichever is later, unless the LEA receives funds under Title III of the Every Student Succeeds Act of 2015 or another federal grant that requires assessment and parental notification within 30 calendar days from the start of the school year or within two calendar weeks of a student enrolling at a school.
- D.** Screening and assessment of students in gifted education. ELs who meet the qualifications for placement in a gifted educational program shall receive programmatic services designed to develop their specific areas of potential and academic ability and may be concurrently enrolled in gifted programs and English language learner programs.
- E.** English language learner programs.
1. All ELs shall be provided daily instruction in English language development appropriate to their level of English language proficiency and consistent with A.R.S. §§ 15-751, 15-752, and, as applicable, § 15-753. The English language instruction shall include listening and speaking skills, reading and writing skills, and cognitive and academic development in English.
 2. ELs shall be provided daily instruction in subject areas required under the minimum course of study adopted by the Board pursuant to R7-2-301 and R7-2-302 that is understandable and appropriate to the level of academic achievement of the EL and is in conformity with accepted strategies for teaching ELs. This subsection does not require an LEA to provide daily instruction in every subject area required pursuant to R7-2-301 and R7-2-302 if those subject areas are not provided daily to English proficient students.
 3. The curriculum of all English language learner programs shall incorporate the Academic Standards adopted by the Board and shall be comparable in amount, scope and quality to that provided to English language proficient students.
 4. ELs who are not progressing toward achieving proficiency of the Arizona Academic Standards adopted by the Board, as evidenced by the failure to improve scores on the statewide assessment, shall be provided compensatory instruction to assist them in achieving those Arizona Academic Standards. A WICP describing the compensatory instruction provided shall be kept in the student's academic file.
 5. On request of a parent or legal guardian of an EL the principal of the EL's school shall require a meeting with the principal or principal's designee, the parent or legal guardian and the classroom teacher to review the student's progress in achieving proficiency in the English language or in making progress toward the Arizona Academic Standards adopted by the Board, to identify any problems, to determine appropriate solutions and to identify the person or persons responsible for implementing the changes and determining their effectiveness.
- F.** Reassessment for reclassification.
1. The purpose of reassessment is to determine if an EL has developed the English language skills necessary to succeed in the English language curricula.
 2. An EL in grades one through 12 may be reassessed for reclassification during test windows established by the Department if the mid-year test requirements are met, but shall be reassessed for reclassification at least once per year. ELs that score at or above the designated score for fluent English language proficiency, adopted by the Department and based on the test publishers' designated scores, shall be reclassified as FEP.
 3. LEAs shall notify the parents or legal guardians in writing that their child has been reclassified as FEP when the student meets the criteria for such reclassification.
- G.** Evaluation of FEP students after exit from EL programs.
1. The LEA shall monitor exited students based on the criteria provided in this Section during each of the two years after being reclassified as FEP to determine whether these students are performing satisfactorily in achieving the Arizona Academic Standards adopted by the Board. Such students will be monitored in reading, writing and mathematics skills and mastery of academic content areas, including science and social studies. The criteria shall be grade-appropriate and uniform throughout the LEA, and upon request, is subject to Board review. Students who are not making satisfactory progress shall, with parent consent, be provided compensatory instruction or shall be re-enrolled in an EL program. A WICP describing the compensatory instruction provided shall be maintained in the students' EL files.
 2. The LEA shall use statewide assessment scores to determine progress toward achieving the Arizona Academic Standards in monitoring FEP students after exit from an EL program unless no score is available. Performing satisfactorily will be measured by whether a student meets or exceeds the state standards in reading, writing, and mathematics as measured by the statewide assessment.
 3. If a statewide assessment score is not available because the test is not administered in the students' grade or to assess progress in academic subjects not assessed by the statewide assessment, the LEA shall use one or more of the following criteria in its evaluation to determine progress toward achieving the Arizona Academic Standards in monitoring FEP students after exit from an EL program:
 - a. LEA-developed criterion-referenced tests of academic achievement that demonstrate alignment to the Arizona Academic Standards; or
 - b. Standardized tests measuring academic achievement that demonstrate alignment to the Arizona Academic Standards; or
 - c. Nationally norm-referenced test scores; or
 - d. Teacher recommendations based on classroom assessments that demonstrate alignment to the Arizona Academic Standards.
- H.** Monitoring of EL programs.
1. Each year the Department shall monitor at least 32 LEAs, as follows:
 - a. At least 12 of the 50 LEAs with the highest EL enrollment;
 - b. At least 10 LEAs with ELs that are not included in the 50 described above;
 - c. At least 10 LEAs that have reported that they have 25 or fewer EL students in their schools; and

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- d. Other LEAs upon receipt of a documented written complaint from any Arizona resident, the U.S. Department of Education, or the U.S. Office for Civil Rights, alleging that the LEA is not complying with state or federal law regarding ELs.
 2. All of the 50 LEAs in subsection (H)(1)(a) shall be monitored by the Department at least once every four years.
 3. The monitoring shall be on-site monitoring and shall include classroom observations, curriculum reviews, faculty interviews, student records reviews, and review of EL programs. The Department may use personnel from other schools to assist in the monitoring.
 4. The Department shall issue a report on the results of its monitoring within 45 days after completing the monitoring. If the Department determines that an LEA is not complying with state or federal laws applicable to EL students, the LEA shall prepare and submit to the Department, within 60 days of the Department's determination, a corrective action plan that sets forth steps that the LEA will take to correct the deficiencies noted in the report.
 5. The Department shall review and return such corrective action plan to the LEA within 30 days, noting any required changes. No later than 30 days after receiving its corrective action plan back from the Department, the LEA shall begin implementing the measures set forth in the plan, including any revisions required by the Department.
 6. The Department shall conduct a follow-up evaluation of the LEA within one year after returning the corrective action plan to the LEA.
 7. If the Department finds continued non-compliance during the follow-up evaluation, the LEA shall be referred to the Board for a determination of non-compliance. If the Board determines the LEA to be out of compliance with state or federal laws applicable to EL students, it may take one or more of the following actions:
 - a. Temporarily withhold cash payments of federal EL grant monies;
 - b. Disallow (that is deny both use of funds and matching credit for) all or part of the cost of the activity or action not in compliance;
 - c. Wholly or partly suspend or terminate the current award of federal EL grant monies;
 - d. Withhold further awards of federal EL grant monies for the program.
 8. The Department shall monitor all LEAs that the Board has determined to be non-compliant and which have had federal EL grant monies withheld or terminated to ensure that such LEAs do not reduce the amount of funds spent on their EL programs as the result of its loss of funds.
- A. For the purposes of this Section, the following definitions shall apply:
 1. "DANTES" means the Defense Activity for Non-Traditional Education Support.
 2. "Department" means the Adult Education Services Division of the Arizona Department of Education.
 3. "Equivalency Test" means a High School Equivalency Test approved by the State Board of Education.
 4. "High School Equivalency Testing Center" means a testing center established by the Department for the purpose of administering High School Equivalency tests and providing High School Equivalency testing services pursuant to the requirements established by a State Board approved testing provider and state jurisdictional rules.
 5. "USAFI" means the United States Armed Forces Institute.
 - B. Eligibility requirements. Any individual who is 16 years of age or older and who has officially been withdrawn from school may take a High School Equivalency Test.
 1. Individuals shall be required to provide the High School Equivalency Testing Center with positive identification and proof of age, and
 2. Individuals who are at least 16 years of age and under 18 years of age shall also be required to provide:
 - a. A signed and notarized statement of consent from a parent or legal guardian, and
 - b. A letter from the last school attended verifying that the individual has officially withdrawn from the school.
 - C. Issuance of a diploma. The Department shall issue a high school equivalency diploma to any individual who has not received a high school diploma or high school equivalency certificate or diploma if the individual:
 1. Meets the eligibility requirements specified in subsection (B) and has received passing scores on a High School Equivalency Test; or
 2. Is a member of the U.S. Armed Forces and has received passing scores on a High School Equivalency Test through USAFI or DANTES provided that the individual's last high school enrollment was in an Arizona high school. Individuals who have taken a High School Equivalency Test through USAFI or DANTES shall send their military permanent record and application card to DANTES with a request that the official High School Equivalency Test scores and application card be forwarded to the Department; or
 3. Has received passing scores on a High School Equivalency Test taken at an approved testing provider's site, provided that the Department receives an official transcript directly from the approved testing provider.
 - D. The Department shall keep a record of test scores for each individual who has taken a High School Equivalency Test.
 - E. The Arizona Department of Education may collect fees for the issuance of High School Equivalency Diplomas and Transcripts. Fees established pursuant to this Section shall not exceed \$20.
 1. The State Board of Education will deposit, pursuant to A.R.S. §§ 35-146 and 35-147, fees collected under this Section in the High School Equivalency Testing Revenue Account within the Arizona Department of Education budget, to be used to offset costs of providing these services.

Historical Note

Repealed effective December 4, 1978 (Supp. 78-6). New Section R7-2-306 adopted effective July 10, 1979 (Supp. 79-4). Amended effective August 20, 1981 (Supp. 81-4). Former Section R7-2-306 repealed, new Section R7-2-306 adopted effective November 14, 1984 (Supp. 84-6). Amended by final rulemaking at 10 A.A.R. 353, effective March 8, 2004 (Supp. 04-1). Amended by final exempt rulemaking at 26 A.A.R. 66, effective December 13, 2019 (Supp. 19-4). The word "twelve" was changed to the numeral "12" for consistency in Chapter style and format (Supp. 21-2).

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2. If the state fee for General High School Equivalency Diplomas and/or Transcripts presents a financial hardship for the examinee, the examinee may request a fee waiver.
3. A fee waiver shall be granted if all of the following apply:
 - a. Applicant presents documented proof of Arizona residency.
 - b. Applicant submits a completed Fee Waiver Request Form, available from the State High School Equivalency Testing Office or from any official High School Equivalency Testing Center.
 - c. Applicant demonstrates sufficient need for a fee waiver. This may include, but is not limited to the following:
 - i. Proof of eligibility for public assistance and/or federally subsidized housing,
 - ii. Residence in a foster home,
 - iii. Enrollment in a program for the economically disadvantaged such as Upward Bound, or
 - iv. Participation in a free or reduced lunch program.
3. Applications shall include budgets and be submitted according to the standard procurement and grants management policies of the Department of Education for the awarding of competitive grants.
- C. Board priorities and criteria for application approval
 1. Priority shall be given to projects funded during the previous fiscal year which:
 - a. Adhered to all applicable state and federal rules and regulations.
 - b. Operated in an efficient and effective manner demonstrating high levels of student educational gains as measured by standardized assessments and student retention as compared with the state average for these projects.
 - c. Completed and submitted all required state and federal reports.
 - d. Utilized volunteers where possible.
 2. Equal opportunity for project application approval will be given to eligible applicants who demonstrate previous comparable experience and performance in another adult literacy program.
 3. Criteria for approval shall include a determination by the project review committee that the application meets state and federal rules and regulations and the policies and procedures contained in the Arizona State Plan for Adult Education.

Historical Note

Adopted effective August 20, 1981 (Supp. 81-4). Amended subsections (A), (C), and (G) effective October 2, 1984 (Supp. 84-5). Amended effective December 22, 1997 (Supp. 97-4). Amended effective December 31, 1998 (Supp. 98-4). Amended by exempt rulemaking at 18 A.A.R. 1023, effective October 24, 2011 (Supp. 12-2). Amended by final exempt rulemaking at 21 A.A.R. 1781, effective September 23, 2013 (Supp. 15-3). The word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-308. Adult Education

- A. For the purposes of this Section the following definitions apply:
 1. "Adult Basic Education" (ABE) means instruction in reading, writing and math equivalent to grades one through eight, speaking and citizenship skills.
 2. "Adult Secondary Education" (ASE) means instruction in reading, writing, math, science and social studies equivalent to the completion of high school.
 3. "Eligible applicants" may include local educational agencies, community based organizations, volunteer literacy organizations, institutions of higher education, public or private nonprofit organizations, institutions of higher education, public or private nonprofit agencies, libraries, public housing authorities, and consortiums of any of the aforementioned entities.
 4. "English Language Acquisition for Adults" (ELAA) means a program of instruction designed to help individuals of limited English proficiency achieve competency in the English language, including reading, writing, listening and speaking.
 5. "Literacy" means an individual's ability to read, write and speak in English, compute and solve problems at levels of proficiency necessary to function on the job, in the family and in society.
 6. "Project" means the approved and funded application which is administered by the eligible applicant.
- B. Application for funding
 1. Only eligible applicants may apply for funding.
 2. Contracts shall be awarded through a competitive funding process.
- D. Use of funds and student reporting
 1. Federal and state funds shall not be co-mingled.
 2. Projects shall not assess students a tuition charge for instruction or fees for books, instructional supplies, or materials used in the program.
 3. Student attendance hours reported to the Adult Education Division shall not be used in securing financing from any other source. Classes taught by volunteers are not to be reported unless they are administered and supervised by the local project.
- E. An adult education certificate issued by the Board shall be required to teach in the Adult Education Program.
- F. Students enrolled in adult education classes must be at least 16 years of age and officially withdrawn from school.
- G. Course of study
 1. Adult Basic Education (A.B.E.) students shall be functioning academically below the eighth grade level. The sequential course of study shall:
 - a. Develop and improve communication and computational skills of students.
 - b. Raise the general educational level of students.
 - c. Improve the student's ability to benefit from occupational training.
 - d. Increase opportunities for more productive and profitable employment.
 - e. Assist students to be better able to meet their adult responsibilities as parents, citizens and as co-workers.
 2. Adult Secondary Education (A.S.E.) students shall be functioning below the 12th grade level. The course of study shall:
 - a. Give the students a foundation in the areas of English, social studies, literature, science and math.
 - b. Enable students, through the development of critical thinking, to utilize new learning experiences in recognizing, evaluating and solving problems of daily life.

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- c. Attempt to motivate students to continue their education through more advanced study and to become more proficient in observing and adopting new skills in a changing society.
 - d. Equip students with the knowledge prerequisite for satisfactory achievement on a High School Equivalency Test approved by the State Board of Education.
3. English Language Acquisition for Adults (ELAA) and citizenship students shall be resident aliens. The course of study shall:
- a. Develop an increasing ability to speak, understand, read, and write English.
 - b. Encourage the student to become a participating citizen and give insight into the values of such participation.
 - c. Help the student prepare for the Naturalization Test for U.S. Citizenship by developing a background in American history and government.
 - d. Create a desire for continued learning and self-realization.

H. Reports

- 1. Each project shall maintain bookkeeping records and must be able to substantiate expenditures.
- 2. A financial report shall be filed quarterly for each project with the Adult Education Division within 30 days after the close of the quarter.
- 3. Projects shall be completed by June 30. A fiscal completion report which has been reconciled with the County School Superintendent's Office, or if another agency, that agency's comparable administrative office, shall be filed with the Adult Education Division within 60 days after the project ending date.
- 4. Participation in the project reporting system designed to collect student and staff attendance, demographic information and student performance data is required. These reports shall be filed with the Adult Education Division monthly.
- 5. An annual written report on the year's activities, including internal written monitoring reports, shall be submitted to the Adult Education Division, no later than August 15.

- I. If changes in the approved program or budget are desired, an amendment shall be submitted to the Adult Education Division for review and approval prior to expending any funds for the proposed changes.

Historical Note

Adopted effective December 14, 1984 (Supp. 84-6).
Amended by exempt rulemaking at 15 A.A.R. 1292, effective June 26, 2006 (Supp. 09-1). Amended by final exempt rulemaking at 21 A.A.R. 1781, effective September 23, 2013 (Supp. 15-3). The word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-309. Completion of Grade 10

Completion of grade 10 is accomplished when a student has earned 10 credits which shall include:

- 1. Two credits of English.
- 2. One credit of mathematics.
- 3. One credit of science.
- 4. Six credits of additional courses prescribed by the local Governing Board.

Historical Note

Adopted effective March 13, 1986 (Supp. 86-2). The Section heading has been updated to title case, governing board has been changed to lowercase to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-310. Pupil Achievement Testing

- A. The statewide assessments adopted by the Board shall be administered annually during the testing windows established by the Department. By June 1 of each year, the Department shall designate the window for testing for the next school year and all school districts and charter schools shall administer the test during the windows designated.
- B. The superintendent or head of the local education agency shall be responsible for:
 - 1. Reviewing, and attesting to have reviewed, the policies, procedures and guidance provided by the Department regarding administration of statewide assessments.
 - 2. Providing school district enrollment data to the Department annually for purposes of test material distribution.
 - 3. Verifying the count of test materials received and distributing the test materials to each public school in the local education agency.
 - 4. Securing the test materials prior to distribution to pupils or persons administering the tests at the time of testing, as well as after the time of testing. Test materials shall be kept in locked storage.
 - 5. Advising all district and school employees that the test materials are not to be reproduced in any manner.
 - 6. Familiarizing each person who will administer the test with the test publishers' directions for administering the tests, the timing of the tests and the testing schedule. This is to be accomplished through meetings which shall be held near the window for testing.
 - 7. Distributing actual test materials to persons administering the tests on the day of testing and collecting test materials at the end of the day of testing.
 - 8. Training persons administering the tests on how to properly complete the identification information and how to code the information required on the variables being collected according to A.R.S. § 15-741, et seq.
 - 9. Properly packaging all scorable and nonscorable materials which are to be returned to the scoring contractor. Packaging shall comply with instructions furnished by the scoring contractor or the Department.
 - 10. Forwarding all scorable and nonscorable materials which are to be returned to the scoring contractor per instructions. Materials for the entire local education agency should be forwarded in one shipment.
 - 11. Retaining all unused and reusable test materials, reporting them in the school's inventory, storing them in a safe and secure manner and returning the test materials at the end of the testing window per instructions.
 - 12. Immediately reporting to the Department any losses of test materials or other irregularities.
 - 13. The superintendent or head of the local education agency may designate a testing coordinator to act on their behalf.
- C. Persons designated by the superintendent or head of the local education agency to administer the test shall:
 - 1. Keep all test materials in locked storage.
 - 2. Not reproduce any test materials in any manner.
 - 3. Not disclose any actual test items to pupils prior to testing.
 - 4. Not provide answers of any test items to any pupils.

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5. Administer only sample tests which are provided by the test publishers. Previous editions of the test series being used in the statewide testing program may not be used as sample tests.
 6. Strictly observe all timed statewide assessments, if the assessments are timed. The test publishers' suggested time limits for untimed subtests shall be followed as closely as possible in order to maintain uniformity in test administration.
 7. Follow directions for administering the test explicitly. No test item may be repeated unless otherwise indicated in the directions.
 8. Not change a pupil's answer.
 9. Return all test materials to the superintendent or head of the local education agency immediately upon completion of testing.
- D.** Local education agencies shall administer the statewide assessment to all students in the grades designated by the Board. Failure to administer a statewide assessment to at least 95 percent of all students will be factored into the statewide accountability system.
- E.** All violations of this Section shall be referred by the superintendent or head of the local education agency to the State Superintendent of Public Instruction, for appropriate action.

Historical Note

Adopted effective March 13, 1986 (Supp. 86-2). Amended subsections (A) and (B) effective February 25, 1987 (Supp. 87-1). Amended effective October 22, 1991; amended effective December 20, 1991 (Supp. 91-4). The Section heading has been updated to title case, the numeral "3" has been changed to "three," the numeral "7" has been changed to "seven," the numeral "8" has been changed to "eight," and the word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 2342 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-311. Pupil Testing Variable Information

Persons designated by the superintendent or head of the local education agency to administer the State Board approved statewide assessments shall assure that information requested by the Department is properly completed for each pupil that is administered a statewide assessment.

Historical Note

Adopted effective June 25, 1986 (Supp. 86-3). The Section heading has been updated to title case to reflect current standards in Chapter style and format (Supp. 21-1). Amended by final exempt rulemaking at 27 A.A.R. 2342 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-312. Honorary High School Diploma

- A.** An honorary high school diploma shall be provided to an individual who has never obtained a high school diploma and who meets both of the following requirements:
1. Currently resides in Arizona; and
 2. Provides documented evidence from the Arizona Department of Veterans' Services that the individual enlisted in the armed forces of the United States and served in World War I, World War II, the Korean conflict or the Vietnam conflict.
- B.** All high schools shall provide for the presentation of an honorary high school diploma to an individual eligible pursuant to

subsection (A). The individual shall not be required to reside within the school boundaries. The Arizona Department of Education may issue an honorary high school diploma to an individual eligible pursuant to subsection (A).

Historical Note

Adopted effective December 15, 1989 (Supp. 89-4). Repealed effective February 20, 1997 (Supp. 97-1). New Section made by final rulemaking at 9 A.A.R. 1125, effective May 10, 2003 (Supp. 03-1). Amended by final exempt rulemaking at 27 A.A.R. 241, effective January 25, 2021 (Supp. 21-1).

R7-2-313. Academic Contests Fund

The State Board of Education establishes an academic contests fund consisting of monies appropriated by the legislature or received as gifts or grants for deposit in the academic contests fund pursuant to A.R.S. § 15-1241.

1. The Superintendent of Public Instruction shall, at least annually, compile a list of national contests to be presented to the State Board of Education for approval. Contest requirements are:
 - a. Shall be sponsored by a recognized national organization.
 - b. Shall be academic in nature, motivate pupils to be creative and demonstrate excellence.
 - c. Shall be open to all pupils, regardless of race, creed, sex or national origin. Contests may separate pupils by age or grade level.
2. School districts shall submit an application for academic contest funds to the Superintendent of Public Instruction for student and chaperone expenses. Requirements are:
 - a. No other sponsoring agency is assuming the total costs.
 - b. The participation of the students shall be the result of successfully competing at the local or state level, or both, of that contest.
 - c. The governing board of the school district in which the students attend shall approve the participation and travel of the students.
 - d. The fiscal agent applying for academic contest funds shall be an authorized district representative and responsible for the disbursement of travel funds.
 - e. A school district receiving academic contest funds shall submit a completion report and return any unused portion within 90 days after completion of travel to the Department of Education.
3. Application review and approval; funding limitations.
 - a. The State Board of Education shall annually set expenditure limitations for expenses of students and chaperones. These limitations shall be based on the number of applicants, monies available and current state travel regulations.
 - b. The Superintendent of Public Instruction shall review applications for academic contest funds and shall approve applications based upon the criteria set forth in this Section and the availability of funds.

Historical Note

Adopted effective December 15, 1989 (Supp. 89-4). The Section heading has been updated to title case, the word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-314. Definitions

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The following definitions apply to Sections R7-2-315 and R7-2-315.01:

1. "Board examination system" means a complete instructional system that includes all of the following components:
 - a. A coherent group of courses that collectively constitutes a core curriculum at the high school level,
 - b. A comprehensive syllabus for each course,
 - c. Appropriate instructional and teaching materials for each course,
 - d. High quality examinations that are closely aligned with the course syllabus,
 - e. Professional scoring of examinations, and
 - f. Teacher education that is designed to train teachers to properly teach those courses.
2. "Grand Canyon Diploma" means a high school diploma that is offered to any student who demonstrates readiness for college level mathematics and English according to standards prescribed by an interstate compact on board examination systems, who has passing grades on an additional set of required approved board examinations in core academic courses as determined by the State Board of Education.
3. "Readiness for college level mathematics and English" means that a student has the mathematics and English skills and knowledge needed to succeed in college level courses that count toward a degree or certificate without taking remedial or developmental coursework.

Historical Note

Adopted effective August 14, 1991 (Supp. 91-4).
 Repealed effective February 20, 1997 (Supp. 97-1). New
 Section made by exempt rulemaking at 18 A.A.R. 1025,
 effective January 24, 2011 (Supp. 12-2).

R7-2-315. Board Examination Systems; Offerings; Procedures

- A. The State Board of Education shall select board examination systems that may be used by traditional public schools and charter schools in accordance with the requirements of this Section. Board examination systems selected by the State Board of Education shall:
 1. Be approved by an interstate compact on board examination systems,
 2. Be periodically modified to reflect core standards selected by an interstate compact on board examination systems,
 3. Be aligned to State Board of Education approved academic standards,
 4. Have common passing scores that are prescribed by an interstate compact on board examination systems that are set to the level of literacy required to succeed in college-level courses offered by community colleges in this state that count toward a degree or certificate without taking remedial or developmental coursework.
- B. The State Board of Education shall contract with a private organization to act as primary administrator of approved board examination systems. The private organization shall:
 1. Identify, select and contract with a national organization that is devoted to issues concerning education and the economy and that is selected by the State Board of Education to provide technical services to develop and maintain an interstate system of approved board examination systems.
 2. Provide data and other information to a national organization that is devoted to issues concerning education and the economy and that is selected by the State Board of Education to provide technical services the national organization deems necessary to set appropriate performance standards for students in this state. The Department of Education shall provide data and other information to the private organization, as necessary.
 3. Conduct technical studies required by the State Board of Education to compare the scores on approved board examinations by the students in this state to scores on the Arizona Instrument to Measure Standards Test and other measures deemed necessary to ensure the efficacy of the approved board examinations. The private organization may contract with other entities that are selected by the State Board of Education for the purpose of conducting technical studies.
 4. In cooperation with the Superintendent of Public Instruction and the State Board of Education, solicit monies from all lawful private and public sources, including federal monies, to offset the costs of instruction provided to students pursuant to this Section.
 5. Exercise general supervision over the implementation of the approved board examination systems in this state.
 6. Prepare an annual report for the State Board of Education, which shall forward it to the legislature and the governor, on the progress made toward the goals established in A.R.S. Title 15, Chapter 7, Article 6. Participating schools and the Department of Education shall provide data to the private organization as needed in order to complete the annual report.
 7. Identify, select and represent this state on the national governing body of an interstate compact on board examination systems, as approved by the State Board of Education.
 8. Select this state's representatives in an interstate compact on board examination systems in accordance with the policies prescribed by that interstate compact.
 9. Develop the Grand Canyon Diploma to be approved and adopted by the State Board of Education.
- C. The Department of Education shall develop a system, subject to State Board of Education approval, to track the academic progress of pupils who participate in board examination systems.
- D. School districts or charter schools wishing to implement an approved board examination in one or more schools shall:
 1. Send written notice to the private organization described in this Section indicating that school district's or charter school's interest in implementing an approved board examination system,
 2. Submit an implementation plan to the private organization described in this Section that includes at least the following elements:
 - a. The specific approved board examination system the school district wishes to implement;
 - b. A proposed timeline for the implementation of an approved board examination system;
 - c. A description of the funding model that will be employed to ensure the sustainability of the approved board examination system offering;
 - d. A communication plan for students and parents that provides an overview of the selected approved board examination system, potential course offerings, a description of student support systems, and contact

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information for students and parents to obtain more detailed information regarding board examination systems and the Grand Canyon Diploma option, as defined in R7-2-315.01.

- E. Upon receipt of an implementation plan described in this Section the private organization shall work cooperatively with the applicable school district or charter school to ensure that the plan is feasible and to modify any elements of the plan deemed necessary for successful implementation of the approved board examination system.

Historical Note

Adopted effective November 17, 1994 (Supp. 94-4).
Repealed effective February 20, 1997 (Supp. 97-1). New
Section made by exempt rulemaking at 18 A.A.R. 1025,
effective January 24, 2011 (Supp. 12-2).

R7-2-315.01. Grand Canyon Diploma

- A. School districts and charter schools in this state may choose to offer a Grand Canyon Diploma beginning in the 2012 – 2013 school year. A high school student who is enrolled in a school district or charter school that offers a Grand Canyon Diploma may choose to pursue a Grand Canyon Diploma.
- B. A student may be awarded a Grand Canyon Diploma at the end of grade 10 or during or at the end of grade 11 or 12 provided that the student has passed both the mathematics and English assessments for the applicable approved board examination system, and the student has successfully completed the following subject area requirements within board examination system curriculum:
1. Two credits of English;
 2. Two credits of mathematics;
 3. Two credits of science, including lab-based science, engineering or information technologies;
 4. One credit of American History;
 5. One credit of World History;
 6. One credit of fine arts or career and technical education and vocational education; and
 7. One-half credit of economics.
- C. A student that satisfies all the criteria for issuance of a Grand Canyon Diploma is exempt from the minimum course of study requirements delineated in R7-2-302.02.
- D. Students who earn a Grand Canyon Diploma shall have multiple pathways available to them and may:
1. Enroll the following semester in a community college under the jurisdiction of a community college in this state. Students who take community college courses on high school campuses pursuant to this subsection shall be eligible to participate in extracurricular activities, including interscholastic sports, through the end of grade 12.
 2. Remain in high school and enroll in additional advanced preparation board examination programs that are designed to prepare students for admission to high quality postsecondary institutions that offer baccalaureate degree programs. These board examination programs shall be selected from a list provided by an interstate compact for board examination systems and approved by the State Board of Education. Students who elect to remain in high school pursuant to this subsection shall be eligible to participate in extracurricular activities, including interscholastic sports, through the end of grade 12.
 3. Enroll in a full-time career and technical education program offered on a community college campus, a high school campus or a joint technical education district campus, or any combination of these campuses. Students who

elect to remain in high school pursuant to this subsection shall be eligible to participate in extracurricular activities, including interscholastic sports, through the end of grade 12.

4. Return to a traditional academic program without completing the next level of board examination systems curriculum through the end of grade 12. Students who elect to remain in high school pursuant to this subsection shall be eligible to participate in extracurricular activities, including interscholastic sports, through the end of grade 12.
- E. Students who pursue but do not earn a Grand Canyon Diploma at the end of grade 10 or 11 shall receive a customized program of assistance during the next school year that addresses the areas in which the student demonstrated deficiencies in the approved board examinations. These students may retake the board examinations at the next available examination administration. Students may choose to return to a traditional academic program without completing the board examination system curriculum.
- F. A student who remains in a board examination system curriculum through grade 12 and does not pass the board examination may graduate with a standard diploma provided that the student meets the following requirements:
1. The student has passed the Arizona Instrument to Measure Standards assessments in mathematics and English or received a sufficient score as determined by the State Board of Education on the ACT, SAT, or an approved board examination in mathematics and English.
 2. The student has earned at least 22 credits and has passed a State Board of Education approved sequence of courses within the board examination system curriculum. For the purpose of this requirement the private organization and the Department of Education shall recommend for State Board of Education approval a sequence of courses for each approved board examination system. The sequence of courses for each board examination system shall ensure that students receive instruction in all State Board of Education approved academic standards encompassed in R7-2-302.02(1)(a) through (e).
- G. A student who is enrolled in a school district or charter school that does not offer a board examination system curriculum may earn a Grand Canyon Diploma by:
1. Obtaining a passing score on the assessments of an approved board examination system in each of the subject areas delineated in R7-2-315.01(B)(1) through (6), and
 2. Completing a high school course in economics.

Historical Note

New Section made by exempt rulemaking at 18 A.A.R.
1025, effective January 24, 2011 (Supp. 12-2).

Appendix A. Repealed**Historical Note**

Adopted effective November 17, 1994 (Supp. 94-4).
Repealed effective February 20, 1997 (Supp. 97-1).

R7-2-316. Charter Schools Stimulus Fund

- A. "Start-up costs" mean those costs associated with developing or implementing the following essential components of a charter school:
1. The hiring of teachers and other essential staff members;
 2. The hiring of a chief administrative officer and other costs associated with instituting the administrative structure of the school;

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3. Curriculum development and implementation;
 4. The leasing of physical facilities or equipment and costs associated with establishment of utility services and accounts;
 5. Operational expenses incurred prior to the date on which the charter school begins operations;
 6. The development and implementation of an accounting system which complies with the uniform system of financial records requirements;
 7. Obtaining insurance, including prepayment of premiums which will effectuate insurance coverage during the first year of operation;
 8. Costs associated with licensing and compliance with other health, safety and civil rights requirements.
- B.** "Costs associated with renovating or remodeling existing buildings and structures" means those costs associated with the following essential components:
1. Modifications affecting the structural integrity of the building, including those changes needed to meet building code and zoning standards.
 2. Modifications needed to meet non-structural building code requirements, such as those related to plumbing, electrical wiring and fire safety.
 3. Modifications needed to meet state health standards, such as those related to rest rooms and food preparation and service.
 4. Adjusting the size of rooms to accommodate the number of students to be served.
 5. Construction-related finish work, such as exterior and interior replastering and painting, carpeting, flooring, baseboards and door hanging.
 6. Roofing and air conditioning/heating installation or repair required prior to operation of the school.
 7. Access requirements for persons with disabilities.
- C.** The State Board of Education shall, subject to legislative appropriation, provide an initial grant or an additional grant from the charter schools stimulus fund to applicants who have a charter or application that has been approved by a sponsor pursuant to A.R.S. § 15-183 and who meet the requirements of A.R.S. § 15-188 and this Section. The grant may be in any amount up to \$100,000 per charter school applicant or charter school.
- D.** The application for an initial grant shall include:
1. A copy of the applicant's charter;
 2. The identity of the sponsor which approved the charter;
 3. The total amount of funding requested;
 4. An itemization of the specific start-up costs and costs associated with renovating or remodeling existing building and structures for which the funds will be used. Itemization shall include the amount of funds requested for each essential component and a detailed explanation of the basis for calculating the amount requested;
 5. The number of students to be served at the school;
 6. The dimensions of the facility in which the school is to be operated;
 7. A description of the extent to which the facility must be remodeled or renovated in order to meet applicable health and safety standards, unless this information is included in the applicant's charter.
- E.** The application for an additional grant shall be in a format approved by the State Board of Education and shall include:
1. The date and amount of the initial grant award.
 2. A copy of any amendments or other modifications to the charter or application which formed the basis for the initial grant.
 3. The identity of the current sponsor of the charter school.
 4. An itemized accounting of the expenditures made with the initial grant monies.
 5. The total amount of additional funding requested.
 6. An itemization of the specific start-up costs associated with renovating or remodeling existing buildings and structures for which the additional funds will be used. Itemization shall include the amount of funds requested for each essential component and a detailed explanation of the basis for calculating the amount requested.
- F.** In its review of an application for a stimulus fund grant, the State Board of Education may receive information concerning the application from the Department of Education, an advisory committee, and any other source. The State Board may award a grant in an amount different from that requested by the applicant. No grant shall be awarded pursuant to this Section unless the State Board determines that:
1. Every amount requested in the applicant's itemization of costs is for the essential component with which the amount is associated; and
 2. Based on all of the information before the State Board concerning the application, there is a rational basis for the award of funds.
- G.** No applicant or charter school shall be eligible for more than one initial grant and one additional grant, regardless of the amount awarded.
- H.** An applicant who receives an initial grant and fails to begin operating a charter school within the 18 months following the date of the award shall reimburse the Department of Education for the amount of the initial grant plus interest calculated at a rate of 10% per year. Such reimbursement is immediately due and payable at the end of the initial 18-month period.
- I.** An applicant who receives an additional grant and fails to begin operating a charter school within the 18 months following the date of the award shall reimburse the Department of Education for the amount of the initial grant plus interest calculated at a rate of 10% per year. Such reimbursement is immediately due and payable at the end of the applicable 18-month period and is in addition to any amounts required by subsection (H).
- J.** An applicant for a grant pursuant to this Section shall be notified of the date at which the State Board of Education shall consider the application no less than 10 days in advance thereof. Written notification of the Board's decision concerning an application for a grant shall be mailed to the applicant within 10 days following such decision.

Historical Note

Adopted effective April 20, 1995 (Supp. 95-2). The word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-317. State Seal of Biliteracy Program

- A.** Definitions. For purposes of this Section, "foreign language" means any language other than English.
- B.** School districts and charter schools in this state may choose to participate in the State Seal of Biliteracy Program (Program) which recognizes students who have attained a high level of proficiency in one or more foreign languages, in addition to English. School districts and charter schools participating in the Program may award the State Seal of Biliteracy to any high school student who graduates from a school operated by the

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school district or charter school and who meets the requirements of subsections (B)(1) or (2), and subsection (B)(3).

1. **Assessment Method.** To demonstrate language proficiency through the assessment method, the student must attain the required score on a language assessment as adopted by the State Board of Education, upon recommendation by the Arizona Department of Education, for purposes of demonstrating language proficiency for the Program in the four domains of speaking, writing, listening, and reading.
2. **Alternative evidence model.** A school district or charter school may choose to award the State Seal of Biliteracy through an alternative evidence method.
 - a. An alternative evidence method may be used in any of the following circumstances:
 - i. No standardized assessment exists for the targeted foreign language;
 - ii. Evaluating the language proficiency of a student with disabilities for whom the standardized assessment is inappropriate as determined by the student's Individualized Education Program team or a student on a 504 plan as determined by the student's 504 plan committee; or
 - iii. The standardized assessment for the targeted foreign language does not assess one or more of the four domains of speaking, writing, listening and reading.
 - b. Any alternative evidence method used shall consist of a student portfolio that contains evidence of experience in the targeted foreign language, as well as work samples, test results and other accomplishments that demonstrate proficiency, as established in the guidelines developed by the Arizona Department of Education, in the targeted foreign language in the four domains of speaking, writing, listening and reading. Student portfolios shall comply with guidelines adopted by the Department.
 - c. A school district or charter school that uses an alternative evidence model must notify the Arizona Department of Education.
3. To be eligible to be awarded the State Seal of Biliteracy, each student shall also demonstrate proficiency in English by meeting the following requirements:
 - a. The student must successfully complete all English Language Arts requirements for graduation, pursuant to R7-2-302, with an overall grade point average in those classes of 2.0 or higher on a 4.0 scale, or the equivalent; and
 - b. The student receives a passing score in English Language Arts on one of the following:
 - i. The statewide assessment adopted pursuant to A.R.S. § 15-741, an assessment approved by the Board pursuant to A.R.S. § 15-741.02, or another state's statewide assessment;
 - ii. A nationally recognized college entrance exam;
 - iii. An exam that is accepted for credit or admission by at least one university under the jurisdiction of the Arizona Board of Regents; or
 - iv. An end of course exam administered as part of a dual enrollment or concurrent enrollment course.
 - c. If the student has a primary home language other than English, the student shall obtain a score of pro-

ficient based on the English language proficiency standards pursuant to A.R.S. § 15-756.

- C. By October 1 of each year, the Arizona Department of Education shall make an electronic facsimile of the State Seal of Biliteracy available to each school district or charter school participating in the Program. Each participating school district or charter school shall identify each student who has met the requirements of the Program, affix the State Seal of Biliteracy to the student's diploma upon graduation, and shall note the receipt of the State Seal of Biliteracy on the transcript of the student.
- D. The Arizona Department of Education shall post on its website by July 1 of each year, the list of acceptable language assessments and the score to be achieved on each, as approved by the Board, which qualifies the student as proficient in a foreign language. The Arizona Department of Education shall ensure that all approved assessments are aligned to the Arizona world and native languages standards adopted by the Board.
- E. Each school district and charter school that chooses to participate in the Program shall meet the following requirements:
 1. Notify the Arizona Department of Education of its intent to participate in the Program at least 30 days prior to issuing the seal by filling out the form provided on the Arizona Department of Education's website.
 2. Designate at least one individual to serve as coordinator of the Program and provide that individual's name and contact information to the Arizona Department of Education.
 3. Using a format prescribed by the Arizona Department of Education, submit a report no later than 90 days after the end of the school year with the total number of students awarded the State Seal of Biliteracy, the number of seals for each targeted foreign language and the method used to determine proficiency in the foreign language.
 4. Make available to parents and students information regarding the Program and the name and contact information for the coordinator of the Program.
- F. The Arizona Department of Education shall establish guidelines and procedures to assist school districts and charter schools in the administration of the Program.

Historical Note

New Section made by final exempt rulemaking at 22 A.A.R. 3367, effective October 24, 2016 (Supp. 16-4). The word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 1529, effective August 27, 2021 (Supp. 21-3).

R7-2-318. K through Three Reading Program

- A. In this Section, unless the context otherwise requires:
 1. "Intensive reading instruction" is a proactive instructional approach used to reduce the likelihood of future reading problems by addressing severe and persistent difficulties with learning to read through the use of evidence-based instruction in smaller-group settings, increased instructional time, and increased intensity that is aligned to individual student needs or deficiencies and is driven by ongoing student performance data from a valid assessment tool.
 2. "Interventions" are instructional supports provided to students with the purpose of preventing and remediating reading difficulties. These supports are organized in tiers which provide increasing instructional intensity and support with each level.

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3. "Motivational assessments" are measures of motivation or attitudes toward reading and produce information to monitor student progress.
 4. "Prevention" is instructional support provided to students before students have experienced failure in learning to read.
 5. "Remediation" is instructional support provided to students after a student has experienced significant and persistent difficulties in learning to read.
 6. "Universal screeners" are very brief measures based on established standardized benchmarks or performance targets developed through extensive research designed to improve accuracy of identifying students who will likely need additional support for meeting grade level reading standards.
- B.** Prior to the release of monies generated by the K through three reading support level weight, a school district or charter school assigned a letter grade of C, D or F, or that has more than ten percent of its pupils in grade three who do not demonstrate sufficient reading skills as established by the Board, shall submit to the Department on or before October 1, a comprehensive local education agency K through three reading program plan, using the format prescribed by the Department. Each school district or charter school assigned a letter grade of A or B shall submit its plan to the Department on or before October 1 in odd numbered years only beginning in 2016-2017.
- C.** Pursuant to A.R.S. §§ 15-211, 15-701 and 15-704, the K through three reading program plan submission shall contain the following components for pupils in half-day and full-day kindergarten programs and grades one through three:
1. School literacy contacts, literacy team members and master reading schedules;
 2. A list of the staff who reviewed and approved the individual school K through 3 reading program plans;
 3. Program expenditures for the prior school year and a budget for the current school year regarding the monies used only on instructional purposes intended to improve reading proficiency from the K through three support level weight and the K through three reading support level weight;
 4. An analysis of the effectiveness of the local education agency's K through three reading program for the previous school year and plans for improvement for the current school year;
 5. Core reading programs which teach the essential components of reading instruction including explicit and systematic phonics pursuant to A.R.S. § 15-704(H)(1), with a description of the frequency and duration of the instruction;
 6. Date of last K through three reading curriculum review for standards alignment;
 7. Tier II and Tier III intensive reading intervention programs, including frequency and duration;
 8. A sample template of a parental notification letter;
 9. Evidence-based intervention and remedial services provided to students; and
 10. Evidence of ongoing teacher training based on evidence-based reading research.
- D.** The local education agency shall submit universal screening data on October 1, winter benchmark data on February 1 and end of year assessment data on June 1 for pupils in kindergarten programs and grades one through three.
- E.** Each school district or charter school governing body shall submit data for the prior school year on the total number of

pupils that were subject to retention, the total number that were promoted, the total number actually retained and the interventions administered pursuant to A.R.S. § 15-701 to the Department no later than October 1 and prior to the release of monies generated by the K through three reading support level weight.

Historical Note

New Section made by final exempt rulemaking at 23 A.A.R. 1637, effective May 22, 2017 (Supp. 17-2). The hyphen between "K-3" and the numeral "3" have been corrected to the words "through three" for consistency in Chapter style and format (Supp. 21-2).

R7-2-319. State Seal of Personal Finance Proficiency

- A.** School districts and charter schools may participate in the State Seal of Personal Finance Proficiency Program (Program), which recognizes students who have attained a high level of proficiency in personal finance. School districts and charter schools participating in the Program may award the State Seal of Personal Finance Proficiency to any high school student who graduates from a school operated by the school district or charter school and who meets the requirements of the Program outlined in subsections (A)(1) and (A)(2) of this subsection. To be eligible to be awarded the State Seal of Personal Finance Proficiency, each student shall do each of the following:
1. Complete all Social Studies requirements for graduation with GPA of 3.0 or higher on a 4.0 scale, or the equivalent; and
 2. Complete all of the following activities:
 - a. Passage of an assessment. The student shall attain the required score on one personal finance assessment as adopted by the State Board of Education, defined by the Arizona Department of Education, for purposes of demonstrating personal finance proficiency;
 - b. Completion of an approved Personal Finance Program. The student shall complete one of the personal finance programs as adopted by the State Board of Education, defined by the Arizona Department of Education, for purposes of demonstrating personal finance proficiency;
 - c. Participation in a curricular or extracurricular program. The student shall complete one personal finance curricular or extracurricular program as adopted by the State Board of Education, defined by the Arizona Department of Education, for purposes of demonstrating personal finance proficiency; and
 - d. Demonstrated college and/or career readiness plan. The student shall complete one college and career readiness plan as adopted by the State Board of Education, defined by the Arizona Department of Education, for purposes of demonstrating personal finance proficiency.
- B.** By October 1 of each year, the Arizona Department of Education shall make an electronic facsimile of the State Seal of Personal Finance Proficiency available to each school district or charter school participating in the Program. Each participating school district or charter school shall identify each student who has met the requirements of the Program, affix the State Seal of Personal Finance Proficiency to the student's diploma upon graduation, and shall note the receipt of the State Seal of Personal Finance Proficiency on the transcript of the student.

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- C. The Arizona Department of Education shall post on its website by July 1 of each year:
1. The list of acceptable personal finance assessments and the score to be achieved on each, as approved by the Board, which meet the requirements of R7-2-319(A)(2)(a);
 2. The list of acceptable personal finance programs, as approved by the Board, which meet the requirements of R7-2-319(A)(2)(b);
 3. The list of acceptable personal finance curricular or extra-curricular programs, as approved by the Board, which meet the requirements of R7-2-319(A)(2)(c); and
 4. The list of acceptable college and/or career readiness plans, as approved by the Board, which meet the requirements of R7-2-319(A)(2)(d).
- D. Each school district and charter school that participates in the Program shall meet the following requirements:
1. Notify the Arizona Department of Education of its intent to participate in the Program at least 30 days prior to issuing the seal by filling out the form provided on the Arizona Department of Education's website;
 2. Designate at least one individual to serve as coordinator of the Program and provide that individual's name and contact information to the Arizona Department of Education;
 3. Using a format prescribed by the Arizona Department of Education, submit a report no later than 90 days after the end of the school year with the total number of students awarded the State Seal of Personal Finance Proficiency; and
 4. Make available to parents and students information regarding the Program and the name and contact information for the coordinator of the Program.
- E. The Arizona Department of Education shall establish guidelines and procedures to assist school districts and charter schools in the administration of the Program.
- Historical Note**
New Section made by final exempt rulemaking at 25 A.A.R. 962, effective March 25, 2019 (Supp. 19-1).
- R7-2-320. State Seal of Civics Literacy**
- A. School districts and charter schools may participate in the State Seal of Civics Literacy Program (Program), which recognizes students who have attained a high level of proficiency in Civics. School districts and charter schools participating in the Program may award the State Seal of Civics Literacy to any high school student who graduates from a school operated by the school district or charter school and who meets the requirements of the Program outlined in subsections (A)(1), (2) and (3) of this subsection. To be eligible, each student shall do all of the following:
1. Complete all Social Studies requirements for graduation with GPA of 3.0 or higher on a 4.0 scale, or the equivalent;
 2. Pass the Civics test prescribed in R7-2-302; and
 3. Complete all of the following activities:
 - a. Civic Learning Programs. The student shall complete the required number of civic learning programs for purposes of demonstrating civic literacy.
 - i. Students graduating in school year 2019-2020 shall complete at least two approved civic learning programs.
 - ii. Students graduating in school year 2020-2021 and thereafter shall complete at least three approved civic learning programs.
 - b. Civic Engagement Activities. The student shall complete the required number of civic engagement activities as for purposes of demonstrating civic literacy.
 - i. Students graduating in school year 2019-2020 shall complete at least one approved civic engagement activity.
 - ii. Students graduating in school year 2020-2021 and thereafter shall complete at least two approved civic engagement activities.
 - c. Service Learning and/or Community Service for a public agency or charitable organization that serves the public good. The student shall complete the required number of hours engaged in Service Learning and/or Community Service for a public agency or charitable organization that serves the public good for purposes of demonstrating civic literacy proficiency.
 - i. Students graduating in school year 2019-2020 shall complete at least 30 hours engaged in Service Learning and/or Community Service for a public agency or charitable organization that serves the public good.
 - ii. Students graduating in school year 2020-2021 shall complete at least 45 hours engaged in Service Learning and/or Community Service for a public agency or charitable organization that serves the public good.
 - iii. Students graduating in school year 2021-2022 shall complete at least 60 hours engaged in Service Learning and/or Community Service for a public agency or charitable organization that serves the public good.
 - iv. Students graduating in school year 2022-2023 and thereafter shall complete at least 75 hours engaged in Service Learning and/or Community Service for a public agency or charitable organization that serves the public good.
 - d. Written Reflection. The student shall complete a writing assignment as adopted by the State Board of Education for purposes of demonstrating civic literacy proficiency.
- B. By October 1 of each year, the Arizona Department of Education shall make an electronic facsimile of the State Seal of Civics Literacy available to each school district or charter school participating in the Program. Each participating school district or charter school shall identify each student who has met the requirements of the Program, affix the State Seal of Civics Literacy to the student's diploma upon graduation, and shall note the receipt of the State Seal of Civics Literacy on the transcript of the student.
- C. The Arizona Department of Education shall post on its website by July 1 of each year:
1. The list of acceptable civic learning programs, as approved by the Board, which meet the requirements of R7-2-320(A)(3)(a);
 2. The list of acceptable civic engagement activities, as approved by the Board, which meet the requirements of R7-2-320(A)(3)(b);
 3. The defined number of hours of service learning and/or community service for a public agency or charitable organization.

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nization that serves the public good, as approved by the Board, which meet the requirements of R7-2-320(A)(3)(c); and

4. The list of written assignments, as approved by the Board, which meet the requirements of R7-2-320(A)(3)(d).
- D. Each school district and charter school that chooses to participate in the Program shall meet the following requirements:
1. Notify the Arizona Department of Education of its intent to participate in the Program at least 30 days prior to issuing the seal by filling out the form provided on the Arizona Department of Education's website;
 2. Designate at least one individual to serve as coordinator of the Program and provide that individual's name and contact information to the Arizona Department of Education;
 3. Using a format prescribed by the Arizona Department of Education, submit a report no later than 90 days after the end of the school year with the total number of students awarded the State Seal of Civics Literacy; and
 4. Make available to parents and students information regarding the Program and the name and contact information for the coordinator of the Program.
- E. The Arizona Department of Education shall establish guidelines and procedures to assist school districts and charter schools in the administration of the Program.

Historical Note

New Section made by final exempt rulemaking at 25 A.A.R. 962, effective March 25, 2019 (Supp. 19-1).

R7-2-321. State Seal of Arts Proficiency

- A. School districts and charter schools in this state may choose to participate in the State Seal of Arts Proficiency Program, which recognizes students who have attained a high level of proficiency in the Arts. School districts and charter schools participating in the Program may award the State Seal of Arts Proficiency to any high school student who graduates from a school operated by the school district or charter school and who meets the requirements of the Program outlined in subsections (A)(1) and (2). To be eligible, a student shall do both of the following:
1. Complete all qualifying Arts and Career and Technical Education (CTE) courses with GPA of 3.0 or better on a 4.0 scale, or the equivalent.
 2. Complete the required activities from each of the following three categories:
 - a. Minimum Credit Requirements. The student shall complete one of the following credit pathways of Arts and CTE classes as follows:
 - i. A minimum of 4 credits in one artistic discipline; or
 - ii. 3 credits in one artistic discipline, and 1 qualifying creative industries CTE credit or separate artistic discipline; or
 - iii. 2 credits in one artistic discipline, and 2 credits in a qualifying creative industries CTE credits or separate artistic discipline.
 - b. Arts related extracurricular activities. The student shall complete the required number of hours engaged in arts related extracurricular activity for purposes of demonstrating arts proficiency as follows:
 - i. Students graduating in school year 2019-2020 must complete at least 30 hours engaged in arts

related extracurricular activities as identified by the school district or charter school.

- ii. Students graduating in school year 2020-2021 must complete at least 45 hours engaged in arts related extracurricular activities as identified by the school district or charter school.
 - iii. Students graduating in school year 2021-2022 must complete at least 60 hours engaged in arts related extracurricular activities as identified by the school district or charter school.
 - iv. Students graduating in school year 2022-2023 and beyond must complete at least 80 hours engaged in arts related extracurricular activities as identified by the school district or charter school.
- c. Student Capstone Project. The student shall complete a Capstone Project, as defined by the Arizona Department of Education, for purposes of demonstrating arts proficiency.
- B. By October 1 of each year, the Arizona Department of Education shall make the State Seal of Arts Proficiency available to each school district or charter school participating in the Program. Each participating school district or charter school shall identify each student who has met the requirements of the Program, affix the State Seal of Arts Proficiency to the student's diploma upon graduation, and shall note the receipt of the State Seal of Arts Proficiency on the transcript of the student.
- C. The Arizona Department of Education shall post on its website by July 1 of each year:
1. A list of arts and CTE classes which meet the requirements of R7-2-321(A)(2)(a);
 2. A list of extracurricular arts activities which meet the requirements of R7-2-321(A)(2)(b);
 3. A list of student capstone examples which meet the requirements of R7-2-321(A)(2)(c).
- D. Each school district and charter school that chooses to participate in the Program shall meet the following requirements:
1. Notify the Arizona Department of Education of its intent to participate in the Program by September 15 by filling out the form provided on the Arizona Department of Education's website.
 2. Designate at least one individual to serve as coordinator of the Program and provide that individual's name and contact information to the Arizona Department of Education.
 3. Using a format prescribed by the Arizona Department of Education, submit a list of qualifying students who have met graduation and Arts Seal pathway requirements to the Arizona Department of Education by April 15 of each year.
 4. Make information available to parents and students regarding the Program and the name and contact information for the coordinator of the Program.
- E. The Arizona Department of Education shall establish guidelines and procedures to assist school districts and charter schools in the administration of the Program.

Historical Note

New Section made by final exempt rulemaking at 25 A.A.R. 3399, effective October 28, 2019 (Supp. 19-4).

ARTICLE 4. SPECIAL EDUCATION

Authority: Laws 2017, Ch. 337

R7-2-401. Special Education Standards for Public Agencies

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Providing Educational Services

- A.** For the purposes of this Article, the Individuals with Disabilities Education Improvement Act (IDEA), 20 U.S.C. 1400 et seq. and its implementing regulations, 34 CFR 300.1 et seq., are incorporated herein by reference. Copies of the incorporated material can be obtained from the U.S. Government Printing Office, <https://bookstore.gpo.gov/catalog/law-regulations> or the Arizona Department of Education, Exceptional Student Services, 1535 West Jefferson Street, Phoenix, Arizona 85007.
- B.** Definitions. All terms defined in the IDEA, its implementing regulations and A.R.S. § 15-761 are applicable, with the following additions:
1. "Accommodations" means the provisions made to allow a student to access the general education curriculum and demonstrate learning. Accommodations do not substantially change the instructional level, content or performance criteria, but are made in order to provide a student equal access to learning and equal opportunity to demonstrate what is known. Accommodations shall not alter the content of the curriculum or a test, or provide inappropriate assistance to the student within the context of the test.
 2. "Administrator" means the chief administrative official or designee authorized to act on behalf of a public education agency.
 3. "Boundaries of responsibility" means for:
 - a. A school district, the geographical area within its legally designated boundaries.
 - b. A charter school, the population of students enrolled in the charter school.
 - c. A public education agency other than a school district or charter school, the population of students receiving educational services from a public education agency.
 4. "Child with a disability," has the same meaning prescribed in A.R.S. § 15-761.
 5. "Department" means the Arizona Department of Education.
 6. "Exceptional Student Services" means the Exceptional Student Services Division of the Arizona Department of Education.
 7. "Evaluator" means a person trained and knowledgeable in a field relevant to the child's disability who administers specific and individualized assessment for the purpose of special education evaluation and placement.
 8. "Full and individual evaluation" means procedures used in accordance with the IDEA to determine whether a child has a disability and the nature and extent of the special education and related services that the child needs. This evaluation includes:
 - a. A review of existing information about the child;
 - b. A decision regarding the need for additional information;
 - c. If necessary, the collection of additional information; and
 - d. A review of all information about the child and a determination of eligibility for special education services and needs of the child.
 9. "Independent educational evaluation" means an evaluation conducted by an evaluator who is not employed by the public education agency responsible for the education of the child in question.
 10. "Informed written consent" means a person has been fully informed of all information relevant to the activity for which consent is sought, in the person's native language or through another mode of communication; the person understands and agrees in writing to the carrying out of the activity for which consent is sought; and the person understands that the granting of consent is voluntary and may be revoked at any time.
 11. "Interpreter" means a person trained to translate orally or in sign language in matters pertaining to special education identification, evaluation, placement, the provision of free appropriate public education (FAPE), or assurance of procedural safeguards for parents and students who converse in a language other than spoken English. Each student's IEP team determines the level of interpreter skill necessary for the provision of FAPE.
 12. "Multidisciplinary Evaluation Team" has the same meaning prescribed in A.R.S. § 15-761.
 13. "Modifications" means substantial changes in what a student is expected to learn and to demonstrate. Changes may be made in the instructional level, the content or the performance criteria. Such changes are made to provide a student with meaningful and productive learning experiences, environments, and assessments based on individual needs and abilities.
 14. "Private school" means any nonpublic educational institution where academic instruction is provided, including nonsectarian and parochial schools, that are not under the jurisdiction of the state or a public education agency.
 15. "Private special education school" means a nonpublic educational institution where instruction is provided primarily to students with disabilities. The school may also serve students without disabilities.
 16. "Public education agency" or "PEA" means a school district, charter school, accommodation school, state supported institution, or other political subdivision of the state that is responsible for providing education to children with disabilities.
 17. "Qualified professionals" means individuals who have met state approved or recognized degree, certification, licensure, registration or other requirements that apply in the areas in which the individuals are providing services such as screening, identification, evaluation, general education, special education or related services, including supplemental aids and services.
 18. "Specially designed instruction" has the same meaning prescribed in A.R.S. § 15-761.
 19. "Special education teacher" means a teacher holding a special education certificate from the Arizona Department of Education.
 20. "Suspension" has the same meaning prescribed in A.R.S. § 15-840.
- C.** Public Awareness.
1. Each public education agency shall inform the general public and all parents, within the public education agency's boundaries of responsibility, of the availability of special education services for students aged 3 through 21 years and how to access those services. This includes information regarding early intervention services for children aged birth through 2 years.
 2. School districts are responsible for public awareness in private schools located within their boundaries of responsibility.
- D.** Child Identification and Referral.
1. Each public education agency shall establish, implement, and make available, either in writing or electronically, to

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- its school-based personnel and all parents, within the public education agency boundaries of responsibility, written procedures for the identification and referral of all children with disabilities, aged birth through 21, including children with disabilities attending private schools and home schools, regardless of the severity of their disability.
2. Each public education agency shall require appropriate school-based personnel to review the written procedures related to child identification and referral on an annual basis. The public education agency shall maintain documentation of school-based personnel review.
 3. Procedures for child identification and referral shall meet the requirements of the IDEA and regulations, A.R.S. Title 15, Chapter 7, Article 4 and these rules.
 4. The public education agency responsible for child identification activities is the school district in which the parents reside unless:
 - a. The student is enrolled in a charter school or public education agency that is not a school district. In that event, the charter school or public education agency is responsible for child identification activities;
 - b. The student is enrolled in a non-profit private school. In that event, the school district within whose boundaries the private school is located is responsible for child identification activities.
 5. Identification (screening for possible disabilities) shall be completed within 45 calendar days after:
 - a. Entry of each preschool or kindergarten student and any student enrolling without appropriate records of screening, evaluation, and progress in school; or
 - b. Notification to the public education agency by parents of concerns regarding developmental or educational progress by their child aged 3 years through 21 years.
 6. Screening procedures shall include vision and hearing status and consideration of the following areas: cognitive or academic, communication, motor, social or behavioral, and adaptive development. Screening does not include detailed individualized comprehensive evaluation procedures.
 7. For a student transferring into a school; the public education agency shall review enrollment data and educational performance in the prior school. If there is a history of special education for a student not currently eligible for special education, or poor progress, the name of the student shall be submitted to the administrator for consideration of the need for a referral for a full and individual evaluation or other services.
 8. If a concern about a student is identified through screening procedures or through review of records, the public education agency shall notify the parents of the student of the concern within 10 school days and inform them of the public education agency procedures to follow-up on the student's needs.
 9. Each public education agency shall maintain documentation of the identification procedures utilized, the dates of entry into school or notification by parents made pursuant to subsection (D)(5), and the dates of screening. The results shall be maintained in the student's permanent records in a location designated by the administrator. In the case of a student not enrolled, the results shall be maintained in a location designated by the administrator.
 10. If the identification process indicates a possible disability, the name of the student shall be submitted to the administrator for consideration of the need for a referral for a full and individual evaluation or other services. A parent or a student may request an evaluation of the student. For parentally-placed private school students the school district within whose boundaries the non-profit private school is located is responsible for such evaluation.
 11. If, after consultation with the parent, the responsible public education agency determines that a full and individual evaluation is not warranted, the public education agency shall provide prior written notice and procedural safeguards notice to the parent in a timely manner.
- E. Evaluation/re-evaluation.**
1. Each public education agency shall establish, implement, and make available to school-based personnel and parents within its boundaries of responsibility written procedures for the initial full and individual evaluation of students suspected of having a disability, and for the re-evaluation of students previously identified as being eligible for special education.
 2. Procedures for the initial full and individual evaluation of children suspected of having a disability and for the re-evaluation of students with disabilities shall meet the requirements of IDEA and its regulations, state statutes and State Board of Education rules.
 3. The initial evaluation of a child being considered for special education, or the re-evaluation per a parental request of a student already receiving special education services, shall be conducted within 60 calendar days from the public education agency's receipt of the parent's informed written consent and shall conclude with the date of the Multidisciplinary Evaluation Team (MET) determination of eligibility.
 4. If the parent requests the evaluation the PEA must, within a reasonable amount of time not to exceed 15 school days from the date it receives a parent's written request for an evaluation, either begin the evaluation by reviewing existing data, or provide prior written notice refusing to conduct the requested evaluation. The 60-day evaluation period shall commence upon the PEA's receipt of the parent's informed written consent.
 5. The 60-day evaluation period may be extended for an additional 30 days, provided it is in the best interest of the child, and the parent and PEA agree in writing to such an extension. Neither the 60-day evaluation period nor any extension shall cause a re-evaluation to exceed the timelines for a re-evaluation within three years of the previous evaluation.
 6. The public education agency may accept current information about the student from another state, public agency, public education agency, or through an independent educational evaluation. In such instances, the Multidisciplinary Evaluation Team shall be responsible for reviewing and approving or supplementing an evaluation to meet the requirements identified in subsections (E)(1) through (7).
 7. For the following disabilities, the full and individual initial evaluation shall include:
 - a. Emotional disability: verification of a disorder by a qualified professional.
 - b. Hearing impairment:
 - i. An audiological evaluation by a qualified professional, and

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- ii. An evaluation of communication/language proficiency.
 - c. Other health impairment: verification of a health impairment by a qualified professional.
 - d. Specific learning disability: a determination of whether the child exhibits a pattern of strengths and weaknesses in performance, achievement, or both, relative to age, state-approved grade-level standards, or intellectual development that meets the public education agency criteria through one of the following methods:
 - i. A discrepancy between achievement and ability;
 - ii. The child's response to scientific, research-based interventions; or
 - iii. Other alternative research-based procedures.
 - e. Orthopedic impairment: verification of the physical disability by a qualified professional.
 - f. Speech/language impairment: an evaluation by a qualified professional.
 - g. For students whose speech impairments appear to be limited to articulation, voice, or fluency problems, the written evaluation may be limited to:
 - i. An audiometric screening within the past calendar year,
 - ii. A review of academic history and classroom functioning,
 - iii. An assessment of the speech problem by a speech therapist, or
 - iv. An assessment of the student's functional communication skills.
 - h. Traumatic brain injury: verification of the injury by a qualified professional.
 - i. Visual impairment: verification of a visual impairment by a qualified professional.
8. The Department shall develop a list, subject to review and approval of the State Board of Education, of qualified professionals eligible to conduct the appropriate evaluations prescribed in subsection (E)(7).
9. The Multidisciplinary Evaluation Team shall determine, in accordance with the IDEA and regulations, whether the requirements of subsections (E)(7)(a) through (i) are required for a student's re-evaluation.
- F. Parental Consent.**
- 1. A public education agency shall obtain informed written consent from the parent of the child with a disability before the initial provision of special education and related services to the child.
 - 2. If the parent of a child fails to respond to a request for, or refuses to consent to, the initial provision of special education and related services, the public education agency may not use mediation or due process procedures in order to obtain agreement or a ruling that the services may be provided to the child.
 - 3. If the parent of the child refuses to consent to the initial provision of special education and related services, or the parent fails to respond to a request to provide consent for the initial provision of special education and related services, the public education agency:
 - a. Will not be considered to be in violation of the requirement to make available FAPE to the child because of the failure to provide the child with the special education and related services for which the parent refuses to or fails to provide consent, and
 - b. Is not required to convene an IEP Team meeting or develop an IEP in accordance with these rules.
4. If, at any time subsequent to the initial provision of special education and related services, the parent of a child revokes consent in writing for the continued provision of special education and related services, the public education agency:
- a. May not continue to provide special education and related services to the child, but shall provide prior written notice before ceasing the provision of special education and related services;
 - b. May not use the mediation procedures or the due process procedures in order to obtain agreement or a ruling that the services may be provided to the child;
 - c. Will not be considered to be in violation of the requirement to make FAPE available to the child because of the failure to provide the child with further special education and related services; and
 - d. Is not required to convene an IEP Team meeting or develop an IEP for the child for further provision of special education and related services.
5. If a parent revokes consent in writing for their child's receipt of special education services after the child is initially provided special education and related services, the public agency is not required to amend the child's education records to remove any references to the child's receipt of special education and related services because of the revocation of consent.
- G. Individualized Education Program (IEP).**
- 1. Each public education agency shall establish, implement, and make available to its school-based personnel and parents written procedures for the development, implementation, review, and revision of IEPs.
 - 2. Procedures for IEPs shall meet the requirements of the IDEA and its regulations, state statutes and State Board of Education rules.
 - 3. Procedures shall include the incorporation of Arizona academic standards as adopted by the State Board of Education into the development of each IEP and address grade-level expectations and grade-level content instruction.
 - 4. Each IEP of a student with a disability shall be developed in accordance with IDEA and its regulations, state statutes and State Board of Education rules. If appropriate to meet the needs of a student and to ensure access to the general curriculum, an IEP team may include specially designed instruction in the IEP that may be delivered in a variety of educational settings by a general education teacher or other certificated personnel provided that certificated special education personnel are involved in the planning, progress monitoring and when appropriate, the delivery of the specially designed instruction.
 - 5. Each student with a disability who has an IEP shall participate in the state assessment system. Students with disabilities can test with or without accommodations or modifications as indicated in the student's IEP. Students who are determined to have a significant cognitive disability based on the established eligibility criteria will be assessed with the state's alternate assessment as determined by the IEP team.
 - 6. A meeting of the IEP team shall be conducted to review and revise each student's IEP at least annually, or more frequently if the student's progress substantially deviates from what was anticipated. The public education agency

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shall provide written notice of the meeting to the parents of the student to ensure that parents have the opportunity to participate in the meeting. After the annual review, the public education agency and parent may agree not to convene an IEP team meeting for the purposes of making changes, and instead may develop a written document to amend or modify the student's current IEP.

7. A parent or public education agency may request in writing a review of the IEP, and shall identify the basis for requesting review. Such review shall take place within 45 school days of the receipt of the request at a mutually agreed upon date and time.

H. Least Restrictive Environment.

1. Each public education agency shall establish, implement, and make available to its school-based personnel and parents, written procedures to ensure the delivery of special education services in the least restrictive environment as identified by IDEA and its regulations, state statutes and State Board of Education rules.
2. A continuum of services and supports for students with disabilities shall be available through each public education agency.

I. Procedural Safeguards.

1. Each public education agency shall establish, implement, and make available to school-based personnel and parents of students with disabilities written procedures to ensure children with disabilities and their parents are afforded the procedural safeguards required by federal statute and regulation and state statute. These procedures shall include dissemination to parents information about the public education agency's and state's dispute resolution options.
2. In accordance with the requirements of IDEA, prior written notice shall be provided to the parents of a child within a reasonable time after the PEA proposes to initiate or change, or refuses to initiate or change, the identification, evaluation, educational placement or the provision of FAPE to the child, but before the decision is implemented.

J. Confidentiality.

1. Each public education agency shall establish, implement, and make available to its personnel and parents written policies and procedures to ensure the confidentiality of records and information in accordance with the IDEA and its regulations, the Family Educational Rights and Privacy Act (FERPA) and its regulations, and state statutes.
2. Parents shall be fully informed about the requirements of the IDEA and regulations, including an annual notice of the policies and procedures that the PEA shall follow regarding storage, disclosure to a third party, retention, and destruction of personally identifiable information.
3. The rights of parents regarding education records are transferred to the student at age 18, unless the student has been adjudicated incapacitated, or the student has executed a delegation of rights to make educational decisions pursuant to A.R.S. § 15-773.
4. Upon receiving a written request, each public education agency shall forward special education records to any other public education agency in which a student has enrolled or is seeking to enroll. Records shall be forwarded within the time-frame specified in A.R.S. § 15-828(F). The public education agency shall also forward records to any other person or agency for which the parents have given signed consent.

- K. Preschool Programs.** Each public education agency responsible for serving preschool children with disabilities shall establish, implement, and make available to its personnel and parents, written procedures for:
 1. The operation of the preschool program, in accordance with federal statute and regulation, and state statute, that provides a continuum of placements to students;
 2. The smooth and effective transition from the Arizona Early Intervention Program to a public school preschool program in accordance with the agreement between the Department of Economic Security and the Department; and
 3. The provision of a minimum of 360 minutes per week of instruction in a program that meets at least 216 hours over the minimum number of days.

- L. Children in Private Schools.** Each education agency shall establish, implement, and make available to its personnel and parents written procedures regarding the access to special education services to students enrolled in private schools by their parents as identified by the IDEA and its regulations, state statutes and State Board of Education rules.

M. Department Responsible for General Supervision and Obligations Related to and Methods of Ensuring Services.

1. The Department is responsible for the general supervision of services to children with disabilities aged 3 through 21 served through a public education agency.
2. The Department shall ensure through fund allocation, monitoring, dispute resolution, and technical assistance that all eligible students receive FAPE in conformance with the IDEA and its regulations, A.R.S. Title 15, Chapter 7, Article 4, and these rules.
3. In exercising its general supervision responsibilities, the Department shall ensure that when it identifies noncompliance with the requirements of the IDEA Part B, the noncompliance is corrected as soon as possible, and in no case later than one year after the Department's written notification to the PEA of its identification of the noncompliance.

N. Procedural Requirements Relating to Public Education Agency Eligibility.

1. Each public education agency shall establish eligibility for funding with the Department in accordance with the IDEA and its regulations, state statutes and with schedules and methods prescribed by the Department.
2. In the event the Department determines that a public education agency does not meet eligibility for funding requirements, the public education agency has a right to a hearing before such funding is withheld.
3. The Department may suspend payments during any time period when a public education agency has not corrected deficiencies in eligibility for federal funds as a result of fiscal requirements of monitoring, auditing, complaint and due process findings.
4. Each public education agency shall, on an annual basis, determine the number of children within each disability category who have been identified, located, evaluated, and/or receiving special education services. This includes children residing within the boundaries of responsibility of the public education agency who have been placed by their parents in private schools or who are home schooled.

O. Public Participation.

1. Each public education agency shall establish, implement, and make available to personnel and parents written pro-

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cedures to ensure that, prior to the adoption of any policies and procedures needed to comply with federal and state statutes and regulations, there are:

- a. Public hearings;
- b. Notice of the hearings; and
- c. An opportunity for comment available to the general public, including individuals with disabilities and parents of children with disabilities.

2. This requirement does not pertain to day-to-day operating procedures.

P. Suspension and Expulsion.

1. Each public education agency shall establish, implement, and make available to personnel and parents written procedures for the suspension and expulsion of students with disabilities.
2. Each public education agency shall require all school-based staff involved in the disciplinary process to review the policies and procedures related to suspension and expulsion on an annual basis. The public education agency shall maintain documentation of staff review.
3. Procedures for such suspensions and expulsions shall meet the requirements of the IDEA and its regulations, and state statutes.

Historical Note

Amended effective December 11, 1974. Amended effective July 14, 1975 (Supp. 75-1). Amended effective July 1, 1977 (Supp. 77-4). Amended effective April 26, 1978 (Supp. 78-2). Former Section R7-2-401 repealed, new Section R7-2-401 adopted effective December 4, 1978 (Supp. 78-6). Amended by adding subsection (H) as an emergency effective July 20, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Amended (D)(11), (E)(5)(b) and added (H) effective December 14, 1984 (Supp. 84-6). Amended as an emergency effective June 18, 1985, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 85-3). Emergency expired. Amended subsection (D) by adding subsection (12) effective March 13, 1986 (Supp. 86-2). Amended subsection (G) effective July 8, 1986 (Supp. 86-4). Amended subsections (D) and (H) and added subsection (I) effective June 22, 1987 (Supp. 87-2). Amended effective August 2, 1988 (Supp. 88-3). Amended effective December 6, 1995 (Supp. 95-4). Amended by final rulemaking at 7 A.A.R. 1541, effective March 19, 2001 (Supp. 01-1). Amended to correct a manifest typographical error in subsection (D)(1) (Supp. 01-3). Subsections (D)(9), (E)(4), and (E)(6) amended under A.R.S. § 41-1011 to correct subsection cross-references (Supp. 02-2). Amended by final rulemaking at 9 A.A.R. 4633, effective December 8, 2003 (Supp. 03-4). Amended by exempt rulemaking at 15 A.A.R. 1838, effective August 29, 2006 (Supp. 09-1). Amended by exempt rulemaking at 15 A.A.R. 1849, effective May 19, 2008 (Supp. 09-2). Amended by exempt rulemaking at 16 A.A.R. 201, effective December 7, 2009 (Supp. 10-1). Amended by final exempt rulemaking at 24 A.A.R. 140, effective October 23, 2017; filed in the Office on January 2, 2018 (Supp. 18-1).

R7-2-402. Standards for Approval of Special Education Programs in Private Schools

- A.** Definitions. All terms defined in the regulations for the Individuals with Disabilities Education Improvement Act (IDEA)

Amendments, A.R.S. § 15-761, and State Board of Education Section R7-2-401 are applicable.

- B.** No student may be placed by a public education agency in a private special education school program unless the facility has been approved as meeting the standards as outlined in this Section, and the public education agency is unable to provide satisfactory education and services through its own facilities and personnel.

- C.** In order for a private special education school to be approved by the Department for the purpose of contracting with a public education agency, the private facility shall:

1. Provide special education instructional programs for students with disabilities that are at least comparable to those provided by the public schools of Arizona and meet the requirements of IDEA.
2. Provide the following documentation:
 - a. Policies and procedures based on IDEA and state statutes;
 - b. Curriculum that is aligned with the Arizona Academic Standards;
 - c. A completed application;
 - d. Copies of all teacher and related service personnel certifications and licenses; and
 - e. If applicable, a copy of North Central Accreditation.
3. Provide certificated special education teachers in each classroom to implement the IEPs of those students assigned to that classroom.
4. Provide related services to meet the needs of the students as indicated on their IEPs.
5. Provide administration personnel such as head teacher, principal, or other administrator certificated in an administrative area or experienced and certificated in the appropriate area of special education.
6. Provide an education that meets the standards that apply to education provided by the public education agency.
7. Maintain student records in accordance with the statutory requirements.
8. Accept all responsibilities concerning instructional programs to the disabled student and parent or guardian that are required of the public schools of Arizona. Ultimate responsibility for any student under contract in a private special education school rests with the public education agency contracting for the students' education.
9. Administer all required statewide assessments to those students placed in the private facility by a PEA or through the educational voucher system.
10. Maintain adequate liability insurance.
11. Maintain an accounting system and budget which includes the costs of operation, maintenance, transportation, and capital outlay, and which is open to review upon request.
12. Maintain an attendance reporting system that provides public education agencies and the Department with required information.
13. Provide notification to contracting public education agencies and the Department of any changes in staff or deletion of programs within 10 school days of the change or deletion.
14. Provide notification to the contracting PEA of any intent to discontinue, suspend, or terminate services to a student for longer than 10 days. Services to the student must be continued by the private school until an IEP meeting with the PEA is convened to determine an appropriate alternative placement. The PEA must be given up to 10 school

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days to arrange for the transition of the student after the IEP determination.

15. Permit onsite evaluation of the program by the Department or its designees, and the representatives of the public education agencies.
16. Request approval to contract with public education agencies from the Department in accordance with the prescribed procedures.

Historical Note

Former Section R7-2-402 repealed, new Section R7-2-402 adopted effective December 4, 1978 (Supp. 78-6). Amended by final rulemaking at 7 A.A.R. 1541, effective March 19, 2001 (Supp. 01-1). Amended by final rulemaking at 9 A.A.R. 4633, effective December 8, 2003 (Supp. 03-4). Amended by exempt rulemaking at 15 A.A.R. 1849, effective May 19, 2008 (Supp. 09-2). The word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-403. Repealed**Historical Note**

Adopted effective December 4, 1978 (Supp. 78-6). Amended as an emergency effective September 26, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-5). Former emergency adoption now adopted effective December 4, 1979 (Supp. 79-6). Section repealed by final rulemaking at 9 A.A.R. 4633, effective December 8, 2003 (Supp. 03-4).

R7-2-404. Special Education Voucher Program Policies and Procedures

- A. Institutional vouchers. Students residing and attending special education programs at the Arizona Schools for the Deaf and the Blind (ASDB) or the Arizona State Hospital (ASH) or students attending special education day programs provided by ASDB may be eligible for special education institutional voucher funding.
 1. Eligibility criteria.
 - a. Student shall be between the ages of 3 and 22 years.
 - b. Student shall have a recognized disability as documented by a current educational evaluation. Evaluations shall be completed by the institution or the student's home school district (HSD), as determined by a multidisciplinary evaluation team (MET).
 - c. Student shall have a current individualized education program (IEP) identifying the placement as the most appropriate and least restrictive educational environment.
 2. Institutional voucher application/approval.
 - a. Applications for special education institutional vouchers shall be completed by the institution and submitted to the Exceptional Student Services Division of the Department of Education. The institution shall provide all student information requested on the institutional voucher application.
 - b. Institutions shall sign a Statement of Assurance guaranteeing their maintenance of and ability to produce all supporting documentation for each application.
 - c. Institutional voucher applications shall be reviewed and approved or disapproved by the voucher unit manager. Applications that are disapproved may be corrected and resubmitted. Institutional voucher

payments will not be made for student attendance prior to voucher approval date.

- d. Voucher identification numbers shall be assigned for each new student approval, and shall be used by the institution to complete claims for payment and the special education census form.
- e. Institutional vouchers are approved for the current year only; therefore the application process shall be repeated each school year for each student.
- f. Institutions shall report any changes in student status, including withdrawals, transfers, current evaluation dates and changes in disability categories to the Exceptional Student Services Division of the Department of Education. Changes shall be submitted within ten days of the occurrence.
3. Institutional voucher claim for payment.
 - a. The special education institutional voucher claim for payment form shall be completed by the institution at the end of each calendar month. The claim shall be submitted in accordance with procedures established by the School Finance Division of the Department of Education.
 - b. Claims for payment shall be submitted to the School Finance Division of the Department of Education.
4. Special education census.

All institutional voucher students shall be reported on the special education census in accordance with procedures established by the School Finance Division of the Department of Education.
5. Review of placement.
 - a. It is the responsibility of the HSD to review student progress at least once a semester.
 - b. The IEP may be completed by the institution but is ultimately the responsibility of the student's HSD to ensure that it is reviewed and revised annually.
 - c. It is the responsibility of the HSD to ensure that re-evaluations are conducted on a tri-annual basis or more frequently as needed.
- B. Residential vouchers: Students placed in private residential treatment facilities (PRF) may be eligible for residential voucher funding for the educational portion of the placement.
 1. Eligibility Criteria.
 - a. Students shall be enrolled in and eligible for educational services from a Public Education Agency (PEA).
 - b. Placement shall be made by one of the State Placing Agencies. They are the Department of Economic Security (DES), the Department of Health Services (DHS), the Administrative Office of the Courts (AOC), or the Department of Juvenile Corrections (ADJC).
 - c. Residential facilities shall be licensed by the Department of Health Services or Department of Economic Security and approved by the Department of Education for the specific educational needs of each student placed there.
 - d. The following conditions invalidate eligibility.
 - i. Placement by any agency other than those noted in subsection (B)(1)(b).
 - ii. Placement in facilities not appropriately licensed by DHS or DES or approved by the Department of Education.
 - iii. Student attendance at a PEA while residing in a residential facility.

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- e. Eligible students are divided into three categories.
 - i. Non-special education (NSE): Students not eligible for special education services who are placed by a State Placing Agency for their care, safety, or treatment.
 - ii. Care special education (CSE): Students eligible for special education services who are placed by a State Placing Agency for their care, safety, or treatment.
 - iii. Residential special education (RSE): Students requiring residential placement to benefit from educational programming who are placed by an IEP team.
2. Voucher application/approval process. The process differs depending on category.
 - a. NSE and CSE options:
 - i. When a placement decision is reached, the State Placing Agency (SPA) shall complete a SPA Application for Voucher Funding, and forward a copy to the student's Home School District (HSD) for appropriate signatures within five days of placement.
 - ii. Upon placement, copies of the completed voucher shall be provided to the PRF and the Exceptional Student Services of the Department of Education (ESS).
 - iii. Upon receipt and review of the application and verification of facility approval, the SPA application will be approved for the initial 60 days of placement. An approval memo is sent to the PRF and the HSD. The Exceptional Student Services shall assign a student identification number to each approved voucher student. This number shall be used by the private facility when completing the special education census form and the claim for payment form.
 - iv. The HSD shall submit the HSD Application for Education Voucher Funding packet and submit it to the Exceptional Student Services of the Department of Education. Appropriate documentation of eligibility for special education and provision of services, if applicable, shall be included.
 - v. The HSD voucher application packet shall be reviewed and approved or disapproved by the voucher unit manager. Applications that are disapproved may be corrected and resubmitted. Approvals are granted from the date of receipt through the end of the school year. An approval memo is sent to the PRF and the HSD.
 - vi. If the HSD cannot complete the requirements for the HSD application packet within the initial 60-day approval period, they shall submit an Application For Extension Of Education Voucher Funding.
 - b. RSE option.

The HSD shall follow statutory requirements and procedures agreed upon by the ADE, DHS, and DES when considering placement in a PRF for educational reasons. If a need for such a placement is determined, the HSD shall complete and submit the HSD Application for Education Voucher Funding packet to the ESS. Documentation of the necessity for PRF placement, measurable exit criteria, and a reintegration plan shall be required.
3. Changes in placement/Discharge.
 - a. If a student is discharged or is absent without leave for more than ten days from the PRF, the facility shall notify the State Placing Agency, Home School District and the Exceptional Student Services Division of the Department of Education in writing within five days.
 - b. Students returning to a facility after a discharge or students transferred from one facility to another require a new SPA voucher application.
 - c. Students placed under the RSE option shall not be discharged without the consent of the IEP team.
4. Voucher claim for payment.
 - a. A special education voucher claim for payment shall be submitted in accordance with procedures established by the School Finance Division of the Department of Education.
 - b. Claim for payment shall be submitted to the School Finance Division of the Department of Education.
5. Special education census.

A special education census form shall be completed for all voucher students in accordance with procedures established by the School Finance Division of the Department of Education.
6. Review and continuation of placement.
 - a. The Home School District (HSD) shall regularly monitor the progress of students, ensure the annual review and revision of IEPs, and complete three-year re-evaluations as applicable.
 - b. Voucher approval is for one school year only. Students remaining in an PRF from the end of one school year to the beginning of the next year require new voucher applications. Prior to the beginning of the new school year, the PRF shall submit an Application for Continuing Voucher funding, signed by both the SPA and the HSD. For a student who is eligible for special education services, a current IEP shall accompany the continuing application if the IEP has been reviewed or revised after the original voucher was approved.

Historical Note

Adopted effective December 4, 1978 (Supp. 78-6).
 Amended by final rulemaking at 9 A.A.R. 4633, effective
 December 8, 2003 (Supp. 03-4).

Editor's Note: The following Section was erroneously published in Supp. 04-2 with amendments that were not approved by the Attorney General's Office. It is republished with the text in effect before Supp. 04-2. The correct notice was published at 10 A.A.R. 3274 (Supp. 04-3).

R7-2-405. Special Education Dispute Resolution; Due Process

A. Definitions. The following definitions are applicable to this Section:

1. "Due process hearing" means a fair and impartial administrative hearing conducted by the State Education Agency by an impartial hearing officer through the Arizona Office of Administrative Hearings in accordance with the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.) and its implementing regulations (34 CFR 300).

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2. "Impartial hearing officer" or "hearing officer" means an Administrative Law Judge ("ALJ") of the Arizona Office of Administrative Hearings ("OAH") and who is knowledgeable in the laws governing special education and administrative hearings.
3. "Public agency" ("PEA") has the same definition as provided in R7-2-401.
4. "State Education Agency" ("SEA") means the Department of Education, Exceptional Student Services Section.
- B.** The due process procedures specified in this Section apply to all public agencies dealing with the identification, evaluation, special education placement of, and the provision of a free appropriate public education ("FAPE") for children with disabilities.
- C.** The SEA shall establish procedures concerning:
 1. Impartial due process hearings, and
 2. Confidentiality and access to student records.
- D.** An impartial hearing officer shall be:
 1. Unbiased - not prejudiced for or against any party in the hearing;
 2. Disinterested - not having any personal or professional interest that would conflict with objectivity in the hearing;
 3. Independent - may not be an officer, employee, or agent of a public agency involved in the education or care of the child or the SEA. A person who otherwise qualifies to conduct a hearing is not an employee of the public agency or the SEA solely because the person is paid by the public agency to serve as a hearing officer;
 4. Trained by the SEA as to the state and federal laws pertaining to the identification, evaluation, placement of, and the provision of FAPE for children with disabilities.
- E.** Hearing officer qualifications and training.
 1. All hearing officers shall participate in all required training conducted by the SEA as to the state and federal laws pertaining to the identification, evaluation, educational placement, and the provision of FAPE for children with disabilities.
 2. A hearing officer shall meet the requirements set forth by OAH regarding ALJs. A hearing officer shall not have represented a parent in a special education matter during the preceding 12 months, and shall not have represented a school district in any matter during the preceding 12 months.
- F.** Selection of hearing officers.
 1. The SEA shall prepare and maintain a list of individuals who meet the qualifications specified in subsection (E) to serve as hearing officers. This list shall also include the qualifications of each hearing officer.
 2. A hearing officer shall be assigned in accordance with the procedures of the Office of Administrative Hearings.
- G.** Request for due process hearing.
 1. The due process complaint must allege a violation that occurred not more than two years before the date the parent or public education agency knew or should have known about the alleged action that forms the basis of the due process complaint.
 2. A parent shall submit a written request for a due process hearing to the public education agency and the SEA. The SEA shall provide a model form that a parent may use in requesting a due process hearing. Upon receipt of a written request, there shall be no change in the educational placement of the child except under the applicable provisions of IDEA, unless the PEA and parents agree. If a parent requests a due process hearing, the public education agency shall advise the parents of any free or low-cost legal services available, and provide a copy of the procedural safeguards notice. All correspondence to the parent shall be provided in English and the primary language of the home. If the written request involves an application for initial admission, the child, with the consent of the parent, shall be placed in the public school until the completion of all proceedings.
3. If the public education agency requests a due process hearing, such request may be made on a model form, as noted in subsection (G)(2), and a copy shall be provided to the parent and the SEA. Upon receipt of a written request, there shall be no change in the educational placement of the child except under the applicable provisions of IDEA, unless the PEA and the parents agree. In conjunction with its request for due process hearing, the public education agency shall advise the parents of any free or low-cost legal services available and provide a copy of the procedural safeguards notice. All correspondence to the parent, including the due process request, shall be provided in English and the primary language of the home. If the written request involves an application for initial admission, the child, with the consent of the parent, shall be placed in the public school until the completion of all proceedings.
- H.** An impartial due process hearing shall be conducted in accordance with the following procedures:
 1. The hearing officer shall hold a pre-hearing conference, either telephonically or at a location that is reasonably convenient to the parents and the child involved, to determine if the complaint is a legitimate due process complaint, to ensure that all matters are clearly defined, to establish the proceedings that will be used for the hearing, to determine who will represent and/or advise each party, and to set the time and dates for the hearing.
 2. The hearing officer shall conduct the hearing at a location that is reasonably convenient to the parents and the child involved.
 3. The hearing officer shall preside at the hearing and shall conduct the proceedings in a fair and impartial manner, and shall ensure that all parties involved have an opportunity to:
 - a. Present their evidence and confront, cross-examine, and compel the attendance of witnesses;
 - b. Object to the introduction of any evidence at the hearing that has not been disclosed to all parties at least five business days before the hearing;
 - c. Produce outside expert witnesses;
 - d. Be accompanied and advised by counsel and by individuals with special knowledge or training with respect to the problems of children with disabilities.
 4. The parent involved in the hearing shall be given the right to:
 - a. Have the child who is the subject of the hearing present,
 - b. Have the hearing conducted in public,
 - c. Have an interpreter provided by the public agency.
 5. The hearing officer shall review all relevant facts concerning the identification, evaluation, the educational placement, and the provision of FAPE. This shall include any Independent Education Evaluation secured by the parent.

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- a. The hearing officer shall determine whether the public agency has met all requirements of federal and state law, rules, and regulations.
 - b. The hearing officer shall render findings of fact and a decision, which shall be binding on all parties unless appealed pursuant to this Section.
6. The hearing officer's findings of fact and decision shall be in writing and shall be provided to the parent, the public education agency, the SEA, and their respective representatives. The parent may choose to receive an electronic verbatim record of the hearing and electronic findings of fact and decision relative to the hearing in addition to the written findings of fact and decision. The hearing officer's findings of fact and decision shall be delivered by certified mail or by hand within 45 calendar days after notification to the hearing officer that the parties have been unable to resolve the matter in accordance with 20 U.S.C. 1415(f)(1)(B). A hearing officer may grant specific extensions of time beyond the 45 calendar days for good cause shown at the request of either party.
 7. The findings of fact and decision of the hearing officer shall be final at the administrative level. The notification of the findings of fact and decision shall contain notice to the parties that they have a right to judicial review.
 8. Any party to the proceeding has the right to appeal a final administrative decision to a court of competent jurisdiction within 35 calendar days after receipt of the decision.
 9. The SEA, after deleting any personally identifiable information, shall make such written findings of fact and decision available to the public.
- I. Expedited hearing.**
1. An expedited hearing regarding disciplinary matters may be requested in accordance with federal law as set forth in 20 U.S.C. 1415(k).
 2. Hearing officers for an expedited hearing shall be assigned by the Office of Administrative Hearings.
 3. The expedited hearing shall be conducted within 20 school days of the date the hearing is requested and shall result in a determination within 10 school days after the hearing.

Historical Note

Adopted effective December 4, 1978 (Supp. 78-6). Amended subsection (V) effective May 1, 1987 (Supp. 87-2). Amended effective July 20, 1990 (Supp. 90-3). Emergency amendment adopted effective November 21, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-4). Emergency expired. Emergency amendment readopted effective March 21, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-1). Amended effective May 2, 1991 (Supp. 91-2). Amended effective November 17, 1994 (Supp. 94-4). Amended effective December 6, 1995 (Supp. 95-4). Amended by final rulemaking at 5 A.A.R. 3211, effective August 24, 1999 (Supp. 99-4). Amended by final rulemaking at 10 A.A.R. 2399, effective July 23, 2004 (Supp. 04-2). Supp. 04-2 Historical Note entry is in error. R7-2-405 was erroneously included in Supp. 04-2 with amendments that were not approved by the Attorney General's Office. It is republished with the text in effect before Supp. 04-2. The correct notice was published at 10 A.A.R. 3274 (Supp. 04-3). Amended by exempt rulemaking at 15 A.A.R. 1732, effective January 26, 2006 (Supp. 09-1). Amended by exempt rulemaking at 15 A.A.R. 1849, effective May 19, 2008 (Supp. 09-2). Amended by exempt rulemaking

at 16 A.A.R. 201, effective December 7, 2009 (Supp. 10-1). The word "rule" has been replaced with "Section" to reflect current standards in Chapter style and format (Supp. 21-1).

R7-2-405.01. Special Education Dispute Resolution; State Administrative Complaints

- A.** Notwithstanding any other provision of law, a state administrative complaint filed with the Department regarding any alleged violations of Part B of the federal Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1400 et seq.) or its implementing regulations (34 CFR 300) shall be investigated in accordance with the Code of Federal Regulations Title 34.
1. The party filing the complaint shall forward a copy of the state administrative complaint to the public education agency serving the child at the same time the party files the complaint with the Department.
 2. A written decision shall be issued to the complainant and the public education agency that is the subject of the state administrative complaint in accordance with the 60-day time limit specified in the Code of Federal Regulations Title 34.
- B.** The Department shall accept and investigate state administrative complaints that allege a violation that occurred not more than one year prior to the date that the complaint is received by the Department.
- C.** The state administrative complaint shall include all of the following:
1. A statement that a public education agency has violated a requirement of Part B of the IDEA or its implementing regulations.
 2. The facts on which the statement is based.
 3. The signature and contact information for the complainant.
 4. If alleging violations with respect to a specific child, all of the following:
 - a. The name and address of the child.
 - b. The name of the school the child is attending.
 - c. In the case of a homeless child or youth (within the meaning of Section 725(2) of the McKinney-Vento Homeless Assistance Act (20 U.S.C. 11434a(2)), available contact information for the child, and the name of the school the child is attending.
 - d. A description of the nature of the problem of the child, including facts relating to the problem.
 - e. A proposed resolution of the problem to the extent known and available to the party at the time the complaint is filed.
 5. The Department shall develop a model form to assist parents and public agencies in filing a state administrative complaint under this Section.

Historical Note

New Section made by exempt rulemaking at 16 A.A.R. 201, effective December 7, 2009 (Supp. 10-1).

R7-2-405.02. Special Education Dispute Resolution; Mediation

In accordance with the Individuals with Disabilities Education Act, the Department shall provide parents of students with disabilities and public education agencies the opportunity to resolve disputes involving any matter under IDEA, including matters arising prior to the filing of a request for due process, through a mediation process.

1. The mediation process shall:
 - a. Be voluntary on the part of both parties,

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- b. Not be used to deny or delay a parent's right to a due process hearing or any other rights afforded under Part B of the IDEA,
- c. Be conducted by a qualified and impartial mediator who is trained in effective mediation techniques.
- 2. The Department shall maintain a list of individuals who are qualified mediators and knowledgeable in laws and regulations relating to the provision of special education and related services.
- 3. The Department shall select mediators on a random or rotational basis.
- 4. The Department shall bear the cost of the mediation process.
- 5. Each session in the mediation process shall be scheduled in a timely manner and shall be held in a location that is convenient to both the parent and the public education agency.
- 6. If the parties resolve a dispute through the mediation process, the parties shall execute a legally binding agreement that:
 - a. States that all discussions that occurred during the mediation process will remain confidential and may not be used as evidence in any subsequent due process hearings or civil proceedings,
 - b. Is signed by both the parent and a representative of the public education agency who has the authority to bind the agency, and
 - c. Is enforceable in any state court of competent jurisdiction or in a district court of the United States.
- 7. Whether or not the dispute is resolved through mediation, discussions that occur during the mediation process shall be confidential and may not be used as evidence in any subsequent due process hearings or civil proceedings of any federal court or state court.
- 8. Impartiality of the Mediator. An individual who serves as a mediator:
 - a. May not be an employee of the Department or of the public education agency that is involved in the education or care of the student.
 - b. Shall not have a personal or professional interest that conflicts with the person's objectivity.
 - c. Is not an employee of the Department or of a public education agency solely because the mediator is paid by the Department of Education to serve as a mediator.
- c. LEAs shall place transfer students as soon as they have verified eligibility.
- 2. Curriculum, differentiated instruction, and supplemental services for gifted students.
 - a. Expanded academic course offerings may include, for example, one or more of the following: acceleration, enrichment, flexible pacing, interdisciplinary curriculum, and seminars.
 - b. Differentiated instruction, which emphasizes the development of higher order thinking, may include critical thinking, creative thinking, and problem solving skills.
 - c. Supplemental services, which may be offered to meet the individual needs of each gifted student, may include, for example, guidance and counseling, mentorships, independent study, correspondence courses, and concurrent enrollment.
- 3. Parent involvement.
 - a. Each LEA shall provide the following information to all parents or legal guardians:
 - i. Definition of a gifted child;
 - ii. Services mandated for gifted students by the state of Arizona;
 - iii. Services available from the LEA;
 - iv. Written criteria of the LEA for referral, screening, selection and placement.
 - b. Each LEA shall develop policies and procedures which ensure that parents or legal guardians are:
 - i. Given the opportunity to have their children tested;
 - ii. Given advance notice of the week that their children are to be tested;
 - iii. Given the opportunity to withhold permission for testing;
 - c. Each LEA shall:
 - i. Make testing available for students K through 12 on a periodic basis but not less than three times per year;
 - ii. Inform parents or legal guardians of the results of the district-administered test within 30 school days of determining the test results;
 - iii. Upon request, explain test results to parents or legal guardians.
- 4. The scope and sequence shall be a written program description which demonstrates articulation across all grades and schools to ensure opportunities for continuous progress and shall include:
 - a. Statement of purpose;
 - b. General population description;
 - c. Identification process and placement criteria including provisions for special populations;
 - d. Goals and objectives;
 - e. Curriculum, differentiated instruction, and supplemental services;
 - f. Program models;
 - g. Time allocations for services;
 - h. Procedures and criteria for evaluation of student and program outcomes.

Historical Note

New Section made by exempt rulemaking at 16 A.A.R. 201, effective December 7, 2009 (Supp. 10-1).

R7-2-406. Gifted Education Programs and Services

- A. Governing boards shall adopt policies for the education of gifted students which shall include:
 - 1. Procedures for identification and placement of students to be placed in gifted programs.
 - a. Students shall be served who score at or above the 97th percentile on national norms in any one of three areas - verbal, nonverbal, or quantitative reasoning - on any test from the State Board-approved list. Students who score below the 97th percentile also may be served.
 - b. Local educational agencies (LEAs) shall accept, as valid for placement, scores at or above the 97th percentile on any State Board-approved test submitted by other LEAs or by qualified professionals.

- B. The Arizona Department of Education shall develop and make available model policies for the development, implementation, and evaluation of services for gifted students.

Historical Note

Adopted effective December 12, 1990 (Supp. 90-4). The hyphen between "K-12" has been changed to the word

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“through” for consistency in Chapter style and format
(Supp. 21-2).

R7-2-407. Special Education Standards and Assistance for Providing Educational Services and Materials for Visually Impaired Students

- A. All requirements in this Section are in addition to the general special education standards in R7-2-401 for public education agencies providing special education.
- B. For the purposes of this Section, the following definitions apply:
 1. “Accessible Electronic File” means, until the effective date of a nationally adopted file format, a digital file in a mutually agreed upon electronic file format that has been prepared using a markup language that maintains the structural integrity of the information and can be processed by Braille conversion software. Upon the effective date of a nationally adopted file format, such as the Instructional Materials Accessibility Standard (IMAS), “Accessible Electronic File” shall mean an electronic file conforming to the specifications of the nationally adopted file format, including future technical revisions and versions of this nationally adopted file format.
 2. “Individualized Braille literacy assessment” means the Learning Media Assessment or other standardized or individualized assessments that pertain to the child’s reading medium.
 3. “Non-printed instructional materials” means non-printed textbooks and related core materials, including those that require the availability of electronic equipment in order to be used as a learning resource, that are written and published primarily for use in elementary school and secondary school instruction and are required by a state educational agency or a local educational agency for use by pupils in the classroom. These materials shall be available to the extent technologically available, and may include software programs, CD-ROMs and internet-based materials.
 4. “Printed instructional materials” means textbooks and related printed core materials, that are written and published primarily for use in elementary school and secondary school instruction and are required by a state educational agency or a local educational agency for use by pupils in the classroom. This may include workbooks, practice tests, and tests.
 5. “Publisher” means an individual, firm, partnership or corporation that publishes or manufactures printed instructional materials for students attending public schools in Arizona, including an on-line service, a software developer, or a distributor of an electronic textbook.
 6. “Specialized format” means Braille, audio or digital text which is exclusively for use by blind or other persons with disabilities.
 7. “Structural integrity” means the structure of all parts of the printed instructional material will be kept intact to the extent feasible and as mutually agreed upon by the publisher and the local educational agency. This may include appropriate representation of graphic illustrations.
- C. Upon determination of a student having a visual impairment as assessed by a full and initial evaluation defined in R7-2-401(E)(6)(i), a visually impaired student who is determined to be blind as defined by A.R.S. § 15-214(B) shall receive an individualized Braille literacy assessment.
- D. Individualized Education Programs (IEP) for blind students. In addition to the requirements for establishing and implementing an IEP consistent with R7-2-401(F) for a student determined to have a disability, each IEP for a student determined to be “blind” as assessed by R7-2-401(E)(6)(i) and defined by A.R.S. § 15-214(B), shall presume that proficiency in Braille is essential in achieving academic success unless otherwise determined by the IEP team established consistent with the regulations for the most recent reauthorization of the Individuals with Disabilities Education Act (IDEA) and in the manner provided by the most recent reauthorization of the IDEA Act for developing an IEP. An IEP developed under this Section for a student determined to be blind shall include all required provisions of A.R.S. § 15-214(A)(3), including the following:
 1. The results of the individualized Braille literacy assessment.
 2. The date on which Braille instruction will begin, the methods to be used and the frequency and duration of the Braille instruction.
 3. The level of competency expected to be achieved within specified time-frames and the objective measures to be used for evaluation.
 4. The Braille materials and equipment necessary to achieve the stated expected competency gains, including ordering instructional materials to achieve the IEP-stated goals.
 5. The rationale for not providing Braille instruction if Braille is not determined to be an appropriate medium by the IEP team and is not included in the IEP.
- E. The Arizona Department of Education shall designate a central repository for publishers to, upon request, provide accessible electronic files for instructional materials used by public schools in Arizona as defined in subsection (B)(1). The central repository shall be responsible for maintaining a complete list of available accessible electronic files for instructional materials and instructional materials in specialized formats, processing requests from PEAs for instructional materials in specialized formats and providing access to these materials in specialized formats to schools throughout Arizona that are providing services to blind or other students with disabilities.
 1. Upon receipt of a written request certifying to the requirements set forth in subsections (E)(1)(a) through (c) publishers shall deliver to the repository, at no additional cost and consistent with the time-frame for providing materials for students without disabilities, accessible electronic files for printed instructional materials and non-printed instructional materials. Certification shall include all of the following:
 - a. The PEA purchased a copy of the printed instructional material or non-printed instructional material for use by a student who is blind or has a visual impairment in a course that the student is attending or registered to attend;
 - b. The student who will utilize the instructional materials in a specialized format has an IEP stating that such materials and/or equipment are necessary for the student to achieve stated expected competency gains; and
 - c. The instructional materials are for use by the student in connection with a course in which he or she is enrolled, as verified by the person overseeing the education of students who are blind or visually impaired.
 2. A PEA may access the materials maintained by the central repository, upon written request, for instructional use with a student with a visual impairment, as identified by R7-2-401(E)(6)(i), who requires the use of instructional

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materials in a specialized format pursuant to the student's IEP.

3. Nothing in this Section shall be construed to prohibit the central repository from assisting a student with a disability by using the electronic format version of instructional material provided pursuant to this Section solely to transcribe or arrange for the transcription of the printed instructional material into Braille or large print. In the event a Braille transcription is made, the central repository has the right to share the Braille copy of the printed instructional material with other eligible students with disabilities. The PEA will be required to return the specialized format version of the instructional material to the central repository when the student no longer needs the instructional material. The central repository may share the copies of the specialized format of the instructional material with other PEAs who have met the requirements of subsections (B) and (D) to provide services to students who require such services pursuant to R7-2-401(F)(5).

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2399, effective July 23, 2004 (Supp. 04-2). The word "rule" has been changed to "Section," and "of this Section" was removed to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-408. Extended School Year Programs for Children with Disabilities

- A. "Extended school year" (ESY) shall be as defined in A.R.S. § 15-881.
- B. Eligibility. Eligibility shall be determined by the Individualized Education Program (IEP) Team. Criteria for determining eligibility in an extended school year program shall be as defined in A.R.S. § 15-881.
- C. For a student with a disability currently enrolled in special education, eligibility for ESY services shall be determined no later than 45 calendar days prior to the last day of the school year.
- D. The availability of an extended school year program is required for all students for whom the IEP team has determined that it is necessary in order to ensure a free appropriate public education. Student participation in an ESY program is not compulsory. ESY services are not required for all students with a disability.
- E. Factors that are inappropriate for consideration. Eligibility for participation shall not be based on need or desire for any of the following:
 1. A day care or respite care service for students with a disability;
 2. A program to maximize the academic potential of a student with a disability; and
 3. A summer recreation program for students with a disability.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 3211, effective August 24, 1999 (Supp. 99-4). Amended by final rulemaking at 9 A.A.R. 4633, effective December 8, 2003 (Supp. 03-4).

ARTICLE 5. CAREER AND VOCATIONAL EDUCATION**R7-2-501. Repealed****Historical Note**

Not in original publication, correction, Section R7-2-501.

Adopted effective July 2, 1974. Amended effective November 8, 1974. Amended effective August 11, 1975 (Supp. 75-1). Former Section R7-2-501 repealed, new Section R7-2-501 adopted effective December 4, 1978 (Supp. 78-6). Repealed effective February 20, 1997 (Supp. 97-1).

R7-2-502. Vocational Education Provisions and Standards

All eligible recipients receiving federal or state monies or services in support of vocational and technical education programs, courses, or classes shall comply with the applicable provisions and standards of the following plans, which are filed with the Secretary of State, which plans are incorporated herein by reference.

1. 1986-1988 Arizona State Plan for Vocational Education for Federal Funding as required by A.R.S. § 15-784; and
2. Arizona State Plan for Vocational Education for State Funding approved April 22, 1985, as required by A.R.S. § 15-787(C).

Historical Note

Adopted (FY 76) effective July 14, 1975 (Supp. 75-1). Adopted (FY 77) effective June 25, 1976 (Supp. 76-3). Former Section R7-2-502 repealed, new Section R7-2-502 adopted effective December 4, 1978 (Supp. 78-6). Former Section R7-2-502 repealed, new Section R7-2-502 adopted effective March 13, 1986 (Supp. 86-2). The Section heading has been updated to title case to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-503. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-504. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-505. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-506. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-507. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-508. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-509. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-510. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-511. Repealed

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Historical Note

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-512. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-513. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-514. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-515. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-516. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-517. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-518. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-519. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

R7-2-520. Repealed**Historical Note**

Repealed effective December 4, 1978 (Supp. 78-6).

ARTICLE 6. CERTIFICATION**R7-2-601. Definitions**

In this Article, the following definitions apply unless the context otherwise requires:

1. "Accredited institution" means a postsecondary institution that has accreditation that is recognized by the U.S. Department of Education. An institution based outside the United States shall be considered accredited if a Department-approved foreign document evaluation firm verifies that it has accreditation in the foreign country that is comparable to accreditation that is recognized by the U.S. Department of Education.
2. "Accredited training" means training provided by an organization that has accreditation from an association approved by the Board.
3. "Appropriately certified" means holding the certificate, endorsement and approved area that is required for a teaching assignment.
4. "Approved area" means a subject area denoted on a teaching certificate that is taught in Arizona public schools.
5. "Board" means the State Board of Education.
6. "Capstone experience" means a culminating professional experience in a PreK through 12 setting that may include

student teaching or internships in administration, counseling, or school psychology, or alternative path PreK through 12 teaching.

7. "CTE" means Career and Technical Education.
8. "Department" means the Arizona Department of Education.
9. "Practicum" means a period of structured observation and practice of the skills being learned, supervised by an individual trained in that area. The commonly used terms "student teaching," "internship," "residency," or "observation course" are included in this definition.
10. "Professional development" means training to increase skills related to the occupation of education.
11. "Self-contained classroom" means a classroom in which the teacher teaches multiple subjects to one class of students.
12. "Single subject classroom" means a classroom in which the teacher teaches one subject to one class of students.
13. "Teaching experience" means full-time employment which included full responsibility for the planning and delivery of instruction and evaluation of student learning. Except for meeting the capstone experience requirement when applying for a standard teaching certificate, substitute teaching is not considered full-time teaching experience.

Historical Note

Former Section R7-2-601 repealed, new Section R7-2-601 adopted effective December 4, 1978 (Supp. 78-6). Amended subsection (C) effective May 31, 1983 (Supp. 83-3). Amended subsection (I) effective September 12, 1989 (Supp. 89-3). Amended effective August 14, 1991 (Supp. 91-3). Amended effective July 30, 1992 (Supp. 92-3). Section repealed, new Section adopted effective March 10, 1994 (Supp. 94-1). Amended effective July 25, 1994 (Supp. 94-3). Amended effective September 20, 1996 (Supp. 96-3). Amended effective March 6, 1997 (Supp. 97-1). Typographical error corrected in subsection (A) (Supp. 97-3). Section repealed; new Section adopted effective December 3, 1998 (Supp. 98-4). Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-602. Professional Teaching Standards

- A. The standards presented in this Section shall be the basis for approved teacher preparation programs, described in R7-2-604, and the Arizona Teacher Proficiency Assessment, described in R7-2-606.
- B. Standard 1. Learner Development: The teacher understands how learners grow and develop, recognizing that patterns of learning and development vary individually within and across the cognitive, linguistic, social, emotional, and physical areas, and designs and implements developmentally appropriate and challenging learning experiences. The teacher:
 1. Regularly assesses individual and group performance in order to design and modify instruction to meet learners' needs in each area of development (cognitive, linguistic, social, emotional, and physical) and scaffolds the next level of development.
 2. Creates developmentally appropriate instruction that takes into account individual learners' strengths, interests, and needs and that enables each learner to advance and accelerate his/her learning.

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3. Collaborates with families, communities, colleagues, and other professionals to promote learner growth and development.
 4. Understands how learning occurs – how learners construct knowledge, acquire skills, and develop disciplined thinking processes – and knows how to use instructional strategies that promote student learning.
 5. Understands that each learner's cognitive, linguistic, social, emotional, and physical development influences learning and knows how to make instructional decisions that build on learners' strengths and needs.
 6. Identifies readiness for learning, and understands how development in any one area may affect performance in others.
 7. Understands the role of language and culture in learning and, consistent with Arizona law, knows how to modify instruction to make language comprehensible and instruction relevant, accessible, and challenging.
 8. Respects learners' differing strengths and needs and is committed to using this information to further each learner's development.
 9. Is committed to using learners' strengths as a basis for growth, and their misconceptions as opportunities for learning.
 10. Takes responsibility for promoting learners' growth and development.
- C. Standard 2. Learning Differences: The teacher uses understanding of individual differences and diverse cultures and communities to ensure inclusive learning environments that enable each learner to meet high standards. The teacher:
1. Designs, adapts, and delivers instruction to address each student's diverse learning strengths and needs and creates opportunities for students to demonstrate their learning in different ways.
 2. Makes appropriate and timely provisions (e.g., pacing for individual rates of growth, task demands, communication, assessment, and response modes) for individual students with particular learning differences or needs.
 3. Designs instruction to build on learners' prior knowledge and experiences, allowing learners to accelerate as they demonstrate their understandings.
 4. Brings multiple perspectives to the discussion of content, including attention to learners' personal, family, and community experiences and cultural norms.
 5. Incorporates tools of language development into planning and instruction, including strategies for making content accessible to English language learners and for evaluating and supporting their development of English proficiency.
 6. Accesses resources, supports, and specialized assistance and services to meet particular learning differences or needs.
 7. Understands and identifies differences in approaches to learning and performance and knows how to design instruction that uses each learner's strengths to promote growth.
 8. Understands students with exceptional needs, including those associated with disabilities and giftedness, and knows how to use strategies and resources to address these needs.
 9. Knows about second language acquisition processes and knows how to incorporate instructional strategies and resources to support language acquisition.
 10. Understands that learners bring assets for learning based on their individual experiences, abilities, talents, prior learning, and peer and social group interactions, as well as language, culture, family, and community values.
11. Knows how to access information about the values of diverse cultures and communities and how to incorporate learners' experiences, cultures, and community resources into instruction.
12. Believes that all learners can achieve at high levels and persists in helping each learner reach his/her full potential.
13. Respects learners as individuals with differing personal and family backgrounds and various skills, abilities, perspectives, talents, and interests.
14. Makes learners feel valued and helps them learn to value each other.
15. Values diverse languages and dialects and seeks to integrate them into his/her instructional practice to engage students in learning.
- D. Standard 3. Learning Environments: The teacher works with others to create environments that support individual and collaborative learning, and that encourage positive social interaction, active engagement in learning, and self motivation. The teacher:
1. Collaborates with learners, families, and colleagues to build a safe, positive learning climate of openness, mutual respect, support, and inquiry.
 2. Develops learning experiences that engage learners in collaborative and self-directed learning and that extend learner interaction with ideas and people locally and globally.
 3. Collaborates with learners and colleagues to develop shared values and expectations for respectful interactions, rigorous academic discussions, and individual and group responsibility for quality work.
 4. Manages the learning environment to actively and equitably engage learners by organizing, allocating, and coordinating the resources of time, space, and learners' attention.
 5. Uses a variety of methods to engage learners in evaluating the learning environment and collaborates with learners to make appropriate adjustments.
 6. Communicates verbally and nonverbally in ways that demonstrate respect for and responsiveness to the cultural backgrounds and differing perspectives learners bring to the learning environment.
 7. Promotes responsible learner use of interactive technologies to extend the possibilities for learning locally and globally.
 8. Intentionally builds learner capacity to collaborate in face-to-face and virtual environments through applying effective interpersonal communication skills.
 9. Understands the relationship between motivation and engagement and knows how to design learning experiences using strategies that build learner self-direction and ownership of learning.
 10. Knows how to help learners work productively and cooperatively with each other to achieve learning goals.
 11. Knows how to collaborate with learners to establish and monitor elements of a safe and productive learning environment including norms, expectations, routines, and organizational structures.
 12. Understands how learner diversity can affect communication and knows how to communicate effectively in differing environments.

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13. Knows how to use technologies and how to guide learners to apply them in appropriate, safe, and effective ways.
 14. Is committed to working with learners, colleagues, families, and communities to establish positive and supportive learning environments.
 15. Values the role of learners in promoting each other's learning and recognizes the importance of peer relationships in establishing a climate of learning.
 16. Is committed to supporting learners as they participate in decision making, engage in exploration and invention, work collaboratively and independently, and engage in purposeful learning.
 17. Seeks to foster respectful communication among all members of the learning community.
 18. Is a thoughtful and responsive listener and observer.
- E. Standard 4. Content Knowledge: The teacher understands the central concepts, tools of inquiry, and structures of the discipline(s) he or she teaches and creates learning experiences that make these aspects of the discipline accessible and meaningful for learners to assure mastery of the content. The teacher:
1. Effectively uses multiple representations and explanations that capture key ideas in the discipline, guide learners through learning progressions, and promote each learner's achievement of content standards.
 2. Engages students in learning experiences in the discipline(s) that encourage learners to understand, question, and analyze ideas from diverse perspectives so that they master the content.
 3. Engages learners in applying methods of inquiry and standards of evidence used in the discipline.
 4. Stimulates learner reflection on prior content knowledge, links new concepts to familiar concepts, and makes connections to learners' experiences.
 5. Recognizes learner misconceptions in a discipline that interfere with learning, and creates experiences to build accurate conceptual understanding.
 6. Evaluates and modifies instructional resources and curriculum materials for their comprehensiveness, accuracy for representing particular concepts in the discipline, and appropriateness for his or her learners.
 7. Uses supplementary resources and technologies effectively to ensure accessibility and relevance for all learners.
 8. Creates opportunities for students to learn, practice, and master academic language in their content.
 9. Accesses school and/or district-based resources to evaluate the learner's content knowledge in his or her primary language.
 10. Understands major concepts, assumptions, debates, processes of inquiry, and ways of knowing that are central to the discipline(s) he or she teaches.
 11. Understands common misconceptions in learning the discipline and how to guide learners to accurate conceptual understanding.
 12. Knows and uses the academic language of the discipline and knows how to make it accessible to learners.
 13. Knows how to integrate culturally relevant content to build on learners' background knowledge.
 14. Has a deep knowledge of student content standards and learning progressions in the discipline(s) he or she teaches.
 15. Realizes that content knowledge is not a fixed body of facts but is complex, culturally situated, and ever evolving. The teacher keeps abreast of new ideas and understandings in the field, and ensures instruction is consistent with Arizona's adopted academic standards.
- F. Standard 5. Application of Content: The teacher understands how to connect concepts and use differing perspectives to engage learners in critical thinking, creativity, and collaborative problem solving related to authentic local and global issues. The teacher:
1. Develops and implements projects that guide learners in analyzing the complexities of an issue or question using perspectives from varied disciplines and cross-disciplinary skills (e.g., a water quality study that draws upon biology and chemistry to look at factual information and social studies to examine policy implications).
 2. Engages learners in applying content knowledge to real world problems through the lens of interdisciplinary themes (e.g., financial literacy, environmental literacy).
 3. Facilitates learners' use of current tools and resources to maximize content learning in varied contexts.
 4. Engages learners in questioning and challenging assumptions and approaches in order to foster innovation and problem solving in local and global contexts.
 5. Develops learners' communication skills in disciplinary and interdisciplinary contexts by creating meaningful opportunities to employ a variety of forms of communication that address varied audiences and purposes.
 6. Engages learners in generating and evaluating new ideas and novel approaches, seeking inventive solutions to problems, and developing original work.
 7. Facilitates learners' ability to develop diverse social and cultural perspectives that expand their understanding of local and global issues and create novel approaches to solving problems.
 8. Develops and implements supports for learner literacy development across content areas.
 9. Understands the ways of knowing in his/her discipline, how it relates to other disciplinary approaches to inquiry, and the strengths and limitations of each approach in addressing problems, issues, and concerns.
 10. Understands how current interdisciplinary themes (e.g., civic literacy, health literacy, global awareness) connect to the core subjects and knows how to weave those themes into meaningful learning experiences.
 11. Understands the demands of accessing and managing information as well as how to evaluate issues of ethics and quality related to information and its use.
 12. Understands how to use digital and interactive technologies for efficiently and effectively achieving specific learning goals.
 13. Understands critical thinking processes and knows how to help learners develop high level questioning skills to promote their independent learning.
 14. Understands communication modes and skills as vehicles for learning (e.g., information gathering and processing) across disciplines as well as vehicles for expressing learning.

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15. Understands creative thinking processes and how to engage learners in producing original work.
 16. Knows where and how to access resources to build global awareness and understanding, and how to integrate them into the curriculum.
 17. Is constantly exploring how to use disciplinary knowledge as a lens to address local and global issues.
 18. Values knowledge outside his/her own content area and how such knowledge enhances student learning.
 19. Values flexible learning environments that encourage learner exploration, discovery, and expression across content areas.
- G. Standard 6. Assessment:** The teacher understands and uses multiple methods of assessment to engage learners in their own growth, to monitor learner progress, and to guide the teacher's and learner's decision making. The teacher:
1. Balances the use of formative and summative assessment as appropriate to support, verify, and document learning.
 2. Designs assessments that match learning objectives with assessment methods and minimizes sources of bias that can distort assessment results.
 3. Works independently and collaboratively to examine test and other performance data to understand each learner's progress and to guide planning.
 4. Engages learners in understanding and identifying quality work and provides them with effective descriptive feedback to guide their progress toward that work.
 5. Engages learners in multiple ways of demonstrating knowledge and skill as part of the assessment process.
 6. Models and structures processes that guide learners in examining their own thinking and learning as well as the performance of others.
 7. Effectively uses multiple and appropriate types of assessment data to identify each student's learning needs and to develop differentiated learning experiences.
 8. Prepares all learners for the demands of particular assessment formats and makes appropriate accommodations in assessments or testing conditions, especially for learners with disabilities and language learning needs.
 9. Continually seeks appropriate ways to employ technology to support assessment practice both to engage learners more fully and to assess and address learner needs.
 10. Understands the differences between formative and summative applications of assessment and knows how and when to use each.
 11. Understands the range of types and multiple purposes of assessment and how to design, adapt, or select appropriate assessments to address specific learning goals and individual differences, and to minimize sources of bias.
 12. Knows how to analyze assessment data to understand patterns and gaps in learning, to guide planning and instruction, and to provide meaningful feedback to all learners.
 13. Knows when and how to engage learners in analyzing their own assessment results and in helping to set goals for their own learning.
 14. Understands the positive impact of effective descriptive feedback for learners and knows a variety of strategies for communicating this feedback.
 15. Knows when and how to evaluate and report learner progress against standards.
 16. Understands how to prepare learners for assessments and how to make accommodations in assessments and testing conditions, especially for learners with disabilities and language learning needs.
17. Is committed to engaging learners actively in assessment processes and to developing each learner's capacity to review and communicate about their own progress and learning.
 18. Takes responsibility for aligning instruction and assessment with learning goals.
 19. Is committed to providing timely and effective descriptive feedback to learners on their progress.
 20. Is committed to using multiple types of assessment processes to support, verify, and document learning.
 21. Is committed to making accommodations in assessments and testing conditions, especially for learners with disabilities and language learning needs.
 22. Is committed to the ethical use of various assessments and assessment data to identify learner strengths and needs to promote learner growth.
- H. Standard 7. Planning for Instruction:** The teacher plans instruction that supports every student in meeting rigorous learning goals by drawing upon knowledge of content areas, curriculum, cross-disciplinary skills, and pedagogy, as well as knowledge of learners and the community context. The teacher:
1. Individually and collaboratively selects and creates learning experiences that are appropriate for curriculum goals and content standards, and are relevant to learners.
 2. Plans how to achieve each student's learning goals, choosing appropriate strategies and accommodations, resources, and materials to differentiate instruction for individuals and groups of learners.
 3. Develops appropriate sequencing of learning experiences and provides multiple ways to demonstrate knowledge and skill.
 4. Plans for instruction based on formative and summative assessment data, prior learner knowledge, and learner interest.
 5. Plans collaboratively with professionals who have specialized expertise (e.g., special educators, related service providers, language learning specialists, librarians, media specialists) to design and jointly deliver as appropriate learning experiences to meet unique learning needs.
 6. Evaluates plans in relation to short- and long-range goals and systematically adjusts plans to meet each student's learning needs and enhance learning.
 7. Understands content and content standards and how these are organized in the curriculum.
 8. Understands how integrating cross-disciplinary skills in instruction engages learners purposefully in applying content knowledge.
 9. Understands learning theory, human development, cultural diversity, and individual differences and how these impact ongoing planning.
 10. Understands the strengths and needs of individual learners and how to plan instruction that is responsive to these strengths and needs.
 11. Knows a range of evidence-based instructional strategies, resources, and technological tools and how to use them effectively to plan instruction that meets diverse learning needs.
 12. Knows when and how to adjust plans based on assessment information and learner responses.
 13. Knows when and how to access resources and collaborate with others to support student learning (e.g., special educators, related service providers, language learner specialists, librarians, media specialists, community organizations).

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14. Respects learners' diverse strengths and needs and is committed to using this information to plan effective instruction.
 15. Values planning as a collegial activity that takes into consideration the input of learners, colleagues, families, and the larger community.
 16. Takes professional responsibility to use short- and long-term planning as a means of assuring student learning.
 17. Believes that plans must always be open to adjustment and revision based on learner needs and changing circumstances.
- I.** Standard 8. Instructional Strategies: The teacher understands and uses a variety of instructional strategies to encourage learners to develop deep understanding of content areas and their connections, and to build skills to apply knowledge in meaningful ways. The teacher:
1. Uses appropriate strategies and resources to adapt instruction to the needs of individuals and groups of learners.
 2. Continuously monitors student learning, engages learners in assessing their progress, and adjusts instruction in response to student learning needs.
 3. Collaborates with learners to design and implement relevant learning experiences, identify their strengths, and access family and community resources to develop their areas of interest.
 4. Varies his/her role in the instructional process (e.g., instructor, facilitator, coach, audience) in relation to the content and purposes of instruction and the needs of learners.
 5. Provides multiple models and representations of concepts and skills with opportunities for learners to demonstrate their knowledge through a variety of products and performances.
 6. Engages all learners in developing higher order questioning skills and metacognitive processes.
 7. Engages learners in using a range of learning skills and technology tools to access, interpret, evaluate, and apply information.
 8. Uses a variety of instructional strategies to support and expand learners' communication through speaking, listening, reading, writing, and other modes.
 9. Asks questions to stimulate discussion that serves different purposes (e.g., probing for learner understanding, helping learners articulate their ideas and thinking processes, stimulating curiosity, and helping learners to question).
 10. Understands the cognitive processes associated with various kinds of learning (e.g., critical and creative thinking, problem framing and problem solving, invention, memorization and recall) and how these processes can be stimulated.
 11. Knows how to apply a range of developmentally, culturally, and linguistically appropriate instructional strategies to achieve learning goals.
 12. Knows when and how to use appropriate strategies to differentiate instruction and engage all learners in complex thinking and meaningful tasks.
 13. Understands how multiple forms of communication (oral, written, nonverbal, digital, visual) convey ideas, foster self expression, and build relationships.
 14. Knows how to use a wide variety of resources, including human and technological, to engage students in learning.
15. Understands how content and skill development can be supported by media and technology and knows how to evaluate these resources for quality, accuracy, and effectiveness.
 16. Is committed to deepening awareness and understanding the strengths and needs of diverse learners when planning and adjusting instruction.
 17. Values the variety of ways people communicate and encourages learners to develop and use multiple forms of communication.
 18. Is committed to exploring how the use of new and emerging technologies can support and promote student learning.
 19. Values flexibility and reciprocity in the teaching process as necessary for adapting instruction to learner responses, ideas, and needs.
- J.** Standard 9. Professional Learning and Ethical Practice: The teacher engages in ongoing professional learning and uses evidence to continually evaluate his/her practice, particularly the effects of his/her choices and actions on others (learners, families, other professionals, and the community), and adapts practice to meet the needs of each learner. The teacher:
1. Engages in ongoing learning opportunities to develop knowledge and skills in order to provide all learners with engaging curriculum and learning experiences based on local and state standards.
 2. Engages in meaningful and appropriate professional learning experiences aligned with his/her own needs and the needs of the learners, school, and system.
 3. Independently and in collaboration with colleagues, uses a variety of data (e.g., systematic observation, information about learners, research) to evaluate the outcomes of teaching and learning and to adapt planning and practice.
 4. Actively seeks professional, community, and technological resources, within and outside the school, as supports for analysis, reflection, and problem-solving.
 5. Reflects on his/her personal biases and accesses resources to deepen his/her own understanding of cultural, ethnic, gender, and learning differences to build stronger relationships and create more relevant learning experiences.
 6. Advocates, models, and teaches safe, legal, and ethical use of information and technology including appropriate documentation of sources and respect for others in the use of social media.
 7. Understands and knows how to use a variety of self-assessment and problem-solving strategies to analyze and reflect on his/her practice and to plan for adaptations/adjustments.
 8. Knows how to use learner data to analyze practice and differentiate instruction accordingly.
 9. Understands how personal identity, worldview, and prior experience affect perceptions and expectations, and recognizes how they may bias behaviors and interactions with others.
 10. Understands and adheres to laws related to learners' rights and teacher responsibilities (e.g., for educational equity, appropriate education for learners with disabilities, confidentiality, privacy, appropriate treatment of learners, reporting in situations related to possible child abuse).
 11. Knows how to build and implement a plan for professional growth directly aligned with his/her needs as a growing professional using feedback from teacher evalu-

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ations and observations, data on learner performance, and school- and system-wide priorities.

12. Takes responsibility for student learning and uses ongoing analysis and reflection to improve planning and practice.
 13. Is committed to deepening understanding of his/her own frames of reference (e.g., culture, gender, language, abilities, ways of knowing), the potential biases in these frames, and their impact on expectations for and relationships with learners and their families.
 14. Sees him/herself as a learner, continuously seeking opportunities to draw upon current education policy and research as sources of analysis and reflection to improve practice.
 15. Understands the expectations of the profession including codes of ethics, professional standards of practice, and relevant law and policy.
- K. Standard 10. Leadership and Collaboration:** The teacher seeks appropriate leadership roles and opportunities to take responsibility for student learning, to collaborate with learners, families, colleagues, other school professionals, and community members to ensure learner growth, and to advance the profession. The teacher:
1. Takes an active role on the instructional team, giving and receiving feedback on practice, examining learner work, analyzing data from multiple sources, and sharing responsibility for decision making and accountability for each student's learning.
 2. Works with other school professionals to plan and jointly facilitate learning on how to meet diverse needs of learners.
 3. Engages collaboratively in the schoolwide effort to build a shared vision and supportive culture, identify common goals, and monitor and evaluate progress toward those goals.
 4. Works collaboratively with learners and their families to establish mutual expectations and ongoing communication to support learner development and achievement.
 5. Working with school colleagues, builds ongoing connections with community resources to enhance student learning and well being.
 6. Engages in professional learning, contributes to the knowledge and skill of others, and works collaboratively to advance professional practice.
 7. Uses technological tools and a variety of communication strategies to build local and global learning communities that engage learners, families, and colleagues.
 8. Uses and generates meaningful research on education issues and policies.
 9. Seeks appropriate opportunities to model effective practice for colleagues, to lead professional learning activities, and to serve in other leadership roles.
 10. Strives to meet the needs of learners and to strengthen the learning environment.
 11. Takes on leadership roles at the school, district, state, and/or national levels.
 12. Understands schools as organizations within a historical, cultural, political, and social context and knows how to work with others across the system to support learners.
 13. Understands that alignment of family, school, and community spheres of influence enhances student learning and that discontinuity in these spheres of influence interferes with learning.

14. Knows how to work with other adults and has developed skills in collaborative interaction appropriate for both face-to-face and virtual contexts.
15. Knows how to contribute to a common culture that supports high expectations for student learning.
16. Actively shares responsibility for shaping and supporting the mission of his/her school as one of advocacy for learners and accountability for their success.
17. Respects families' beliefs, norms, and expectations and seeks to work collaboratively with learners and families in setting and meeting challenging goals.
18. Takes initiative to grow and develop with colleagues through interactions that enhance practice and support student learning.
19. Takes responsibility for contributing to and advancing the profession.
20. Embraces the challenge of continuous improvement and change.

Historical Note

Former Section R7-2-602 repealed, new Section R7-2-602 adopted effective December 4, 1978 (Supp. 78-6).

Amended by adding a new subsection (B) effective August 29, 1988 (Supp. 88-3). Amended effective December 15, 1989 (Supp. 89-4). Amended effective July 10, 1992 (Supp. 92-3). Amended effective March 6, 1997 (Supp. 97-1). Section repealed; new Section adopted effective December 3, 1998 (Supp. 98-4). Amended by exempt rulemaking at 18 A.A.R. 1029, effective December 5, 2011 (Supp. 12-2).

R7-2-602.01. Induction Program Standards for New Teachers

- A.** For the purposes of this Section, the following definitions apply:
1. "Induction" and "mentoring and retention programming" means a program of regular, job-embedded, in-person, one-on-one feedback that is focused on instruction and ensuring new classroom teacher quality, success and retention.
 2. "New classroom teacher" means a classroom teacher who is in the first, second, or third year of teaching.
- B.** The Arizona Teacher Induction Standards, and substantially similar programs developed by local education agencies, shall serve as the form and format of mentoring and retention programming for school districts, charter schools, the State Education System for Committed Youth, and the Arizona State Schools for the Deaf and the Blind who receive grant funds established pursuant to A.R.S. § 15-1281(D)(3). The standards and programs developed by local education agencies shall require that the equivalent of one full-time mentor may be assigned to not more than 15 new classroom teachers employed by the school district or charter school.
- C.** The Department shall:
1. Develop the induction program standards in consultation with state educators and experts in instruction and educator quality, success, and retention.
 2. Present the induction program standards and the development process to the Board for review and approval.
- D.** The Board shall adopt the Arizona Teacher Induction Standards in a meeting following the presentation of the standards to the Board.

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Historical Note

New Section made by final exempt rulemaking at 27
A.A.R. 743, effective April 26, 2021 (Supp. 21-2).

R7-2-603. Professional Administrative Standards

- A.** The standards presented in this Section shall be the basis for approved administrative preparation programs, described in R7-2-604. The Arizona Administrator Proficiency Assessment shall assess proficiency in the standards as a requirement for certification of supervisors, principals, and superintendents, as set forth in R7-2-616.
- B.** Standard 1: Effective educational leaders develop, advocate, and enact a shared mission, vision, and core values of high-quality education and academic success and well-being of each student. Effective leaders:
1. Develop an educational mission for the school to promote the academic success and well-being of each student.
 2. In collaboration with members of the school and the community and using relevant data, develop and promote a vision for the school on the successful learning and development of each child and on instructional and organizational practices that promote such success.
 3. Articulate, advocate, and cultivate core values that define the school's culture and stress the imperative of child-centered education; high expectations and student support; equity, inclusiveness, and social justice; openness, caring, and trust; and continuous improvement.
 4. Strategically develop, implement, and evaluate actions to achieve the vision for the school.
 5. Review the school's mission and vision and adjust them to changing expectations and opportunities for the school, and changing needs and situations of students.
 6. Develop shared understanding of and commitment to mission, vision, and core values within the school and the community.
 7. Model and pursue the school's mission, vision, and core values in all aspects of leadership.
- C.** Standard 2: Effective educational leaders act ethically and according to professional norms to promote each student's academic success and well-being. Effective leaders:
1. Act ethically and professionally in personal conduct, relationships with others, decision-making, stewardship of the school's resources, and all aspects of school leadership.
 2. Act according to and promote the professional norms of integrity, fairness, transparency, trust, collaboration, perseverance, learning, and continuous improvement.
 3. Place children at the center of education and accept responsibility for each student's academic success and well-being.
 4. Safeguard and promote the values of democracy, individual freedom and responsibility, equity, social justice, community, and diversity.
 5. Lead with interpersonal and communication skill, social-emotional insight, and understanding of all students' and staff members' backgrounds and cultures.
 6. Provide moral direction for the school and promote ethical and professional behavior among faculty and staff.
- D.** Standard 3: Effective educational leaders strive for equity of educational opportunity and culturally responsive practices to promote each student's academic success and well-being. Effective leaders:
1. Ensure that each student is treated fairly, respectfully, and with an understanding of each student's culture and context.
 2. Recognize, respect, and employ each student's strengths, diversity, and culture as assets for teaching and learning.
 3. Ensure that each student has equitable access to effective teachers, learning opportunities, academic and social support, and other resources necessary for success.
 4. Develop student policies and address student misconduct in a positive, fair, and unbiased manner.
 5. Confront and alter institutional biases of student marginalization, deficit-based schooling, and low expectations associated with race, class, culture and language, gender and sexual orientation, and disability or special status.
 6. Promote the preparation of students to live productively in and contribute to the diverse cultural contexts of a global society.
 7. Act with cultural competence and responsiveness in their interactions, decision making, and practice.
 8. Address matters of equity and cultural responsiveness in all aspects of leadership.
- E.** Standard 4: Effective educational leaders develop and support intellectually rigorous and coherent systems of curriculum, instruction, and assessment to promote each student's academic success and well-being. Effective leaders:
1. Implement coherent systems of curriculum, instruction, and assessment that promote the mission, vision, and core values of the school, embody high expectations for student learning, align with academic standards, and are culturally responsive.
 2. Align and focus systems of curriculum, instruction, and assessment within and across grade levels to promote student academic success, love of learning, the identities and habits of learners, and healthy sense of self.
 3. Promote instructional practice that is consistent with knowledge of child learning and development, effective pedagogy, and the needs of each student.
 4. Ensure instructional practice that is intellectually challenging, authentic to student experiences, recognizes student strengths, and is differentiated and personalized.
 5. Promote the effective use of technology in the service of teaching and learning.
 6. Employ valid assessments that are consistent with knowledge of child learning and development and technical standards of measurement.
 7. Use assessment data appropriately and within technical limitations to monitor student progress and improve instruction.
- F.** Standard 5: Effective educational leaders cultivate an inclusive, caring, and supportive school community that promotes the academic success and well-being of each student. Effective leaders:
1. Build and maintain a safe, caring, and healthy school environment that meets that the academic, social, emotional, and physical needs of each student.
 2. Create and sustain a school environment in which each student is known, accepted and valued, trusted and respected, cared for, and encouraged to be an active and responsible member of the school community.
 3. Provide coherent systems of academic and social supports, services, extracurricular activities, and accommodations to meet the range of learning needs of each student.
 4. Promote adult-student, student-peer, and school-community relationships that value and support academic learning and positive social and emotional development.

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5. Cultivate and reinforce student engagement in school and positive student conduct.
 6. Infuse the school's learning environment with the cultures and languages of the school's community.
- G.** Standard 6: Effective educational leaders develop the professional capacity and practice of school personnel to promote each student's academic success and well-being. Effective leaders:
1. Recruit, hire, support, develop, and retain effective and caring teachers and other professional staff and form them into an educationally effective faculty.
 2. Plan for and manage staff turnover and succession, providing opportunities for effective induction and mentoring of new personnel.
 3. Develop teachers' and staff members' professional knowledge, skills, and practice through differentiated opportunities for learning and growth, guided by understanding of professional and adult learning and development.
 4. Foster continuous improvement of individual and collective instructional capacity to achieve outcomes envisioned for each student.
 5. Deliver actionable feedback about instruction and other professional practice through valid, research-anchored systems of supervision and evaluation to support the development of teachers' and staff members' knowledge, skills, and practice.
 6. Empower and motivate teachers and staff to the highest levels of professional practice and to continuous learning and improvement.
 7. Develop the capacity, opportunities, and support for teacher leadership and leadership from other members of the school community.
 8. Promote the personal and professional health, well-being, and work-life balance of faculty and staff.
 9. Tend to their own learning and effectiveness through reflection, study, and improvement, maintaining a healthy work-life balance.
- H.** Standard 7: Effective educational leaders foster a professional community of teachers and other professional staff to promote each student's academic success and well-being. Effective leaders:
1. Develop workplace conditions for teachers and other professional staff that promote effective professional development, practice, and student learning.
 2. Empower and entrust teachers and staff with collective responsibility for meeting the academic, social, emotional, and physical needs of each student, pursuant to the mission, vision, and core values of the school.
 3. Establish and sustain a professional culture of engagement and commitment to shared vision, goals, and objectives pertaining to the education of the whole child; high expectations for professional work; ethical and equitable practice; trust and open communication; collaboration, collective efficacy, and continuous individual and organizational learning and improvement.
 4. Promote mutual accountability among teachers and other professional staff for each student's success and the effectiveness of the school as a whole.
 5. Develop and support open, productive, caring, and trusting working relationships among leaders, faculty, and staff to promote professional capacity and the improvement of practice.
6. Design and implement job-embedded and other opportunities for professional learning collaboratively with faculty and staff.
 7. Provide opportunities for collaborative examination of practice, collegial feedback, and collective learning.
 8. Encourage faculty-initiated improvement of programs and practices.
- I.** Standard 8: Effective educational leaders engage families and the community in meaningful, reciprocal, and mutually beneficial ways to promote each student's academic success and well-being. Effective leaders:
1. Are approachable, accessible, and welcoming to families and members of the community.
 2. Create and sustain positive, collaborative, and productive relationships with families and the community for the benefit of students.
 3. Engage in regular and open two-way communication with families and the community about the school, students, needs, problems, and accomplishments.
 4. Maintain a presence in the community to understand its strengths and needs, develop productive relationships, and engage its resources for the school.
 5. Create means for the school community to partner with families to support student learning in and out of school.
 6. Understand, value, and employ the community's cultural, social, intellectual, and political resources to promote student learning and school improvement.
 7. Develop and provide the school as a resource for families and the community.
 8. Advocate for the school and district, and for the importance of education and student needs and priorities to families and the community.
 9. Advocate publicly for the needs and priorities of students, families, and the community.
 10. Build and sustain productive partnerships with public and private sectors to promote school improvement and student learning.
- J.** Standard 9: Effective educational leaders manage school operations and resources to promote each student's academic success and well-being. Effective leaders:
1. Institute, manage, and monitor operations and administrative systems that promote the mission and vision of the school.
 2. Strategically manage staff resources, assigning and scheduling teachers and staff to roles and responsibilities that optimize their professional capacity to address each student's learning needs.
 3. Seek, acquire, and manage fiscal, physical, and other resources to support curriculum, instruction, and assessment; student learning community; professional capacity and community; and family and community engagement.
 4. Are responsible, ethical, and accountable stewards of the school's monetary and non-monetary resources, engaging in effective budgeting and accounting practices.
 5. Protect teachers' and other staff members' work and learning from disruption.
 6. Employ technology to improve the quality and efficiency of operations and management.
 7. Develop and maintain data and communication systems to deliver actionable information for classroom and school improvement.
 8. Know, comply with, and help the school community understand local, state, and federal laws, rights, policies, and regulations so as to promote student success.

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9. Develop and manage relationships with feeder and connecting schools for enrollment management and curricular and instructional articulation.
 10. Develop and manage productive relationships with the central office and school board.
 11. Develop and administer systems for fair and equitable management of conflict among students, faculty and staff, leaders, families, and community.
 12. Manage governance processes and internal and external politics toward achieving the school's mission and vision.
- K. Standard 10: Effective educational leaders act as agents of continuous improvement to promote each student's academic success and well-being. Effective leaders:**
1. Seek to make school more effective for each student, teachers and staff, families, and the community.
 2. Use methods of continuous improvement to achieve the vision, fulfill the mission, and promote the core values of the school.
 3. Prepare the school and the community for improvement, promoting readiness, an imperative for improvement, instilling mutual commitment and accountability, and developing the knowledge, skills, and motivation to succeed in improvement.
 4. Engage others in an ongoing process of evidence-based inquiry, learning, strategic goal setting, planning, implementation, and evaluation for continuous school and classroom improvement.
 5. Employ situationally-appropriate strategies for improvement, including transformational and incremental, adaptive approaches and attention to different phases of implementation.
 6. Assess and develop the capacity of staff to assess the value and applicability of emerging educational trends and the findings of research for the school and its improvement.
 7. Develop technically appropriate systems of data collection, management, analysis, and use, connecting as needed to the district office and external partners for support in planning, implementation, monitoring, feedback, and evaluation.
 8. Adopt a systems perspective and promote coherence among improvement efforts and all aspects of school organization, programs, and services.
 9. Manage uncertainty, risk, competing initiatives, and politics of change with courage and perseverance, providing support and encouragement, and openly communicating the need for, process for, and outcomes of improvement efforts.
 10. Develop and promote leadership among teachers and staff for inquiry, experimentation and innovation, and initiating and implementing improvement.

Historical Note

Former Section R7-2-603 repealed, new Section R7-2-603 adopted effective December 4, 1978 (Supp. 78-6). Amended effective July 21, 1980 (Supp. 80-4). Amended subsection (J) effective August 20, 1981 (Supp. 81-4). Amended subsections (D) and (E) effective April 10, 1984 (Supp. 84-2). Amended subsection (J)(8) and (9) effective October 10, 1984 (Supp. 84-5). Amended subsection (G) effective December 13, 1985. Amended subsection (J)(6), (7), (8) and (9) effective December 18, 1985 (Supp. 85-6). Editorial correction, amendment to subsections (D) and (E) shown effective April 10, 1984 should read Amended subsections (D) and (E) effective

October 1, 1985. Amended by adding subsection (G)(9) and (10) effective January 31, 1986 (Supp. 86-1). Amended by adding subsection (R) effective April 24, 1986 (Supp. 86-2). Amended subsection (G), filed May 5, 1986, effective July 1, 1987 (Supp. 86-3). Amended by adding subsection (J)(10) and (11) effective July 2, 1986; amended by adding subsection (J)(12), (13) and (14), filed August 7, 1986, effective July 1, 1987 (Supp. 86-4). Amended subsection (H) effective September 16, 1987 (Supp. 87-3). Correction: subsection (G)(3), "Provisional" is corrected to read: "Principal" as certified effective December 3, 1985; amended subsection (B) effective July 13, 1988; amended subsection (J)(2) effective August 10, 1988; amended subsection (R)(2)(b) effective August 15, 1988 (Supp. 88-3). Amended effective August 9, 1989, and amended effective September 12, 1989 (Supp. 89-3). Amended effective December 15, 1989 (Supp. 89-4). Amended effective November 6, 1990; Amended effective December 12, 1990 (Supp. 90-4). Amended effective March 21, 1991 (Supp. 91-1). Amended effective May 2, 1991 (Supp. 91-2). Amended effective October 22, 1991 (Supp. 91-4). Section repealed, new Section adopted effective March 10, 1994 (Supp. 94-1). Amended effective December 19, 1996 (Supp. 96-4). Amended effective March 6, 1997 (Supp. 97-1). Typographical error corrected in subsection (J) (Supp. 97-4). Section repealed; new Section adopted effective December 4, 1998 (Supp. 98-4). Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). Amended by exempt rulemaking at 18 A.A.R. 1029, effective December 5, 2011 (Supp. 12-2). Amended by final exempt rulemaking at 22 A.A.R. 3369, effective October 24, 2016 (Supp. 16-4).

R7-2-604. Definitions

In R7-2-604 through R7-2-604.05, unless the context otherwise requires:

1. "Accreditation" means a professional preparation institution's recognition by a national or regional agency or organization acknowledged for meeting identified standards or criteria.
2. "Alternative educator preparation program" means a program designed for individuals who are working as a PreK through 12 teacher or administrator while certified under an alternative teaching certificate or interim administrative certificate. Alternative educator preparation programs may have substantially different program sequences, designs, and/or formats than that of a traditional education preparation program.
3. "Biennial report" means a report submitted every two years to the Department by all Arizona State Board approved professional preparation institutions for each approved educator preparation program.
4. "Biennial status letter" means correspondence issued by the Department to the professional preparation institution within 30 days upon completion of the review of the biennial report, indicating the status of the educator preparation program(s).
5. "Board approved program" means a course of study that is approved by the Board and meets all relevant standards for teachers, administrators, school guidance counselors, or school psychologists.
6. "Capstone experience" means a culminating professional experience in a PreK through 12 setting. This experience may include student teaching or internships in adminis-

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- tration, counseling, or school psychology, or alternative path PreK through 12 teaching.
7. "Classroom-based educator preparation program" means a program administered through a school district or charter school that is approved pursuant to R7-2-604.05.
 8. "Educator preparation program" means a traditional or alternative educator preparation program that prepares PreK through 12 teachers, administrators, school counselors, and school psychologists for an institutional recommendation for an Arizona certificate.
 9. "Field experience" means scheduled, directed, structured, supervised, frequent experiences in a PreK through 12 setting that occurs prior to the capstone experience. Field experiences must assist educator candidates in developing the knowledge, skills, and dispositions necessary to ensure all students learn, and provide evidence in meeting standards described in the Board approved professional teaching standards or professional administrative standards, and relevant Board approved academic standards.
 10. "Institutional recommendation" means a form developed by the Department and issued by a professional preparation institution, that indicates an individual has completed a Board approved educator preparation program.
 11. "Internship" means significant opportunities for candidates to practice and develop the skills identified in relevant state and national standards as measured by substantial and sustained work in real settings, appropriate for the certificate the candidate is seeking, performed under the direction of a supervising practitioner and a program supervisor.
 12. "Locally based school leadership preparation program" means a program administered through a school district or charter school that is approved pursuant to R7-2-604.06.
 13. "National standards" means written expectations for meeting a specified level of performance that are established by, but not limited to, the following organizations: Council for Accreditation of Counseling and Related Education Program (CACREP), Council for the Accreditation of Educator Preparation (CAEP), Council for Exceptional Children. (CEC), The National Educational Leadership Preparation (NELP), Interstate New Teacher Assessment and Support Consortium (InTASC), Professional Standards for Educational Leadership (PSEL), International Society for Technology in Education (ISTE), National Association for the Education of Young Children (NAEYC), National Association of School Psychologists (NASP), National Council for Accreditation of Teacher Education (NCATE) or Teacher Education Accreditation Council (TEAC).
 14. "Probationary educator preparation program" means a program with at least one deficiency identified in the biennial status letter issued by the Department, as a result of a Department review of the biennial report. Programs with the same deficiency(s) in two consecutive biennial status letters are subject to revocation of Board approval. A deficiency may include, but is not limited to, stakeholder surveys, completer data and student achievement data.
 15. "Professional preparation institutions" means organizations that include, but are not limited to, universities and colleges, school districts, not for profit organizations, professional organizations, private businesses, charter schools, and regional training centers that oversee one or more educator preparation programs.
 16. "Program completer" means a student who has met all the professional program institution's requirements of a Board approved educator preparation program necessary to obtain an institutional recommendation.
 17. "Program supervisor" means an educator from the professional preparation institution under whose supervision the candidate for licensure practices during a capstone experience. The program supervisor's professional work experiences must be relevant to the license the candidate is seeking. Program supervisors must also have adequate training from the professional preparation institution.
 18. "Review Team" means a committee that reviews educator preparation programs seeking Board approval that consists of representatives from the Department and at least three of the following entities: institutions under the jurisdiction of the Arizona Board of Regents, Arizona private institutions of higher education, Arizona community colleges, other organizations with a Board approved educator preparation program, professional educator associations, PreK through 12 administrators from local education agencies, National Board Certified Teachers, and a graduate or representative from an Arizona educator preparation program. For alternative educator preparation program applications, the review team shall include at least one graduate or representative from an Arizona alternative educator preparation program.
 19. "Student teaching" means a minimum of 12 weeks of rigorous field-based experiences, appropriate for the certificate the candidate is seeking, performed under the direction of a supervising practitioner and a program supervisor. The student teaching placement must be appropriate for the certification that the applicant is seeking.
 20. "Supervising practitioner" means a standard certified educator, currently employed by a local education agency, private agency or other PreK through 12 setting who supervises the candidate during a capstone experience. Supervising practitioners must have:
 - a. A minimum of three full years of experience relevant to the license the candidate is seeking.
 - b. A current classification of highly effective or effective pursuant to A.R.S. §§ 15-341(A)(41), 15-189.06, when applicable.
 - c. Adequate training from the professional preparation institution.
 21. "Traditional educator preparation program" means a program that includes courses, field experiences, and a capstone experience that is designed to prepare preservice PreK through 12 teachers, administrators, school counselors, and school psychologists."

Historical Note

New Section made by exempt rulemaking at 16 A.A.R. 318, effective August 29, 2006 (Supp. 09-1). Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). Amended by final exempt rulemaking at 21 A.A.R. 2047, effective October 27, 2014 (Supp. 15-3). Amended by final exempt rulemaking at 26 A.A.R. 66, effective December 13, 2019 (Supp. 19-4). Amended by final exempt rulemaking at 26 A.A.R. 1311, effective May 18, 2020 (Supp. 20-2). The word "twelve" has been changed to the numeral "12," the hyphen between "PreK-12" has been changed to the word

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“through” for consistency in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 29 A.A.R. 183 (January 13, 2023), effective December 9, 2022 (Supp. 22-4).

R7-2-604.01. Educator Preparation Programs

- A. Professional preparation institutions shall include evidence that the educator preparation program is aligned to standards described in the Board approved professional teaching standards or professional administrative standards and relevant national standards, and provides field experiences, and a capstone experience.
- B. Educator preparation programs of professional preparation institutions requesting Board approval shall be reviewed by the Department, and the Department shall recommend Board action. Upon the recommendation of the Department, the Board shall evaluate and may approve an educator preparation program. The Board may grant program approval for a period not to exceed six years.
- C. All educator preparation programs that lead to an Arizona certification must be approved by the Board pursuant to these rules. Board approval of educator preparation programs may be granted following the successful evaluation of the program. Board rules in effect at the time of the submission of a program for evaluation shall be the rules upon which the educator preparation program is evaluated.

Historical Note

New Section made by exempt rulemaking at 16 A.A.R. 318, effective August 29, 2006 (Supp. 09-1). Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). Amended by final exempt rulemaking at 21 A.A.R. 2047, effective October 27, 2014 (Supp. 15-3). This Section was inadvertently removed when Supp. 19-4 was published. It has been reinstated as last amended in Supp. 15-3 (Supp. 21-2).

R7-2-604.02. Educator Preparation Program Approval Procedures

- A. Professional preparation institutions with no Board approved educator preparation programs, seeking initial approval for an educator preparation program shall submit to the Department the information necessary to conduct a readiness review of the professional preparation institution. The Department shall prescribe forms to assist professional preparation institutions with providing all information required as part of the readiness review process. The required information, includes the following:
 - 1. An institutional profile demonstrating program and financial stability, a description of the educator preparation program seeking approval, a listing of national or regional accreditations the institution's governance and administrative structures and student demographic data.
 - 2. A description of the professional preparation institution's vision, mission, philosophy and goals, and a description of how this information is shared with students, relevant staff and other relevant stakeholders.
 - 3. Data regarding the professional preparation institution's relevant staff, including the following:
 - a. Demographic data relating to the relevant staff for each educator preparation program seeking approval, including, at a minimum, educational degrees, staff to student ratio, experience teaching in a PreK through 12 setting, and, if available, ethnicity and gender data.
 - b. Definitions of titles and clarification of roles of individuals responsible for courses, seminars, or modules of study; field experiences; capstone experiences; and administration.
 - c. A description of the professional preparation institution's employment policies, including procedures for determining staff assignments, evaluation procedures and professional development opportunities and requirements.
- B. The Department shall provide professional preparation institutions written notification, within 60 days of receiving readiness review materials, either indicating readiness to submit educator preparation programs for review or specifying any deficiencies. The institution has 30 days from receipt of the notice to supply the Department with all required information regarding identified deficiencies.
- C. The Department shall initiate a review of the specific educator preparation programs being considered for Board approval. The Department shall prescribe forms to assist institutions with providing all information required as part of the educator preparation programs review. Professional Preparation Institutions with accreditation may submit accreditation documentation to be considered as part of the review process. To facilitate this review, institutions shall provide the Department with the following:
 - 1. A description of the educator preparation programs being considered for Board approval. This shall include, at a minimum, the criteria for student entry into the program; a summary of the program courses, seminars, or modules of study; field experiences; and capstone experiences. The professional preparation institution must verify that it requires courses, seminars, or modules of study necessary to obtain a full Structured English Immersion endorsement if required for the certificate the candidate is seeking.
 - 2. A description of the field experience and capstone experience policies for the educator preparation programs being considered for Board approval. The review team shall verify that the field experience and capstone experience includes evidence of engagement in the application of relevant standards as articulated in the Board approved professional teaching standards or professional administrative standards and relevant national standards. Educator preparation programs applying for approval in school psychology and guidance counseling shall only be required to demonstrate compliance with applicable national standards.
 - 3. Evidence that candidates are provided instruction and practice in how to gather, evaluate, and synthesize multiple data sources and how to effectively use data in educational and classroom instructional decisions.
 - 4. Provide the Department with evidence that candidates are provided instruction and practice in how to appropriately integrate technology when working with students.
 - 5. A description of the assessment plan for measuring each candidate's competencies as they progress through courses, seminars, or modules of study and field experiences to ensure readiness for a capstone experience. The plan shall require, at a minimum, that candidates demonstrate competencies as articulated in the Board approved professional teaching standards or professional administrative standards, relevant Board approved academic standards, and relevant national standards. The plan shall also describe processes for utilizing performance-based

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assessments and for providing candidates with necessary remediation. Programs applying for approval in school psychology and guidance counseling shall only be required to demonstrate compliance with relevant national standards.

6. A description of the procedures used to monitor and evaluate the operation, scope and quality of the educator preparation program being considered for approval. This shall include the use of internal and external evaluations, and may include stakeholder surveys, program completer employment information, and PreK through 12 student achievement data.
 7. An educator preparation program matrices demonstrating that program course, seminar, or module assessments, field experiences and capstone experiences measure candidates' success in meeting the Board approved professional teaching standards or professional administrative standards, and relevant national standards. Educator preparation programs applying for approval in school psychology and guidance counseling shall only be required to demonstrate compliance with relevant national standards.
 8. A plan for how the education preparation program will notify and assist program participants and partner schools if the educator preparation program closes.
- D.** The Department may schedule and conduct an onsite visit upon completion of the educator preparation programs review for professional preparation institutions seeking initial approval. The onsite visit may include a tour of the professional preparation institution; a review of documentation and related evidence; and interviews of relevant staff, educator candidates, and local education agency, private agency or other PreK through 12 administrators who employ program completers.
- E.** Upon completion of the review, and onsite review if applicable, the Department shall, within 90 days, provide the professional preparation institution with a program report of the Department's findings. This report shall cite any evidence showing deviation from each relevant standard Board approved professional teaching standard, professional administrative standard, and relevant national standard that applies to the educator preparation program. The professional preparation institution shall have 30 days from receipt of the Department's program report to submit a response addressing any identified deficiencies.
- F.** Based upon the Department's program report, the Department shall recommend to the Board that the educator preparation program be approved or denied.
- G.** The Board may grant educator preparation program approval for a period not to exceed six years or deny program approval.
- H.** Within 60 days of the Board's action, a professional preparation institution may request reconsideration of the Board's decision to deny an educator preparation program.
- I.** Professional preparation institutions with Board approval shall make available to the public a statement indicating the valid period for which the educator preparation program has been approved.
- J.** Professional preparation institutions with Board approved educator preparation programs shall comply with the reporting requirements established by Title II of the Higher Education Act (P.L. 110-315).
- K.** Each approved professional preparation institution shall submit a biennial report with the Department documenting educa-

tor preparation program activities for the previous two years. The biennial report shall include the following:

1. A description of any substantive changes in courses, seminars, modules, assessments, field experiences or capstone experiences in Board approved educator preparation programs;
 2. Electronic access to relevant educator preparation program information;
 3. The name, title and original signature of the certification officer for the professional preparation institution;
 4. Relevant data on the educator preparation program, relevant staff, and candidates, which may include, but is not limited to, stakeholder surveys, completer data, and student achievement data required as a condition of initial or continuing program approval.
- L.** The Department shall provide annual updates to the Board and make publicly available information summarizing the biennial reports to include, but not limited to, program status, deficiencies, and commendations.
- M.** Board approved educator preparation programs shall provide their program completers with an institutional recommendation for issuance of the appropriate Arizona certification within 45 days.
- N.** To maintain Board educator preparation program approval, the professional preparation institution shall be in continuous operation and training candidates in accordance with its mission and program objectives, fulfill all reporting requirements, and maintain compliance with all applicable local, state, tribal and federal requirements.
- O.** The Department shall provide a timeline for professional preparation institutions to submit educator preparation programs for approval.
- P.** Professional preparation Institutions seeking renewal of educator preparation program approval shall submit the required preliminary documents for review at least six month prior to the program expiration date.

Historical Note

New Section made by exempt rulemaking at 16 A.A.R. 318, effective August 29, 2006 (Supp. 09-1). Amended by final exempt rulemaking at 21 A.A.R. 2047, effective October 27, 2014 (Supp. 15-3). The hyphen between "PreK-12" was replaced with the word "through" for consistency in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 29 A.A.R. 183 (January 13, 2023), effective December 9, 2022 (Supp. 22-4).

R7-2-604.03. Alternative Educator Preparation Program Approval Process

- A.** An organization that includes, but is not limited to, universities under the jurisdiction of the Arizona Board of Regents, community colleges in this state, private postsecondary institutions licensed by this state, school districts, charter schools, professional organizations, nonprofit organizations, private entities and regional training centers that oversee one or more educator preparation program which wishes to offer a program for an alternative route for the certification of teachers and administrators in this State shall apply to the Department of Education for review to become an approved provider of such a program. The Department of Education shall convene a review team to review the application, using a rubric approved by the Board, and submit a recommendation to the Board. The application shall include:
1. The name and location of the applicant;

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2. The name of the program;
 3. If the applicant is accredited, the name of the regional accrediting body and the accreditation status of the applicant;
 4. If the applicant is a private postsecondary educational institution, evidence that the applicant is licensed to operate by the State Board of Private Postsecondary Education pursuant to A.R.S. § 32-3021;
 5. A description of the budget of the program;
 6. A list of all staff members responsible for the administration of the program, the roles and responsibilities of each person and his or her credentials;
 7. The areas of certification for which the applicant will offer the program;
 8. A description of the program, which shall include:
 - a. The way in which the elements of the program will comply with the requirements of this Section and R7-2-602, R7-2-603 as applicable and A.R.S. § 15-501.01;
 - b. The application and review process for persons to enroll in the program, including a copy of all forms that will be used in the process;
 - c. A summary of the program courses, seminars, or modules of study; and
 - d. The supervised, school-based experiences the applicant will provide, including:
 - i. The name of each school and school district that will participate in the supervised, school-based experience, evidenced by a letter or other communication from the school or school district that demonstrates interest in participating;
 - ii. The length of time for which a candidate will be required to participate in the supervised, school-based experience, including any orientation that the candidate must complete;
 - iii. The manner by which candidates will be mentored by an effective or highly effective teacher and evaluated during the supervised, school-based experience;
 - iv. How the supervised, school-based experience will promote the effectiveness of teachers and administrators, as appropriate; and
 - v. A copy of all forms that will be used for the supervised, school-based experience process;
 9. If available, data on the efficacy of its preparation program which may include stakeholder surveys, completer data, and student achievement data;
 10. A statement of the estimated time it will take a candidate enrolled in the program to complete the program, which shall allow for completion of the program within one year but not more than three years;
 11. A description of the manner by which the applicant will evaluate the success or failure of each candidate enrolled in the program and track the progress of each such candidate, including a copy of all forms that will be used for the evaluation and tracking;
 12. A description of how the applicant will evaluate the success of the program, which must include the information required for the evaluation pursuant to R7-2-604.02(K)(4);
 13. A plan for how the education preparation program will notify and assist program participants and partner schools if the educator preparation program closes.
- B.** Upon receipt of an application for approval as an approved provider pursuant to subsection (A), the Department of Education shall convene a review team that shall:
 1. Examine the application;
 2. Determine whether to recommend that the State Board of Education grant its approval of the application based upon the requirements of this Section and the Board-approved rubric without any additional requirements; and
 3. Submit its recommendation to the State Board of Education within 90 days of receipt of the application.
 - C.** The State Board of Education shall review the recommendation of the review team and provide to the applicant written notice of its approval or denial. The State Board of Education may grant provisional approval to an applicant pursuant to subsection (D). If the State Board of Education denies an application, the applicant may correct any deficiencies identified in the notice of denial and resubmit the application for review by the Department within 30 days of the denial. The review team shall review the resubmitted application and submit its recommendation to the Board within 60 days of receipt of the resubmitted application.
 - D.** If the State Board of Education grants an applicant provisional approval, the applicant may offer the program for an alternative route to certification described in the application for the period prescribed by the State Board of Education. The applicant must remove all the provisions under which the approval was issued before the expiration of the provisional approval. If the applicant removes the provisions within the prescribed time, the State Board of Education will grant nonprovisional approval to the applicant as an approved provider. Provisional approval is valid for two years after the date on which the State Board of Education granted provisional approval. If an applicant does not remove all the provisions within the prescribed time, the provisional approval is automatically revoked.
 - E.** Except as otherwise provided in subsection (D), if an applicant is approved as an approved provider pursuant to this Section, the approval is valid for six years after the date of approval. To continue the approval, the qualified provider must submit an application for renewal before the expiration of the approval to the Department of Education. If the application for renewal is approved by the State Board of Education, the renewal is valid for six years after the date of the approval.
 - F.** If an approved provider intends to offer a program for an alternative route to certification for an area of certification that is different from the area of certification for which the qualified provider has been approved, the qualified provider must submit a new application pursuant to subsection (A) to offer a program for an alternative route to certification for that area of certification.
 - G.** An approved provider shall provide its program completers with an institutional recommendation for issuance of the appropriate Arizona alternative path certification within 45 days. An approved provider seeking renewal of its program approval shall submit the required renewal application for review at least 90 days prior to the program expiration date.
 - H.** Each qualified provider must submit a report once every two years which includes:
 1. A description of any substantive changes in courses, seminars, modules or assessments in the Board approved educator preparation programs;
 2. The name, title and original signature of the certification officer for the professional preparation institution; and
 3. Relevant data on the educator preparation program, relevant staff, and candidates, which may include, but is not

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limited to, stakeholder surveys, completer data, and student achievement data required as a condition of continuing program approval.

- I. The Department shall:
 1. Present the results of the report to the State Board of Education; and
 2. After the results have been presented to the State Board of Education, post the report on the Department's website.
- J. Each qualified provider shall cooperate with the State Board of Education and the Department in the evaluation of the effectiveness of this Section.

Historical Note

New Section made by exempt rulemaking at 16 A.A.R. 728, effective March 22, 2010 (Supp. 10-3). Amended by final exempt rulemaking at 21 A.A.R. 2047, effective October 27, 2014 (Supp. 15-3). Amended by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1). Amended by final exempt rulemaking at 25 A.A.R. 965, effective March 25, 2019 (Supp. 19-1). Amended by final exempt rulemaking at 26 A.A.R. 1311, effective May 18, 2020 (Supp. 20-2). Amended by final exempt rulemaking at 29 A.A.R. 183 (January 13, 2023), effective December 9, 2022 (Supp. 22-4).

R7-2-604.04. Revocation of Approval of Qualified Provider: Notification of Intent; Requirements of Exit Plan

- A. The State Board of Education may revoke its approval of an approved provider if the Board determines that the program for an alternative route to certification offered by the qualified provider does not meet the applicable requirements of R7-2-604.03.
- B. Before the Board revokes its approval of an approved provider, the Board will notify the qualified provider of its intent to revoke approval. The notice must include the specific reasons upon which the Board is basing its decision. Not later than 30 days after the date on which the qualified provider receives the notice, the qualified provider may submit a written response to the Board which sets forth the reasons why approval should not be revoked. The Board will review the notice and any response submitted by the qualified provider and will determine whether to:
 1. Revoke the approval of the qualified provider;
 2. Allow the qualified provider to continue providing the program for an alternative route to certification if certain enumerated conditions are met; or
 3. Allow the continued approval of the qualified provider without conditions.
- C. If the Board revokes its approval of an approved provider, the qualified provider must provide an exit plan which includes a description of how the qualified provider will assist candidates enrolled in the program for an alternative route to certification in completing another program with a different qualified provider at no cost to the candidate.

Historical Note

New Section made by exempt rulemaking at 16 A.A.R. 728, effective March 22, 2010 (Supp. 10-3). Amended by final exempt rulemaking at 21 A.A.R. 2047, effective October 27, 2014 (Supp. 15-3). Amended by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1).

R7-2-604.05. Classroom-Based Alternative Preparation Program Approval Process**gram Approval Process**

- A. A school district or charter school may apply to the Board for approval as a classroom-based alternative preparation program provider. The Department shall facilitate the Board approval process and prescribe an application form that shall include the following:
 1. The name of the program and the school district or charter school applying;
 2. The areas of certification for which the applicant will offer the program;
 3. Verification that individuals enrolled in the program will have a bachelor's degree from an accredited institution, or will meet all of the following criteria:
 - a. Will be currently enrolled in an accredited public or private postsecondary institution's bachelor's degree program;
 - b. Will not be a contracted or permanent full-time teacher or teacher of record for any classroom of students, except those enrollees may be employed by the school district or charter school; and
 - c. Will not regularly instruct students without the presence of a full-time teacher, certificated teacher, instructional coach or instructional mentor unless the individual possesses other means of certification.
 4. Verification that individuals to be enrolled in the program will meet the background requirements and have a valid fingerprint card issued by the Arizona Department of Public Safety pursuant to A.R.S. § 15-534;
 5. Data supporting the efficacy of its teacher preparation program, which may include stakeholder surveys, completer data and student achievement data. The school district or charter school may contract with a third party provider to provide the classroom-based alternative preparation program and may use that program's efficacy data to meet this requirement.
 6. A list of all staff members responsible for administering the program and the roles and responsibilities of each person;
 7. A description of the program, which shall include the following:
 - a. A program sequence or training schedule; and
 - b. Information regarding the mentoring and coaching of teacher candidates.
 8. The school district or charter school may provide information on professional expectations, professional requirements, or student achievement requirements that exceed expectations and requirements of this section, including requiring candidates to complete specified coursework or trainings.
 9. A plan for how the program will notify and assist program participants if the program or school closes.
- B. Upon receipt of an application for approval as a classroom-based preparation program provider, the Department shall convene a review team that shall:
 1. Examine the application;
 2. Determine whether to recommend that the Board grant its approval of the application based upon the requirements of this Section and a Board-approved rubric; and
 3. Submit its recommendation to the State Board of Education within 90 days of receipt of the application.
- C. The State Board of Education shall review the recommendation of the review team and provide to the applicant written notice of its approval or denial.

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- D. If the Board denies an applicant for program approval, the applicant may correct any deficiencies identified in the notice of denial and resubmit the application for review by the Department within 30 days of the denial. The review team shall review the resubmitted application and submit its recommendation to the Board within 60 days of receipt of the resubmitted application.
 - E. If the Board approves an applicant as a classroom-based preparation program provider, the approval is valid for six years after the date of approval. To continue as a program provider, the school district or charter school shall apply for renewal before the expiration of its current approval. If the application for renewal is approved by the Board, the renewal is valid for six years after the date of the approval.
 - F. Approved classroom-based alternative preparation program providers shall submit a new application pursuant to subsection (A) to offer a program in an additional certification area.
 - G. Each qualified provider shall submit a report once every two years that includes:
 1. A description of any substantive changes in courses, seminars, modules or assessments in the Board approved classroom-based preparation programs;
 2. The name, title and original signature of the certification officer for the approved program provider;
 3. Relevant data on the educator preparation program, relevant staff, and candidates, which may include, but is not limited to, stakeholder surveys, completer data, and student achievement data required as a condition of continuing program approval.
 - H. Classroom-based preparation program providers shall provide program completers with an institutional recommendation for the appropriate Classroom-Based Standard Teaching Certificate within 45 days of program completion.
- 6. Verification that individuals enrolled in the program will have a bachelor's degree from an accredited institution;
 - 7. Verification that individuals enrolled in the program will meet the background requirements and have a valid fingerprint card issued by the Arizona Department of Public Safety pursuant to A.R.S. § 15-534.
 - 8. A plan for how the program will notify and assist program participants if the program or school closes.
- B. Upon receipt of an application for approval as a locally-based school leadership preparation program provider, the Department shall convene a review team that shall:
 1. Examine the application;
 2. Determine whether to recommend that the Board grant its approval of the application based upon the requirements of this Section and a Board-approved rubric; and
 3. Submit its recommendation to the State Board of Education within 90 days of receipt of the application.
 - C. The State Board of Education shall review the recommendation of the review team and provide to the applicant written notice of its approval or denial.
 - D. If the Board denies an applicant for program approval, the applicant may correct any deficiencies identified in the notice of denial and resubmit the application for review by the Department within 30 days of the denial. The review team shall review the resubmitted application and submit its recommendation to the Board within 60 days of receipt of the resubmitted application.
 - E. If the Board approves an applicant as a locally based school leadership preparation program provider, the approval is valid for six years after the date of approval. To continue as a locally based school leadership program provider, the school district or charter school shall apply for renewal before the expiration of its current approval. If the application for renewal is approved by the Board, the renewal is valid for six years after the date of the approval.
 - G. Locally based leadership program providers shall provide program completers with an institutional recommendation for the appropriate locally based pathway standard administrative certificate within 45 days of program completion.

Historical Note

New Section made by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1). Amended by final exempt rulemaking at 26 A.A.R. 1311, effective May 18, 2020 (Supp. 20-2). Amended by final exempt rulemaking at 29 A.A.R. 183 (January 13, 2023), effective December 9, 2022 (Supp. 22-4).

R7-2-604.06. Locally Based School Leadership Preparation Program Approval Process

- A. A school district or charter school may apply to the Board for approval as a locally based school leadership preparation program provider. The Department shall administer the Board approval process and prescribe an application form, which shall include the following:
 1. The name of the program and the school district or charter school applying;
 2. A list of all staff members responsible for administering the program and the roles and responsibilities of each person;
 3. The areas of certification for which the applicant will offer the program;
 4. A description of the program, which shall include the following:
 - a. A program sequence or training schedule; and
 - b. Information regarding the learning experiences, mentoring and coaching of school leader candidates.
 5. Evidence supporting the efficacy of the school district's or charter school's preparation program. A school district or charter school may contract with a third party provider

Historical Note

New Section made by final exempt rulemaking at 29 A.A.R. 183 (January 13, 2023), effective December 9, 2022 (Supp. 22-4).

R7-2-605. Certification Responsibility

The Superintendent of Public Instruction or the Superintendent's designee shall be responsible for the issuance and evaluation of the appropriate certificates based on the applicant's compliance with the statutes and rules.

Historical Note

Repealed effective December 4, 1978 (Supp. 78-6). New Section R7-2-605 adopted effective April 10, 1984 (Supp. 84-2). Editorial correction, new Section R7-2-605 shown adopted effective April 10, 1984 should read new Section R7-2-605 adopted effective October 1, 1985. Amended by adding a new subsection (B) effective December 18, 1985 (Supp. 85-6). Amended by adding subsection (C), filed May 5, 1986, effective July 1, 1987; amended by adding subsection (D) effective June 30, 1986 (Supp. 86-3). Correction to Historical Note dated June 30, 1986, second part should have read: "...amended

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by adding subsections (D), (E), (F), (G) and (H) effective June 30, 1986"; amended subsection (A) effective August 10, 1988 (Supp. 88-3). Amended effective September 12, 1989 (Supp. 89-3). Amended effective November 6, 1990; Amended effective December 12, 1990 (Supp. 90-4). Amended effective March 10, 1994 (Supp. 94-1). Section repealed; new Section adopted effective December 4, 1998 (Supp. 98-4). Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4).

R7-2-606. Proficiency Assessments

- A. The Arizona Teacher Proficiency Assessment is adopted as the proficiency assessment for applicants for teaching certificates. The Arizona Administrator Proficiency Assessment is adopted as the proficiency assessment for applicants for administrative certificates.
- B. The subject knowledge portion of the Arizona Teacher Proficiency Assessment shall assess proficiency as described in R7-2-602 related to the teacher's knowledge of the certification subject area or areas.
- C. The professional knowledge portion of the Arizona Teacher Proficiency Assessment shall assess proficiency as described in R7-2-602 related to the teacher's pedagogical knowledge.
- D. The Arizona Administrator Proficiency Assessment shall assess professional knowledge as described in R7-2-603 as a requirement for certification of administrators, supervisors, principals, and superintendents.
- E. The passing score for each assessment shall be determined by the Board using the results of validity and reliability studies. The passing score for each assessment shall be reviewed by the Board at least every three years.
- F. The proficiency assessments for professional knowledge and subject knowledge for a certificate, endorsement, or approved area shall be approved by the Board.

Historical Note

Repealed effective December 4, 1978 (Supp. 78-6). New Section adopted effective March 10, 1994 (Supp. 94-1). Amended effective March 6, 1997 (Supp. 97-1). Section repealed; new Section adopted effective December 4, 1998 (Supp. 98-4). Section R7-2-606 amended by emergency rulemaking under A.R.S. § 41-1026 at 8 A.A.R. 2562, effective May 23, 2002 for a period of 180 days (Supp. 02-2). Emergency Section R7-2-606 amended by emergency rulemaking under A.R.S. § 41-1026 at 8 A.A.R. 3739, effective August 5, 2002 for a period of 180 days (Supp. 02-3). May 23, 2002 emergency rulemaking renewed under A.R.S. § 41-1026 at 8 A.A.R. 5132, effective November 19, 2002 for a period of 180 days (Supp. 02-4). August 5, 2002 emergency rulemaking renewed under A.R.S. § 41-1026 at 9 A.A.R. 522, effective January 31, 2003 for a period of 180 days (Supp. 03-1). Amended by final rulemaking at 9 A.A.R. 1605, effective May 5, 2003 (Supp. 03-2). Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). Amended by final exempt rulemaking at 24 A.A.R. 1427, effective April 23, 2018 (Supp. 18-2).

R7-2-607. General Certification Provisions

- A. The evaluation to determine qualification for certification shall not begin until an institutional recommendation or application for certification and official transcripts, and the appropriate fees have been received by the Department. Course descriptions, verification of employment, and other documents may also be required for the evaluation.

- B. Unless otherwise specified, a standard certificate shall be issued for 12 years and may be issued with deficiencies. Applicants may receive a standard certificate with the following deficiencies of requirements to be completed within three years: research-based phonics; reading instruction including for students with dyslexia; professionalism and ethics; and U.S. and Arizona Constitutions. If an applicant fails to meet these requirements within the prescribed time period, the Department of Education or the Board shall temporarily suspend the standard certificate, but the suspension is not considered a disciplinary action and the individual shall be allowed to correct the deficiency within the remaining time of the standard certification.
- C. The effective date of a new certificate shall be the date the evaluation is completed by the Department. The effective date of a renewed certificate shall be the date the evaluation for renewal is completed by the Department.
- D. Unless otherwise specified, all certificates and provisional endorsements issued for three years or less shall expire on the date of issuance in the year of expiration. All certificates issued for more than three years shall expire on the holder's birth date in the year of expiration.
- E. Only those degrees awarded by an accredited institution shall be considered to satisfy the requirements for certification.
- F. Professional preparation programs, courses, practica, and examinations required for certification shall be taken at an accredited institution or a Board-approved teacher preparation program.
- G. Only those courses in which the applicant received a passing grade or credit shall be considered to satisfy the requirements for certification.
- H. All certificates issued by the Department are considered to have been issued in conformance with these rules, except on a finding that an applicant submitted falsified or misrepresented documents, records, or facts in an application for certification or on a finding that a certificate was issued in error due to an error by the verifying authority or issuing authority. If the Department makes a finding pursuant to this subsection, the Department shall provide notice to the applicant of the finding. Within 60 days of the date of the notice, the applicant shall submit proof to the Department that the applicant meets the requirements for the certification. If the applicant is unable to provide proof they meet the requirements within 60 days of receipt of notice, the Department shall reclaim the certificate. Reclaiming a certificate pursuant to this subsection is not considered a disciplinary action but the Department shall refer the case for investigation pursuant to R7-2-1308 for findings that an applicant submitted falsified or misrepresented documents, records, or facts.
- I. The Department shall issue a comparable standard Arizona certificate described in R7-2-608, R7-2-609, R7-2-610, R7-2-611, R7-2-612 or R7-2-613 to an applicant who holds a valid certification from the National Board for Professional Teaching Standards, possess a valid fingerprint clearance card issued by the Arizona Department of Public Safety, and holds a bachelor's, master's or doctoral degree from an accredited institution. These applicants are exempt from all portions of the Arizona Teacher Proficiency Assessment.
- J. An applicant is not required to take any portion of the Arizona Teacher Proficiency Assessment if the applicant has at least three years of full-time teaching experience in any state, including this state, in the comparable area of certification or endorsement in which the person is applying for certification, regardless of whether the applicant was certified or uncerti-

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fied. An applicant is not required to take any portion of the Arizona Administrator Proficiency Assessment if the person has at least three years of full-time experience in a school leadership position in any state, including this state, regardless of whether the applicant was certified or uncertified.

- K.** An applicant is exempt from the testing requirements for Arizona certificates if the applicant passed corresponding portions of a professional or subject knowledge examinations, or administrator examination adopted by a state agency in another state that are similar to the Arizona Teacher Proficiency Assessments or the Arizona Administrator Proficiency Assessment.
- L.** An applicant is exempt from the subject knowledge portion of the Arizona Teacher Proficiency Assessment if:
 1. The applicant provides verification of teaching courses relevant to a content area or subject matter for the last two consecutive years, and for a total of at least three years at one or more accredited postsecondary institutions; or
 2. The applicant obtained a bachelor's, master's or doctoral degree from an accredited institution in a relevant subject area; or
 3. The applicant provides verification of a minimum of five years of work experience that is relevant to a subject area of certification.
- M.** Unless otherwise specified, individuals who hold a valid Arizona elementary, middle grades or secondary certificate, or a special education certificate that includes grades six through 12, may add an approved area to their certificate by passing the appropriate subject area portion of the Arizona Teacher Proficiency Assessment or as provided in subsections (J), (K) and (L). Any approved area shall be specified on the certificate. If a proficiency assessment is not offered in a subject area, an approved area shall consist of a minimum of 24 semester hours of courses in the subject.
- N.** If a language assessment is not offered through the Arizona Teacher Proficiency Assessment, a passing score on a nationally accredited test of a foreign language approved by the Board may demonstrate proficiency of that foreign language in lieu of the 24 semester hours of courses in that subject.
- O.** A teacher's language proficiency in a Native American language shall be verified by a person, persons, or entity designated by the appropriate tribe in lieu of the 24 semester hours of courses in that subject.
- P.** Teachers of homebound students shall hold the same certificate that is required of a classroom teacher.
- Q.** Fingerprint clearance cards shall be issued by the Arizona Department of Public Safety.
- R.** A person who surrenders their teaching certificate for any reason shall not submit an application for certification with the Board for a period of five years. A person re-applying after the five-year ban must apply under the current rules at the time of re-application.
- S.** Notwithstanding any other provision, an individual with a deficiency in the Arizona and U.S. Constitutions who teaches an academic course that focuses primarily on history, government, social studies, citizenship, law or civics shall be issued a standard certificate subject to suspension in one year if that deficiency is not removed. The suspension is not considered a disciplinary action and the individual shall be allowed to correct that deficiency within the remaining time of the standard certification.
- T.** As used in this Article, unless otherwise provided, "work experience" means paid or unpaid work, including teaching experience as a certificated or noncertificated educator at a

public or private school, which demonstrates knowledge or skill relevant to a subject area. Work experience, and its relevance to a subject area, shall be verified with one of the following:

1. A letter from a superintendent or personnel director that the applicant demonstrates knowledge or skill in the subject area that is comparable to holding a bachelor's degree, master's degree, or doctoral degree in that subject area, as identified in a resume;
 2. A letter from a public or private school superintendent or personnel director, in this state or in another state, that the applicant has the requisite experience teaching the most advanced Arizona academic standards, or comparable out-of-state standards, in the subject area sought; or
 3. If an applicant is unable to obtain a letter described in subsections (T)(1) or (2), the applicant may submit a letter from a current or former supervisor verifying that the applicant demonstrates knowledge or skill in the subject area that is comparable to holding a bachelor's degree, master's degree, or doctoral degree in that subject area, as determined by the Department.
- U.** Single subject classroom teachers in grades six through 12 are required to be appropriately certified for the subject they teach for the greater part of their instructional schedule. If a teacher is assigned to two or more subjects for equal parts of their instructional schedule, the teacher is required to be appropriately certified in each subject.
 - V.** The requirements to be considered appropriately certified for a self-contained, single subject, or other classroom shall be established in the Certification Guidelines for Teaching Assignments, which shall be approved by the Board and on file with the Department.

Historical Note

Adopted effective December 5, 1977 (Supp. 77-6).
 Repealed effective December 4, 1978 (Supp. 78-6). New Section adopted effective May 3, 1993 (Supp. 93-2).
 Amended effective March 6, 1997 (Supp. 97-1). Section repealed; new Section adopted effective December 4, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1).
 Amended by exempt rulemaking at 16 A.A.R. 102, effective May 1, 2009 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 160, effective October 26, 2009 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 324, effective January 25, 2010 (Supp. 10-3).
 Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). Amended by final exempt rulemaking at 21 A.A.R. 2054, effective December 8, 2014 (Supp. 15-3). Amended by final exempt rulemaking at 22 A.A.R. 648, effective January 25, 2016 (Supp. 16-1). Amended by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1). Amended by final exempt rulemaking at 27 A.A.R. 2353, (October 22, 2021), effective September 27, 2021 (Supp. 21-4).
 Amended by final exempt rulemaking at 29 A.A.R. 183 (January 13, 2023), effective December 9, 2022 (Supp. 22-4).

R7-2-607.01 Subject Areas – Waiver

Notwithstanding any other provision in this Article, any individual with a valid Elementary or Secondary certificate, or a Special Education certificate that includes grades six through 12, issued prior to August 1, 2016 may add one or more approved areas to the certifi-

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cate prior to August 1, 2017 without any additional requirements provided the individual received an evaluation in the top two levels of performance on the most recent teacher evaluation related to one or more of the subject areas and meets one of the following requirements:

1. The individual was teaching in one or more subject areas based on a verified Arizona High, Objective, Uniform, State Standard of Evaluation (HOUSSE) rubric as highly qualified to teach the subject area(s) as defined under the No Child Left Behind Act; or
2. The individual has completed of a minimum of 24 semester hours of courses in the subject area(s).

Historical Note

New Section made by final exempt rulemaking at 23 A.A.R. 725, effective January 23, 2017 (Supp. 17-1).

R7-2-608. Early Childhood Teaching Certificates

- A. A standard early childhood education certificate shall be required for individuals teaching in public school early childhood education programs, except as provided in R7-2-611 or in R7-2-615(N). For individuals teaching in grades kindergarten through three, this certificate is optional. An Early Childhood Special Education certificate as described in R7-2-611 is not required for individuals who hold the Early Childhood Teaching Certificate as described in this Section in combination with an Arizona cross-categorical mild-moderate disabilities, specialized special education, or moderate to severe disabilities teaching certificate as described in R7-2-611.
- B. For the purposes of this Section, public school early childhood education programs means education programs provided by local education agencies, including their sub-grantees and contracted providers, for children birth through age 8 for the purpose of providing academically and developmentally appropriate learning opportunities that are standards-based with defined curriculum and comprehensive in content to include all appropriate developmental and academic areas as defined by the Arizona Early Childhood Education Standards or the Arizona K through 12 Academic Standards approved by the Board.
- C. Except as noted, all certificates are subject to the general certification provisions in R7-2-607 and the renewal requirements in R7-2-619.
- D. Standard Professional Early Childhood Education Certificate – birth through age 8 or through grade three. The requirements are:
 1. A bachelor's degree, and
 2. One of the following:
 - a. Completion of a teacher preparation program in early childhood education from an accredited institution or a teacher preparation program approved by the Board, or
 - b. Early childhood education coursework and practicum experience which teaches the knowledge and skills described in R7-2-602 and includes both of the following:
 - i. Thirty-seven semester hours of early childhood education courses to include all of the following areas of study:
 - (1) Foundations of early childhood education;
 - (2) Child guidance and classroom management;
 - (3) Characteristics and quality practices for typical and atypical behaviors of young children;
 - ii. Child growth and development, including health, safety and nutrition;
 - (5) Child, family, cultural and community relationships;
 - (6) Developmentally appropriate instructional methodologies for teaching language, math, science, social studies and the arts;
 - (7) Early language and literacy development;
 - (8) Assessing, monitoring and reporting progress of young children; and
- E. Standard Professional Early Childhood Education Certificate – birth through age 8 or through grade three for applications received on and after August 1, 2018.
 1. The requirements include all of the following:
 - a. A bachelor's degree;
 - b. Completion of a teacher preparation program in early childhood education from a Board-approved educator preparation program or from an accredited institution offering substantially similar training addressing the following topics and any others as required by law:
 - i. Research-based systematic phonics, including early language and literacy development;
 - ii. Research-based instructional strategies for delivering differentiated reading instruction, assessment, intervention and remediation to support readers of varying ages and ability levels, including students with dyslexia;

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- iii. Foundations of early childhood education;
 - iv. Teaching students with exceptionalities;
 - v. Child guidance and classroom management, including characteristics and quality practices for typical and atypical behaviors of young children;
 - vi. Child growth and development, including health, safety and nutrition;
 - vii. Child, family, cultural and community relationships;
 - viii. Developmentally appropriate instructional methodologies for teaching language, math, science, social studies and the arts;
 - ix. Assessing, monitoring and reporting progress of young children;
 - x. Instructional design and lesson planning, including modifications and accommodations;
 - xi. Practicum as described in R7-2-604 serving children birth through preschool;
 - xii. Professional responsibility and ethical conduct; and
 - xiii. Twelve-week capstone experience as described in R7-2-604 children in kindergarten through grade three, which may be completed during the valid period of a teaching intern or student teaching intern certificate. For individuals seeking dual certification, any capstone experience requirements may be met through separate eight-week capstone experiences in each of the certification areas sought.
- c. A valid Fingerprint Clearance Card issued by the Arizona Department of Public Safety;
 - d. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment; and
 - e. A passing score on the early childhood subject knowledge portion of the Arizona Teacher Proficiency Assessment, unless the applicant has a bachelor's, master's or doctoral degree in a relevant content area or otherwise qualifies for a waiver of the subject knowledge examination.
2. Applicants may meet the requirements in subsection (E)(1)(b) with the submission of an application for the Standard Professional Early Childhood Education certificate that includes evidence of two years of verified full-time teaching experience serving children birth through grade three, and Board-approved or accredited training or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (E)(1)(b)(i) through (xii). One year of verified full-time teaching experience serving children in kindergarten through grade three may be substituted for the capstone experience.

Historical Note

Adopted effective May 20, 1994 (Supp. 94-2). Section repealed; new Section adopted effective December 4, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Section R7-2-608 amended by emergency rulemaking under A.R.S. § 41-1026 at 8 A.A.R. 2562, effective May 23, 2002 for a period of 180 days (Supp. 02-2). May 23, 2002 emergency rulemaking renewed under A.R.S. § 41-1026 at 8 A.A.R. 5132, effective November 19, 2002 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R.

1605, effective May 5, 2003 (Supp. 03-2). Former Section R7-2-608 recodified to R7-2-609 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1). New Section R7-2-608 made by exempt rulemaking at 16 A.A.R. 52, effective December 8, 2008 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 119, effective September 21, 2009 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 235, effective December 7, 2009 (Supp. 10-3). Amended by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1).

R7-2-609. Elementary Teaching Certificates

- A. Except as noted, all certificates are subject to the general certification provisions in R7-2-607 and the renewal requirements in R7-2-619.
- B. Standard Professional Elementary Certificate – grades K through eight. The requirements are:
 - 1. A bachelor's degree,
 - 2. One of the following:
 - a. Completion of a teacher preparation program in elementary education from an accredited institution or a Board-approved teacher preparation program, described in R7-2-604; or
 - b. Forty-five semester hours of education courses which teach the knowledge and skills described in R7-2-602, including at least eight semester hours of practicum in grades K through eight. Two years of verified teaching experience in grades Prekindergarten through eight may be substituted for the eight semester hours of practicum; or
 - c. A valid elementary certificate from another state.
 - 3. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment;
 - 4. A passing score on the subject knowledge portion of the Arizona Teacher Proficiency Assessment unless the applicant has a bachelor's, master's or doctoral degree in a relevant content area or otherwise qualifies for a waiver of the subject knowledge assessment;
 - 5. A valid fingerprint card issued by the Arizona Department of Public Safety; and
 - 6. Forty-five hours or three semester hours of instruction in research-based systematic phonics. An accredited institution or other provider may provide this instruction.
- C. Standard Professional Elementary Certificate – grades kindergarten through eight for applications received on and after August 1, 2018.
 - 1. The requirements include all of the following:
 - a. A bachelor's degree;
 - b. Completion of a teacher preparation program in elementary education from a Board-approved educator preparation program or from an accredited institution offering substantially similar training, addressing the following topics and any others as required by law:
 - i. At least forty-five hours or three semester hours of instruction in research-based systematic phonics, including language and literacy development;
 - ii. For applications received on and after October 15, 2020, at least forty-five hours or three semester hours of instruction in research-based instructional strategies for delivering differentiated reading instruction, assessment, intervention and remediation to support readers of

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- varying ages and ability levels, including students with dyslexia;
 - iii. Developmentally appropriate instructional delivery, facilitation and methodologies for teaching language, math, science, social studies and the arts;
 - iv. Instructional design and lesson planning, including modifications, and accommodations;
 - v. The learning environment, including classroom management;
 - vi. Assessing, monitoring and reporting progress;
 - vii. Teaching students with exceptionalities;
 - viii. Professional responsibility and ethical conduct; and
 - ix. Twelve weeks of capstone experience as described in R7-2-604 in grades kindergarten through eight, which may be completed during the valid period of a teaching intern or student teaching intern certificate. One year of verified full-time teaching experience in grades kindergarten through eight may be substituted for the capstone experience requirement. For individuals seeking dual certification, any capstone experience requirements may be met through separate eight-week capstone experiences in each of the certification areas sought.
 - c. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment;
 - d. A passing score on the subject knowledge portion of the Arizona Teacher Proficiency Assessment, unless the applicant has a bachelor's, master's or doctoral degree in a relevant content area or otherwise qualifies for a waiver of the subject knowledge assessment; and
 - e. A valid fingerprint card issued by the Arizona Department of Public Safety.
2. Applicants may meet the requirements in subsection (C)(1)(b) with the submission of an application for the Standard Professional Elementary certificate that includes evidence of two years of verified full-time teaching experience in grades kindergarten through eight, and Board-approved or accredited training or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (C)(1)(b)(i) through (viii).

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4).
 Amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Section R7-2-609 amended by emergency rulemaking under A.R.S. § 41-1026 at 8 A.A.R. 2562, effective May 23, 2002 for a period of 180 days (Supp. 02-2). May 23, 2002 emergency rulemaking renewed under A.R.S. § 41-1026 at 8 A.A.R. 5132, effective November 19, 2002 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 1605, effective May 5, 2003 (Supp. 03-2). Former R7-2-609 recodified to R7-2-610; new R7-2-609 recodified from R7-2-608 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1). R7-2-609 "Pre-kindergarten" corrected to "PreK" at request of the Board, Office File No. M09-444, filed November 24, 2009 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 235, effective December 7, 2009 (Supp. 10-3).
 Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). Amended by final exempt rulemaking at 24 A.A.R. 195, effective August 9,

2017; filed in the Office on January 2, 2018 (Supp. 18-1).
 Amended by final exempt rulemaking at 24 A.A.R. 2947, effective September 24, 2018 (Supp. 18-3).

R7-2-609.01. Middle Grades Teaching Certificate

- A. Except as noted, all certificates are subject to the general certification provisions in R7-2-607 and the renewal requirements in R7-2-619.
- B. Standard Professional Middle Grades Certificate – grades five through nine
 - 1. The requirements include all of the following:
 - a. A bachelor's degree;
 - b. Completion of a teacher preparation program in middle grades education from a Board-approved educator preparation program or from an accredited institution offering substantially similar training, addressing the following topics and any others as required by law:
 - i. Early adolescent psychology;
 - ii. Research-based instructional strategies for delivering differentiated reading instruction, assessment, intervention and remediation to support readers of varying ages and ability levels, including students with dyslexia;
 - iii. Instructional design and lesson planning, including modifications and accommodations;
 - iv. The learning environment, including classroom management;
 - v. Developmentally appropriate instructional delivery, facilitation and methodologies;
 - vi. Assessing, monitoring and reporting progress;
 - vii. Teaching students with exceptionalities;
 - viii. Professional responsibility and ethical conduct; and
 - ix. Twelve weeks of capstone experience as described in R7-2-604 in grades five through nine, which may be completed during the valid period of a teaching intern or student teaching intern certificate. One year of verified full-time teaching experience in grades five through nine may be substituted for the capstone experience requirement. For individuals seeking dual certification, any capstone experience requirements may be met through separate eight-week capstone experiences in each of the certification areas sought.
 - c. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment;
 - d. A passing score on at least one subject knowledge portion of the Arizona Teacher Proficiency Assessment, unless the applicant has a bachelor's, master's or doctoral degree in the relevant content area or otherwise qualifies for a waiver of the subject knowledge assessment; and
 - e. A valid fingerprint card issued by the Arizona Department of Public Safety.
- 2. Applicants may meet the requirements in subsection (B)(1)(b) with the submission of an application for the Standard Professional Middle Grades certificate that includes evidence of two years of verified full-time teaching experience in grades five through nine, and Board-approved or accredited training or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (B)(1)(b)(i) through (viii).

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Historical Note

New Section by final exempt rulemaking at 24 A.A.R. 791, effective March 26, 2018 (Supp. 18-1).

R7-2-610. Secondary Teaching Certificates

- A.** Except as noted, all certificates are subject to the general certification provisions in R7-2-607 and the renewal requirements in R7-2-619.
 - B.** Standard Professional Secondary Certificate – grades six through 12. The requirements are:
 1. A bachelor's degree;
 2. One of the following:
 - a. Completion of a teacher preparation program in secondary education from an accredited institution or a Board-approved teacher preparation program, described in R7-2-604; or
 - b. Thirty semester hours of education courses which teach the knowledge and skills described in R7-2-602, including at least eight semester hours of practicum in grades six through 12. Two years of verified teaching experience in grades six through postsecondary may substitute for the eight semester hours of practicum; or
 - c. A valid secondary certificate from another state.
 3. A passing score on one or more subject knowledge portions of the Arizona Teacher Proficiency Assessment, unless the applicant has a bachelor's, master's or doctoral degree in a relevant subject area or otherwise qualifies for a waiver of the subject knowledge exam;
 4. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment; and
 5. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 - C.** Standard Professional Secondary Certificate – grades six through 12 for applications received on and after August 1, 2018.
 1. The requirements include all of the following:
 - a. A bachelor's degree;
 - b. Completion of a teacher preparation program in secondary education from a Board-approved educator preparation program or from an accredited institution offering substantially similar training, addressing the following topics and any others as required by law:
 - i. Research-based instructional strategies for delivering differentiated reading instruction, assessment, intervention and remediation to support readers of varying ages and ability levels, including students with dyslexia;
 - ii. Instructional design and lesson planning, including modifications and accommodations;
 - iii. The learning environment, including classroom management;
 - iv. Developmentally appropriate instructional delivery, facilitation and methodologies;
 - v. Assessing, monitoring and reporting progress;
 - vi. Teaching students with exceptionalities;
 - vii. Professional responsibility and ethical conduct;
 - viii. Twelve weeks of capstone experience as described in R7-2-604 in grades six through postsecondary, which may be completed during the valid period of a teaching intern or student teaching intern certificate; one year of verified full-time teaching experience in grades six through postsecondary may substitute for the capstone experience requirement. For individuals seeking dual certification, any capstone experience requirements may be met through separate eight-week capstone experiences in each of the certification areas sought.
 - c. A passing score on one or more subject knowledge portions of the Arizona Teacher Proficiency Assessment unless the applicant has a bachelor's, master's or doctoral degree in a relevant subject area or otherwise qualifies for a waiver of the subject knowledge exam;
 - d. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment; and
 - e. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 2. Applicants may meet the requirements in subsection (C)(1)(b) with the submission of an application for the Standard Professional Secondary certificate that includes evidence of two years of verified full-time teaching experience in grades six through postsecondary, and Board-approved or accredited training or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (C)(1)(b)(i) through (vii). One year of verified full-time teaching experience in grades six through postsecondary may be substituted for the capstone experience.
- D.** Notwithstanding any other provision, individuals seeking a secondary certificate with an approved area in science, technology, engineering or mathematics are exempted from the requirements of a passing score on one or more subject knowledge portions of the Arizona Teacher Proficiency Assessment based on:
 1. Verified work experience of five or more years in science, technology, engineering or mathematics; and
 2. Demonstrated adequate knowledge of science, technology, engineering or mathematics by:
 - a. A master's or a doctoral degree in an academic subject that is specific to science, technology, engineering or mathematics; or
 - b. Twenty-four semester hours of relevant coursework in an academic subject that is specific to science, technology, engineering or mathematics.

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Section R7-2-610 amended by emergency rulemaking under A.R.S. § 41-1026 at 8 A.A.R. 2562, effective May 23, 2002 for a period of 180 days (Supp. 02-2). May 23, 2002 emergency rulemaking renewed under A.R.S. § 41-1026 at 8 A.A.R. 5132, effective November 19, 2002 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 1605, effective May 5, 2003 (Supp. 03-2). Amended by final rulemaking at 10 A.A.R. 2399, effective July 23, 2004 (Supp. 04-2). Amended by exempt rulemaking at 15 A.A.R. 1838, effective August 29, 2006 (Supp. 09-1). Former R7-2-610 recodified to R7-2-611; new R7-2-610 recodified from R7-2-609 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 235, effective December 7, 2009 (Supp. 10-3). Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). Amended by final exempt rulemaking at 21 A.A.R. 2054, effective December 8, 2014 (Supp. 14-4).

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15-3). Amended by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1).

R7-2-610.01. Specialized Secondary Teaching Certificates

Specialized Secondary Certificate – Science, Technology, Engineering or Mathematics – grades six through 12

A. The requirements are:

1. One of the following:
 - a. Demonstrate expertise in the subject matter knowledge through:
 - i. A bachelor's, master's or a doctoral degree and 24 semester hours of relevant coursework in an academic subject that is specific to science, technology, engineering or mathematics; or
 - ii. Verified teaching experience for the last two consecutive years, and for a total of at least three years at one or more accredited postsecondary institutions in science, technology, engineering or mathematics
2. Verified work experience of five or more years in science, technology, engineering or mathematics
3. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.

B. An individual who meets the requirements of this Section is exempt from the competency requirements of the United States and Arizona Constitutions, and the professional knowledge and the subject knowledge portions of the Arizona Teacher Proficiency Assessments.**Historical Note**

New Section made by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1).

R7-2-610.02. Subject Matter Expert Standard Teaching Certificate

Subject Matter Expert Standard Teaching Certificate – grades six through 12

A. The requirements are:

1. A bachelor's degree and one of the following:
 - a. Verified teaching experience for the last two consecutive years, and for a total of at least three years at one or more accredited postsecondary institutions in the relevant subject area of certification. An individual seeking certification pursuant to this subdivision is exempt from passing the professional knowledge portion of the Arizona Teacher Proficiency Assessment; or
 - b. A bachelor's, master's or doctoral degree from an accredited postsecondary institution in the specific subject area of certification that is directly relevant to a content area or subject matter taught in public schools; or
 - c. Verification of expertise through work experience of a minimum of five years in the relevant area of certification.
2. A passing score on the professional knowledge Arizona Teacher Proficiency Assessment within two years except as provided by subsection (A)(1)(a). If an applicant fails to meet this requirement within two years, the Department of Education or the Board shall temporarily suspend the standard certificate, but the suspension is not considered a disciplinary action and the individual shall be allowed to correct the deficiency within the remaining time of the standard certification.

3. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 4. Verification that the applicant has reviewed and attests to reviewing the best practices for social media and cellular telephone use between students and school personnel adopted by the Board.
 5. Completion of Board-approved training in professionalism and ethics within two years. If an applicant fails to meet this requirement within two years, the Department or the Board shall temporarily suspend the standard certificate, but the suspension is not considered a disciplinary action and the individual shall be allowed to correct the deficiency within the remaining time of the standard certification.
- B.** An individual who meets the requirements of this Section is exempt from the competency requirements of the United States and Arizona Constitutions and the subject knowledge portion of the Arizona Teacher Proficiency Assessment.

Historical Note

New Section made by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1). Amended by final exempt rulemaking at 24 A.A.R. 2947, effective September 24, 2018 (Supp. 18-3). Amended by final exempt rulemaking at 29 A.A.R. 183 (January 13, 2023), effective December 9, 2022 (Supp. 22-4).

R7-2-611. Special Education Teaching Certificates

- A.** Except as noted, all certificates are subject to the general certification provisions in R7-2-607 and the renewal requirements in R7-2-619. An Early Childhood Special Education certificate as described in this Section is not required for individuals who hold the Early Childhood endorsement as described in R7-2-615 in combination with an Arizona cross-categorical, specialized special education, or moderate/severe disabilities teaching certificate as described in this Section. An Early Childhood Special Education certificate as described in this Section is not required for individuals who hold the Early Childhood Teaching Certificate as described in R7-2-608 in combination with an Arizona cross-categorical, specialized special education, or moderate/severe disabilities teaching certificate as described in this Section.
- B.** Terms used in this Section are defined in A.R.S. § 15-761.
- C.** Standard Professional Mild/Moderate Disabilities Certificate - grades K through 12.
1. The holder is qualified to teach students with mild/moderate disabilities as documented by student needs in the individualized education program and the following categories, including: autism, mild/moderate intellectual disabilities, traumatic brain injury, emotional disability, specific learning disability, orthopedic impairments, developmental delay and/or other health impairments.
 2. The requirements are:
 - a. A bachelor's degree,
 - b. One of the following:
 - i. Completion of a teacher preparation program in special education from an accredited institution which included courses in the instruction and behavior management of students with mild/moderate disabilities; or
 - ii. Forty-five semester hours of education courses which teach the standards described in R7-2-602, including a minimum of 37 semester hours of special education courses and eight semester

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- hours of practicum with students with mild/moderate disabilities. Special education courses shall include foundations of special education, legal aspects, effective collaboration and communication practices, research-based instruction in mathematics, research-based instruction in English language arts, classroom management and behavior analysis, assessment and eligibility, language development and disorders, and electives. Two years of verified teaching experience in mild/moderate special education, grades K through 12 may substitute for the eight semester hours of practicum.
- c. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment;
 - d. A passing score on the subject knowledge portion of the Arizona Teacher Proficiency Assessment, unless the applicant has a bachelor's, master's or doctoral degree in mild/moderate special education or otherwise qualifies for a waiver of the subject knowledge examination, and
 - e. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- D. Standard Professional Mild/Moderate Disabilities Certificate - grades K through 12 for applications received on or after August 1, 2018.**
1. The holder is qualified to teach students with mild/moderate disabilities as documented by student needs in the individualized education program and the following categories, including: autism, mild/moderate intellectual disabilities, traumatic brain injury, emotional disability, specific learning disability, orthopedic impairments, developmental delay and/or other health impairments.
 2. The requirements include all of the following:
 - a. A bachelor's degree;
 - b. Completion of a teacher preparation program in mild/moderate disabilities special education from a Board-approved educator preparation program or from an accredited institution offering substantially similar training addressing the following topics and any others as required by law:
 - i. Research-based systematic phonics;
 - ii. Research-based instructional strategies for delivering differentiated reading instruction, assessment, intervention and remediation to support readers of varying ages and ability levels, including students with dyslexia;
 - iii. Instructional design and lesson planning, including specially designed instruction;
 - iv. The learning environment, including classroom and behavioral management;
 - v. Instructional delivery, facilitation and methodologies;
 - vi. Legal aspects of special education, including individualized education programs and transition planning;
 - vii. Effective collaboration and communication practices, including modifications and accommodations;
 - viii. Research-based instruction in math;
 - ix. Research-based instruction in English language arts;
 - x. Assessment and eligibility, including monitoring and reporting requirements;
 - xi. Language development and disorders;
 - xii. Professional responsibility and ethical conduct;
 - xiii. Twelve weeks of capstone experience as described in R7-2-604 in mild/moderate special education in grades K through 12, which may be completed during the valid period of a teaching intern certificate. One year of verified teaching experience in mild/moderate special education in grades K through 12 may substitute for the capstone experience requirement. For individuals seeking dual certification, any capstone experience requirements may be met through separate eight-week capstone experiences in each of the certification areas sought.
 - c. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment;
 - d. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 3. Applicants may meet the requirements in subsection (D)(2)(b) with the submission of an application for the Standard Professional Mild/Moderate Disabilities Certificate grades K through 12 that includes evidence of two years of verified full-time teaching experience in mild/moderate disabilities special education in grades K through 12 and Board-approved or accredited training or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (D)(2)(b)(i) through (xii).
 4. Board approved educator preparation programs leading to dual certification in mild/moderate disabilities and elementary, middle school, or secondary education may exempt a student from the mild/moderate special education capstone experience upon the completion of the following:
 - a. Verification from the applicable district or charter school administrator that the student was employed continuously as a paraprofessional whose primary responsibility was working with students in mild/moderate special education classrooms for the two years preceding commencement of the capstone experience in elementary, middle school, or secondary education;
 - b. Verification from the applicable district or charter school administrator that the student received evaluations, in each of the preceding two years of employment as a paraprofessional, indicating effectiveness in performance; and
 - c. Completion of the capstone experience in elementary, middle school or secondary education and demonstration of all of the following competencies during the dual certification educator preparation program:
 - i. Participation on a multi-disciplinary evaluation team;
 - ii. Participation in and drafting of an acceptable individualized education program; and
 - iii. Planning and delivery of specially designed instruction for a class of students.
- E. Provisional Specialized Special Education Certificate – grades K through 12.**
1. The certificate is valid for three years and is not renewable.
 2. No new applications for a Provisional Specialized Education Certificate will be accepted after December 31, 2015.

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3. The holder is qualified to teach students with intellectual disabilities, emotional disability, specific learning disability, orthopedic impairments or other health impairments, as specified on the certificate.
- F. Standard Professional Specialized Special Education Certificate – grades K through 12.**
 1. The certificate is valid for 12 years and may be renewed.
 2. The holder is qualified to teach students with intellectual disabilities, emotional disability, specific learning disability, orthopedic impairments or other health impairments, as specified on the certificate.
 3. The requirements are:
 - a. A valid Arizona Provisional Specialized Special Education certificate, or a Provisional Specialized Special Education certificate which has not expired for more than one year;
 - b. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- G. Standard Professional Moderate/Severe Disabilities Certificate – grades K through 12.**
 1. The holder is qualified to teach students with moderate/severe disabilities as documented by student needs in the individualized education program and the following categories, including: autism, moderate/severe intellectual disabilities, traumatic brain injury, emotional disability, orthopedic impairments, and/or other health impairments.
 2. The requirements are:
 - a. A bachelor's degree,
 - b. One of the following:
 - i. Completion of a teacher preparation program in moderate/severe disabilities education from an accredited institution; or
 - ii. Forty-five semester hours of education courses which teach the standards described in R7-2-602, including a minimum of 37 semester hours of special education courses and eight semester hours of practicum with students with moderate/severe disabilities. Special education courses shall include foundations of low incidence disabilities, legal aspects, effective collaboration and communication practices, adaptive communication, instructional strategies across the curriculum, classroom management and behavior analysis, assessment and eligibility, and electives. Two years of verified special education teaching experience in with students with moderate/severe disabilities, grades K through 12 may substitute for the eight semester hours of practicum.
 - c. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment,
 - d. A passing score on the subject knowledge portion of the Arizona Teacher Proficiency Assessment, unless the applicant has a bachelor's, master's or doctoral degree in moderate/severe special education or otherwise qualifies for a waiver of the subject knowledge examination, and
 - e. A valid fingerprint card issued by the Arizona Department of Public Safety.
- H. Standard Professional Moderate/Severe Disabilities Certificate – grades K through 12 for applications received on or after August 1, 2018.**
 1. The holder is qualified to teach students with moderate/severe disabilities as documented by student needs in the individualized education program and the following categories, including: autism, moderate/severe intellectual disabilities, traumatic brain injury, emotional disability, orthopedic impairments, and/or other health impairments.
 2. The requirements include all of the following:
 - a. A bachelor's degree;
 - b. Completion of a teacher preparation program in moderate/severe disabilities education from a Board-approved educator preparation program or from an accredited institution offering substantially similar training addressing the following topics and any others as required by law:
 - i. Research-based systematic phonics;
 - ii. Research-based instructional strategies for delivering differentiated reading instruction, assessment, intervention and remediation to support readers of varying ages and ability levels, including students with dyslexia;
 - iii. Instructional design and lesson planning, including specially designed instruction;
 - iv. The learning environment, including classroom and individual behavioral management;
 - v. Instructional delivery, facilitation and methodologies for teaching research-based instruction in math and English language arts;
 - vi. Legal aspects of special education, including individualized education programs and transition planning;
 - vii. Effective collaboration and communication practices, including modifications and accommodations;
 - viii. Adaptive communication, including language development and disorders;
 - ix. Assessment and eligibility, including monitoring and reporting requirements;
 - x. Professional responsibility and ethical conduct;
 - xi. Twelve weeks of capstone experience as described in R7-2-604 in special education in moderate/severe disabilities grades K through 12, which may be completed during the valid period of a teaching intern certificate. One year of verified full-time teaching experience in special education in moderate/severe disabilities grades K through 12 may substitute for the capstone experience requirement. For individuals seeking dual certification, any capstone experience requirements may be met through separate eight-week capstone experiences in each of the certification areas sought.
 - c. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment,
 - d. A passing score on the subject knowledge portion of the Arizona Teacher Proficiency Assessment unless the applicant has a bachelor's, master's or doctoral degree in moderate/severe special education or otherwise qualifies for a waiver of the subject knowledge examination, and
 - e. A valid fingerprint card issued by the Arizona Department of Public Safety.
 3. Applicants may meet the requirements in subsection (H)(2)(b) with the submission of an application for the Standard Professional Moderate/Severe Disabilities Cer-

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tificate grades K through 12 that includes evidence of two years of verified full-time teaching experience in moderate/severe disabilities special education in grades K through 12 and Board-approved or accredited training or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (H)(2)(b)(i) through (x).

I. Standard Professional Hearing Impaired Certificate – birth through grade 12. The requirements are:

1. A bachelor's degree,
2. One of the following:
 - a. Completion of a teacher preparation program in hearing impaired education from an accredited institution; or
 - b. Forty-five semester hours of education courses which teach the knowledge and skills described in R7-2-602, including 21 semester hours of special education courses for the hearing impaired and eight semester hours of practicum. Special education courses shall include survey of exceptional students, teaching methodologies for students with hearing impairment, foundations of instruction of students with hearing impairment, and diagnostic and assessment procedures for the hearing impaired. Two years of verified teaching experience in the area of hearing impaired in grade PreK through 12 may be substituted for the eight semester hours of practicum.
3. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment,
4. A passing score on the subject knowledge portion of the Arizona Teacher Proficiency Assessment unless the applicant has a bachelor's, master's or doctoral degree in hearing impaired special education or otherwise qualifies for a waiver of the subject knowledge examination, and
5. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.

J. Standard Professional Hearing Impaired Certificate – birth through grade 12 for applications received on or after August 1, 2018.

1. The requirements include all of the following:
 - a. A bachelor's degree;
 - b. Completion of a teacher preparation program in hearing impaired education from a Board-approved educator preparation program or from an accredited institution offering substantially similar training addressing the following topics and any others as required by law:
 - i. Research-based systematic phonics;
 - ii. Research-based instructional strategies for delivering differentiated reading instruction, assessment, intervention and remediation to support readers of varying ages and ability levels, including students with dyslexia;
 - iii. Survey of exceptional students;
 - iv. Teaching methodologies for students with hearing impairment;
 - v. Foundations of instruction of students with hearing impairment;
 - vi. Diagnostic and assessment procedures for the hearing impaired;
 - vii. Professional responsibility and ethical conduct;
 - viii. Twelve weeks of capstone experience as described in R7-2-604 in hearing impaired special education birth through grade 12, which

may be completed during the valid period of a teaching intern certificate. One year of verified full-time teaching experience in the area of hearing impaired in birth through grade 12 may be substituted for the capstone experience requirement. For individuals seeking dual certification, any capstone experience requirements may be met through separate eight-week capstone experiences in each of the certification areas sought.

- c. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment;
 - d. A passing score on the subject knowledge portion of the Arizona Teacher Proficiency Assessment unless the applicant has a bachelor's, master's or doctoral degree in hearing impaired special education or otherwise qualifies for a waiver of the subject knowledge examination; and
 - e. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
2. Applicants may meet the requirements in subsection (J)(1)(b) with the submission of an application for the Standard Professional Hearing Impaired Certificate – birth through grade 12 that includes evidence of receipt of two years of verified full-time teaching experience in hearing impaired special education birth through grade 12 and training or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (J)(1)(b)(i) through (vii).

K. Standard Professional Visually Impaired Certificate – birth through grade 12. The requirements are:

1. A bachelor's degree,
2. One of the following:
 - a. Completion of a teacher preparation program in visual impairment from an accredited institution; or
 - b. Forty-five semester hours of education courses which teach the knowledge and skills described in R7-2-602, including 21 semester hours of special education courses for the visually impaired and eight semester hours of practicum. Special education courses shall include survey of exceptional students, teaching methodologies for students with visual impairment, foundations of instruction of students with visual impairment, and diagnostic and assessment procedures for the visually impaired. Two years of verified teaching experience in the area of visually impaired in grades PreK through 12 may be substituted for the eight semester hours of practicum.
3. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment,
4. A passing score on the subject knowledge portion of the Arizona Teacher Proficiency Assessment, and
5. Demonstration of competency in Braille through one of the following:
 - a. A passing score on the original version of the National Library of Congress certification exam, or
 - b. A valid certificate for a literary Braille transcriber issued by the National Library of Congress, or
 - c. A passing score on a Braille exam administered by another state, or
 - d. A passing score on the Braille exam developed and administered by the University of Arizona. Individu-

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als who take this test and are not students at the University of Arizona may be assessed a fee.

6. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- L. Standard Professional Visually Impaired Certificate – birth through grade 12 for applications received on or after August 1, 2018.
 1. The requirements include all of the following:
 - a. A bachelor's degree;
 - b. Completion of a teacher preparation program in visual impairment from a Board-approved educator preparation program or from an accredited institution offering substantially similar training addressing the following topics and any others as required by law:
 - i. Research-based systematic phonics;
 - ii. Research-based instructional strategies for delivering differentiated reading instruction, assessment, intervention and remediation to support readers of varying ages and ability levels, including students with dyslexia;
 - iii. Survey of exceptional students;
 - iv. Teaching methodologies for students with visual impairment;
 - v. Foundations of instruction of students with visual impairment;
 - vi. Diagnostic and assessment procedures for the visually impaired;
 - vii. Professional responsibility and ethical conduct;
 - viii. Twelve weeks of capstone experience as described in R7-2-604 in visually impaired special education birth through grade 12, which may be completed during the valid period of a teaching intern certificate. One year of verified full-time teaching experience in the area of visually impaired in birth through grade 12 may be substituted for the capstone experience requirement. For individuals seeking dual certification, any capstone experience requirements may be met through separate eight-week capstone experiences in each of the certification areas sought.
 - c. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment,
 - d. A passing score on the subject knowledge portion of the Arizona Teacher Proficiency Assessment,
 - e. Demonstration of competency in Braille through one of the following:
 - i. A passing score on the original version of the National Library of Congress certification exam, or
 - ii. A valid certificate for a literary Braille transcriber issued by the National Library of Congress, or
 - iii. A passing score on a Braille exam administered by another state, or
 - iv. A passing score on the Braille exam developed and administered by the University of Arizona. Individuals who take this test and are not students at the University of Arizona may be assessed a fee.
 - f. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
2. Applicants may meet the requirements in subsection (L)(1)(b) with the submission of an application for the Standard Professional Visually Impaired Certificate – birth through grade 12 that includes evidence of two years of verified full-time teaching experience in visually impaired special education birth through grade 12 and Board-approved or accredited training or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (L)(1)(b)(i) through (vii).
- M. Standard Professional Early Childhood Special Education Certificate – Birth through age 8 or grade three.
 1. The requirements are:
 - a. A bachelor's degree,
 - b. Completion of a teacher preparation program in early childhood special education from an accredited institution,
 - c. A passing score on the subject knowledge portion of the Arizona Teacher Proficiency Assessment, unless the applicant has a bachelor's, master's or doctoral degree in early childhood special education or otherwise qualifies for a waiver of the subject knowledge examination,
 - d. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment,
 - e. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 2. Applicants may meet the requirements in subsection (M)(1)(b) with completion of the following:
 - a. Thirty-seven semester hours of early childhood education which teach the standards described in R7-2-602 which include the following areas of study:
 - i. Foundations early childhood education and special education;
 - ii. Behavioral interventions for children with and without disabilities;
 - iii. Characteristics and quality practices for typical and atypical behaviors of young children;
 - iv. Typical and atypical child growth and development, including health, safety and nutrition with an emphasis on special health care needs for children birth through grade three;
 - v. Child, family, cultural and community relationships including community organizations that support and assist children with disabilities and their families;
 - vi. Developmentally appropriate instructional and inclusive methodologies for teaching social and emotional development, language arts, math, science, social studies, and the arts;
 - vii. Diagnosis and remediation of learning difficulties;
 - viii. Early language and literacy development including communication methods in early childhood education/special education;
 - ix. Assessment and evaluation for early childhood special education to include observing, assessing, monitoring and reporting on the progress of young children;
 - x. A minimum of four semester hours in a supervised field experience, practicum, internship or student teaching setting serving children with identified special needs birth through preschool or one year of full-time teaching experience

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- with children identified with special needs birth through preschool; and
- xi. A minimum of four semester hours in a supervised student teaching setting serving children with identified special needs in kindergarten through grade three or one year of full time teaching experience with children identified with special needs kindergarten through grade three.
- N. Standard Professional Early Childhood Special Education Certificate – birth through age 8 or grade three for applications received on or after August 1, 2018.
1. The requirements include all of the following:
 - a. A bachelor's degree;
 - b. Completion of a teacher preparation program in early childhood special education from a Board-approved educator preparation program or from an accredited institution offering substantially similar training addressing the following topics and any others as required by law:
 - i. Research-based systematic phonics;
 - ii. Research-based instructional strategies for delivering differentiated reading instruction, assessment, intervention and remediation to support readers of varying ages and ability levels, including students with dyslexia;
 - iii. Teaching students with exceptionalities;
 - iv. Characteristics and quality practices for typical and atypical behaviors of young children, including behavioral interventions for children with and without disabilities;
 - v. Typical and atypical child growth and development, including health, safety and nutrition with an emphasis on special health care needs for children birth through grade three;
 - vi. Child, family, cultural and community relationships including community organizations that support and assist children with disabilities and their families;
 - vii. Developmentally appropriate instructional and inclusive methodologies for teaching social and emotional development, language arts, math, science, social studies, the arts and diagnosis and remediation of learning difficulties;
 - viii. Early language and literacy development including communication methods in early childhood education/special education;
 - ix. Assessment and evaluation for early childhood special education to include observing, assessing, monitoring and reporting on the progress of young children;
 - x. Substantial experience in practicum as described in R7-2-604 serving children with exceptionalities birth through preschool and kindergarten through grade three;
 - xi. Professional responsibility and ethical conduct; and
 - xii. Twelve weeks of capstone experience as described in R7-2-604 serving children with exceptionalities in birth through grade three, which may be completed during the valid period of a teaching intern certificate. For individuals seeking dual certification, any capstone experience requirements may be met through separate eight-week capstone experiences in each of the certification areas sought.
 - c. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment;
 - d. A passing score on the subject knowledge portion of the Arizona Teacher Proficiency Assessment unless the applicant has a bachelor's, master's or doctoral degree in early childhood special education or otherwise qualifies for a waiver of the subject knowledge examination; and
 - e. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
2. Applicants may meet the requirements in subsection (N)(1)(b) with the submission of an application for the Standard Professional Early Childhood Special Education Certificate – birth through age 8 or grade three that includes two years of verified full-time teaching experience in early childhood special education serving children birth through prekindergarten and kindergarten through grade three and Board-approved or accredited training or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (N)(1)(b)(i) through (xi).
 3. Board approved educator preparation programs leading to dual certification in early childhood special education and early childhood teaching may exempt a student from the early childhood special education capstone experience upon completion of the following:
 - a. Verification from the applicable district or charter school administrator that the student was employed continuously as a paraprofessional whose primary responsibility was working with students in early childhood special education for two years preceding commencement of the early childhood teaching capstone experience;
 - b. Verification from the applicable district or charter school administrator that the student received evaluations, in each of the preceding two years of employment as a paraprofessional, indicating effectiveness in performance; and
 - c. Completion of the capstone experience in early childhood education and demonstration of all of the following competencies during the dual certification educator preparation program:
 - i. Participation on a multi-disciplinary evaluation team;
 - ii. Participation in and drafting of an acceptable individualized education program; and
 - iii. Planning and delivery of specially designed instruction for a class of students.
- O. Provisional Cross-Categorical Special Education Certificate – grades K through 12
1. No new applications for the Provisional Cross-Categorical Special Education certificate are accepted as of December 31, 2015.
 2. Individuals who hold a valid Provisional Cross-Categorical Special Education certificate are qualified to teach students with mild to moderate autism, intellectual disabilities, traumatic brain injury, emotional disability, specific learning disability, orthopedic impairments, developmental delay and/or other health impairments.
 3. The Provisional certificate may not be renewed or extended. Individuals who hold a valid Provisional Cross-Categorical Special Education certificate, or a Pro-

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visional Cross-Categorical certificate which has not expired for more than one year, may apply for a Standard Professional Cross-Categorical Special Education certificate.

- P.** Standard Professional Cross-Categorical Special Education Certificate – grades K through 12.
1. The Standard Professional Cross-Categorical is valid for 12 years and may be renewed.
 2. Individuals who hold a valid Standard Professional Cross-Categorical Special Education certificate are qualified to teach students with autism, intellectual disabilities, traumatic brain injury, emotional disability, specific learning disability, orthopedic impairments, developmental delay and/or other health impairments.
 3. The requirements are:
 - a. An Arizona Provisional Cross-Categorical Special Education Certificate that is either valid or has not expired for more than one year.
 - b. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Amended by emergency rulemaking under A.R.S. § 41-1026 at 8 A.A.R. 5139, effective November 19, 2002 for a period of 180 days (Supp. 02-4). Emergency rulemaking renewed under A.R.S. § 41-1026(D) at 9 A.A.R. 1547, effective April 29, 2003 for a period of 180 days (Supp. 03-2). Emergency rulemaking repealed under A.R.S. § 41-1026(E) and permanent R7-2-611 amended by final rulemaking at 9 A.A.R. 3950, effective October 21, 2003 (Supp. 03-3). Former R7-2-611 recodified to R7-2-612; new R7-2-611 recodified from R7-2-610 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1). R7-2-611 “Prekindergarten” corrected to “PreK” at request of the Board, Office File No. M09-444, filed November 24, 2009 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 119, effective September 21, 2009 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 235, effective December 7, 2009 (Supp. 10-3). Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). Amended by final exempt rulemaking at 21 A.A.R. 2056, effective December 2, 2013 (Supp. 15-3). Amended by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1). Amended by final exempt rulemaking at 24 A.A.R. 1427, effective April 23, 2018 (Supp. 18-2). The word “kindergarten” has been changed to the letter “K,” the term, “grade 3” has been changed to “grade three,” the word “twelve” has been changed to the numeral “12,” and “age eight” has been changed to “age 8” for consistency in this Section at the request of the Board (Supp. 21-2).

R7-2-612. Career and Technical Education Teaching Certificates

- A.** Except as noted, all certificates are subject to the general certification provisions in R7-2-607, and the renewal requirements in R7-2-619.
- B.** For purposes of this Section, the following definitions apply:
1. “Career and Technical Education means a field of study in any area relating to a CTE program approved by the Arizona Department of Education as described in the

Guidance on CTE Teacher Certification, which is on file with the Arizona Department of Education.

2. “Occupational Area” means employment in any area relating to a CTE program approved by the Department as described in the Guidance on CTE Teacher Certification, which is on file with the Arizona Department of Education.
 3. “Verified Work Experience” means written documentation from a current or former supervisor for paid or unpaid work, a current school superintendent, or the Department of Education Career and Technical Education Programmatic State Supervisor indicating that an applicant for a career and technical education certificate performed work in a business or industry setting related to an approved CTE program occupational area.
- C.** Standard Career and Technical Education (CTE) Certificate – CTE Field of Study – grades K through 12
1. The requirements include all of the following:
 - a. Within three years, obtain a passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment or qualification for a waiver of this assessment.
 - b. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 - c. At least one of the following options:
 - i. Option A – Bachelor’s degree in the specified CTE field of study – requirements include all of the following:
 - (1) A bachelor’s or more advanced degree in the specified CTE field of study from an accredited institution.
 - (2) Thirty semester hours of courses in the specified CTE field of study.
 - (3) Two hundred forty clock hours of verified work experience in the specified CTE occupational area. Hours may have been accumulated before obtaining a certification.
 - (4) Within three years, complete 15 semester hours of courses in professional knowledge in career and technical education, to include any of the following areas: principles/philosophy of career and technical education, developmentally appropriate instructional delivery, facilitation and methodologies, instructional technology, instructional design and lesson planning, including modifications and accommodations, assessing, monitoring and reporting progress, the learning environment, including classroom management, teaching students with exceptionalities, or professional responsibility and ethical conduct. Hours may be obtained prior to issuance of the standard career and technical education certificate in the specified CTE field of study. Fifteen semester hours may be obtained through Department or Board-CTE approved professional development. Fifteen clock hours equals one semester hour.
 - ii. Option B – Valid non-CTE Arizona Provisional or Standard teaching certificate or an Arizona CTE teaching certificate in another CTE field

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of study – requirements include all of the following:

- (1) A valid Arizona provisional or standard teaching certificate for teachers in birth through grade 12 issued pursuant to this Article.
 - (2) One year of the most recent teacher evaluation(s) approved by a certificated administrator, or the administrator's designee, in a grades PreK through 12 school setting and issued during the term of the Arizona teaching certificate exhibiting satisfactory performance in the classroom.
 - (3) Three semester hours of courses in professional knowledge in career and technical education to include any of the following areas: principles/philosophy of career and technical education, developmentally appropriate instructional delivery, facilitation and methodologies for career and technical education, or instructional technology. Three semester hours may be obtained through Department or Board-CTE approved professional development. Fifteen clock hours equals one semester hour.
 - (4) Two hundred forty clock hours of verified work experience in the specified CTE occupational area. Hours may have been accumulated before obtaining a certification.
 - (5) Within three years, complete nine semester hours of subject knowledge courses in the CTE field of study.
- iii. Option C – Business and industry professional - requirements include 6,000 clock hours of verified work experience in an occupational area. Within three years, complete 15 semester hours of courses in professional knowledge in career and technical education to include any of the following areas: principles/philosophy of career and technical education, developmentally appropriate instructional delivery, facilitation and methodologies, instructional design and lesson planning, including modifications and accommodations, assessing, monitoring and reporting progress, instructional technology, the learning environment, including classroom management, teaching students with exceptionalities, or professional responsibility and ethical conduct. Fifteen semester hours may be obtained through Department or Board-CTE approved professional development. Fifteen clock hours equals one semester hour; and
- iv. Option D – Bachelor's degree in the specified CTE field of study teacher preparation program – requirements include both of the following:
- (1) A bachelor's or more advanced degree that included completion of a Board approved teacher preparation program in the CTE field of study or from an accredited institution offering substantially similar training, addressing the following topics in career and technical education

and any others as required by law: Principles/philosophy of career and technical education, instructional design and lesson planning, including modifications and accommodations; the learning environment, including classroom management; developmentally appropriate instructional delivery, facilitation and methodologies; assessing, monitoring and reporting progress; teaching students with exceptionalities; professional responsibility and ethical conduct; and

- (2) Two hundred forty clock hours of verified work experience in the specified occupational area. Hours shall have been accumulated before obtaining a certification.
2. If an applicant fails to meet these requirements within the prescribed time period, the Department of Education or the Board shall temporarily suspend the standard certificate, but the suspension is not considered a disciplinary action and the individual shall be allowed to correct the deficiency within the remaining time of the standard certification.

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Section R7-2-612 amended by emergency rulemaking under A.R.S. § 41-1026 at 8 A.A.R. 2562, effective May 23, 2002 for a period of 180 days (Supp. 02-2). May 23, 2002 emergency rulemaking renewed under A.R.S. § 41-1026 at 8 A.A.R. 5132, effective November 19, 2002 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 1605, effective May 5, 2003 (Supp. 03-2). Amended by final rulemaking at 11 A.A.R. 1885, effective June 26, 2005 (Supp. 05-2). Amended by exempt rulemaking at 15 A.A.R. 1292, effective June 26, 2006 (Supp. 09-1). Amended by exempt rulemaking at 15 A.A.R. 1893, effective September 25, 2006 (Supp. 09-2). Amended by exempt rulemaking at 15 A.A.R. 2086, effective May 19, 2008 (Supp. 09-3). Former R7-2-612 recodified to R7-2-613 at 15 A.A.R. 2146, effective August 25, 2008 (Supp. 09-4). New Section made by exempt rulemaking at 15 A.A.R. 2143, effective August 25, 2008 (Supp. 09-4). Former R7-2-612 recodified to R7-2-613; new R7-2-612 recodified from R7-2-611 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 102, effective May 1, 2009 (Supp. 10-1). Amended by final exempt rulemaking at 21 A.A.R. 2063, effective August 26, 2013 (Supp. 15-3). Amended by final exempt rulemaking at 23 A.A.R. 725, effective January 23, 2017 (Supp. 17-1). Amended by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1). Amended by final exempt rulemaking at 23 A.A.R. 694, effective February 26, 2018 (Supp. 18-1). The word "fifteen" has been changed to the numeral "15," the words "six thousand" have been changed to the numeral "6,000," and the word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-612.01. Standard Specialized Career and Technical Education (CTE) Certificates – grades K through 12

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- A.** Standard Specialized CTE certificates are subject to the general certification provisions in R7-2-607 and the renewal requirements in R7-2-619.
- B.** The holder is qualified to teach in an area that is specified on the certificate relating to a CTE program approved by the Arizona Department of Education as described in Guidance on CTE Teacher Certification which is on file with the Arizona Department of Education.
- C.** The requirements are:
1. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 2. Demonstration of expertise in the specified CTE area through one of the following:
 - a. A Bachelor's, master's or doctoral degree in the specified CTE area; or
 - b. A Bachelor's or more advanced degree and completion of 24 semester hours of coursework in the specified CTE area; or
 - c. An Associate's degree in the specified CTE area; or
 - d. An industry certification, license, or credential in the specified CTE area approved by the appropriate Department of Education Career and Technical Education Program Specialist or Career and Technical Education Program Services Director; or
 - e. Verified teaching experience for the last two consecutive years, and for a total of at least three years at one or more accredited postsecondary institutions in a subject that is specific to the CTE course being taught.
 3. Verification of five years of work experience in the specified CTE occupational area.
 4. An individual who meets the requirements of this Section is exempt from the competency requirements of the United States and Arizona Constitutions, the professional knowledge and subject knowledge portions of the Arizona Teacher Proficiency Assessments, and structured English immersion endorsement requirements.
- Historical Note**
 New Section made by final exempt rulemaking at 22 A.A.R. 2617, effective August 22, 2016 (Supp. 16-4).
 Amended by final exempt rulemaking at 23 A.A.R. 694, effective February 26, 2018 (Supp. 18-1). The term "twenty-four" has been changed to the numeral "24," the hyphen between "PreK-12" has been replaced with the word "through" in the Section heading for consistency in Chapter style and format (Supp. 21-1).
- R7-2-613. PreK through 12 Teaching Certificates**
- A.** Except as noted, all certificates are subject to the general certification provisions in R7-2-607 and the renewal requirements in R7-2-619.
- B.** Standard Professional PreK through 12 Arts Education Certificate: art, dance, dramatic arts or music. The requirements are:
1. A bachelor's degree.
 2. One of the following:
 - a. Completion of a teacher preparation program in PreK through 12 arts education in one of the following approved areas: art, dance, dramatic arts or music from a Board-approved teacher preparation program, described in R7-2-604; or
 - b. Completion of a teacher preparation program in PreK through 12 arts education in one of the following approved areas: art, dance, dramatic arts or music from an institution accredited by the National Association of Schools of Art and Design, National Association of Schools of Dance, National Association of Schools of Theatre, the National Association of Schools of Music, or National Council for Accreditation of Teacher Education; or
 - c. Thirty semester hours of education or arts education courses which teach the knowledge and skills described in R7-2-602, including at least eight semester hours of elementary and secondary methods in the certificate area and 12 semester hours of practicum in the certificate area grades PreK through 12. Two years of verified full-time teaching experience in the certificate area in grades PreK through 12 may substitute for the 12 semester hours of practicum; or
 - d. A valid PreK through 12 arts education certificate from another state.
 3. A passing score on the appropriate subject knowledge portion of the Arizona Teacher Proficiency Assessment, unless the applicant has a bachelor's, master's or doctoral degree in a relevant content area or otherwise qualifies for a waiver of the subject knowledge assessment. If a proficiency assessment is not offered in a subject area, an approved area shall consist of a minimum of 24 semester hours of courses in the subject.
 4. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment.
 5. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- C.** Standard Professional PreK through 12 Arts Education Certificate for applications received on or after August 1, 2018.
1. The requirements include all of the following:
 - a. A bachelor's degree;
 - b. Completion of a teacher preparation program in PreK through 12 arts education from a Board-approved teacher educator preparation program or from an accredited institution offering substantially similar training, addressing the following topics and any others as required by law:
 - i. Studio art;
 - ii. Art history and analysis;
 - iii. Advanced work in studio or art application areas;
 - iv. Technical processes;
 - v. Instructional design and lesson planning, including modifications, and accommodations;
 - vi. The learning environment, including classroom management;
 - vii. Assessing, monitoring and reporting progress;
 - viii. Professional responsibility and ethical conduct;
 - ix. Twelve weeks of capstone experience as described in R7-2-604 in grades PreK through 12 arts education, which may be completed during the valid period of a teaching intern or student teaching intern certificate. One year of verified full-time teaching experience in the certificate area in grades PreK through 12 arts education may substitute for the capstone experience requirement;
 - c. A passing score on the appropriate subject knowledge portion of the Arizona Teacher Proficiency Assessment, unless the applicant has a bachelor's, master's or doctoral degree in a relevant content area

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or otherwise qualifies for a waiver of the subject knowledge assessment.

- d. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment and

- e. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.

2. Applicants may meet the requirements in subsection (C)(1)(b) with the submission of an application for the Standard Professional PreK through 12 Arts Education certificate that includes evidence of two years of verified full-time teaching experience in grades PreK through 12 arts education, and Board-approved or accredited training or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (C)(1)(b)(i) through (vii). One year of verified full-time teaching experience in grades PreK through 12 arts education may be substituted for the capstone experience.

D. Standard Professional PreK through 12 Dance Education Certificate

1. The requirements include all of the following:
 - a. A bachelor's degree;
 - b. Completion of a teacher preparation program in PreK through 12 dance education from an accredited institution offering substantially similar training, addressing the following topics and any others as required by law:
 - i. Performance;
 - ii. Choreography;
 - iii. Theoretical and historical studies of dance;
 - iv. Technical processes;
 - v. Instructional design and lesson planning, including modifications, and accommodations;
 - vi. The learning environment, including classroom management;
 - vii. Assessing, monitoring and reporting progress;
 - viii. Professional responsibility and ethical conduct; and
 - ix. Twelve weeks of capstone experience as described in R7-2-604 in grades PreK through 12 dance education, which may be completed during the valid period of a teaching intern or student teaching intern certificate. One year of verified full-time teaching experience in grades PreK through 12 dance education may substitute for the capstone experience requirement; and
 - c. A passing score on the appropriate subject knowledge portion of the Arizona Teacher Proficiency Assessment, unless the applicant has a bachelor's, master's or doctoral degree in a relevant content area or otherwise qualifies for a waiver of the subject knowledge assessment.
 - d. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment; and
 - e. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
2. Applicants may meet the requirements in subsection (D)(1)(b) with the submission of an application for the Standard Professional PreK through 12 Dance Education certificate that includes evidence of two years of verified full-time teaching experience in grades PreK through 12 dance education, and Board-approved or accredited training or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (D)(1)(b)(i) through (viii). One year of verified full-time teaching experience in grades PreK through 12 dance education may be substituted for the capstone experience.

ing or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (D)(1)(b)(i) through (viii). One year of verified full-time teaching experience in grades PreK through 12 dance education may be substituted for the capstone experience.

E. Standard Professional PreK through 12 Theatre Education Certificate

1. The requirements include all of the following:
 - a. A bachelor's degree;
 - b. Completion of a teacher preparation program in PreK through 12 theatre education from an accredited institution offering substantially similar training, addressing the following topics and any others as required by law:
 - i. Foundations of production;
 - ii. Aesthetics, theatre history, literature, theory and criticism;
 - iii. Advanced work in theatre performance;
 - iv. Instructional design and lesson planning, including modifications, and accommodations;
 - v. The learning environment, including classroom management;
 - vi. Assessing, monitoring and reporting progress;
 - vii. Professional responsibility and ethical conduct and;
 - viii. Twelve weeks of capstone experience as described in R7-2-604 in grades PreK through 12 theatre education, which may be completed during the valid period of a teaching intern or student teaching intern certificate. One year of verified full-time teaching experience in grades PreK through 12 theatre education may substitute for the capstone experience requirement; and
 - c. A passing score on the appropriate subject knowledge portion of the Arizona Teacher Proficiency Assessment, unless the applicant has a bachelor's, master's or doctoral degree in a relevant content area or otherwise qualifies for a waiver of the subject knowledge assessment.
 - d. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment; and
 - e. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
2. Applicants may meet the requirements in subsection (E)(1)(b) with the submission of an application for the Standard Professional PreK through 12 Theatre Education certificate that includes evidence of two years of verified full-time teaching experience in grades PreK through 12 theatre education, and Board-approved or accredited training or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (E)(1)(b)(i) through (vii). One year of verified full-time teaching experience in grades PreK through 12 theatre education may be substituted for the capstone experience.

F. Standard Professional PreK through 12 Music Education Certificate

1. The requirements include all of the following:
 - a. A bachelor's degree;
 - b. Completion of a teacher preparation program in PreK through 12 music education from an accredited institution offering substantially similar training,

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addressing the following topics and any others as required by law:

- i. Performance;
- ii. Musicianship skills and analysis;
- iii. Composition and improvisation;
- iv. Music history and repertoire;
- v. Instructional design and lesson planning, including modifications, and accommodations;
- vi. The learning environment, including classroom management;
- vii. Assessing, monitoring and reporting progress;
- viii. Professional responsibility and ethical conduct; and
- ix. Twelve weeks of capstone experience as described in R7-2-604 in grades PreK through 12 music education, which may be completed during the valid period of a teaching intern or student teaching intern certificate. One year of verified full-time teaching experience in grades PreK through 12 music education may substitute for the capstone experience requirement; and

- c. A passing score on the appropriate subject knowledge portion of the Arizona Teacher Proficiency Assessment, unless the applicant has a bachelor's, master's or doctoral degree in a relevant content area or otherwise qualifies for a waiver of the subject knowledge assessment.
- d. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment; and
- e. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.

2. Applicants may meet the requirements in subsection (F)(1)(b) with the submission of an application for the Standard Professional PreK through 12 Music Education certificate that includes evidence of two years of verified full-time teaching experience in grades PreK through 12 music education, and Board-approved or accredited training or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (F)(1)(b)(i) through (viii). One year of verified full-time teaching experience in grades PreK through 12 music education may be substituted for the capstone experience.

G. Standard Professional PreK through 12 Physical Education Certificate. The requirements are:

1. A bachelor's degree.
2. One of the following:
 - a. Completion of a teacher preparation program in PreK through 12 physical education, including 12 semester practicum hours evenly split between elementary and secondary physical education from an accredited institution or a Board-approved teacher preparation program; or
 - b. Thirty-three semester hours of education or physical education courses, including:
 - i. At least nine semester hours of elementary, secondary and adaptive physical education methods;
 - ii. Foundational coursework in the areas of Growth and Motor Development, Movement Activities, Lifelong Physical Fitness and Comprehensive School Physical Activity Programming; and

- iii. Twelve semester hours of practicum in physical education in PreK through 12 grades, evenly split between elementary and secondary physical education, and supervised by a licensed or certified physical education teacher. Two years of verified full-time teaching experience in the certificate area in grades PreK through 12 may substitute for the 12 semester hours of practicum; or

- c. A valid PreK through 12 physical education certificate from another state.

3. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment.
4. A passing score on the Physical Education subject knowledge portion of the Arizona Teacher Proficiency Assessment, unless the applicant has a bachelor's, master's or doctoral degree in a relevant content area or otherwise qualifies for a waiver of the subject knowledge assessment.
5. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.

H. Standard Professional PreK through 12 Physical Education Certificate for applications received on or after August 1, 2018.

1. The requirements include all of the following:
 - a. A bachelor's degree;
 - b. Completion of a teacher preparation program in PreK through 12 physical education a Board-approved educator preparation program or from an accredited institution offering substantially similar training, addressing the following topics and any others as required by law:
 - i. Elementary, secondary and adaptive physical education methods;
 - ii. Foundational coursework in the areas of Growth and Motor Development;
 - iii. Movement Activities;
 - iv. Lifelong Physical Fitness;
 - v. Instructional design and lesson planning, including modifications, and accommodations;
 - vi. The learning environment, including classroom management;
 - vii. Assessing, monitoring and reporting progress;
 - viii. Professional responsibility and ethical conduct and;
 - ix. Twelve weeks of capstone experience as described in R7-2-604 in grades PreK through 12 physical education, serving students in elementary and secondary physical education, which may be completed during the valid period of a teaching intern or student teaching intern certificate. One year of verified full-time teaching experience in the certificate area in grades PreK through 12 physical education may substitute for the capstone experience requirement;
- c. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment;
- d. A passing score on the Physical Education subject knowledge portion of the Arizona Teacher Proficiency Assessment, unless the applicant has a bachelor's, master's or doctoral degree in a relevant content area or otherwise qualifies for a waiver of the subject knowledge assessment; and

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- e. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
2. Applicants may meet the requirements in subsection (H)(1)(b) with the submission of an application for the Standard Professional PreK through 12 Physical Education certificate that includes evidence of two years of verified full-time teaching experience in grades PreK through 12 physical education, and Board-approved or accredited training or coursework which teaches the knowledge and skills described in R7-2-602 and subsections (H)(1)(b)(i) through (viii). One year of verified full-time teaching experience in grades PreK through 12 physical education may be substituted for the capstone experience.

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4). Amended by final rulemaking at 10 A.A.R. 4581, effective December 18, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 1885, effective June 26, 2005 (Supp. 05-2). Amended by exempt rulemaking at 15 A.A.R. 1225, effective December 5, 2006 (Supp. 09-1). Amended by exempt rulemaking at 15 A.A.R. 1259, effective March 26, 2007 (Supp. 09-2). Amended by exempt rulemaking at 15 A.A.R. 1298, effective July 18, 2007 (Supp. 09-3). Former R7-2-613 recodified to R7-2-614; new R7-2-613 recodified from R7-2-612 at 15 A.A.R. 2146, effective August 25, 2008 (Supp. 09-4). Former R7-2-613 recodified to R7-2-614; new R7-2-613 recodified from R7-2-612 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 235, effective December 7, 2009 (Supp. 10-3). Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). Amended by final exempt rulemaking at 21 A.A.R. 2073, effective June 22, 2015 (Supp. 15-3). Amended by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1). The hyphen between "PreK-12" has been changed to the word "through" in the Section heading and subsections for consistency in Chapter style and format (Supp. 21-1).

R7-2-614. Other Teaching Certificates

- A. Except as noted, all certificates are subject to the general certification provisions in R7-2-607.
- B. Substitute Certificate - PreK through 12
 1. The certificate is valid for six years and renewable by reapplication.
 2. The certificate entitles the holder to substitute in the temporary absence of a regular contract teacher. A person holding only a substitute certificate shall not be assigned a contract teaching position.
 3. An individual who holds a valid teaching or administrator certificate shall not be required to hold a substitute certificate to be employed as a substitute teacher.
 4. The requirements for issuance are:
 - a. A bachelor's degree, and
 - b. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 5. Substitute certificates previously issued as valid for life under this Section shall remain valid for life.
- C. Emergency Substitute Certificate - PreK through 12
 1. The certificate is valid for two school years or part thereof. The expiration date shall be July 1 in the year of expiration.

2. The certificate entitles the holder to substitute only in the district that has a verified emergency employment situation.
 3. The certificate entitles the holder to substitute in the temporary absence of a regular contract teacher. A person holding only an emergency substitute certificate shall not be assigned a contract teaching position.
 4. The holder of an emergency substitute certificate shall be limited to 120 days of substitute teaching in the same school each school year. A person holding an emergency substitute certificate may be exempt from the limit on teaching 120 days in the same school each school year if the school district superintendent provides verification to the Department that the position has been continuously advertised on a statewide basis at a minimum of three sites with at least one being a higher education institution and that an employable candidate was not found. An exemption from teaching 120 days shall not be granted to the same individual more than three times.
 5. The requirements for initial issuance are:
 - a. A high school diploma, General Education diploma, or associate's degree;
 - b. Verification from the school district superintendent that an emergency employment situation exists; and
 - c. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 6. The requirements for each reissuance are:
 - a. Two semester hours of academic courses completed since the last issuance of the Emergency Substitute Certificate. District in-service programs designed for professional development may substitute for academic courses. Fifteen clock hours of in-service is equivalent to one semester hour. In-service hours shall be verified by the district superintendent or personnel director. Academic courses and in-service programs completed pursuant to this Section may include classroom management and professionalism and ethics. Individuals who have earned 30 or more semester hours are exempt from this requirement,
 - b. Verification from the school district superintendent that an emergency employment situation exists, and
 - c. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- D. Emergency Teaching Certificate - birth through grade 12**
1. The emergency teaching certificate is valid one school year or part thereof. The expiration date shall be the following July 1. Excluding an emergency teaching certificate issued under subsection (D)(6), an emergency teaching certificate shall not be issued more than three times to an individual.
 2. The emergency teaching certificate entitles the holder to enter into a teaching contract.
 3. Emergency teaching certificates shall be issued for early childhood, elementary and secondary certificates required by A.R.S. § 15-502(B) and required endorsements.
 4. The emergency teaching certificate entitles the holder to teach only in the district or charter school that verifies that an emergency employment situation exists.
 5. The requirements for initial issuance are:
 - a. A bachelor's degree,
 - b. Verification from the school district superintendent or charter school administrator that an emergency employment situation exists, and

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- c. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 - 6. Notwithstanding this subsection, an emergency teaching certificate entitling the holder to teach in any Arizona school district or charter school may be issued for early childhood, elementary, middle grades, secondary, special education, and PreK through 12 teaching certificates for applicants who meet the following requirements:
 - a. A bachelor's degree,
 - b. Completion of a teacher preparation program in the certification area, as described in R7-2-608, R7-2-609, R7-2-609.01, R7-2-610, R7-2-611 and R7-2-613, from a Board-approved educator preparation program or from an accredited institution offering substantially similar training,
 - c. Verification that the applicant was unable to take one or all portions of the proficiency assessments required for the requested certificate as the result of a public health emergency declared by the governor or a public health official, and
 - d. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 - 7. Emergency teaching certificates issued pursuant to subsection (D)(6) shall not be renewed or re-issued.
 - E. Alternative Teaching Certificate - PreK through 12
 - 1. The certificate is valid for two years from the date of initial issuance and may be extended yearly for no more than two consecutive years at no cost to the applicant if the provisions in subsection (E)(5) are met.
 - 2. The alternative teaching certificate entitles the holder to enter into a teaching contract while completing the requirements for an Arizona teaching certificate. During the valid period of the alternative teaching certificate the holder may teach in a Structured English Immersion classroom, or in any subject area in which the holder has passed the appropriate Arizona Teacher Proficiency Assessment. Alternative Teaching certificate holders who teach in a Structured English Immersion classroom shall hold a valid Provisional or full Structured English Immersion Endorsement, an English as a Second Language Endorsement, or a Bilingual Endorsement, if applicable. The candidate shall be enrolled in a Board authorized alternative path to certification program or a Board approved teacher educator preparation program.
 - 3. An individual is not eligible to hold the alternative teaching certificate more than once in a five year period.
 - 4. The requirements for initial issuance of the alternative teaching certificate are:
 - a. A bachelor's degree or higher from an accredited institution;
 - b. Verification of enrollment in a Board approved alternative path to certification program, or a Board approved educator preparation program; and
 - c. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 - 5. The requirements for the extension of the alternative teaching certificate are:
 - a. The alternative teaching certificate outlined in subsection (E)(4),
 - b. Verification from the educator preparation program in which the alternative teaching certificate holder is enrolled, that the certificate holder has made adequate progress toward completion of the program,
 - c. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 - 6. The holder of the alternative teaching certificate may apply for a Standard teaching certificate upon completion of the following:
 - a. Successful completion of a Board authorized alternative path to certification program or a Board-approved educator preparation program.
 - b. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment as applicable;
 - c. A passing score on one or more subject knowledge portions of the Arizona Teacher Proficiency Assessment that corresponds to the Board approved alternative path to certification program in which the applicant is enrolled, unless the applicant has a bachelor's, master's or doctoral degree in the corresponding content area;
 - d. The submission of an application for a Standard teaching certificate to the Department;
 - e. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 - 7. Placement decisions of alternative teaching certificate holders shall only be based on agreements between the educator preparation provider, the provider's partner organizations and the local education agency except as otherwise provided in this subsection.
- F. Standard Adult Education Certificate
 - 1. The holder is qualified to teach Adult Basic Education, Adult Secondary Education, English Language Acquisition for Adults, or Citizenship.
 - 2. The requirements are:
 - a. A valid fingerprint clearance card issued by the Arizona Department of Public Safety, and
 - b. A bachelor's degree.
 - 3. The renewal requirements are completion of a professional development program, described in R7-2-619.
- G. Junior Reserve Officer Training Corps Teaching Certificate - grades nine through 12
 - 1. The standard certificate is valid at any local education agency which conducts an approved Junior Reserve Officer Training Corps program of the Air Force, Army, Navy, or Marine Corps.
 - 2. The requirements are:
 - a. Verification by the district of an approved Junior Reserve Officer Training Corps program of instruction in which the applicant will be teaching,
 - b. Verification by the district that the applicant meets the work experience required by the respective military service, and
 - c. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- H. Athletic coaching certificate - grades seven through 12
 - 1. The standard certificate entitles the holder to perform coaching duties in interscholastic and extracurricular athletic activities. It is not required for teachers who hold a valid elementary, secondary or special education certificate.
 - 2. The requirements are:
 - a. Valid certification in first aid and Coronary and Pulmonary Resuscitation (CPR);
 - b. Completion of courses, Board-approved or accredited seminars or modules of study which shall include the following:

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- i. Methods of coaching,
 - ii. Anatomy and physiology,
 - iii. Sports psychology,
 - iv. Adolescent psychology,
 - v. The prevention and treatment of athletic injuries; and
 - vi. Signs of physical abuse, emotional abuse, sexual abuse, neglect, bullying, hazing and cyberbullying.
- c. Two hundred fifty hours of verified coaching experience in the sport to be coached. Coaching experience may include experience as a head coach or assistant coach in a school program or in an organized athletic league; and
- d. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- 4. Renewal requirements are:
 - a. Completion of a professional development program described in R7-2-619,
 - b. Valid certification in first aid and CPR.
- I. International Teaching Certificate**
 - 1. The International Teaching certificate is issued to teachers from foreign countries who are contracted through the foreign teacher program as authorized by federal statutes enacted by the Congress of the United States or other foreign teacher recruitment programs approved by the United States Department of State or the United States Citizenship and Immigration Services.
 - 2. This certificate is valid for the length of the certificate holder's visa, not to exceed 12 years.
 - 3. The requirements are:
 - a. Verification that the applicant has completed teacher preparation in the home country or country of legal residence that is comparable to the requirements to qualify for an Arizona teaching certificate as provided in R7-2-608, R7-2-609, R7-2-610, R7-2-610.01, R7-2-610.02, R7-2-611 and R7-2-613.
 - b. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 - c. A valid non-immigrating visa issued by the United States Department of State or the United States Citizenship and Immigration Services for international teachers.
 - d. Verification that the applicant has been contracted by an Arizona school through a foreign teacher program.
 - 4. An individual with an international teaching certificate may qualify for a certificate to instruct students in a language other than English with submission of a letter from a department chair or dean of an accredited institution in another country or in the United States verifying that the applicant is proficient in the language.
 - 5. The international teaching certificate may be extended with the following:
 - a. Verification of an extended visa issued by the United States Department of State or the United States Citizenship and Immigration Services for international teachers. The certificate may be extended to the new expiration date of the visa not to exceed 12 years.
 - b. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- J. Native American Language Certificate**
 - 1. The standard certificate is optional and issued to individuals to teach only a Native American language in grades PreK through 12.
 - 2. The requirements are:
 - a. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 - b. Language proficiency in a Native American Language. Proficiency shall be verified on official letterhead by a person, persons, or entity designated by the appropriate tribe.
 - 3. The certificate may be renewed upon completion of professional development, as prescribed in R7-2-619.
- K. Student Teaching Intern Certificate - PreK through 12**
 - 1. The student teaching intern certificate is optional and is not a requirement for participation in a student teaching capstone experience.
 - 2. The certificate entitles the holder to perform teaching duties under the supervision of a program supervisor as defined in R7-2-604(14) and is only valid in the school district or charter school requesting the certificate.
 - 3. The certificate is valid for one year from date of initial issuance and may be extended for one year at no cost to the applicant if the provisions in subsection (K)(4) are met.
 - 4. The requirements are:
 - a. Verification of enrollment in the culminating student teaching capstone experience of a Board approved educator preparation program pursuant to R7-2-604.01,
 - b. Verification documenting completed coursework with a minimum GPA of 3.0 on a 4.0 scale or the equivalent,
 - c. A passing score on the professional knowledge portion of the Arizona Teacher Proficiency Assessment that corresponds to the teaching certificate the student teaching intern is pursuing,
 - d. A passing score on the subject knowledge portion of the Arizona Teacher Proficiency Assessment that corresponds to the teaching certificate the student teaching intern is pursuing,
 - e. A request for issuance of the student teaching intern certificate from the district superintendent or charter school superintendent and the educator preparation program.
 - f. Verification from the educator preparation provider that a written supervision plan, approved by the Board, includes the following:
 - i. The educator preparation provider's roles and responsibilities for the Program Supervisor, and
 - ii. The onsite mentorship and induction provided by the Local Education Agency.
 - g. A valid fingerprint card issued by the Arizona Department of Public Safety.
 - 5. Placement decisions of student teaching intern certificate holders shall only be based on collaborative agreements between the Board approved educator preparation provider and the local education agency. Notwithstanding any other provision, a student teaching intern certificate holder may not teach in a special education classroom unless the certificate holder has a bachelor's degree.
 - 6. The holder of the student teaching certificate may apply for an Arizona Teaching Certificate upon completion of the following:

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- a. Successful completion of a Board approved educator preparation program.
- b. The submission of an application, and all required documentation including an institutional recommendation, for the Arizona teaching certificate to the Department.
- L. Classroom-Based Standard Teaching Certificate
 - 1. The requirements are:
 - a. A bachelor's degree;
 - b. Successful completion of a Board-approved Classroom-Based Alternative Preparation Program;
 - c. Verification of satisfactory progress and achievement with students;
 - d. Demonstration of subject knowledge proficiency with:
 - i. Verification of teaching courses relevant to a content area or subject matter for the last two consecutive years, and for a total of at least three years at one or more accredited postsecondary institutions; or
 - ii. A bachelor's, master's or doctoral degree from an accredited institution in the applicable subject area; or
 - iii. Verification of a minimum of five years of work experience in the applicable subject area of certification; or
 - iv. Three years of verified teaching experience in the same area of certification in which the individual is applying for certification; or
 - v. A passing score on the applicable subject knowledge portion of the Arizona Teacher Proficiency Assessment;
 - e. Demonstration of professional knowledge proficiency with:
 - i. Three years of verified teaching experience in the same area of certification in which the individual is applying for certification; or
 - ii. A passing score on the applicable professional knowledge portion of the Arizona Teacher Proficiency Assessment;
 - f. An individual seeking certification who was teaching courses or subjects tested by the statewide assessment must also provide:
 - i. Verified evidence of two years of full-time teaching; and
 - ii. Verified evidence that the individual's students performed at grade level; or
 - iii. Verified evidence that the individual's students achieved at least one year of academic growth at a rate equivalent to the state average for the students' associated peer groups;
 - g. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Section R7-2-614 amended by emergency rulemaking under A.R.S. § 41-1026 at 8 A.A.R. 3739, effective August 5, 2002 for a period of 180 days (Supp. 02-3). Emergency rulemaking renewed under A.R.S. § 41-1026 at 9 A.A.R. 522, effective January 31, 2003 for a period of 180 days (Supp. 03-1). Amended by final rulemaking at 9 A.A.R. 1605, effective May 5, 2003 (Supp. 03-2). Amended by exempt rulemaking at 15

A.A.R. 1304, effective June 26, 2006 (Supp. 09-1). Amended by exempt rulemaking at 15 A.A.R. 1898, effective April 28, 2008 (Supp. 09-2). Former R7-2-614 recodified to R7-2-615; new R7-2-614 recodified from R7-2-613 at 15 A.A.R. 2146, effective August 25, 2008 (Supp. 09-4). Former R7-2-614 recodified to R7-2-615; new R7-2-614 recodified from R7-2-613 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 52, effective December 8, 2008 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 63, effective June 22, 2009 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 728, effective March 22, 2010 (Supp. 10-3). Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). R7-2-614(J) amended by final exempt rulemaking at 21 A.A.R. 2073, effective August 27, 2012; R7-2-614(I) amended by final exempt rulemaking at 21 A.A.R. 2073, effective June 24, 2013; R7-2-614(B)(C)(E) amended by final exempt rulemaking at 21 A.A.R. 2073, effective January 26, 2015 (Supp. 15-3). Amended by final exempt rulemaking at 22 A.A.R. 667, effective January 25, 2016; filed in the Office March 1, 2016 (Supp. 16-3). Amended by final exempt rulemaking at 22 A.A.R. 2617, effective August 22, 2016 (Supp. 16-4). Amended by final exempt rulemaking at 23 A.A.R. 725, effective January 23, 2017 (Supp. 17-1). Amended by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1). Amended by final exempt rulemaking at 24 A.A.R. 2947, effective September 24, 2018 (Supp. 18-3). Amended by final exempt rulemaking at 26 A.A.R. 1311, effective May 18, 2020 (Supp. 20-2). The hyphen between "PreK-12" has been changed to the word "through," and the word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 28 A.A.R. 366 (February 11, 2022), with an immediate effective date of January 24, 2022 (Supp. 22-1).

R7-2-615. Endorsements

- A. An endorsement shall be automatically renewed with the certificate on which it is posted.
- B. Except as noted, all endorsements are subject to the general certification provisions in R7-2-607.
- C. Endorsements which are optional as specified herein may be required by local governing boards.
- D. Special subject endorsements, grades Pre-K through 12
 - 1. Special subject endorsements shall be issued in the area of art, computer science, dance, dramatic arts, music, or physical education.
 - 2. Special subject endorsements are optional.
 - 3. The requirements are:
 - a. An Arizona elementary, secondary, or special education certificate;
 - b. One course in the methods of teaching the subject at the elementary level and one course in the methods of teaching the subject at the secondary level; and
 - c. One of the following:
 - i. Thirty semester hours of courses in the subject area which may include the courses listed in subsection (D)(3)(b);
 - ii. A passing score on the subject area portion of the Arizona Teacher Proficiency Assessment, if an assessment has been adopted by the Board; or

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- iii. A passing score on a comparable out-of-state subject area assessment.
- E. Mathematics Specialist Endorsement, grades K through eight.** This subsection is valid until June 30, 2011.
1. The mathematics specialist endorsement is optional.
 2. The requirements are:
 - a. An Arizona elementary or special education certificate,
 - b. Three semester hours of courses in the methods of teaching elementary school mathematics, and
 - c. Fifteen semester hours of courses in mathematics education for teachers of elementary or middle school mathematics.
- F. Mathematics Endorsement, grades K through eight.** This subsection becomes effective on July 1, 2011.
1. The mathematics endorsement is optional for all K through eight teachers, but recommended for an individual in the position of mathematics specialist, consultant, interventionist, or coach. Nothing in this Section prevents school districts from requiring certified staff to obtain a mathematics endorsement as a condition of employment. The mathematics endorsement does not waive the requirements set forth in R7-2-607.
 2. The requirements are:
 - a. An Arizona elementary or special education certificate;
 - b. Three years of full-time teaching experience in grades K through eight; and
 - c. Eighteen semester hours to include:
 - i. Three semester hours of data analysis, probability, and discrete mathematics;
 - ii. Three semester hours of geometry and measurement;
 - iii. Six semester hours of patterns, algebra, and functions; and
 - iv. Six semester hours of number and operations.
 - d. Six semester hours to include:
 - i. Three semester hours of mathematics classroom assessment;
 - ii. Three semester hours of research-based practices, pedagogy, and instructional leadership in mathematics.
 - e. A passing score on the middle school mathematics knowledge portion of the Arizona Educator Proficiency Assessment may be substituted for the 18 semester hours described in subsection (F)(2)(c).
 - f. Completion of a comparable valid mathematics specialist certificate or endorsement from another state may be substituted for the requirements described in subsection (F)(2)(c) and (d).
- G. Reading Specialist Endorsement, grades K through 12.** This subsection is valid until June 30, 2011.
1. The reading specialist endorsement shall be required of an individual in the position of reading specialist, reading consultant, remedial reading teacher, special reading teacher, or in a similar position.
 2. The requirements are:
 - a. An Arizona elementary, secondary, or special education certificate; and
 - b. Fifteen semester hours of courses to include decoding, diagnosis and remediation of reading difficulties, and practicum in reading.
- H. Reading Endorsement.** This subsection becomes effective on July 1, 2011.
1. A reading endorsement shall be required of an individual in the position of reading or literacy specialist, reading or literacy coach, and reading or literacy interventionist.
 2. Reading Endorsement for grades K through eight. The requirements are:
 - a. A valid Arizona elementary special education or early childhood certificate,
 - b. Three years of full-time teaching experience,
 - c. Three semester hours of a supervised field experience or practicum in reading completed for the grades K through eight, and
 - d. One of the following:
 - i. Twenty-one semester hours beyond requirements of initial provisional or standard teaching certificate to include the following:
 - (1) Three semester hours in the theoretical and research foundations of language and literacy;
 - (2) Three semester hours in the essential elements of elementary reading and writing instruction (grades K through eight);
 - (3) Three semester hours in the elements of elementary content area reading and writing (grades K through eight);
 - (4) Six total semester hours in reading assessment systems;
 - (5) Three semester hours in leadership; and
 - (6) Three semester hours of elective courses in an area of focus that will deepen knowledge in the teaching of reading to elementary students, such as children's literature, or teaching reading to English Language Learners.
 - ii. Proof of a comparable valid reading specialist certificate or endorsement from another state may be substituted for the requirements described in subsections (H)(2)(c) and (d)(i).
 3. Reading Endorsement for grades six through 12. The requirements are:
 - a. A valid Arizona elementary, secondary, or special education certificate;
 - b. Three years of full-time teaching experience;
 - c. Three semester hours of supervised field experience or practicum in reading completed for the grades six through 12; and
 - d. One of the following:
 - i. Twenty-one semester hours beyond requirements of initial provisional or standard teaching certificate to include the following:
 - (1) Three semester hours in the theoretical and research foundations of language and literacy;
 - (2) Three semester hours in the essential elements of reading and writing instruction for adolescents (grades six through 12);
 - (3) Three semester hours in the elements of content area reading and writing for adolescents (grades six through 12);

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- (4) Six total semester hours in reading assessment systems;
 - (5) Three semester hours in leadership; and
 - (6) Three semester hours of elective courses in an area of focus that will deepen knowledge in the teaching of reading such as adolescent literature, or teaching reading to English Language Learners.
 - ii. Proof of a comparable valid reading specialist certificate or endorsement from another state may be substituted for the requirements described in subsections (H)(3)(c) and (d)(i).
 - e. A passing score on the reading endorsement subject knowledge portion of the Arizona Educator Proficiency Assessment for grades six through 12 may be substituted for 21 semester hours of reading endorsement coursework as described in subsection (H)(3)(d)(i).
4. Reading Endorsement, grades K through 12. The requirements are:
 - a. A valid Arizona elementary, secondary, special education certificate or early childhood certificate;
 - b. Three years of full-time teaching experience;
 - c. Three semester hours of a supervised field experience or practicum in reading completed for the grades K through five;
 - d. Three semester hours of a supervised field experience or practicum in reading completed for the grades six through 12; and
 - e. One of the following:
 - i. Twenty-four semester hours beyond requirements of initial provisional or standard teaching certificate to include the following:
 - (1) Three semester hours in the theoretical and research foundations of language and literacy,
 - (2) Three semester hours in the essential elements of elementary reading and writing instruction (grades K through eight),
 - (3) Three semester hours in the essential elements of reading and writing instruction for adolescents (grades six through 12),
 - (4) Three semester hours in the elements of elementary content area reading and writing (grades K through eight),
 - (5) Three semester hours in the elements of content area reading and writing for adolescents (grades six through 12),
 - (6) Six total semester hours in reading assessment systems, and
 - (7) Three semester hours in leadership,
 - ii. Proof of a comparable valid reading specialist certificate or endorsement from another state may be substituted for the requirements described in subsections (H)(4)(c), (d) and (e)(i).
 - f. A passing score on the reading endorsement subject knowledge portion of the Arizona Educator Proficiency Assessment for grades K through eight and a passing score on the reading endorsement professional knowledge portion of the Arizona Educator Proficiency Assessment for grades six through 12 may be substituted for 24 semester hours of reading endorsement coursework as described in subsection (H)(4)(e)(i).
- I. Elementary Foreign Language Endorsement, grades K through eight
 - 1. The elementary foreign language endorsement is optional.
 - 2. The requirements are:
 - a. An Arizona elementary, secondary or special education certificate.
 - b. Proficiency in speaking, reading, and writing a language other than English, verified by the appropriate language department of an accredited institution. American Indian language proficiency shall be verified by an official designated by the appropriate tribe.
 - c. Three semester hours of courses in the methods of teaching a foreign language at the elementary level.
- J. Bilingual Endorsements, PreK through 12
 - 1. A provisional bilingual endorsement or a bilingual endorsement is required of an individual who is a bilingual classroom teacher, bilingual resource teacher, bilingual specialist, or otherwise responsible for providing bilingual instruction.
 - 2. The provisional bilingual endorsement is valid for three years and is not renewable. The requirements are:
 - a. An Arizona elementary, secondary, supervisor, principal, superintendent, special education, early childhood, arts education or CTE certificate; and
 - b. Proficiency in a spoken language other than English, verified by one of the following:
 - i. A passing score on the Arizona Classroom Spanish Proficiency exam;
 - ii. A passing score on a foreign language subject knowledge portion of the Arizona Teacher Proficiency Assessment or a comparable foreign language subject knowledge exam from another state;
 - iii. If an exam in the language is not offered through the Arizona Teacher Proficiency Assessment or the American Council on the Teaching of Foreign Languages, proficiency may be verified by the language department of an accredited institution. A minimum passing score of "Advanced Low" is required on the American Council on the Teaching of Foreign Languages for Speaking and Writing Exams in the foreign language;
 - iv. Proficiency in American Indian languages shall be verified by an official designated by the appropriate tribe; or
 - c. Proficiency in sign language is verified through 24 hours of coursework from an accredited institution.
 - 3. The holder of the bilingual endorsement is also authorized to teach English as a Second Language.
 - 4. The requirements are:
 - a. An Arizona elementary, secondary, supervisor, principal, superintendent, special education, early childhood, arts education or CTE certificate;
 - b. Completion of a bilingual education program from an accredited institution or the following courses:
 - i. Three semester hours of foundations of instruction for non-English-language-background students;
 - ii. Three semester hours of bilingual methods;

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- iii. Three semester hours of English as a Second Language for bilingual settings;
 - iv. Three semester hours of courses in bilingual materials and curriculum, assessment of limited-English-proficient students, teaching reading and writing in the native language, or English as a Second Language for bilingual settings;
 - v. Three semester hours of linguistics to include psycholinguistics, sociolinguistics, first language acquisition, and second language acquisition for language minority students, or American Indian language linguistics;
 - vi. Three semester hours of courses dealing with school, community, and family culture and parental involvement in programs of instruction for non-English-language-background students; and
 - vii. Three semester hours of courses in methods of teaching and evaluating handicapped children from non-English-language backgrounds. These hours are only required for bilingual endorsements on special education certificates.
 - c. A valid bilingual certificate or endorsement from another state may be substituted for the courses described in subsection (J)(4)(b);
 - d. Practicum in a bilingual program or two years of verified bilingual teaching experience; and
 - e. Proficiency in a spoken language other than English, verified by one of the following:
 - i. A passing score on the Arizona Classroom Spanish Proficiency exam;
 - ii. A passing score on a foreign language subject knowledge portion of the Arizona Teacher Proficiency Assessment or a comparable foreign language subject knowledge exam from another state;
 - iii. If an exam in the language is not offered through the Arizona Teacher Proficiency Assessment or the American Council on the Teaching of Foreign Languages, proficiency may be verified by the language department of an accredited institution. A minimum passing score of "Advanced Low" is required on the American Council on the Teaching of Foreign Languages for Speaking and Writing Exams in the foreign language;
 - iv. Proficiency in American Indian languages shall be verified by an official designated by the appropriate tribe; or
 - f. Proficiency in sign language is verified through 24 hours of coursework from an accredited institution.
- K. English as a Second Language (ESL) Endorsements, grades Pre-K through 12**
- 1. An ESL or bilingual endorsement is required of an individual who is an ESL classroom teacher, ESL specialist, ESL resource teacher, or otherwise responsible for providing ESL instruction.
 - 2. The provisional ESL endorsement is valid for three years and is not renewable. The requirements are:
 - a. An Arizona elementary, secondary, supervisor, principal, superintendent, special education, early childhood, arts education or CTE certificate; and
 - b. Six semester hours of courses specified in subsection (K)(3)(b), including at least one course in methods of teaching ESL students.
3. The requirements for the ESL endorsement are:
- a. An Arizona elementary, secondary, supervisor, principal, superintendent, special education, early childhood, arts education or CTE certificate;
 - b. Completion of an ESL education program from an accredited institution or the following courses:
 - i. Three semester hours of courses in foundations of instruction for non-English-language-background students. Three semester hours of courses in the nature and grammar of the English language, taken before January 1, 1999, may be substituted for this requirement;
 - ii. Three semester hours of ESL methods;
 - iii. Three semester hours of teaching of reading and writing to limited-English-proficient students;
 - iv. Three semester hours of assessment of limited-English-proficient students;
 - v. Three semester hours of linguistics; and
 - vi. Three semester hours of courses dealing with school, community, and family culture and parental involvement in programs of instruction for non-English-language-background students.
 - c. A passing score on a foreign language subject knowledge portion of the Arizona Teacher Proficiency Assessment or a comparable foreign language subject knowledge exam from another state; or
 - d. Three semester hours of a practicum or two years of verified ESL or bilingual teaching experience, verified by the district superintendent;
 - e. Second language learning experience, which may include sign language. Second language learning experience may be documented by any of the following:
 - i. Six semester hours of courses in a single second language, or the equivalent, verified by the department of language, education, or English at an accredited institution;
 - ii. Completion of intensive language training by the Peace Corps, the Foreign Service Institute, or the Defense Language Institute;
 - iii. Placement by the language department of an accredited institution in a third-semester level;
 - iv. Placement at level 1-intermediate/low or more advanced score on the Oral Proficiency Interview, verified by the American Council for the Teaching of Foreign Languages;
 - v. Passing score on the Arizona Classroom Spanish Proficiency Examination approved by the Board; or
 - vi. Proficiency in an American Indian language, verified by an official designated by the appropriate tribe.
 - f. A passing score on a foreign language subject knowledge portion of the Arizona Teacher Proficiency Assessment or a comparable foreign language subject knowledge exam from another state; or

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- e. A valid ESL certificate or endorsement from another state may be substituted for the requirements described in subsection (K)(3)(b), (c) and (d).
- L. Structured English Immersion (SEI) Endorsement, Pre-K through 12. A Provisional or full Structured English Immersion (SEI) endorsement, or an English as a Second Language or Bilingual endorsement, shall be required of a teacher who is instructing students in a sheltered English immersion or structured English immersion model.
 - 1. The provisional SEI endorsement is valid for three years and is not renewable. The requirements are:
 - a. An Arizona elementary, secondary, special education, CTE, early childhood, Pre-K through 12 teaching, supervisor, principal or superintendent certificate; and
 - b. One semester hour or 15 clock hours of professional development in Structured English Immersion methods of teaching English Language Learner (ELL) students, including but not limited to instruction in SEI strategies, teaching with the ELL Proficiency Standards adopted by the Board and monitoring ELL student academic progress using a variety of assessment tools through a training program that meets the requirements of A.R.S. § 15-756.09(B).
 - 2. The requirements for the SEI endorsement are: an Arizona elementary, secondary, special education, CTE, early childhood, Pre-K through 12 teaching, supervisor, principal, or superintendent certificate; and one of the following:
 - a. Three semester hours of courses related to the teaching of the English Language Learner Proficiency Standards adopted by the Board, including but not limited to instruction in SEI strategies, teaching with the ELL Proficiency Standards adopted by the Board and monitoring ELL student academic progress using a variety of assessment tools; or
 - b. Completion of 45 clock hours of professional development in the teaching of the English Language Learner Proficiency Standards adopted by the Board, including but not limited to instruction in SEI strategies, teaching with the ELL Proficiency Standards adopted by the Board and monitoring ELL student academic progress using a variety of assessment tools through a training program that meets the requirements of A.R.S. § 15-756.09(B).
 - c. A passing score on the Structured English Immersion portion of the Arizona Teacher Proficiency Assessment.
 - 3. Nothing in this Section prevents a school district or charter school from requiring certified staff to obtain an SEI, ESL or bilingual endorsement as a condition of employment.
- M. Gifted Endorsements, grades Pre-K through 12
 - 1. The gifted endorsements authorize the holder to teach gifted students within the grade range and subject area of the prerequisite certificate. A gifted endorsement is required for all district teachers who have primary responsibility for teaching gifted pupils.
 - 2. The provisional gifted endorsement is valid for three years and is not renewable. The requirements are:
 - a. A valid Arizona International or Standard Professional teaching certificate.
 - b. One of the following:
 - i. Six semester hours of courses in gifted education; or
 - ii. Verification from a public school superintendent or personnel director that the applicant completed a minimum of 90 clock hours of in-service training in gifted education, or the equivalent through competency-based credentials, that is aligned to the Teacher Preparation Standards in Gifted and Talented Education adopted by the National Association for Gifted Children and the Council for Exceptional Children.
 - 3. Requirements for the gifted endorsement are:
 - a. A valid Arizona International or Standard Professional teaching certificate;
 - b. One of the following:
 - i. Verification from a public school superintendent or personnel director that the applicant completed a minimum of 180 clock hours of in-service training in gifted education, or the equivalent through competency-based credentials, that is aligned to the Teacher Preparation Standards in Gifted and Talented Education adopted by the National Association for Gifted Children and the Council for Exceptional Children; or
 - ii. Completion of 12 semester hours of courses in gifted education. No more than six semester hours of courses in gifted education may be obtained through completion of in-service training that is aligned to the Teacher Preparation Standards in Gifted and Talented Education adopted by the National Association for Gifted Children and the Council for Exceptional Children. Fifteen clock hours of in-service is equivalent to one semester hour. In-service hours shall be verified by the district superintendent or personnel director.
- N. Early Childhood Education Endorsements, birth through age eight
 - 1. When combined with an Arizona elementary education teaching certificate or an Arizona special education teaching certificate, the early childhood endorsement may be used in lieu of an early childhood education certificate as described in R7-2-608. When combined with an Arizona cross-categorical, specialized special education, or severe and profound teaching certificate as described in R7-2-611, the early childhood endorsement may be used in lieu of an Early Childhood Special Education certificate.
 - 2. The provisional early childhood endorsement is valid for three years and is not renewable. The requirements are:
 - a. A valid Arizona elementary teaching certificate as provided in R7-2-609 or a valid Arizona special education teaching certificate as provided in R7-2-611, and
 - b. A passing score on the early childhood subject knowledge portion of the Arizona Teacher Proficiency Assessment.
 - 3. The requirements for the early childhood endorsement are:
 - a. A valid Arizona elementary education teaching certificate as provided in R7-2-609 or a valid Arizona

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- special education teaching certificate as provided in R7-2-611, and
- b. Early childhood education coursework and practicum experience which includes both of the following:
 - i. Twenty-one semester hours of early childhood education courses to include all of the following areas of study:
 - (1) Foundations of early childhood education;
 - (2) Child guidance and classroom management;
 - (3) Characteristics and quality practices for typical and atypical behaviors of young children;
 - (4) Child growth and development, including health, safety and nutrition;
 - (5) Child, family, cultural and community relationships;
 - (6) Developmentally appropriate instructional methodologies for teaching language, math, science, social studies and the arts;
 - (7) Early language and literacy development;
 - (8) Assessing, monitoring and reporting progress of young children; and
 - ii. A minimum of eight semester hours of practicum including:
 - (1) A minimum of four semester hours in a supervised field experience, practicum, internship or student teaching setting serving children birth through preschool. One year of full-time verified teaching experience with children in birth through preschool may substitute for this student teaching experience. This verification may come from a school-based education program or center-based program licensed by the Department of Health Services or regulated by tribal or military authorities; and
 - (2) A minimum of four semester hours in a supervised student teaching setting serving children in kindergarten through grade three. One year of full-time verified teaching experience with children in kindergarten through grade three in an accredited school may substitute for this student teaching experience;
 - c. A valid fingerprint clearance card issued by the Arizona Department of Public Safety, and
 - d. A passing score on the early childhood professional knowledge portion of the Arizona Educator Proficiency Assessment may be substituted for the 21 semester hours of early childhood education courses as described in subsection (N)(3)(b)(i); and
 - e. A passing score on the early childhood subject knowledge portion of the Arizona Educator Proficiency Assessment.
4. Teachers with a valid Arizona elementary education certificate or Arizona special education certificate meet the requirements of this Section with evidence of the following:
 - a. A minimum of three years infant/toddler, preschool or kindergarten through grade three classroom teaching experience; and
 - b. A passing score on the early childhood subject knowledge portion of the Arizona Educator Proficiency Assessment.
- O. Library-Media Specialist Endorsement, grades Pre-K through 12**
 1. The library-media specialist endorsement is optional.
 2. Requirements are:
 - a. An Arizona elementary, secondary, early childhood or special education certificate;
 - b. A passing score on the Library Media Specialist portion of the Arizona Teacher Proficiency Assessment. A master's degree in Library Science may be substituted for a passing score on the assessment; and
 - c. One year of teaching experience.
 - P. Middle Grade Endorsement, grades five through nine**
 1. The middle grade endorsement is optional. The middle grade endorsement may expand the grades a teacher is authorized to teach on an elementary or secondary certificate.
 2. The requirements are:
 - a. An Arizona elementary or secondary certificate, and
 - b. Six semester hours of courses in middle grade education to include:
 - i. One course in early adolescent psychology;
 - ii. One course in middle grade curriculum; and
 - iii. A practicum or one year of verified teaching experience, in grades five through nine.
 - Q. Drivers Education Endorsement**
 1. The drivers education endorsement is optional.
 2. The requirements are:
 - a. An Arizona teaching certificate,
 - b. A valid Arizona driver's license,
 - c. One course in each of the following:
 - i. Safety education,
 - ii. Driver and highway safety education, and
 - iii. Driver education laboratory experience, and
 - d. A driving record with less than seven violation points and no revocation or suspension of driver's license within the two years preceding application.
 3. For the purposes of this Section, a course is defined as a three hour semester course offered by an accredited institution of higher learning or 45 clock hours of educational classes approved by the Department. Each semester hour of courses shall be equivalent to 15 clock hours of training. If semester hours are used, the required documentation for the semester hours shall be an official transcript.
 - R. Cooperative Education Endorsement, grades K through 12**
 1. The cooperative education endorsement is required for individuals who coordinate or teach CTE.
 2. The requirements are:
 - a. A provisional or standard CTE certificate in the areas of agriculture, business, family and consumer sciences, health occupations, marketing, or industrial technology; and
 - b. One course in CTE.
 - S. Computer Science, PreK through eight Endorsement**
 1. The computer science, PreK through eight endorsement authorizes the holder to teach computer science in prekindergarten through grade eight.
 2. The requirements are:
 - a. An Arizona Standard Professional Early Childhood, Elementary, Middle Grades, Secondary, Special Education, or PreK through 12 Teaching certificate;

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- b. Three semester hours in foundations for teaching computer science which addresses the following topics:
 - i. Introduction to computer science;
 - ii. Inclusive recruitment, retention, and pedagogical strategies in computing education;
 - iii. Computational thinking;
 - iv. Instructional planning based on the Arizona state standards for computer science, or comparable computer science standards.
 - c. Six semester hours in computer science to include the following:
 - i. Three semester hours in teaching and learning programming for educators; and
 - ii. Three semester hours in a computer science elective which may include, but is not limited to, physical computing or mobile computing.
 - 3. Completion of a training program through an Arizona public local education agency or an accredited institution may substitute for the semester hours required in subsections (S)(2)(b) and (c). Fifteen clock hours of training, or the equivalent competency-based credential, is equivalent to one semester hour of college coursework. Training programs shall be verified by a superintendent or personnel director of the Arizona local education agency or the appropriate administrator of an accredited institution.
- T. Computer Science, grades six through 12 Endorsement
 - 1. The computer science, grades six through 12 endorsement authorizes the holder to teach computer science in grades six through 12.
 - 2. The requirements are:
 - a. A valid Arizona Standard Professional Elementary, Middle Grades, Secondary, Hearing Impaired, Visually Impaired, Mild/Moderate Disabilities, Moderate/Severe Disabilities, or PreK through 12 Teaching certificate;
 - b. Three semester hours in foundations for teaching computer science which addresses the following topics:
 - i. Introduction to computer science;
 - ii. Inclusive recruitment, retention, and pedagogical strategies in computing education;
 - iii. Computational thinking;
 - iv. Instructional planning based on the Arizona state standards for computer science or comparable computer science standards.
 - c. Nine semester hours of courses in computer science to include the following:
 - i. Three semester hours in teaching and learning programming for educators; and
 - ii. Six semester hours in computer science electives which may include, but is not limited to, computer programming, cybersecurity, algorithms and data structures, operating systems, artificial intelligence, machine learning, database development and management, computer networks, and data mining and analytics.
 - 3. Completion of a training program through an Arizona public local education agency or an accredited institution may substitute for the semester hours required in subsections (T)(2)(b) and (c). Fifteen clock hours of training, or the equivalent competency-based credential, is equivalent to one semester hour of college coursework. Training programs shall be verified by a superintendent or personnel director of the Arizona local education agency or the appropriate administrator of an accredited institution.
- U. Literacy, K through five Endorsement
 - 1. For the purposes of this Section, the following definitions apply:
 - a. "Literacy instruction" means instruction in English language arts provided by a teacher.
 - b. "Science of reading instruction" means instruction which includes a focus on the elements of structured literacy, to include oral language, phonological awareness, phonics, fluency, vocabulary, comprehension, and foundational writing skills, including spelling and handwriting.
 - c. "Teaching certificate" means an Alternative Teaching certificate, International Teaching certificate, Classroom-Based Standard Teaching certificate, or Standard Professional teaching certificate.
 - 2. An individual who receives a teaching certificate in early childhood education, elementary education, middle grades education, or special education issued on or before August 1, 2025, and who provides literacy instruction in kindergarten programs or in any of grades one through five must obtain a Literacy, K through five endorsement, a Reading Specialist endorsement, grades K through 12, a Reading endorsement for grades K through 12, or a Reading endorsement for grades K through eight by August 1, 2028.
 - 3. An individual who receives a teaching certificate in early childhood education, elementary education, middle grades education, or special education issued after August 1, 2025, and who provides literacy instruction in kindergarten or in any of grades one through five must obtain a Literacy, K through five endorsement, a Reading Specialist endorsement, grades K through 12, a Reading endorsement for grades K through 12, or a Reading endorsement for grades K through eight within three years after the teaching certificate is issued.
 - 4. Literacy, K through Five Endorsement
 - a. The Literacy, K through five Endorsement authorizes the holder to provide literacy instruction within the grade range and subject area of the teaching certificate it endorses. The requirements are:
 - i. A valid teaching certificate in early childhood education, elementary education, middle grades education, or special education;
 - ii. Three semester hours in the science of reading instruction, including systematic phonics instruction;
 - iii. Three semester hours in reading instruction, including assessments, instructional practices, and interventions to improve student reading proficiency for struggling readers, including students with the characteristics of dyslexia;
 - iv. A passing score on a literacy instruction assessment approved by the Board for the Literacy, K through five endorsement.
 - b. Completion of Department-approved training may substitute for the semester hours required in subsections (U)(4)(a)(ii) and (iii). Fifteen clock hours of training, or the equivalent competency-based credential, is equivalent to one semester hour.
 - 5. Applicants may meet the requirements described in subsections (U)(4)(a)(ii), (iii), and (iv) with verification from an Arizona public school superintendent, principal or per-

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sonnel director that the applicant meets the following requirements: The applicant is a teacher who provides literacy instruction in kindergarten through grade five and has demonstrated through classroom observations and student achievement data across subgroups using evidence-based measures for at least three consecutive years, based on criteria established by the Board, that the teacher possesses the instructional knowledge and skills to:

- a. Effectively teach foundational reading skills, phonological awareness, phonics, fluency, vocabulary, and comprehension; and
- b. Implement reading instruction using high-quality instructional materials; and
- c. Provide effective instruction and interventions for students with reading deficiencies, including students with characteristics of dyslexia.

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Amended by exempt rulemaking at 15 A.A.R. 1838, effective August 29, 2006 (Supp. 09-1). Amended by exempt rulemaking at 15 A.A.R. 1306, effective September 26, 2006 (Supp. 09-1). Former R7-2-615 recodified to R7-2-616; new R7-2-615 recodified from R7-2-614 at 15 A.A.R. 2146, effective August 25, 2008 (Supp. 09-4). Former R7-2-615 recodified to R7-2-616; new R7-2-615 recodified from R7-2-614 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 52, effective December 8, 2008 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 119, effective September 21, 2009 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 129, effective September 21, 2009 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 734, effective July 1, 2011 (Supp. 10-3). Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). Amended by exempt rulemaking at 16 A.A.R. 1496, effective July 1, 2011 (Supp. 11-1). Amended by final exempt rulemaking at 22 A.A.R. 227, effective June 23, 2014; filed in the Office January 20, 2016 (Supp. 16-2). Amended by final exempt rulemaking at 22 A.A.R. 1912, effective October 1, 2011; filed in the Office July 1, 2016 (Supp. 16-3). Amended by final exempt rulemaking at 22 A.A.R. 219, effective June 5, 2015; filed in the Office January 20, 2016 (Supp. 16-4). Amended by final exempt rulemaking at 22 A.A.R. 233, effective September 28, 2015 and filed in the Office January 20, 2016 (Supp. 17-1). Amended by final exempt rulemaking at 22 A.A.R. 670, effective January 1, 2016, filed in the Office March 2, 2016; amended by final exempt rulemaking at 22 A.A.R. 2241, effective August 6, 2016, filed in the Office August 5, 2016 (Supp. 17-2). Amended by final exempt rulemaking at 25 A.A.R. 1552, effective May 20, 2019 (Supp. 19-2). The hyphen between “6-12,” “PreK-8,” and “PreK-12” have been corrected to the word “through,” the numeral “6” has been changed to “six,” and the numeral “8” has been changed to “eight” for consistency in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021; amended by final exempt rulemaking at 28 A.A.R.

180, (January 14, 2022) effective January 25, 2022 (Supp. 21-4).

R7-2-615.01 Special Education Endorsements

- A. Except as noted, special education endorsements are subject to the general certification provisions in R7-2-607.
- B. Mild/Moderate Disabilities Endorsement:
 1. The endorsement authorizes the holder to teach students with mild/moderate disabilities in preschool through grade 12.
 2. A provisional mild/moderate disabilities endorsement is valid for three years and is not renewable. The requirements are:
 - a. A valid Arizona Standard Professional Early Childhood, Elementary, Middle Grades, Secondary, Visually Impaired, Hearing Impaired, Early Childhood Special Education, or Moderate/Severe Disabilities certificate;
 - b. Three years of full-time teaching experience in preschool through grade 12;
 - c. Six semester hours of special education courses to include both of the following:
 - i. Behavior management for students with disabilities; and
 - ii. Special education assessment and individualized education program planning.
 - d. Completion of 15 clock hours of practicum in mild/moderate disabilities special education that may be included in the courses listed in (B)(2)(c).
 3. The requirements for the mild/moderate disabilities endorsement are:
 - a. A valid Arizona Standard Professional Early Childhood, Elementary, Middle Grades, Secondary, Visually Impaired, Hearing Impaired, Early Childhood Special Education, or Moderate/Severe Disabilities certificate;
 - b. Three years of full-time teaching experience in preschool through grade 12;
 - c. Fifteen semester hours of special education courses to include all of the following:
 - i. Methods for teaching students with disabilities;
 - ii. Behavior management for students with disabilities;
 - iii. Special education law;
 - iv. Special education assessment and individualized education program planning;
 - v. Language development and disorders.
 - d. Completion of 45 clock hours of practicum in mild/moderate disabilities special education that may be included in the courses listed in (B)(3)(c).
- C. Moderate/Severe Disabilities Endorsement
 1. The endorsement authorizes the holder to teach students with moderate/severe disabilities in preschool through grade 12.
 2. A provisional moderate/severe disabilities endorsement is valid for three years and is not renewable. The requirements are:
 - a. A valid Arizona Standard Professional Early Childhood, Elementary, Middle Grades, Secondary, Visually Impaired, Hearing Impaired, Early Childhood Special Education, or Mild/Moderate Disabilities certificate;
 - b. Three years of full-time teaching experience in preschool through grade 12; and

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- c. Six semester hours of special education courses to include both of the following:
 - i. Behavior management for students with disabilities; and
 - ii. Special education assessment and individualized education program planning.
 - d. Completion of 15 clock hours of practicum in moderate/severe disabilities special education that may be included in the courses listed in (C)(2)(c).
 - 3. The requirements are for the moderate/severe disabilities endorsement are:
 - a. A valid Arizona Standard Professional Early Childhood, Elementary, Middle Grades, Secondary, Visually Impaired, Hearing Impaired, Early Childhood Special Education, or Mild/Moderate Disabilities certificate;
 - b. Three years of full-time teaching experience in pre-school through grade 12;
 - c. Fifteen semester hours of special education courses to include all of the following:
 - i. Behavior management for students with disabilities;
 - ii. Special education law;
 - iii. Special education assessment and individualized education program planning;
 - iv. Methods for teaching students with severe disabilities;
 - v. Adaptive communication, including language development and disorders.
 - d. Completion of 45 clock hours of practicum in moderate/severe disabilities special education that may be included in the courses listed in (C)(3)(c).
 - D. Deaf/Hard of Hearing Endorsement**
 - 1. The endorsement authorizes the holder to teach students who are deaf or hard of hearing from birth through grade 12.
 - 2. The requirements are:
 - a. A valid Standard Professional Early Childhood, Elementary, Middle Grades, Secondary, Mild/Moderate Disabilities, Moderate/Severe Disabilities, Early Childhood Special Education, Specialized Special Education, Cross-Categorical Special Education, or Visually Impaired teaching certificate.
 - b. Three years of full-time teaching experience in pre-school through grade 12.
 - c. Six semester hours of special education courses to include all of the following:
 - i. Special education law and individualized education program planning,
 - ii. Behavior management for students with disabilities,
 - iii. The use of instructional and assistive technologies in the classroom.
 - d. Fifteen semester hours of courses in deaf/hard of hearing education that adhere to a guidance document approved by the Board and include all of the following:
 - i. Methods for facilitating language acquisition and literacy development in children who are deaf or hard of hearing;
 - ii. Auditory skill development for students who are deaf or hard of hearing;
 - iii. Assessment of students who are deaf or hard of hearing;
 - iv. Principles of audiology;
 - v. Social and cultural foundations and family involvement for students who are deaf or hard of hearing;
 - vi. Early intervention and parental involvement to enhance the early language skills of students who are deaf or hard of hearing;
 - vii. Methods for teaching students who are deaf or hard of hearing with multiple disabilities, including deaf-blindness.
 - e. Completion of at least 90 clock hours of supervised practicum in teaching students who are deaf or hard of hearing, which may be included in the courses listed under subsections (2)(c) or (d).
 - f. American Sign Language learning experience documented by one of the following:
 - i. A passing score on an American Sign Language proficiency assessment approved by the Board. An applicant who meets the requirement in this subsection under this option shall qualify for a deaf/hard of hearing endorsement with an American Sign Language proficiency designation; or
 - ii. Verification of proficiency in American Sign Language from an accredited institution; or
 - iii. Completion of six semester hours of courses in American Sign Language.
- E. Visually Impaired Endorsement**
 - 1. The endorsement authorizes the holder to teach students who are blind or visually impaired in birth through grade 12.
 - 2. The requirements are:
 - a. A valid Standard Professional Early Childhood, Elementary, Middle Grades, Secondary, Mild/Moderate Disabilities, Moderate/Severe Disabilities, Early Childhood Special Education, Specialized Special Education, Cross-Categorical Special Education, or Hearing Impaired teaching certificate.
 - b. Three years of full-time teaching experience in pre-school through grade 12.
 - c. Six semester hours of special education courses to include all of the following:
 - i. Special education law and individualized education program planning,
 - ii. Behavior management for students with disabilities,
 - iii. The use of instructional and assistive technologies in the classroom.
 - d. Fifteen semester hours of courses in visually impaired special education that adhere to a guidance document approved by the Board and include all of the following:
 - i. Instructional approaches for teaching students who have vision impairments;
 - ii. Methods for facilitating literacy development in children who are blind or low vision;
 - iii. Assistive technologies for students with vision impairments;
 - iv. Assessment of students with vision impairment;
 - v. Early intervention and parental involvement to enhance early skills of students with vision impairment;
 - vi. Anatomy and physiology of the eye;

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- vii. Methods for teaching orientation and mobility to students who have visual impairments;
- viii. Methods for teaching students who have visual impairments with multiple disabilities, including deaf-blindness.
- e. Completion of a minimum of 90 clock hours of supervised practicum in teaching students who have visual impairments, which may be included in the courses listed under subsections (2)(c) or (d).
- f. Proficiency in braille verified by one of the following:
 - i. Successful completion of a nationally validated braille test approved by the Board; or
 - ii. Successful completion of a braille test developed in the program in visual impairment at the University of Arizona.

Historical Note

New Section made by final exempt rulemaking at 26 A.A.R. 595, effective February 24, 2020 (Supp. 20-1).
Amended by final exempt rulemaking at 27 A.A.R. 743, effective April 26, 2021 (Supp. 21-2).

R7-2-616. Standard Professional Administrative Certificates

- A. All certificates are subject to the general certification provisions in R7-2-607 and the renewal requirements in R7-2-619.
- B. Standard Professional Supervisor Certificate – grades PreK through 12
 - 1. Except for individuals who hold a valid Arizona principal or superintendent certificate, the supervisor certificate is required for all personnel, except for superintendents pursuant to R7-2-616(D), whose primary responsibility is administering instructional programs, supervising certified personnel, or similar administrative duties.
 - 2. The requirements are:
 - a. A valid Arizona Standard Professional teaching certificate, Career and Technical Education certificate, Classroom-Based Standard Teaching Certificate, Subject Matter Expert Standard Teaching Certificate, or Specialized Secondary Teaching Certificate or an other professional certificate established in R7-2-617 issued by the Department;
 - b. A master's or more advanced degree;
 - c. Three years of verified full-time teaching experience or related education services experience in a PreK through 12 setting;
 - d. Completion of a program in educational administration which shall consist of a minimum of 18 graduate semester hours of educational administration courses which teach the knowledge and skills described in R7-2-603 to include three semester hours in school law and three semester hours in school finance;
 - e. A practicum in educational administration or two years of verified educational administrative experience in grades PreK through 12;
 - f. A passing score on the Supervisor, Principal, or Superintendent portion of the Arizona Administrator Proficiency Assessment; and
 - g. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- C. Standard Professional Principal Certificate – grades PreK through 12

- 1. The principal certificate is required for all personnel who hold the title of principal, assistant principal, or perform the duties of principal or assistant principal as delineated in A.R.S. Title 15.
- 2. The requirements are:
 - a. A master's or more advanced degree;
 - b. Three years of verified teaching experience in grades PreK through 12;
 - c. Completion of a program in educational administration for principals including at least 30 graduate semester hours of educational administration courses teaching the knowledge and skills described in R7-2-603 to include three semester hours in school law and three semester hours in school finance;
 - d. A practicum as a principal or two years of verified experience as a principal or assistant principal under the supervision of a certified principal in grades PreK through 12;
 - e. A passing score on either the Principal or Superintendent portion of the Arizona Administrator Proficiency Assessment; and
 - f. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.

D. Standard Professional Superintendent Certificate – grades PreK through 12

- 1. The superintendent certificate is optional, but may be required by local governing boards for individuals who hold the title or perform the duties of a superintendent, assistant superintendent or associate superintendent and who perform duties directly relevant to curriculum, instruction, certified employee evaluations, and instructional supervision.
- 2. The requirements are:
 - a. A master's or more advanced degree including at least 60 graduate semester hours;
 - b. Completion of a program in educational administration for superintendents, including at least 36 graduate semester hours of educational administrative courses which teach the standards described in R7-2-603 to include three semester hours in school law and three semester hours in school finance;
 - c. Three years of verified full-time teaching experience or related education services experience in a PreK through 12 setting;
 - d. A practicum as a superintendent or two years verified experience as a superintendent, assistant superintendent, or associate superintendent in grades PreK through 12;
 - e. A passing score on the Superintendent portion of the Arizona Administrator Proficiency Assessment; and
 - f. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4). Former R7-2-616 recodified to R7-2-617; new R7-2-616 recodified from R7-2-615 at 15 A.A.R. 2146, effective August 25, 2008 (Supp. 09-4). Former R7-2-616 recodified to R7-2-617; new R7-2-616 recodified from R7-2-615 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 326, effective January 25, 2010 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). Amended by exempt rulemaking at 16

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A.A.R. 2034, effective October 1, 2010 (Supp. 11-1). Amended by final exempt rulemaking at 22 A.A.R. 219, effective June 5, 2015; filed in the Office January 20, 2016 (Supp. 16-4). Amended by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1). Amended by final exempt rulemaking at 26 A.A.R. 1311, effective May 18, 2020 (Supp. 20-2). Amended by final exempt rulemaking at 29 A.A.R. 183 (January 13, 2023), effective December 9, 2022 (Supp. 22-4).

R7-2-616.01. Standard Administrative Certificates – Locally Based Leadership Program Pathway

- A.** Except as noted, all certificates are subject to the general certification provisions in R7-2-607 and the renewal requirements in R7-2-619.
- B.** Standard Site-Based Supervisor Certificate – grades PreK through 12.
 - 1. The certificate authorizes the holder to administer instructional programs, supervise certified personnel, or perform similar administrative duties at the school-level.
 - 2. The requirements are:
 - a. A bachelor's or more advanced degree; and
 - b. A valid fingerprint clearance card issued by the Arizona Department of Public Safety; and
 - c. Verification from the superintendent of a school district or the principal of a charter school that the applicant has made satisfactory progress in the program sequence and model, which may include professional evaluations, observations of the applicant, student achievement data and demonstration of competencies, skills and knowledge associated with the relevant school leadership position; and
 - d. Verification of successful completion of a Board-approved locally based school leadership preparation program for supervisors; and
 - e. A passing score on the Supervisor, Principal or Superintendent portion of the Arizona Administrator Proficiency Assessment.
- C.** Standard Site-Based Principal Certificate – grades PreK through 12.
 - 1. The certificate authorizes the holder to administer instructional programs, supervise certified personnel, or perform similar administrative and leadership duties at the school-level, and perform the duties and hold the title of principal, assistant principal as delineated in A.R.S. Title 15.
 - 2. The requirements are:
 - a. A bachelor's or more advanced degree; and
 - b. A valid fingerprint clearance card issued by the Arizona Department of Public Safety; and
 - c. Verification from the superintendent of a school district or the principal of a charter school that the applicant has made satisfactory progress in the program sequence and model, which may include professional evaluations, observations of the applicant, student achievement data and demonstration of competencies, skills and knowledge associated with the relevant school leadership position; and
 - d. Verification of successful completion of a Board-approved locally based school leadership preparation program for principals; and
 - e. A passing score on the Principal or Superintendent portion of the Arizona Administrator Proficiency Assessment.

Historical Note

New Section made by final exempt rulemaking at 29 A.A.R. 183 (January 13, 2023), effective December 9, 2022 (Supp. 22-4).

R7-2-616.02. Interim Administrative Certificates

- A.** Except as noted, all certificates are subject to the general certification provisions in R7-2-607.
- B.** The certificate authorizes the holder to serve an administrator while completing the requirements for a standard administrator certificate.
- C.** Interim administrative certificates are valid for one year and may be extended yearly for no more than two consecutive years at no cost to the certificate holder if the requirements in subsection (I) are met.
- D.** An individual is not eligible for issuance of an interim administrative certificate more than once in a five-year period.
- E.** Interim administrative certificate holders shall be enrolled in a Board approved alternative administrator preparation program, a Board approved locally based leadership preparation program, or a Board approved traditional administrator preparation program.
- F.** Interim Supervisor Certificate – grades PreK through 12:
 - 1. The Interim Supervisor Certificate authorizes the holder for a position in which the primary responsibility is administering instructional programs, supervising certified personnel, or similar administrative duties. An individual who is enrolled in a locally-based school leadership program shall be limited to a supervisor position at the school-level.
 - 2. The requirements are:
 - a. A valid Arizona Standard Professional teaching certificate, Career and Technical Education Certificate, Classroom-Based Standard Teaching Certificate, Subject Matter Expert Standard Teaching Certificate, Specialized Secondary Teaching Certificate or an other professional certificate established in R7-2-617; and
 - b. A bachelor's or more advanced degree; and
 - c. Verification of three years of full-time teaching or related education services experience in a PreK through grade 12 setting; and
 - d. Verification of enrollment in a Board approved alternative administrator preparation program, a Board approved locally based school leadership program, or a Board approved administrator preparation program; and
 - e. Verification that the certificate holder will be employed as an administrator and will be under the direct supervision of an Arizona certified administrator or the appropriate county school superintendent; and
 - f. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- G.** Interim Principal Certificate – grades PreK through 12
 - 1. The Interim Principal certificate authorizes the holder to administer instructional programs, supervise certified personnel, perform the duties, hold the title of principal or assistant principal as delineated in A.R.S. Title 15, and perform similar administrative duties. An individual who is enrolled in a locally-based school leadership program shall be limited to an administrative position at the school-level.
 - 2. The requirements are:
 - a. A bachelor's or more advanced degree; and

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- b. Verification of three years of full-time teaching in grades PreK through 12; and
 - c. Verification of enrollment in a Board approved alternative administrator preparation program, a Board approved locally based school leadership program, or a Board approved administrator preparation program; and
 - d. Verification that the certificate holder will be employed as a principal or assistant principal under the direct supervision of an Arizona certified principal, an Arizona certified superintendent, or the appropriate county school superintendent; and
 - e. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- H. Interim Superintendent Certificate – Grades PreK through 12:**
 - 1. The superintendent certificate is optional, but may be required by local governing boards for individuals who hold the title or perform the duties of a superintendent, assistant superintendent or associate superintendent and who perform duties directly relevant to curriculum, instruction, certified employee evaluations, and instructional supervision
 - 2. The requirements are:
 - a. A master's degree or more advanced degree;
 - b. Three years of verified full-time teaching experience or related education services experience in a PreK through 12 setting;
 - c. Verification of enrollment in a Board approved alternative path to administrator certification program, or a Board approved administrator preparation program;
 - d. Verification that the holder of the interim certificate shall be employed as a superintendent, assistant superintendent, or associate superintendent and working under the direct supervision of an Arizona certified superintendent or the appropriate county school superintendent; and
 - e. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- I. Interim Administrative Certificate Extension**
 - 1. The Interim Administrative certificate may be extended yearly for no more than two consecutive years at no cost to the applicant.
 - 2. The requirements to extend an Interim Administrative Certificate are:
 - a. Qualification and issuance of the initial Interim Administrative certificate;
 - b. Verification from the Board approved program provider that the applicant is enrolled and has made adequate progress towards completion of the Board approved alternative administrator preparation program, Board approved locally based leadership preparation program, or Board approved traditional administrator preparation program;
 - c. Verification that the holder meets the employment and supervision requirements for the Interim Administrative certificate as described in subsection (F)(2)(e), (G)(2)(d), and (H)(2)(d); and
 - d. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- J. The holder of an interim administrative certificate may apply for the appropriate Arizona standard administrative certificate with verification of the following:**
 - 1. Successful completion of the Board approved alternative path to administrator certification program, Board approved locally based leadership program, or Board approved administrator preparation program; and
 - 2. A passing score on the required portion of the Arizona Administrator Proficiency Assessment; and
 - 3. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 - 4. Individuals who have completed a locally based leadership program shall also submit verification from the superintendent of a school district or the principal of a charter school that the applicant has made satisfactory progress in the program sequence and model, which may include professional evaluations, observations of the applicant, student achievement data and demonstration of competencies, skills and knowledge associated with the relevant school leadership position.
- K. Interim Administrative Certificates – Public Health Emergency**
 - 1. Notwithstanding this Section, an Interim Administrative Certificate entitling the holder to serve as a supervisor, principal, or superintendent may be issued to an applicant who meets the following requirements:
 - a. Completion of all requirements for the Standard Professional Supervisor, Standard Professional Principal, or Standard Professional Superintendent certificate, as described in subsection (B)(2), (C)(2), and (D)(2), with the exception of a passing score on the Arizona Administrator Proficiency Assessment.
 - b. Verification that the applicant was unable to take the Arizona Administrator Proficiency Assessment required for the Standard Professional Administrative certificate as the result of a public health emergency declared by the governor or a public health official.
 - 2. A certificate issued pursuant to this subsection shall be issued for one year and shall not be renewed or extended.

Historical Note

New Section made by final exempt rulemaking at 29 A.A.R. 183 (January 13, 2023), effective December 9, 2022 (Supp. 22-4).

R7-2-617. Other Professional Certificates

- A.** All certificates are subject to the general certification provisions in R7-2-607 and the renewal requirements in R7-2-619.
- B.** Standard School Counselor Certificate - grades PreK through 12.
 - 1. The school counselor certificate is optional but may be required by local governing boards.
 - 2. The requirements are:
 - a. A master's or more advanced degree,
 - b. Completion of a graduate program in guidance and counseling,
 - c. A valid fingerprint clearance card issued by the Arizona Department of Public Safety, and
 - d. One of the following:
 - i. Completion of a supervised counseling practicum in school counseling;
 - ii. Two years of verified, full-time experience as a school counselor; or
 - iii. Three years of verified teaching experience.
 - 3. The certificate may be renewed consistent with the provisions of R7-2-619 that may include continuing education in the area of college and career readiness.

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4. Applicants may meet the requirements in subsection (B)(2)(b) with completion of one of the following:
 - a. Completion of a graduate program in counseling, social work, or psychology and six semester hours of courses in any of the following areas: school counseling, college and career guidance, or academic advising; or
 - b. A valid license as an associate counselor, professional counselor, master or clinical social worker, or marriage and family therapist issued by the Arizona Board for Behavioral Health Examiners and six semester hours of courses in any of the following areas: school counseling, college and career guidance, or academic advising; or
 - c. Completion of a graduate program in academic advising and six semester hours of courses in school counseling to include any of the following areas: social and emotional development, mental health counseling, trauma and disaster counseling, multiculturalism in counseling, theories of counseling, foundations of school counseling, or child and adolescent counseling.
 5. Applicants who otherwise qualify but are deficient in the required six semester hours of courses described in subsections (B)(4)(a), (b), or (c) may receive a Standard School Counselor certificate with a deficiency in the required courses to be completed within three years. If an applicant fails to meet this requirement within the prescribed time, the Department of Education shall temporarily suspend the certificate, but the suspension is not considered a disciplinary action and the individual shall be allowed to correct the deficiency within the remaining timeframe of the certificate.
 6. Applicants who otherwise qualify but are deficient in the requirements prescribed in subsection (B)(2)(d) may receive a Standard School Counselor certificate with a deficiency in the required experience or practicum to be completed within three years. If an applicant fails to meet this requirement within the prescribed time, the Department of Education shall temporarily suspend the certificate, but the suspension is not considered a disciplinary action and the individual shall be allowed to correct the deficiency within the remaining timeframe of the certificate.
- C. Standard School Psychologist Certificate - grades PreK through 12**
1. A standard school psychologist certificate is required for all personnel whose primary responsibility is in the role of a school psychologist providing services that include but are not limited to the duties of student psychoeducational assessment, therapeutic consultation and intervention, and involvement in the process of determination of student disabilities or disorders.
 2. The requirements are:
 - a. A master's or more advanced degree;
 - b. Completion of a graduate program in school psychology consisting of at least 60 graduate semester hours, or completion of a doctoral program in psychology and completion of a re-training program in school psychology from an accredited institution or Board approved program with a letter of institutional endorsement from the head of the school psychology program;
 - c. A supervised internship of at least 1200 clock hours with a minimum of 600 of those hours in a school setting. Three years experience as a certified school psychologist within the last 10 years may be substituted for the internship requirement; and
 - d. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
 3. Any of the following may be substituted for the requirement described in subsection (C)(3)(b):
 - a. Five years experience within the last 10 years working full time in the capacity of a school psychologist in a school setting serving any portion of grades kindergarten through 12; or
 - b. A Nationally Certified School Psychologist Credential; or
 - c. A diploma in school psychology from the American Board of School Psychology.
- D. Standard Speech-Language Pathologist Certificate - grades PreK through 12**
1. The standard speech-language pathologist certificate is required for school-based speech-language pathologists.
 2. The certificate may be renewed consistent with the provisions of R7-2-619 with relevant professional development in the field of speech pathology, or professional development in the areas of articulation, voice, fluency, language, low incidence disabilities, curriculum and instruction, professional issues and ethics, or service delivery models.
 3. The requirements are:
 - a. A master's or more advanced degree, from an accredited institution, in speech pathology or communication disorders;
 - b. A minimum of 250 clinical clock hours supervised by a university or a speech-language pathologist with a certificate of clinical competence;
 - c. A certificate of clinical competence, or a passing score on the national exam, or a passing score on the speech and language impaired special education portion of the Arizona Teacher Proficiency Assessment; and
 - d. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- E. Standard Speech-Language Technician - grades PreK through 12**
1. The standard speech-language technician certificate is required for school-based speech-language professionals.
 2. No new applications for a speech-language technician certificate will be accepted after June 30, 2014.
 3. The certificate may be renewed consistent with the provisions of R7-2-619 with professional development in the areas of articulation, voice, fluency, language disorders, low incidence disabilities, professional issues and ethics, or service delivery models.
 4. The requirements are:
 - a. A bachelor's degree from an accredited program in Speech-Language Pathology, Speech Hearing Sciences, or Communication Disorders;
 - b. A minimum of 50 hours of university supervised observation;
 - c. A minimum of 150 university clinical clock hours, or 150 clock hours supervised by a master's level licensed speech-language pathologist, or two years' experience as a school speech-language therapist or technician;

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- d. A passing score on the speech and language impaired special education portion of the Arizona Teacher Proficiency Assessment; and
 - e. A valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- F. Standard School Social Worker Certificate - grades PreK through 12**
- 1. The standard School Social Worker certificate is optional but may be required by local governing boards.
 - 2. The requirements are:
 - a. Master's or more advanced degree in social work from an accredited institution or completion of a Board approved school social worker program;
 - b. A valid fingerprint clearance issued by the Arizona Department of Public Safety; and
 - c. One of the following:
 - i. Completion of at least six semester hours of practicum in social work in a school setting completed through an accredited institution; or
 - ii. One year of full time experience as a social worker in a setting which primarily serves children in preschool through grade 12.
- 2. Evaluation of qualification for an endorsement: \$30.
 - 3. Issuance of a certificate, endorsement, or letter of non-qualification: \$30.
 - 4. Renewal of a certificate: \$20.
 - 5. Name change, duplicate copy, or changes of coding to existing files or certificates: \$20.
- B.** Fees shall be paid by credit or debit card, money order, cashier's check, certified check, business check, or personal check and shall be made payable to the order of the Arizona Department of Education. If a check offered in payment for services is not cleared by the financial institution, the applicant shall be notified to pay the fees by money order or certified check. If a certificate has been issued or renewed and payment is not received within two weeks of notification to the applicant, the Department may file a statement of complaint pursuant to R7-2-1302. If a certificate or renewal has not been issued, no certificate or renewal shall be issued until the fees are paid by cashier's check or money order.
- C.** Fees paid pursuant to this Section are not refundable.
- D.** Notwithstanding this Section and pursuant to A.R.S. § 41-1080.01, the Superintendent or the Superintendent's designee shall waive any certification fee for initial certification, including for endorsements, for any of the following individuals if the individual is applying for the specific certification or endorsement in this state for the first time:
- 1. Any individual applicant whose family income does not exceed 200 percent of the federal poverty guidelines;
 - 2. Any active duty military service member's spouse.
 - 3. Any honorably discharged veteran who has been discharged not more than two years before application.
- E.** Applicants who are requesting a waiver of a certification fee shall submit an attestation and appropriate documentation verifying that they meet the criteria as described in subsection (D).

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4). Amended by emergency rulemaking under A.R.S. § 41-1026 at 8 A.A.R. 5139, effective November 19, 2002 for a period of 180 days (Supp. 02-4). Emergency rulemaking renewed under A.R.S. § 41-1026(D) at 9 A.A.R. 1547, effective April 29, 2003 for a period of 180 days (Supp. 03-2). Emergency rulemaking repealed under A.R.S. § 41-1026(E) and permanent R7-2-617 amended by final rulemaking at 9 A.A.R. 3950, effective October 21, 2003 (Supp. 03-3). Amended by exempt rulemaking at 15 A.A.R. 1264, effective May 22, 2006 (Supp. 09-1). Former R7-2-617 recodified to R7-2-618; new R7-2-617 recodified from R7-2-616 at 15 A.A.R. 2146, effective August 25, 2008 (Supp. 09-4). Former R7-2-617 recodified to R7-2-618; new R7-2-617 recodified from R7-2-616 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1). R7-2-617 "Prekindergarten" corrected to "PreK" at request of the Board, Office File No. M09-444, filed November 24, 2009 (Supp. 10-1). Office corrected labeling error in subsection (C) under A.R.S. § 41-1011 and A.A.C. R1-1-108 (Supp. 10-4). Amended by final exempt rulemaking at 21 A.A.R. 2077, effective October 28, 2013 (Supp. 15-3). Amended by final exempt rulemaking at 23 A.A.R. 231, effective December 19, 2016 (Supp. 17-1). Amended by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1). Amended by final exempt rulemaking at 24 A.A.R. 2947, effective September 24, 2018 (Supp. 18-3). The hyphen between "PreK-12" has been changed to the word "through" for consistency in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 28 A.A.R. 276 (January 28, 2022), effective April 29, 2019; filed January 11, 2022 (Supp. 22-1).

R7-2-618. Fees

- A.** The Superintendent of Public Instruction or the Superintendent's designee shall collect proper fees for certification services and shall transmit the fees to the state Treasurer. The following fees are established for certification services:
- 1. Evaluation of qualification for a certificate: \$30.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 2002, effective May 27, 1999 (Supp. 99-2). Former R7-2-618 recodified to R7-2-619; new R7-2-618 recodified from R7-2-617 at 15 A.A.R. 2146, effective August 25, 2008 (Supp. 09-4). Former R7-2-618 recodified to R7-2-619; new R7-2-618 recodified from R7-2-617 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). Amended by final exempt rulemaking at 29 A.A.R. 183 (January 13, 2023), effective December 9, 2022 (Supp. 22-4).

R7-2-619. Renewal Requirements

- A.** A certificate may be renewed within six months of its expiration date except that an individual holding multiple valid certificates may renew all certificates at one time in order to align the expiration dates of each certificate. Certificates being aligned shall be renewed at the same time as the certificate that will expire first. Individuals seeking to align certificates shall meet the renewal requirements for each certificate being aligned. Certificates that are renewed or aligned pursuant to this Section shall be valid for 12 years.
- B.** A certificate may be renewed within ten years after it expires. Individuals whose certificates have been expired for more than ten years shall reapply for certification under the requirements in effect at the time of reapplication. Nothing in this Section shall imply that an individual may be employed in a position that requires certification after the expiration of the relevant certificate.

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- C. Renewal of certificates requires the completion of continuing education credits after the most recent issuance or renewal of the certificate, except that continuing education credits completed during the valid term of the certificate that expires first meets the requirement of certificates being aligned. Fifteen hours of continuing education credits are required each year of the certificate term to renew a certificate, which may be accumulated in various increments per year prior to renewal. One hour of continuing education credit shall be equivalent to one clock hour of a professional development activity. Continuing education credits must relate to Arizona academic or professional educator standards or apply toward the attainment of an additional Arizona certificate, endorsement, or approved area, and may include training regarding suicide awareness and prevention; child abuse, human trafficking of children and the sexual abuse of children, including warning signs that a child may be a victim of child abuse, human trafficking, or sexual abuses; screening, intervention, accommodation, use of technology and advocacy for students with reading impairments, including dyslexia; or other training programs explicitly permitted or required by state law. Professional development that may be counted toward the required hours of continuing education credit shall consist of any of the following activities:
1. Courses related to education or a subject area taught in Arizona schools, taken from an accredited institution. Each semester hour of courses shall be equivalent to 15 clock hours of professional development. The required documentation shall be an official transcript.
 2. Professional activities such as conferences and workshops related to the profession of teaching or the field of public education. A maximum of 30 clock hours per year may be earned by attendance at professional conferences and workshops. The required documentation shall be a conference agenda and a statement or certificate from the sponsoring organization noting the clock hours earned.
 3. District-sponsored or school-sponsored in-services or activities which are specifically designed for professional development. The required documentation shall be written verification from the sponsoring district or school stating the dates of participation and the number of clock hours earned.
 4. Internships in business settings. The internship shall be based on an agreement between a business and a district or school with the stated objective of aligning teaching curriculum with workplace skills. A maximum of 80 clock hours may be earned through business internships. The required documentation shall be written verification by the sponsoring business and district or school stating the dates of participation and number of clock hours earned.
 5. Educational research. The research shall be sponsored by a research facility or an accredited institution or funded by a grant. The required documentation shall be the published report of the research or verification by the sponsoring agency; and a statement of the dates of participation and the number of clock hours earned.
 6. Serving in a leadership role of a professional organization that provides training, activities, or projects related to the profession of teaching or the field of public education. A maximum of 30 clock hours per year may be earned by serving in a leadership role of a professional organization. The required documentation shall be written verification by the governing body of the professional organization of the dates of service and clock hours earned.
 7. Serving on a visitation team for a school accreditation agency. A maximum of 60 clock hours per year may be earned by serving on a visitation team. The required documentation shall be written verification from the accreditation agency of the dates of service and clock hours earned.
- D. An individual holding a Standard teaching certificate, a standard administrative certificate, or other professional certificate may renew the certificate for 12 years upon completion of 15 hours of continuing education credits each year of the certificate term which may be accumulated in various increments per year prior to renewal or with one of the following:
1. A valid professional license as a counselor, social worker, psychologist, or speech pathologist issued by the appropriate state agency in this state or in another state;
 2. A valid certificate issued by the National Board of Professional Teaching Standards;
 3. A valid Certificate of Clinical Competence in Speech-Language Pathology issued by the American Speech-Language Hearing Association; or
 4. A Nationally Certified School Psychologist credential issued by the National Association of School Psychologists.
- E. An individual who is employed by a school or school district at the time of renewal shall submit the required documentation of professional development to the district superintendent, director of personnel, or other designated administrator for verification. A certified individual who is not employed by a school or school district at the time of renewal shall submit the required documentation of professional development to a county school superintendent, the dean of a college of education, or the Department for verification. The school or district official, county school superintendent, or the dean of a college of education shall verify on forms provided by the Department the number of hours of professional development completed by the individual during the valid period of the certificate being renewed.
- F. The Department shall issue a Standard teaching certificate of the same type.
- G. Notwithstanding any other provision in this Section, an individual with a valid fingerprint clearance card who has had a certificate or certificates expire for at least two years but not more than 10 years may renew the expired certificate or certificates and any endorsements or approved areas if the individual is in good standing. Individuals who apply for renewal under this provision are exempt from the continuing education requirements described in subsections (C) and (D). Standard certificates issued to that individual pursuant to this subsection shall be identical to the expired certificate or certificates.

Historical Note

New Section made by exempt rulemaking at 8 A.A.R. 2396, effective May 10, 2002 (Supp. 02-2). Amended by exempt rulemaking at 15 A.A.R. 1225, effective December 5, 2006 (Supp. 09-1). Former R7-2-619 recodified to R7-2-620; new R7-2-619 recodified from R7-2-618 at 15 A.A.R. 2146, effective August 25, 2008 (Supp. 09-4). Former R7-2-619 recodified to R7-2-620; new R7-2-619 recodified from R7-2-618 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 242, effective December 7, 2009 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 1249, effective May 24, 2010 (Supp. 10-4). Amended by final exempt rulemaking at 22 A.A.R. 648, effective January 25, 2016 (Supp. 16-1). Amended by

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final exempt rulemaking at 22 A.A.R. 2246, effective August 6, 2016 (Supp. 16-3). Amended by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1). Amended by final exempt rulemaking at 26 A.A.R. 214, effective January 27, 2020 (Supp. 20-1). Amended by final exempt rulemaking at 27 A.A.R. 2694 (November 19, 2021), effective October 25, 2021 (Supp. 21-4). Amended by final exempt rulemaking at 29 A.A.R. 183 (January 13, 2023), effective December 9, 2022 (Supp. 22-4).

R7-2-620. Certification Time-frames

- A.** For certification by the State Board of Education (Board), Certification Division (Division), the time-frames required by A.R.S. § 41-1072 et seq are:
 1. Overall time-frame: 165 days.
 2. Administrative review time-frame: 45 days.
 3. Substantive review time-frame: 120 days.
- B.** Administrative completeness review time-frame. The Division shall issue a written notice of administrative completeness or deficiency to an applicant for certification within 45 days of receipt of the application.
 1. If the Division determines that an application for certification is not administratively complete, the Division shall include a comprehensive list of the specific deficiencies in the written notice.
 2. If the Division issues a written notice of deficiency, the administrative completeness review time-frame and the overall time-frame are suspended from the date the notice is issued until the date that the Division receives the missing information from the applicant.
 3. If the Division does not issue a notice of administrative completeness or deficiency within 45 days of receipt of the application, the application is deemed administratively complete.
- C.** Substantive review time-frame. Within 120 days after the administrative completeness review time-frame is complete, the Division shall determine whether an applicant for certification meets all substantive criteria required by statute or rule.
 1. During the substantive review time-frame, the Division may make one comprehensive written request for additional information. If the Division issues a comprehensive written request for additional information, the substantive review time-frame and the overall time-frame are suspended from the date the request is issued until the date that the Division receives the additional information from the applicant.
 2. The Division and the applicant may mutually agree in writing to allow the Division to submit supplemental requests for additional information. If the Division issues a supplemental request by mutual written agreement for additional information, the substantive review time-frame and the overall time-frame are suspended from the date the request is issued until the date that the Division receives the additional information from the applicant.
- D.** Overall time-frame. The Division shall issue a written notice that the Board has granted or denied a certificate no later than 165 days after receipt of an application for certification, or no later than the time-frame extension allowed under subsection (E).
 1. Written notice denying an applicant certification shall include justification for the denial with references to the statutes or rules on which the denial is based and an explanation of the applicant's right to appeal the denial.

2. The explanation of an applicant's right to appeal the denial shall include the number of days the applicant has to file an appeal challenging the denial and the name and telephone number of the Executive Director of the Board as the contact person who can answer questions regarding the appeals process.
- E.** By mutual written agreement, the Division and an applicant for certification may extend the substantive review time-frame and the overall time-frame. An extension of the substantive review time-frame and the overall time-frame may not exceed 33 days.
- F.** If the Division does not issue to an applicant written notice granting or denying a certificate within the overall time-frame or any extension mutually agreed upon in writing, the Division shall refund to the applicant all fees charged, excuse payment of any fees that have not yet been paid, and pay all penalties required by A.R.S. § 41-1077.
- G.** The Division shall issue all written notices under this Section to the last known address of the applicant by regular, 1st-class mail. The written notices are deemed "issued" on the postmark date.
- H.** By August 1 of each year, the Division shall report to the Executive Director of the Board the Division's compliance with the overall time-frames for the prior fiscal year. The Division shall include the number of certificates issued or denied within the time-frames specified in this Section and the dollar amount of all fees returned or excused. The Division shall also include the amount of all penalties paid to the state general fund due to the Division's failure to comply with the time-frames.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2399, effective July 23, 2004 (Supp. 04-2). Former R7-2-620 recodified to R7-2-621; new R7-2-620 recodified from R7-2-619 at 15 A.A.R. 2146, effective August 25, 2008 (Supp. 09-4). Former R7-2-620 recodified to R7-2-621; new R7-2-620 recodified from R7-2-619 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1).

R7-2-621. Reciprocity

- A.** The Board shall issue a comparable standard Arizona certificate or endorsement as applicable, if one is established pursuant to this Article, to an applicant who holds a valid certificate or endorsement from another state and is in good standing with that other state. These applicants are exempt from all provisions of the Arizona Teacher proficiency examinations.
- B.** Standard certificates shall be valid for 12 years and are renewable.
- C.** The applicant shall possess a valid fingerprint clearance card issued by the Arizona Department of Public Safety.
- D.** The applicant shall have completed the required class or passed a satisfactory examination on the provisions and principles of the Constitutions of the United States and Arizona.
- E.** Notwithstanding any other provision, the deficiencies allowed pursuant to Arizona Revised Statutes in Arizona Constitution and United States Constitution shall be satisfied prior to the issuance of the same type of certificate prescribed in this Article, but are subject to suspension as follows:
 1. An applicant's standard Arizona teaching certificate shall be suspended three years from the date of issuance if the applicant has not completed the required class or passed a satisfactory examination on the provisions and principles of the Constitutions of the United States and Arizona.

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2. An applicant's standard Arizona teaching certificate shall be suspended one year from the date of issuance if the applicant has not completed the required class or passed a satisfactory examination on the provisions and principles of the Constitutions of the United States and Arizona if the applicant applies for a certificate authorizing the person to teach an academic course that focuses predominantly on history, government, social studies, citizenship, law or civics.
3. The suspension for a deficiency in the Constitutions of the United States and Arizona is not considered a disciplinary action and the applicant shall be allowed to correct that deficiency within the remaining time of the standard certification.

Historical Note

New Section recodified from R7-2-620 at 15 A.A.R. 2146, effective August 25, 2008 (Supp. 09-4). Former R7-2-621 recodified to R7-2-622; new R7-2-621 recodified from R7-2-620 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1). Amended by exempt rulemaking at 16 A.A.R. 135, effective September 21, 2009 (Supp. 10-1). Amended by final exempt rulemaking at 22 A.A.R. 227, effective June 23, 2014; filed in the Office January 20, 2016 (Supp. 16-2). Amended by final exempt rulemaking at 22 A.A.R. 219, effective June 5, 2015; filed in the Office January 20, 2016 (Supp. 16-4). Amended by final exempt rulemaking at 22 A.A.R. 2248, effective August 6, 2016 (Supp. 17-1). Amended by final exempt rulemaking at 24 A.A.R. 195, effective August 9, 2017; filed in the Office on January 2, 2018 (Supp. 18-1).

R7-2-622. Qualification Requirements of Professional, Non-Teaching School Personnel**A. Definitions:**

1. "Educational Interpreter." For the purposes of this Section, "educational interpreter" means a person trained to translate in sign language for students identified to require such services through an Individualized Education Program (IEP) or a 504 accommodation plan in order to access academic instruction. This does not in any way restrict the provisions of R7-2-401(B)(14) which defines "interpreter" and provides that each student's IEP team determines the level of interpreter skill necessary for the provision of FAPE, nor does it restrict a school district's ability to develop a job description for someone in a position of "educational interpreter" that requires additional job responsibilities.
2. "Accommodation plan developed to comply with Section 504 of the Rehabilitation Act of 1973, 29 USC 794, et seq. ("504 accommodation plan")." For the purposes of this Section, "504 accommodation plan" means a plan developed for the purpose of specifying accommodations and/or services that will be implemented by classroom teachers and other school personnel so that students will benefit from their educational program.

B. Educational Interpreters for the Hearing Impaired.

1. Persons employed by or contracting with schools and school districts to provide educational interpreting services for hearing impaired students must meet the following qualifications from and after January 1, 2005:
 - a. Have a high school diploma or GED;
 - b. Hold a valid fingerprint clearance card, and
 - c. Show proficiency in interpreting skills through one of the following:

- i. A minimum passing score of 3.5 or higher on the Educational Interpreter Performance Assessment (EIPA), or
- ii. Hold a valid Certificate of Interpretation (CI) and/or Certificate of Transliteration (CT) from the Registry of Interpreters for the Deaf (RID), or
- iii. Hold a valid certificate from the National Association of the Deaf (NAD) at level 3 or higher.

2. If a public education agency (PEA) is unable to find an individual meeting the above qualifications, the PEA may hire an individual with lesser qualifications, but the PEA is required to provide a professional development plan for the individual they employ to provide educational interpreting services. This professional development plan must include the following:

- a. Proof of at least 24 hours of training in interpreting each year that a valid certification is not held or EIPA passing score is not attained, and
- b. Documentation of a plan for the individual to meet the required qualifications within three years of employment. If the qualifications are not attained within three years, but progress toward attainment is demonstrated, the plan shall be modified to include an intensive program for up to one year to meet the provisions of subsection (B)(1).

3. An individual employed under the provisions of subsection (B)(2) must also have the following:

- a. A valid fingerprint clearance card, and
- b. A high school diploma or GED.

- C. Compliance with these rules will be reviewed at the same time as a PEA is monitored for compliance with the requirements of the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1400, et seq.

Historical Note

New Section recodified from R7-2-621 at 16 A.A.R. 68, effective December 8, 2008 (Supp. 10-1).

R7-2-623. Certification Requirements in a Public Health Emergency

- A. As the result of a public health emergency declared by the governor, the Department may temporarily modify certification requirements established in this Article, subject to review and approval by the Board.
- B. A modification made pursuant to this Section shall:
 1. Not be more restrictive than requirements in effect at the time the public health emergency is declared.
 2. Comply with statutory requirements.
 3. Be limited to requirements that cannot be feasibly completed as the result of the public health emergency.
 4. Be in effect for no more than one year after Board approval.

Historical Note

New Section made by final exempt rulemaking at 26 A.A.R. 1311, effective May 18, 2020 (Supp. 20-2).

ARTICLE 7. ADJUDICATIONS**R7-2-701. Definitions**

In this Article, unless the context otherwise specifies:

1. "Board" means the State Board of Education.
2. "Chairman" means the chairperson of the Professional Practices Advisory Committee, established pursuant to R7-2-205.

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3. "Contested case" means any proceeding in which the legal rights, duties or privileges of a party are required by law to be determined by the State Board of Education after an opportunity for hearing.
4. "Department" means the Department of Education.
5. "Document" includes papers such as complaints, petitions, motions, responses and notices.
6. "Hearing body" means the Board or the Professional Practices Advisory Committee.
7. "Party" means each person or agency named or admitted as a party or properly seeking and entitled as of right to be admitted as a party.
8. "PPAC" means the Professional Practices Advisory Committee, established pursuant to R7-2-205.
9. "Presiding officer" means a hearing officer, with either a minimum of three years of verified experience in the practice of law or a minimum of one year of verified experience in conducting hearings, who shall oversee hearings pursuant to this Article.
10. "Pupil" means any student enrolled in an Arizona public or private school defined in A.R.S. § 15-101. "Pupil" also means any student who was enrolled in an Arizona public or private school at the time of the events which are the subject of a proceeding.
11. "Victim" means any person who has been previously identified pursuant to state law as a victim in a criminal proceeding which is the basis for a contested case.

Historical Note

Adopted effective May 25, 1978 (Supp. 78-3). Former Section R7-2-701 repealed, new Section R7-2-701 adopted effective December 4, 1978 (Supp. 78-6). Amended effective June 27, 1979 (Supp. 79-3). Amended subsection (A) effective October 7, 1980 (Supp. 80-5). Amended by adding subsection (A)(6) effective April 6, 1984 (Supp. 84-2). Amended effective October 19, 1984 (Supp. 84-5). Section R7-2-701 repealed as an emergency, new Section R7-2-701 adopted as an emergency effective January 2, 1985 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 85-1). Emergency expired. Repealed effective December 17, 1987 (Supp. 87-4). New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). Amended by final exempt rulemaking at 21 A.A.R. 1775, effective May 20, 2013 (Supp. 15-3). Amended by final exempt rulemaking at 23 A.A.R. 725, effective January 23, 2017 (Supp. 17-1). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-702. Filing; Computation of Time; Extension of Time

- A. All documents concerning a contested case shall be filed within the time limit, if any, for such filing.
- B. All documents filed in any contested case shall be typewritten or legibly written on paper 8 1/2 by 11 inches in size, shall contain the name and address of the party or other correspondent, shall be properly captioned and designate the title and case number, shall state the name and address of each party served with a copy and how service was made, and shall be signed by the party or, if represented, by the party's attorney. The signature constitutes a certification that the signer has read the document, has a good faith basis for submission of the document, and that it is not filed for the purpose or delay or harassment.

- C. In computing any period of time prescribed or allowed by this Article, or any notice or order concerning a contested case, the day of the act, event, or default from which the designated period of time begins to run shall not be included. When the period of time prescribed or allowed is less than 11 days, intermediate Saturdays, Sundays and legal holidays shall not be included in the computation. When that period of time is 11 days or more, intermediate Saturdays, Sundays and legal holidays shall be included in the computation. The last day of the period so computed shall be included, unless it is a Saturday, Sunday or legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday or a legal holiday.
- D. Whenever a party has the right or is required to do some act within a prescribed period after the service of a notice or other document upon the party by another party, and the notice or other document is served by mail, five days shall be added to the prescribed period.
- E. For good cause shown, the presiding officer may grant continuances and extensions of time for filing notices or other documents.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). The Section heading has been updated to title case to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-703. Contested Cases; Notice; Hearing Records

- A. In a contested case, the parties shall be afforded an opportunity for hearing after reasonable notice. The notice shall be given at least 20 days prior to the date set for the hearing.
- B. The notice shall include:
 1. A statement of the time, place and nature of the hearing.
 2. A statement of the legal authority and jurisdiction under which the hearing is to be held.
 3. A reference to the particular sections of the statutes and rules involved.
 4. A short and plain statement of the matters asserted. If a party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter upon application a more definite and detailed statement shall be furnished.
- C. Opportunity shall be afforded all parties to respond and present evidence and argument on the issues involved.
- D. The Board may dispose of any contested case by decision or approved stipulation, agreed settlement, consent agreement or by default.
- E. A hearing before a hearing body in a contested case or any part thereof shall be recorded manually or by a recording device and shall be transcribed on request of any party, unless otherwise provided by law. The cost of such transcript shall be paid by the party making the request, unless otherwise provided by law or unless assessment of the cost is waived by the Board.
- F. The Board or the presiding officer may reschedule the hearing, maintaining due regard for the interests of justice and the orderly and prompt conduct of the proceedings.
- G. The record in a contested case shall include:
 1. All pleadings, motions and interlocutory rulings.
 2. Evidence received or considered, including confidential evidence received in executive session.

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3. A statement of matters officially noticed.
 4. Objections and offers of proof and rulings thereon.
 5. Proposed findings of fact, conclusions of law and recommendations of the hearing body.
 6. All staff memoranda, other than privileged communications, or data submitted to the hearing body in connection with its consideration of the case.
 7. A victim impact statement, if submitted by the victim.
- H.** Findings of fact shall be based exclusively on the evidence and on matters officially noticed.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). Amended by final exempt rulemaking at 21 A.A.R. 1775, effective May 20, 2013 (Supp. 15-3). The Section heading has been updated to title case to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-704. Service; Proof of Service

- A.** The Board shall serve notices of hearing, findings of fact, conclusions of law, and recommendations of the hearing body, and decisions and final orders of the Board, either by personal service or by certified mail. All other documents required to be served by the Board may be served by regular or certified mail or may be personally served.
- B.** After service of a notice of hearing in a contested case, a copy of every document filed by a party, or individual seeking to intervene, shall be served on all parties to the contested case, or their lawyers if represented, at the same time the document is filed. Filing with the Board and service shall be completed by personal delivery, first-class mail or email.
- C.** The following evidences completed service:
1. If personally served, an affidavit of personal service, sworn to by the individual serving the document and stating the name of the individual upon whom it was served, where service was made, and the date of such service; or
 2. If served by certified mail, proof of delivery; or
 3. If served by email or regular mail, either a statement subscribed on the document filed, or an affidavit indicating the date mailed and listing those to whom it was mailed.
- D.** When a party is represented by an attorney, service shall be made on the attorney. If a notice of hearing shows service on the Attorney General, all documents served thereafter shall be served on the Assistant Attorney General named on the notice of hearing or who later appears on behalf of the Attorney General, or if no Assistant Attorney General is named, then on the Attorney General, Education and Health Section, Education Unit.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-705. Hearings and Evidence

- A.** Parties may participate in the hearing in person or through an attorney.
- B.** The parties may submit proposed findings of fact and conclusions of law prior to the hearing. The presiding officer or hearing body may require that the parties submit proposed findings of fact and conclusions of law prior to the hearing or at the close of evidence.

- C.** A hearing in a contested case shall be conducted in an informal manner and without adherence to the rules of evidence required in judicial proceedings. Irrelevant, immaterial or unduly repetitious evidence shall be excluded. A party to such proceedings may be represented by counsel and shall have the right to submit evidence in open hearing and conduct cross examination. Hearings may be held in any location or manner determined by the Board.
- D.** Copies of documentary evidence may be received in the discretion of the presiding officer. Upon request, the parties shall be given an opportunity to compare the copy with the original.
- E.** Notice may be taken of judicially cognizable facts. In addition, notice may be taken of generally recognized technical or scientific facts within the specialized knowledge of the hearing body. Parties shall be notified either before or during the hearing or by reference in preliminary reports or otherwise of the material noticed including any staff memoranda or data and they shall be afforded an opportunity to contest the material so noticed. The hearing body's experience, technical competence and specialized knowledge may be utilized in the evaluation of the evidence.
- F.** If a party fails to appear at a hearing, the hearing body may proceed with the presentation of the evidence of the appearing party.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). Amended by final exempt rulemaking at 23 A.A.R. 725, effective January 23, 2017 (Supp. 17-1). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-706. Request for Hearing

When a request for a hearing is filed with the Board, the request shall be in writing and shall state the specific grounds which are the basis of the hearing request and the statute, rule or other legal basis entitling the person to a hearing.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4).

R7-2-707. Denial of Request for Hearing

If the Board denies the request for a hearing, the denial shall be in writing and shall state the reasons therefor. A denial of a request for hearing is final and not subject to further administrative review.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). The Section heading has been updated to title case to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-708. Repealed**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). Section repealed by final rulemaking at 11 A.A.R. 696, effective March 29, 2005 (Supp. 05-1).

R7-2-709. Rehearing and Review of Decisions

- A.** After a hearing is held, a party in a contested case who is aggrieved by a decision rendered by the Board may file with the Board, not later than 30 days after such decision has been made, a written motion for rehearing specifying the particular grounds therefor. A response may be filed within 15 days after

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service of such motion by any other party. The Board may require the filing of written briefs on the issues raised in the motion or response and may provide for oral argument.

- B.** A rehearing of a decision by the Board may be granted for any of the following causes materially affecting the moving party's rights:
1. Irregularity in the administrative proceedings of the hearing body, or abuse of discretion, whereby the moving party was deprived of a fair hearing.
 2. Misconduct of the hearing body or the prevailing party.
 3. Accident or surprise which could not have been prevented by ordinary prudence.
 4. Newly discovered material evidence which could not with reasonable diligence have been discovered and produced at the hearing.
 5. Excessive or insufficient penalties.
 6. Error in the admission or rejection of evidence or other errors of law occurring at the administrative hearing.
 7. That the decision is not justified by the evidence or is contrary to the law.
- C.** The Board may affirm or modify the decision or grant a rehearing before a hearing body to all or any of the parties, on all or part of the issues, for any of the reasons set forth in subsection (B). An order granting a rehearing shall specify with particularity the ground or grounds on which the rehearing is granted, and the rehearing shall cover only those matters so specified.
- D.** After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Board may grant a motion for rehearing for a reason not stated in the motion. The order granting such a rehearing shall specify the grounds therefor.
- E.** Not later than 20 days after a decision is rendered, the Board may, on its own initiative, order a rehearing of its decision for any reasons for which it might have granted a rehearing on motion of a party. The order granting such a rehearing shall specify the grounds therefor.
- F.** When a motion for rehearing is based upon affidavits they shall be served with the motion. An opposing party may, within ten days after service of such motion, serve opposing affidavits and this period may be extended for an additional period not exceeding 20 days, by the Board for good cause shown or by written stipulation of the parties. Reply affidavits may be permitted.
- G.** After a hearing has been held and a final administrative decision has been entered, a party is not required to file a motion for rehearing or review of the decision in order to exhaust the party's administrative remedies.
- H.** Any party in a contested case who is aggrieved by a decision rendered by the Board may file with the Board, not later than 20 days after such decision has been made, a written request for review of the decision. If a review of the decision is granted, the Board may affirm or modify the previous decision.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). The Section heading has been updated to title case to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 2353, (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-710. Repealed**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). Repealed by final exempt rulemaking at 27 A.A.R. 2353, (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-711. Consolidation and Severance

- A.** When proceedings involving a common question of law or fact or common parties are pending before the hearing body, the presiding officer may, upon the presiding officer's own volition or upon request of any party, order a consolidated hearing on any or all the matters at issue.
- B.** In furtherance of convenience, to avoid prejudice, or when separate hearings will be conducive to expedition and economy, the presiding officer may, upon the presiding officer's own volition or upon request of any party, order any proceeding severed with respect to some or all issues or parties.
- C.** The presiding officer shall send a written ruling granting or denying consolidation or severance to all parties, identifying the cases, and the reasons for the decision.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). The Section heading has been updated to title case to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 2353, (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-712. Subpoenas

- A.** The Board may issue subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence on its own volition or at the request of a party. The subpoena shall be signed by a Board employee designated by the Board.
- B.** A request for a hearing subpoena shall be in writing and served on each party at least seven days prior to the date set for hearing and shall state:
1. The name of the contested case, the case number, and the time and place where the witness is expected to appear and testify;
 2. The name and address of the witness subpoenaed;
 3. The documents, if any, sought to be provided; and
 4. A brief statement of the relevance of testimony or documents.
- C.** On application of a party or the agency and for use as evidence, the presiding officer may permit a deposition to be taken, in the manner and upon the terms designated by the presiding officer, of a witness who cannot be subpoenaed or is unable to attend the hearing.
- D.** The individual to whom a subpoena is directed shall comply with its provisions unless, prior to the date set for appearance, the presiding officer grants a written request to quash or modify the subpoena. The request shall be submitted to the Board and state the reasons why it should be granted. The presiding officer shall grant or deny such request by order.
- E.** The party requesting the subpoena shall prepare it and cause it to be served upon the individual to whom it is directed and on all parties in the same manner as provided for service of subpoenas in civil matters before the superior court. The return of service shall be filed with the Board.
- F.** A party, or the person served with a subpoena who objects to the subpoena, or any portion of it, may file an objection with the presiding officer. The objection shall be filed within five days after service of the subpoena, or at the outset of the hear-

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ing, if the subpoena is served fewer than five days before the hearing.

- G. If a subpoena issued for the Board is disobeyed, the Board may petition the superior court to enforce the subpoena pursuant to A.R.S. § 15-203.
- H. If a subpoena issued for a party other than the Board is disobeyed, the party may petition the superior court in the manner provided by law for the enforcement of subpoenas in a civil action.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-713. Conduct of Hearing

- A. The presiding officer may conduct all or part of the hearing by telephone, or other electronic means, as long as each party has an opportunity to participate in the entire proceeding as it takes place.
- B. Except for those hearings which may involve presentation of evidence protected by A.R.S. § 15-350, or which are otherwise closed pursuant to an express provision of law, all hearings are open to public observation.
- C. Conduct at any hearing that is disruptive or shows contempt for the proceedings shall be grounds for exclusion from further participation or observation.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). The Section heading has been updated to title case to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 2353, (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-714. Testimony of Pupils

- A. All individuals present at a hearing regarding an action against a certificate shall:
 - 1. Keep confidential the name and identifying information of any pupil involved in the hearing, unless disclosure is with the consent of the pupil's parent or guardian or the pupil if the pupil is at least 18 years of age at the time of the hearing, or by order of the superior court. This action does not prevent disclosure of the pupil's name to any party to the hearing.
 - 2. Keep confidential the testimony of any pupil, all of which shall be taken in executive session, except that the Board office shall be furnished a confidential copy of the pupil's testimony as part of the complete transcript of the hearing. The individuals present during the executive session shall be determined by the presiding officer in consultation with the Attorney General's office except that the respondent and counsel shall always be permitted to be present. The transcripts of testimony taken during executive session shall be maintained by the Board.
- B. The Board of Education or its designee shall:
 - 1. Make available a consent form which requires the signature of the pupil's parent or guardian or the pupil if the pupil is at least 18 years of age at the time of the hearing, prior to disclosure of the pupil's name;
 - 2. Assign a fictitious name to all witnesses identified as pupils on the witness lists provided by the complainant

and respondent if not in receipt of written parental or guardian consent for disclosure;

- 3. Notify hearing participants, prior to and during the hearing, of any fictitious names to be used.
- C. The presiding officer shall instruct all individuals present at the hearing of the confidentiality requirements of A.R.S. § 15-551 and this Section.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). The Section heading has been updated to title case to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-715. Evidence

- A. All witnesses shall testify under oath or affirmation. At the request of a party, or at the discretion of the presiding officer, the presiding officer may exclude witnesses who are not parties from the hearing room so that they cannot hear the testimony of other witnesses.
- B. The presiding officer shall have the power to administer oaths and affirmations.
- C. All parties shall have the right to present such oral or documentary evidence and to conduct such cross-examination as may be required for a full and fair disclosure of the facts.
- D. The presiding officer shall make rulings necessary to prevent argumentative, repetitive, or irrelevant questioning, to exclude evidence the presiding officer determines to be irrelevant, immaterial, or unduly repetitious, and to expedite the examination to the extent consistent with the disclosure of all relevant testimony and information.
- E. Unless otherwise ordered by the hearing body, documentary evidence shall be limited in size when folded to 8 1/2 by 11 inches. The submitting party shall identify documentary exhibits by number or letter and party and furnish a copy of each exhibit to each party present. One additional copy shall be furnished to the hearing body unless the hearing body otherwise directs. When evidence offered by any party appears in a larger work, containing other information, the party shall plainly designate the portion offered. If the evidence offered is so voluminous as would unnecessarily encumber the record, the book, paper, or document shall not be received in evidence but may be marked for identification and, if properly authenticated, the designated portion may be read into or photocopied for the record. All documentary evidence offered shall be subject to appropriate and timely objection.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). Amended by final exempt rulemaking at 27 A.A.R. 2353, (October 22, 2021) effective September 27, 2021 (Supp. 21-4).

R7-2-716. Stipulations

Parties to any contested case may stipulate, in writing, agreement upon any matter involved in the proceeding. If approved by the presiding officer, agreement on matters of procedure shall be binding upon the parties to the stipulation. No substantive matter agreed to by the parties shall be binding upon the Board unless incorporated into the decision of the Board.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). Amended by

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final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021) effective September 27, 2021 (Supp. 21-4).

R7-2-717. Recommended Decisions

- A. A recommended decision, findings of fact and conclusions of law shall be prepared for the Board by the PPAC.
- B. A recommended decision, findings of fact and conclusions of law shall be delivered to the Board within 90 days after the close of the hearing or the date ordered for submission of proposed findings or legal memoranda, whichever comes last, unless the Board extends the period for good cause.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). Amended by final exempt rulemaking at 27 A.A.R. 2353, (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-718. Decisions and Orders

- A. Any final decision or order adverse to a party in a contested case shall be in writing or stated in the record. Any final decision shall include findings of fact and conclusions of law, separately stated. Findings of fact, if set forth in statutory language, shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings. Parties shall be notified either personally or by mail to their last known address of any decision or order.
- B. When the Board is the hearing body, the decision shall be rendered within 120 days following the final day of the hearing or the date ordered for submission of proposed findings of fact and conclusions of law or legal memoranda, whichever comes last.
- C. Within 30 days after receipt of any recommended decision from the PPAC, the Board shall render a decision to affirm, reverse, adopt, modify, supplement, amend or reject the findings of fact, conclusions of law and recommendations in whole or in part, may remand the matter to the hearing body with instructions, or may convene itself as the hearing body.
- D. If no request for rehearing or review has been timely filed by a party, a decision in a contested case is effective and final ten days from the date served on that party.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 48, effective December 15, 2000 (Supp. 00-4). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021) effective September 27, 2021 (Supp. 21-4).

ARTICLE 8. COMPLIANCE**R7-2-801. Compliance**

- A. Procedures governing noncompliance with laws and rules by school districts.
 - 1. Scope. Except as may be otherwise directed by federal or state statute or by rules adopted by the State Board of Education, this Section shall govern the procedure for determining noncompliance by school districts with laws and rules concerning school districts, the enforcement of which is the statutory responsibility of the State Board of Education or the Department of Education.
 - 2. Preliminary notice of noncompliance and response:
 - a. The Department of Education, upon its own initiative or at the direction of the State Board of Education, shall inform school districts by written notice that the district is in possible noncompliance with laws or rules, the enforcement of which is the statutory responsibility of the Board or the Department.

- b. A preliminary notice of possible noncompliance shall detail in writing the nature of the possible noncompliance and shall identify:
 - i. The law or rule which the school district may be violating; and
 - ii. The manner in which the school district may be in noncompliance with the identified law or rule.
 - c. A school district may submit a written response to the Department of Education within 20 days of receipt of a preliminary notice of noncompliance.
 - d. Nothing contained in this Section is intended to preclude a reasonable attempt between Department of Education personnel and school district personnel to resolve administratively possible noncompliance prior to sending a written preliminary notice of noncompliance.
3. Scheduling a formal hearing
- a. Recommendation by the Department of Education
 - i. After giving a school district preliminary notice as provided in this Section, the Department of Education shall submit a written recommendation to the State Board of Education. This recommendation shall be submitted within 10 days after receipt of a written response from the school district or if no response is received within 30 days of the issuance of the preliminary notice. The Department shall recommend one of the following courses of action to be taken by the Board.
 - (1) A formal hearing should be scheduled before noncompliance is probable and achieving voluntary compliance within a reasonable period of time under the circumstances is unlikely; or
 - (2) A formal hearing should not be scheduled at this time because, although noncompliance is probable, achieving voluntary compliance within a reasonable period of time is likely; or
 - (3) A formal hearing should not be scheduled because the school district is in compliance with the law or rule in question.
 - ii. Any written response of the school district to the preliminary notice of noncompliance shall accompany the written recommendation of the Department of Education.
 - b. Within 30 days of receipt of the recommendation of the Department of Education, the State Board of Education shall either:
 - i. Schedule formal hearing;
 - ii. Postpone the decision to schedule a hearing for a stated time period not to exceed six months, or
 - iii. Dismiss the matter.
 - c. When the State Board of Education determines that a formal hearing is necessary, it shall be scheduled within 30 days after such determination, unless an extension of time is granted by the Board.
 - d. When a formal hearing is scheduled, the Board or its designee shall give notice of the hearing as provided in A.R.S. § 41-1009(A) and (B).
 - e. When the Board decides to postpone scheduling a formal hearing, the Board shall specify the extent of

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- the postponement and the Department of Education shall report periodically, at least every 30 days, unless otherwise directed, with respect to progress by the school district toward compliance with the law or rule in question. At the end of the postponement period, the Board shall again make a determination whether to schedule a hearing, further postpone the determination, or dismiss the matter.
- f. The Board may order further investigation by the Department of Education at any time, and admit into evidence any such report at any subsequent formal hearing.
4. Hearings held pursuant to this Section shall be conducted as provided in A.R.S. § 41-1010.
 5. The Board's decision
 - a. A decision by the State Board of Education shall be determined by a majority of the members of the Board and shall be based upon substantial evidence.
 - b. A decision shall be rendered within 30 days after the hearing.
 - c. Within 30 days after a decision is reached, copies of the written decision shall be delivered to the parties personally or by certified mail.
 - d. The parties shall have the opportunity to provide proposed findings of fact and conclusions of law to the Board no later than five days after the decision of the Board is received.
 6. Rehearing procedure
 - a. Any party aggrieved by a decision rendered by the Board may file with the Board, not later than 15 days after service of the decision, a written motion for rehearing or review of the decision, specifying the particular grounds therefor.
 - b. A motion to alter or amend a decision or order shall be filed not later than 15 days after service of the decision.
 - c. A motion for rehearing under this Section may be amended at any time before it is ruled upon by the Board.
 - d. A response may be filed within 10 days after service of such motion by any other party or by the Attorney General.
 - e. The Board may require the filing of written memoranda upon the issues raised in the motion and may provide for oral argument.
 - f. The Board may consolidate the hearing to consider the motion for rehearing with the requested rehearing.
 - g. A rehearing or review of the decision may be granted for any of the following causes materially affecting the moving party's rights:
 - i. Irregularity in the administrative proceedings of the agency or its hearing officer or the prevailing party, or any order, or abuse of discretion, whereby the moving party was deprived of a fair hearing;
 - ii. Misconduct of the Board of the prevailing party.
 - iii. Accident or surprise which could not have been prevented by ordinary prudence;
 - iv. Newly discovered material evidence which could not with reasonable diligence have been discovered and produced at the original hearing;
 - v. Excessive or insufficient penalty;
 - vi. Error in the admission or rejection of evidence or other errors of law occurring in the administrative hearing;
 - vii. The decision is not justified by the evidence or is contrary to law.
 - h. The Board may affirm or modify the decision or grant a rehearing to all or any of the parties and on all or part of the issues for any of the reasons set forth in subsection (A)(6). An order granting a rehearing shall specify with particularity the ground or grounds on which the rehearing is granted, and the rehearing shall cover only those matters so specified.
 - i. Not later than 15 days after a decision is rendered, the Board may on its own initiative order a rehearing or a review of its decision for any reason for which it might have granted a rehearing on motion of a party. After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Board may grant a motion for rehearing for a reason not stated in the motion. In either case, the order granting such a rehearing shall specify the grounds on which the order is based.
 - j. When a motion for rehearing is based upon affidavits, they shall be served with the motion. An opposing party may, within 10 days after such service, serve opposing affidavits, which period may be extended for an additional period not exceeding 20 days, by the Board for good cause shown, or by the parties by written stipulation. The Board may permit a reply affidavit by the moving party.
 - B. Waiver from administrative rules. Upon request of a school district acting either on its own behalf or on behalf of a school within the district's jurisdiction, the State Board of Education may grant a waiver exempting such district or school from specific administrative rules.
 1. Requests
 - a. Requests for exemption from any State Board of Education rule shall include:
 - i. Evidence that the school or school district is currently in compliance with all state laws and State Board of Education rules;
 - ii. A statement identifying goals that will be accomplished and how the waiver will assist in enhancing school improvement;
 - iii. A three-year plan for school improvement;
 - iv. Identification of the specific rules for which the waiver is requested;
 - v. Evidence of a public hearing held by the school or school district which provided for parental and public involvement and input into the proposed three-year plan.
 - b. Requests for waiver may be granted by the State Board of Education for a period not to exceed three years. The State Board of Education may at any time rescind approved waivers at its discretion.
 - c. Requests for waiver may be submitted by a local governing board and shall be made through the State Superintendent of Public Instruction for consideration by the State Board of Education.
 - d. Local governing boards shall adopt policies and procedures which will allow their schools to request waivers from the State Board of Education and shall

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submit those policies and procedures to the Superintendent of Public Instruction prior to October 1, 1993. Those policies shall be consistent with the criteria specified in subsections (B)(1)(a) and (B)(3). Additionally, those policies shall provide that:

- i. Requests for such waivers by schools be forwarded within 30 days of receipt by the governing board to the Superintendent of Public Instruction. Requests may include additional information as the governing board deems appropriate.
 - ii. Schools not be required to meet criteria other than those specified in subsection (B)(1)(a).
2. Reporting
 - a. Schools or school districts with State Board-approved waivers shall document progress obtained as a result of the waiver and report on or before June 30 of each year to the State Superintendent of Public Instruction.
 - b. A school district having a school with an approved waiver may report the effects that such waiver has had on the operation of the school district. Reports shall be submitted on or before June 30 of each year to the State Superintendent of Public Instruction.
 - c. The State Superintendent of Public Instruction shall report to the State Board of Education, on or before September 30 of each year, the status of those schools and school districts with approved waivers and, as a minimum, include the following:
 - i. The status of meeting the goals as stated in the three-year plan;
 - ii. Recommendations regarding approved continuance of the waiver, conditions for continuance of the waiver, revision of the three-year plan or rescission of the waiver.
 3. Renewal. Upon request from a school district, on behalf of itself or a school within its jurisdiction, waivers may be approved by the State Board of Education for additional three-year periods. Requests shall be made through the State Superintendent of Public Instruction and requests from schools shall be forwarded by the local governing board to the State Superintendent of Public Instruction within 30 days from receipt.

Historical Note

Adopted effective February 27, 1980 (Supp. 80-1).
Amended effective April 9, 1993 (Supp. 93-2). The word "rule" has been updated to "Section" to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-802. School and School District Compliance with the Uniform System of Financial Records and the Uniform System of Financial Records for Charter Schools

- A. Upon receipt of a report from the Auditor General that a school or school district has failed to comply with the Uniform System of Financial Records ("USFR") or the Uniform System of Financial Records for Charter Schools ("USFRCS") within 90 days after having received a notice of noncompliance from the Auditor General, the State Board of Education ("Board") shall review the Auditor General's report to determine whether the school or school district is in noncompliance.
- B. When the Board determines that a school or school district is in noncompliance with the USFR or USFRCS, it shall give written notice to the school or district of its determination. The

written notice shall advise the school or district of the following:

1. The Superintendent of Public Instruction shall withhold distribution of state funds to the school or district until such time as the Auditor General reports compliance with the USFR or USFRCS unless a hearing is requested by the school or district.
 2. The school or district has 10 days from the receipt of the written notice of noncompliance by the Board to submit a written request for a hearing.
 3. If the school or district makes a timely request for a hearing, the hearing will be held pursuant to the hearing procedures specified in R7-2-701 et seq.
- C. The Board's decision
 1. The Board shall determine whether the school or school district was in compliance with the USFR or USFRCS within 90 days after having been informed of noncompliance by the Auditor General, and whether the district is in compliance with the USFR or USFRCS at the time of the hearing.
 2. A decision by the Board shall be determined by a majority of the members of the Board and shall be based upon substantial evidence.

Historical Note

Adopted effective February 27, 1980 (Supp. 80-1).
Amended subsections (A) and (E)(1) and (5) effective December 17, 1981 (Supp. 81-6). Amended effective December 31, 1998 (Supp. 98-4).

R7-2-803. Implementation of the Uniform System of Financial Records

All school districts shall implement the current version of the Uniform System of Financial Records, as prescribed by the Auditor General, in conjunction with the Department of Education. The Uniform System of Financial Records shall include standards to ensure that enrollment is determined by all school districts on a uniform basis.

Historical Note

Adopted effective November 10, 1980 (Supp. 80-6).
Amended effective February 20, 1997 (Supp. 97-1).

R7-2-804. Compliance with Federal Statutes or Regulations

- A. This Section prescribes procedures to be used in filing and processing written complaints alleging the failure of a public agency or school district to comply with federal statutes or regulations applicable to federal education programs conducted and subject to Title 34, Code of Federal Regulations, § 76.780.
- B. The Arizona Department of Education (Department) shall accept and investigate complaints provided that the complaint:
 1. Is written and signed by the complaining party or his or her designated representative;
 2. Sets forth the facts forming the basis of the complaint; the facts set forth in the complaint, if true, could constitute noncompliance by a public agency or school district;
- C. Upon receipt of a complaint setting forth the criteria contained in (B), the Department shall immediately begin an impartial review which may include onsite investigations. If in the course of the review it is determined that the nature of the complaint is not a matter of noncompliance, the complainant will be so informed and advised of appropriate means of resolving the complaint.
- D. A written decision with specific findings shall be issued by the Department within 60 calendar days of receipt of the written

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complaint. If corrective action is required, such action shall be designated in the decision and shall include the time line for correction and possible consequences for continued noncompliance. A copy of the written decision shall be sent to the complaining party and the agency involved on or before the expiration of the 60-day period. An extension of this timeline will be permitted only if exceptional circumstances exist with respect to a particular complaint.

- E. If there appears to be a failure or refusal to comply with the applicable law or regulations, and if the noncompliance or refusal to comply cannot be corrected or avoided by informal means, compliance shall be effected by the Superintendent and the State Board of Education by any means authorized by law or by rule and regulation. The Superintendent shall retain jurisdiction over the issue of noncompliance with the law or regulations and shall retain jurisdiction over the implementation of any corrective action required. However, nothing herein shall preclude the availability of an informal resolution between the complainant and the agency or school district involved, nor shall this Section preclude the availability of any administrative hearing remedies to resolve such disputes or judicial review of such administrative remedies.
- F. If, pursuant to an investigation by the Department, the Superintendent finds a failure to comply with applicable law or regulations, he or she shall so inform the agency or school district and compliance shall be obtained by informal means whenever possible. If corrective action is required, such action shall be designated in this decision and shall include the time lines for correction and the possible consequences for continued noncompliance.
- G. A summary of each complaint received and investigated by the Department and the decision of the Superintendent shall be submitted annually to the State Board of Education for informational purposes only. Any personally identifiable information shall be deleted from the report to the State Board of Education.
- H. The complainant may request the U.S. Department of Education to review the final decision of the Superintendent. The Department shall inform a complainant of the procedures for requesting a review by the U.S. Department of Education.

Historical Note

Adopted effective February 11, 1983 (Supp. 83-1).
Amended subsection (B) effective March 13, 1986 (Supp. 86-2). The Section heading has been updated to title case, the word "rule" has been updated to "Section." Both changes reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-805. Education Division General Administrative Regulations

- A. This Section prescribes procedures to be used for appealing a decision by the Arizona Department of Education (Department) relating to federal programs administered by the Department and subject to the Education Division General Administrative Regulations (EDGAR) Title 34, Code of Federal Regulations § 75 and 76.
- B. A school district or public agency may request a hearing if it alleges that the Department violated a federal statute or regulation by:
 1. Terminating further assistance for an approved project;
 2. Ordering, in accordance with a final state audit resolution determination, the repayment of misspent or misapplied federal funds;

3. Disapproving or failing to approve the application or project in whole or in part; or
 4. Failing to provide funds in amounts in accordance with the requirements of statutes and regulations.
 5. Not approving the school district or public agency's proposal for funding.
- C. When a school district or public agency requests a hearing, the Superintendent of Public Instruction (Superintendent) shall select a hearings appeals panel from Department staff other than those within the same division as the federal program area under which the appeal rose.
 - D. Hearing procedures
 1. An applicant must request a hearing by notifying the Superintendent by certified mail of its decision to appeal a decision as set forth in subsection (B). If the applicant is or represents a school district, authorization to seek a hearing must come from the Governing Board of that school district.
 2. The request for hearing must set forth the nature of the complaint and the facts on which the complaint is based.
 3. The applicant shall request a hearing within 30 days of the date notice of the Department action was sent. For purposes of this Section, the date of notice by the Department is the date of sending notice of the Department action.
 4. A hearing shall be scheduled before the appeal panel within 30 days from the receipt of the request.
 5. The appeals panel chairperson shall give at least 10 days' notice of the hearing date to the complainant.
 6. The parties may submit written materials no later than five days prior to the hearing, such materials to consist of six copies.
 7. At the hearing the parties may present evidence in writing and through witnesses and may be represented by counsel.
 8. The length and order of the presentation may be determined by the appeals panel chairperson.
 9. If the complainant or authorized representative fails to appear at the designated time, place and date of the hearing, the appeal shall be considered closed and the process terminated.
 - E. Decision. No later than five days after the hearing, the appeals panel shall forward to the Superintendent its recommendation relating to the school district or agency's request for review. Within 10 days after the hearing, the Superintendent shall issue his or her written ruling, including findings of fact and reasons for the ruling. If the Superintendent determines that the Department's action was contrary to the statutes and regulations that govern the applicable program, the Superintendent shall rescind the action.
 - F. Appeal. If the Superintendent does not rescind the Department action, the applicant may appeal to the U.S. Department of Education. The applicant shall file a notice of appeal with the U.S. Department of Education within 20 days after the applicant has been notified by the Superintendent of his or her decision by certified mail.
 - G. State Board of Education submission. The Superintendent shall annually submit to the State Board of Education as an informational item summaries of all decisions including the findings of fact of hearing procedures conducted pursuant to this Section for State Board of Education review.

Historical Note

Adopted effective June 24, 1983 (Supp. 83-3). The Section heading has been updated to title case, the word

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“rule” has been updated to “Section,” the phrase, “of this rule” has been removed to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-806. Repealed**Historical Note**

Adopted effective February 6, 1984 (Supp. 84-1). Section repealed by final rulemaking at 7 A.A.R. 182, effective December 15, 2000 (Supp. 00-4).

R7-2-807. Repealed**Historical Note**

Adopted as an emergency effective August 2, 1984 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Permanent rule adopted effective November 27, 1984 (Supp. 84-6). Amended effective May 3, 1993 (Supp. 93-2). Repealed effective February 20, 1997 (Supp. 97-1).

R7-2-808. Pupil Participation in Extracurricular Activities

The following standards are effective for students in grade six, if part of a middle school, and grades seven through 12.

1. Definition. Extracurricular activities are:
 - a. All interscholastic activities which are of a competitive nature and involve more than one school where a championship, winner, or rating is determined; and all those endeavors of a continuous and ongoing nature for which no credit is earned in meeting graduation or promotional requirements and are organized, planned, and sponsored by the district consistent with district policy.
 - b. Activities which are an integral part of a credit class shall be excepted from the rule.
2. Eligibility requirements and ineligibility.
 - a. Eligibility. To be eligible to participate in extracurricular activities, a student shall be required to:
 - i. Earn a passing grade in each course in which the student is enrolled; and
 - ii. Maintain satisfactory progress toward promotion or graduation.
 - b. Ineligibility. When it is determined that a student has failed to meet the requirements specified for eligibility, the student shall be declared ineligible to participate in extracurricular activities and shall remain ineligible until the requirements of eligibility are met.
 - i. The governing board shall establish the criteria for a passing grade and satisfactory progress toward promotion or graduation, taking into account the needs of children placed in special education programs pursuant to R7-2-401 et seq. Passing grades shall be determined on a cumulative basis, from the beginning of instruction to the recording of a final grade for the course.
 - ii. Every nine weeks or less, as determined by the governing board, district personnel shall review the progress of students to determine their eligibility status. If a student is declared ineligible, the student shall remain ineligible until a subsequent check is performed and it is determined that the student meets the eligibility requirements specified in subsection (2)(a).
3. Each governing board shall adopt a policy and implement a program pursuant to that policy to provide:

- a. Oral or written preliminary notice to all district students and their parents or guardian of pending ineligibility;
- b. Written notice to students and their parents or guardians when ineligibility has been determined;
- c. Educational support services to students declared ineligible because of this Section, as well as those notified of pending ineligibility.

Historical Note

Adopted effective December 31, 1986 (Supp. 86-6). Amended subsection (B) and added a new subsection (D) effective February 17, 1988 (Supp. 88-1). Amended subsection (A) effective August 15, 1988 (Supp. 88-3). Amended effective April 28, 1989 (Supp. 89-2). Amended effective December 20, 1991 (Supp. 91-4). Section R7-2-808 repealed, new Section adopted effective July 10, 1992 (Supp. 92-3). Amended effective September 20, 1996 (Supp. 96-3). Amended effective December 22, 1997 (Supp. 97-4). Numerals were corrected and the word “rule” was replaced with “Section” to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-809. Emergency Administration of Auto-Injectable Epinephrine**A. Applicability.** This Section applies to:

1. Any school district or charter school that voluntarily chooses to stock auto-injectable epinephrine pursuant to A.R.S. § 15-157.
2. All school districts and charter schools when required to stock auto-injectable epinephrine pursuant to A.R.S. § 15-157.

B. Definitions. The following definitions are applicable to this Section:

1. “Anaphylactic shock” is a severe systemic allergic reaction, resulting from exposure to an allergen, which may result in death.
2. “Auto-injectable epinephrine” means a disposable drug delivery device that is easily transportable and contains a premeasured single dose of epinephrine used to treat anaphylactic shock.
3. “Standing order” means a prescription protocol or instructions issued by the chief medical officer of the department of health services, the chief medical officer of a county health department, a doctor of medicine licensed pursuant to A.R.S. Title 32, Chapter 13, a doctor of naturopathic medicine licensed pursuant to A.R.S. Title 32, Chapter 14, a doctor of osteopathic medicine licensed pursuant to A.R.S. Title 32, Chapter 17, a nurse practitioner licensed pursuant to A.R.S. Title 32, Chapter 15 or a physician assistant licensed pursuant to A.R.S. Title 32, Chapter 25 for non-individual specific epinephrine.

C. Annual training in the administration of auto-injectable epinephrine.

1. Each school district and charter school shall designate at least two school personnel for each school site who shall be required to receive annual training in the proper administration of auto-injectable epinephrine in cases of anaphylactic shock pursuant to standing order. One or more of the trained personnel may be a school nurse or athletic trainer if they are employed by the school.
2. Training in the administration of auto-injectable epinephrine shall be conducted in accordance with minimum standards and curriculum developed by the Arizona

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Department of Health Services in consultation with the Arizona Department of Education.

3. At a minimum, training shall include procedures to follow when responding to anaphylactic shock, including direction regarding summoning appropriate emergency care, and documenting, tracking and reporting of the event.
 4. Training shall also include standards and procedures for acquiring a supply of at least two juvenile doses and two adult doses of auto-injectable epinephrine, restocking auto-injectable epinephrine upon use or expiration, and storing all auto-injectable epinephrine at room temperature and in secure, easily accessible locations on school sites.
 5. Training shall be conducted via courses provided in collaboration with a public health organization or by a regulated health care professional, whose competencies include the administration of auto-injectable epinephrine, including but not limited to a licensed school nurse, certified emergency medical technician or licensed athletic trainer.
 6. School districts and charter schools shall maintain and make available upon request a list of those school personnel authorized and trained to administer auto-injectable epinephrine pursuant to a standing order.
- D.** Annual training on the recognition of anaphylactic shock symptoms and procedures to follow when anaphylactic shock occurs.
1. Each school district and charter school shall require all school site personnel to receive an annual training on the recognition of anaphylactic shock symptoms and procedures to follow when anaphylactic shock occurs.
 2. Training shall be conducted in accordance with minimum training standards developed by the Arizona Department of Health Services in consultation with the Arizona Department of Education and shall follow the most current guidelines issued by the American Academy of Pediatrics.
 3. Training shall be conducted in collaboration with a public health organization by a regulated health care professional whose competencies include the recognition of anaphylactic shock symptoms and procedures to follow when anaphylactic shock occurs, including but not limited to a licensed school nurse, certified emergency medical technician or licensed athletic trainer.
- E.** Procedures for annually requesting a standing order for auto-injectable epinephrine.
1. Each school district or charter school shall obtain a standing order from its designated district or charter school physician licensed pursuant to A.R.S. Title 32, Chapter 13, 14, 17, 15, or 25 and if no such physician is available to provide a standing order, from the chief medical officer of the Department of Health Services or the chief medical officer of a county health department.
 2. Standing orders shall be renewed annually and upon the change of any designated school district or charter school physician.
 3. Standing orders shall identify the appropriate dosage of auto-injectable epinephrine to administer based upon weight and the frequency at which auto-injectable epinephrine may be administered if symptoms persist or return.
- F.** Procedures for the administration of auto-injectable epinephrine in emergency situations.
1. All school districts and charters schools shall adopt procedures for the emergency administration of auto-injectable epinephrine by designated trained personnel.
 2. Procedures shall address, at a minimum, the following requirements:
 - a. Determining if symptoms indicate possible anaphylactic shock.
 - b. Selecting the appropriate dosage of auto-injectable epinephrine to administer pursuant to a standing order.
 - c. Injecting epinephrine via auto-injector pursuant to a standing order, noting the time and dose given.
 - d. Calling 911 to advise that anaphylactic shock is suspected and epinephrine was administered.
 - e. Keeping the person stable until emergency responders arrive.
 - f. Advising school medical personnel and administration of the incident.
 - g. Repeating dose pursuant to a standing order when symptoms persist and emergency responders have not arrived.
 - h. Providing emergency responders with used epinephrine auto-injector labeled with name, date and time administered.
 - i. Assuring that parents/guardians have been notified and advised to promptly alert student's primary care physician of the incident.
 - j. Completing written documentation of the incident, detailing who administered the injection, the rationale for administering the injection, the approximate time of the injection or injections, and notifications made to school administration, emergency responders, the student's parents or guardians, and the doctor or chief medical officer who issued the standing order.
 - k. Ordering replacement dose or doses of auto-injectable epinephrine.
 - l. Reviewing any incident involving emergency administration of epinephrine to determine the adequacy of response.
- G.** All school districts and charter schools shall report to the Arizona Department of Health Services all incidents of use of auto-injectable epinephrine pursuant to this Section in the format prescribed by the Arizona Department of Health Services.

Historical Note

Adopted effective July 30, 1992 (Supp. 92-3). Amended effective April 9, 1993 (Supp. 93-2). Repealed effective February 20, 1997 (Supp. 97-1). Amended by final exempt rulemaking at 21 A.A.R. 1784, effective February 24, 2014 (Supp. 15-3). Amended by final exempt rulemaking at 24 A.A.R. 3279, effective October 22, 2018 (Supp. 18-4). The word "rule" has been updated to "Section" to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 1531, effective August 27, 2021 (Supp. 21-3).

R7-2-810. Emergency Administration of Inhalers

- A.** Applicability. This Section applies to:
1. Any school district or charter school that voluntarily chooses to stock inhalers pursuant to A.R.S. § 15-158.
 2. All school districts when required to stock inhalers pursuant to A.R.S. § 15-158.

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B. Definitions. The following definitions are applicable to this Section:

1. "Authorized Entity" refers to any school district or charter school.
2. "Bronchodilator" means Albuterol or another short-acting bronchodilator that is approved by the United States Food and Drug Administration for the treatment of respiratory distress.
3. "Inhaler" means a device that delivers a bronchodilator to alleviate symptoms of respiratory distress that is manufactured in the form of a metered-dose inhaler or dry-powder inhaler that includes a spacer or holding chamber that attaches to the inhaler to improve the delivery of the bronchodilator.
4. "Personnel" means employees at a school district or charter school or nurses who are under contract with the school district or charter school.
5. "Respiratory distress" includes the perceived or actual presence of coughing, wheezing or shortness of breath.
6. "Standing order" means a prescription protocol or instructions issued by the chief medical officer of a county health department, physicians licensed pursuant to A.R.S. Title 32, Chapter 13, 14, or 17, or nurse practitioners licensed pursuant to A.R.S. Title 32, Chapter 15.

C. Annual training on recognition of symptoms of respiratory distress and administration of inhalers:

1. Each school district and charter school that elects to administer inhalers shall designate at least two personnel at each school site who shall be required to be trained in the recognition of respiratory distress symptoms, the procedures to follow when respiratory distress occurs, and the administration of inhalers, as directed on the prescription protocol. While each school is required to have two trained personnel in order to implement the stock inhaler policies, schools may train as many personnel as they feel necessary.
2. Training in the administration of inhalers shall be conducted by a nationally recognized organization or professionally certified medical professionals that are experienced in training laypersons in emergency health treatment.
3. Training may be conducted online or in person and at a minimum shall include:
 - a. How to recognize signs and symptoms of respiratory distress in accordance with good clinical practice.
 - b. Standards and procedures for the storage of inhalers.
 - c. Standards and procedures for the administration of an inhaler, as directed on the prescription protocol.
 - d. If necessary, emergency follow-up procedures after the administration of an inhaler.
4. The organization that conducts the training shall issue a certificate to each person who successfully completes the training. The personnel shall submit this certificate to the school.
5. Annual training is required for all designated personnel of the school.
6. School districts and charter schools shall maintain and make available on request a list of school personnel who are authorized to administer inhalers pursuant to a standing order.

D. Procedures for annually requesting a standing order and the prescription for the inhaler and holding chamber

1. Each participating school district or charter school shall obtain a standing order and prescription for inhalers and

spacers or holding chambers pursuant to A.R.S. § 15-158 from the chief medical officer of a county health department, a physician licensed pursuant to A.R.S. Title 32, Chapter 13, 14, or 17, or a nurse practitioner pursuant to A.R.S. Title 32, Chapter 15.

2. Standing orders and prescriptions shall be requested and renewed annually.

E. Procedures for the administration of inhalers in emergency situations:

1. School districts and charter schools that elect to administer inhalers shall:
 - a. Prescribe and enforce policies and procedures for the emergency administration of inhalers by designated and trained medical and non-medical personnel.
 - b. Designate at least two personnel at each school to be trained to recognize respiratory distress and administer inhalers.
 - c. Require designated personnel to participate in annual training and provide a certificate of successful completion to the school.
 - d. Designate personnel who have completed the required training to be responsible for the storage, maintenance, control and general oversight of the inhalers and spacers or holding chambers acquired by the school.
 - e. Acquire and stock a supply of inhalers and spacers or holding chambers pursuant to a standing order prescription.
 - f. Store medication in a secure, temperature appropriate location, unlocked and readily accessible to designated personnel.
2. Pursuant to a standing order, school district or charter school personnel who are trained in the administration of inhalers may administer or assist in the administration of an inhaler to a pupil or adult whom the personnel believes in good faith to be exhibiting symptoms of respiratory distress while at school or a school-sponsored activity.
3. Procedures adopted by school districts and charter schools shall address at a minimum, the following requirements:
 - a. Determine if symptoms indicate possible respiratory distress or emergency and determine if the use of an inhaler will properly address the respiratory distress or emergency.
 - b. Administer the correct dose of inhaler medication, as directed by the prescription protocol, regardless of whether the individual who is believed to be experiencing respiratory distress has a prescription for an inhaler and spacer or holding chamber or has been previously diagnosed with a condition requiring an inhaler.
 - c. Restrict physical activity, encourage slow breaths and allow the individual to rest.
 - d. Assure that trained personnel stay with the subject who has been administered inhaler medication until it is determined whether the medication alleviates symptoms.
 - e. If applicable, instruct office staff to notify the school nurse if the inhaler is administered by a trained but non-licensed person.
 - f. Instruct school staff to notify the parent or guardian.
 - g. Call 911 if severe respiratory distress continues. Advise that inhaler medication was administered

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- and stay with the person until emergency medical responders arrive.
 - h. If the individual shows improvement, keep the individual under supervision until breathing returns to normal, with no more chest tightness or shortness of breath, and the individual can walk and talk easily.
 - i. Allow a student to return to class if breathing has returned to normal and all symptoms have resolved.
 - j. Notify a parent or guardian once the inhaler has been administered and the student has returned to class.
 - k. Document the incident detailing who administered the inhaler, the approximate time of the incident, notifications made to the school administration, emergency responders, and parents/guardians.
 - l. Retain the incident data on file at the school pursuant to the general records retention schedule regarding health records for school districts and charter schools established by the Arizona State Library, Archives and Public Records.
 - m. Order replacement inhalers, spacers and holding chambers as needed.
4. A school district or charter school may accept monetary donations for or apply for grants for the purchase of inhalers and spacers or holding chamber or may accept donations of inhalers and spacers or holding chambers directly from the product manufacturers.
- F. Immunity from civil liability is prescribed in A.R.S. § 15-158.

Historical Note

New Section made by final exempt rulemaking at 24 A.A.R. 146, effective August 9, 2018; filed in the Office on January 2, 2018 (Supp. 18-1). Amended by final exempt rulemaking at 24 A.A.R. 3279, effective October 22, 2018 (Supp. 18-4). The word “rule” has been updated to “Section” to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 1531, effective August 27, 2021 (Supp. 21-3).

ARTICLE 9. SCHOOL DISTRICT BUDGET AND ACCOUNTING**R7-2-901. Teacher Experience Index Provisions**

- A. General purpose. These guidelines are provided for local governing boards to assist in development of policies identifying activities which contribute to the instructional programs at the local school level. The policies will define what constitutes a full-time vs. a part-time teacher position for the purpose of developing a school district’s Teacher Experience Index.
- B. Local governing boards may include the following activities in their policies as those which contribute toward an instructional program. This listing is not intended to be exclusive, and districts may utilize additional activities:
1. Classroom related:
 - a. Classroom instruction,
 - b. Preparation time,
 - c. Supervision,
 - d. Evaluation,
 - e. Curriculum development,
 - f. Housekeeping chores, i.e., daily reports, blackboard preparation, etc.
 2. School related:
 - a. Teacher conferences,
 - b. Parent conferences,
 - c. Professional association activities,
 - d. Professional days,

- e. District directed reports,
- f. Participation in activities related to education scheduled by county, state, or federal agencies.

Professional association activities must be, in the opinion of the local governing board, for a public purpose and must not be for the sole benefit of the professional association.

3. Other district related:

- a. Special assignments,
- b. School board approved leave,
- c. Home visitation,
- d. Home instruction,
- e. Off-site instruction,
- f. Research,
- g. In-service training.

In-service training activities are those approved by the local governing board and intended to promote the educational advancement of the youth of the district. These activities may be conducted either during the regular school day or at other times.

- C. A local governing board may exercise its option to contract with certified personnel on a less than full-time basis in order to meet local district needs.
- D. In those instances where a district may contract with certificated personnel, and the responsibilities specified within the contract include activities not related to instruction, then the district must define in terms of “full-time equivalencies” that portion which is instruction-related.

Historical Note

Adopted as an emergency effective May 21, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-3). Former emergency adoption now adopted without change effective October 7, 1980 (Supp. 80-5).

R7-2-902. Independent Accounting Responsibilities

The governing board of a school district applying to operate with full independence from the county school superintendent as provided in Laws 1987, Chapter 132, shall submit a plan for accounting responsibility to the State Board of Education no later than January 1, 1988, which documents the following:

1. Administrative and internal accounting controls designed to achieve compliance with the Uniform System of Financial Records and the following objectives:
 - a. Procedures for approving, preparing and signing vouchers and warrants;
 - b. Procedures to ensure verification of administrators’ and teachers’ certification records with the Department of Education for all classroom and administrative personnel required to hold a certificate by the State Board pursuant to A.R.S. § 15-203, before issuing warrants for their services;
 - c. Procedures to account for all revenues, including allocation of certain revenues to funds as provided in Section III-C of the February 1986 Uniform Accounting Manual for Arizona County School Superintendents, incorporated herein by reference and on file with the Office of the Secretary of State;
 - d. Procedures for reconciling the accounting records monthly to the county treasurer as provided in Section III-G of the February 1986 Uniform Accounting Manual for Arizona County School Superintendents, incorporated herein by reference and on file with the Office of the Secretary of State.

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2. No amendments or additions to Sections III-C and G of the February 1986 Uniform Accounting Manual for Arizona County School Superintendents made after the effective date of this Section are included in these procedures. Copies of Sections III-C and G are available at the State Board office and from the Arizona Auditor General.
3. A compilation of resources required to implement accounting responsibility, including personnel, training and equipment, and a comprehensive analysis of the budgetary implications of accounting responsibility for the school district and the county treasurer.

Historical Note

Adopted effective February 4, 1988 (Supp. 88-1). The word "rule" has been updated to "Section" to reflect current standards in Chapter style and format (Supp. 21-2).

ARTICLE 10. SCHOOL DISTRICT PROCUREMENT**PART I. IN GENERAL****R7-2-1001. Definitions**

In Articles 10 and 11, unless the context otherwise requires:

1. "Acceptance period" means the period of time specified in the solicitation that a bid or proposal is irrevocable, except as specified in R7-2-1030.
2. "Actual energy production" means the actual amount of energy that flows from the energy production measure on an annual basis as measured by a meter in kilowatt hours alternating current.
3. "Advantageous to the school district" means in the best interest of the school district, but does not necessarily mean lowest bid/cost.
4. "Affiliate" means any person whose governing instruments require it to be bound by the decision of another person or whose governing board includes enough voting representatives of the other person to cause or prevent action, whether or not the power is exercised. It also may include persons doing business under a variety of names, or where there is a parent-subsidiary relationship between persons.
5. "Alternative project delivery methods for construction" means construction-manager-at-risk, design-build, and job-order-contracting construction services.
6. "Architect services," "engineer services," "land surveying services," "geologist services" and "landscape architect services" mean those professional services within the scope of the practice of those services as provided in A.R.S. Title 32, Chapter 1, Article 1.
7. "Award" means a determination by the school district that it is entering into a contract with one or more bidders or offerors.
8. "Bid" means a response to an invitation for bids and includes an offer to contract with the school district.
9. "Bidder" means a person submitting a bid in response to an invitation for bids.
10. "Brand name or equal specification" means a written description that uses one or more manufacturers' names or catalog numbers to describe the standard of quality, performance, and other characteristics needed to meet the school district's requirements, and that provides for the submission of equivalent products.
11. "Brand name specification" means a written description limited to one or more items by manufacturers' names or catalog numbers.
12. "Business" means any corporation, partnership, individual, sole proprietorship, joint stock company, joint venture or any other private legal entity.
13. "Change order" means a written order that is approved by the governing board and that directs the contractor to make changes that the changes clause of the contract authorizes the governing board to order.
14. "Clergy" means a minister of a religion.
15. "Coefficient" means the contractor's price adjustment to the unit price in a job order contract. Several coefficients may apply to the unit price book.
16. Construction:
 - a. Means the process of building, altering, repairing, improving or demolishing any school district structure or building, or other public improvements of any kind to any public real property.
 - b. Construction does not include:
 - i. The routine operation, routine repair or routine maintenance of existing facilities, structures, buildings or real property.
 - ii. The investigation, characterization, restoration or remediation due to an environmental issue of existing facilities, structures, buildings or real property.
17. "Construction-manager-at-risk" means a project delivery method in which:
 - a. There is a separate contract for design services and a separate contract for construction services, except that instead of a single contract for construction services, the school district may elect separate contracts for preconstruction services during the design phase, for construction during the construction phase and for any other construction services.
 - b. The contract for construction services may be entered into at the same time as the contract for design services or at a later time.
 - c. Design and construction of the project may be either:
 - i. Sequential with the entire design complete before construction commences.
 - ii. Concurrent with the design produced in two or more phases and construction of some phases commencing before the entire design is complete.
 - d. Finance services, maintenance services, operations services, preconstruction services and other related services may be included.
18. "Construction services" means either of the following for construction-manager-at-risk, design-build and job-order-contracting project delivery methods:
 - a. Construction, excluding services, through the construction-manager-at-risk or job-order-contracting project delivery methods.
 - b. A combination of construction and, as elected by the school district, one or more related services, such as finance services, maintenance services, operations services, design services and preconstruction services, as those services are authorized in the definitions of construction-manager-at-risk, design-build or job-order-contracting in this Section.
19. "Contract" means all types of agreements, including purchase orders, regardless of what they may be called, for the procurement of materials, services, construction or construction services, or the disposal of materials.

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20. "Contract modification" means any written alteration in the terms and conditions of any contract accomplished by mutual action of the parties to the contract.
21. "Contractor" means any person who has a contract with a school district.
22. "Cooperative purchasing" means procurement conducted by, or on behalf of, more than one public procurement unit.
23. "Cost" means the aggregate cost of all materials and services, including labor performed by school district employees.
24. "Cost data" means information concerning the actual or estimated cost of labor, material, overhead and other cost elements that have been actually incurred or that are expected to be incurred by the offeror or contractor in performing the contract.
25. "Cost-plus-a-percentage-of-cost contract" means a contract that, prior to completion of the work, the parties agree that the fee will be a predetermined percentage of the cost of the work.
26. "Data" means documented information, regardless of form or characteristic.
27. "Days" means calendar days and shall be computed pursuant to A.R.S. § 1-243.
28. "Defective data" means data that is inaccurate, incomplete or outdated.
29. "Dentist" means a person licensed pursuant to A.R.S. Title 32, Chapter 11.
30. "Descriptive literature" means information available in the ordinary course of business that shows the characteristics, construction or operation of an item offered in a bid or proposal.
31. "Design-bid-build" means a project delivery method in which:
 - a. There is a sequential award of two separate contracts.
 - b. The first contract is for design services.
 - c. The second contract is for construction.
 - d. Design and construction of the project are in sequential phases.
 - e. Finance services, maintenance services and operations services are not included.
32. "Design-build" means a project delivery method in which:
 - a. There is a single contract for design services and construction services, except that instead of a single contract for design services and construction services, the school district may elect separate contracts for preconstruction services and design services during the design phase, for construction and design services during the construction phase and for any other construction services.
 - b. Design and construction of the project may be either:
 - i. Sequential with the entire design complete before construction commences.
 - ii. Concurrent with the design produced in two or more phases and construction of some phases commencing before the entire design is complete.
 - c. Finance services, maintenance services, operations services, preconstruction services and other related services may be included.
33. "Design professional" means an individual or firm that is registered by the state board of technical registration pursuant to A.R.S. Title 32, Chapter 1 to practice architecture, engineering, geology, landscape architecture or land surveying or any combination of those professions and any person employed by the registered individual or firm.
34. "Design professional service contract" means a written agreement relating to the planning, design, construction administration, study, evaluation, consulting, inspection, surveying, mapping, material sampling, testing or other professional, scientific or technical services furnished in connection with any actual or proposed study, planning, survey, environmental remediation, construction, improvement, alteration, repair, maintenance, relocation, moving, demolition or excavation of a structure, street or roadway, appurtenance, facility or development or other improvement to land.
35. "Design professional services" means architect services, engineer services, land surveying services, geologist services or landscape architect services or any combination of those services performed by or under the supervision of a design professional or an employee or subconsultant of the design professional.
36. "Design requirements" means at a minimum:
 - a. The school district's written description of the project or service to be procured, including:
 - i. The required features, functions, characteristics, qualities and properties.
 - ii. The anticipated schedule, including start, duration and completion.
 - iii. The estimated budgets applicable to the specific procurement for design and construction and, if applicable, for operation and maintenance.
 - b. May include:
 - i. Drawings and other documents illustrating the scale and relationship of the features, functions and characteristics of the project, which shall all be prepared by a design professional who is registered pursuant to A.R.S. § 32-121.
 - ii. Additional design information or documents that the school district elects to include.
37. "Design services" means architect services, engineer services or landscape architect services.
38. "Designee" means the governing board member or school district employee who has been delegated procurement authority by the governing board as specified by board action.
39. "Detailed record" means minutes, that shall include the date, time, place, persons in attendance and a summary of what was said by whom and the decisions made. The minutes may be made either in writing or by a recording.
40. "Discussions" means an exchange or series of exchanges between the school district and a person who has submitted an unpriced technical offer or a proposal, resulting in an opportunity for the person to revise the unpriced technical offer or proposal prior to final evaluation by the school district.
41. "District representative" means a district employee or the governing board acting within the limits of the district representative's authority. There may be more than one appointed for different purposes and different procurements.

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42. "Earth-moving, material-handling, road maintenance and construction equipment" means a track-type tractor, motor grader, excavator, landfill compactor, wheel tractor scraper, off-highway truck, wheel loader or track loader, having a published manufacturer's minimum unit list price of \$50,000 or more and a minimum expected life cycle of three years.
43. "Effective utility rate" means the average price per kilowatt hour that a school district paid to its utility provider for electricity service to the facility that is the subject of the guaranteed energy production contract over the previous twelve months.
44. "Eligible procurement unit" means a public procurement unit, a nonprofit corporation, or an external procurement activity.
45. "Employee" means an individual drawing a salary from a school district and any noncompensated individual performing personal services for any school district.
46. "Energy baseline" means a calculation of the amount of energy used in an existing facility before the installation or implementation of the energy cost savings measures.
47. "Energy cost savings" means one or both of the following:
 - a. An estimated reduction in net fuel costs, energy costs, water costs, stormwater fees or other utility costs, or related net operating costs, including costs for anticipated equipment replacement and repair, from or as compared to an established baseline of those costs.
 - b. An estimated revenue increase associated with additional facility use or the use of improved meters or other measuring devices due to improvements included in the guaranteed energy cost savings contract.
48. "Energy cost savings measure" means a training program or facility alteration designed to reduce energy consumption, which may include one or more of the measures authorized in A.R.S. § 15-213.01, and any related meters or other measuring devices.
49. "Energy production measure" means renewable and alternative energy projects or renewable energy power service agreements.
50. "Established catalog price" means the price included in a catalog, price list, schedule or other form that:
 - a. Is regularly maintained by a manufacturer, distributor or contractor.
 - b. Is either published or otherwise available for inspection by customers.
 - c. States prices at which sales are currently or were last made to a significant number of any category of buyers or buyers constituting the general buying public for the materials or services involved.
51. "Excess materials" means any materials which have a remaining useful life but which are no longer required by the using school district in possession of the materials.
52. "External procurement activity" means any buying organization not located in this state that would qualify as a public procurement unit.
53. "Fair market value" means the price at which sales have been consummated for materials of like type, quality, and quantity in a particular market at the time of acquisition.
54. "Filed" means delivery to the district representative, school district or its hearing officer, whichever is applicable. A time/date stamp affixed to a document by the school district shall be determinative of the time or delivery for purposes of filing.
55. "Finance services" means financing for a construction services project.
56. "General Services Administration contract" means contracts awarded by the United States government General Services Administration.
57. "Gift or benefit" means a payment, distribution, expenditure, advance, deposit or donation of monies, any intangible personal property or any kind of tangible personal or real property that is not of nominal value such as a greeting card, t-shirt, mug or pen. Gift or benefit does not include either:
 - a. Food or beverage.
 - b. Expenses or sponsorships relating to a special event or function to which individuals involved in procurement and purchasing are invited.
58. "Governing board" has the meaning defined in A.R.S. § 15-101.
59. "Governing instruments" means legal documents that establish the existence of an organization and define its powers, including articles of incorporation or association, constitution, charter, by-laws, or similar documents.
60. "Guaranteed energy cost savings contract" means a contract for implementing one or more energy cost savings measures.
61. "Guaranteed energy price" means the agreed on price to be charged to the school district for each kilowatt hour alternating current of actual energy production as such may change on an annual basis as set forth in the guaranteed energy production contract.
62. "Guaranteed energy production" means the amount of energy, measured in kilowatt hours alternating current, that the qualified provider guarantees for each year of the guaranteed energy production contract.
63. "Guaranteed energy production contract" means a contract for implementing one or more energy production measures between one or more qualified providers and a school district.
64. "Guaranteed energy production shortfall" means the amount, if any, that the actual energy production is less than the guaranteed energy production in any given year.
65. "Incremental award" means an award of portions of a definite quantity requirement to more than one contractor. Each portion is for a definite quantity and the sum of the portions is the total definite quantity required.
66. "Interested party" means an actual or prospective bidder or offeror whose economic interest may be affected substantially and directly by the issuance of a solicitation, the award of a contract or by the failure to award a contract. Whether an actual or prospective bidder or offeror has an economic interest will depend upon the circumstances of each case.
67. "Internet" means the international computer network of both federal and nonfederal interoperable packet switched data networks, including the graphical subnetwork called the world wide web.
68. "Invitation for bids" means all documents, whether attached or incorporated by reference, which are used for soliciting bids in accordance with the procedures prescribed in R7-2-1024.
69. "In writing" has the same meaning as "written" or "writing" in A.R.S. § 47-1201, which includes printing, type-

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- writing, electronic transmission, facsimile, or any other intentional reduction to tangible form.
70. "Job-order-contracting" means a project delivery method in which:
 - a. The contract is a requirements contract for indefinite quantities of construction.
 - b. The construction to be performed is specified in job orders issued during the contract.
 - c. Finance services, maintenance services, operations services, preconstruction services, design services and other related services may be included.
 71. "Legal counsel" means a person licensed as an attorney by the Arizona Supreme Court.
 72. "Life cycle" means the useful life of the earth-moving, material-handling, road maintenance and construction equipment to the original using school district.
 73. "Local public procurement unit" means any political subdivision, any agency, board, department or other instrumentality of such political subdivision, and any nonprofit corporation created solely for the purpose of administering a cooperative purchase under Articles 10 and 11.
 74. "Maintenance services" means routine maintenance, repair and replacement of existing facilities, structures, buildings or real property.
 75. "Materials" means all property, including equipment, supplies, printing, insurance and leases of property, but does not include land, a permanent interest in land or real property or leasing space.
 76. "May" denotes the permissive.
 77. "Minor" means mistakes, excluding judgmental errors, that have negligible effect on price, quantity, quality, delivery or other contractual terms and the waiver or correction of such mistake does not prejudice other bidders or offerors.
 78. "Multiple award" means award of multiple contracts for identical or similar materials or services to more than one bidder or offeror.
 79. "Multistep sealed bidding" means a 2-phase process consisting of a technical first phase composed of one or more steps in which bidders submit unpriced technical offers to be evaluated by the school district and a second phase in which those bidders whose technical offers are determined to be acceptable during the first phase have their price bids considered.
 80. "Negotiation" means an exchange or series of exchanges between the school district and a person with a goal of establishing the terms, conditions and prices in a contract between the school district and the person, where such negotiation is authorized in Articles 10 and 11.
 81. "Nonexpendable materials" means all tangible materials which have an original acquisition cost over an amount set by regulation and a probable useful life of more than one year.
 82. "Nonprofit corporation" means any nonprofit corporation as designated by the Internal Revenue Service under section 501(c)(3) through 501(c)(6) or under section 115, if created by two or more local public procurement units, and includes certified nonprofit agencies that serve individuals with disabilities as defined in A.R.S. § 41-2636.
 83. "Offeror" means a person submitting a proposal in response to a request for proposals.
 84. "Operations services" means routine operation of existing facilities, structures, buildings or real property.
 85. "Outright purchase" means the initial cost to the school district for the earth-moving, material-handling, road maintenance and construction equipment, including all vendor charges and financing costs.
 86. "Owner" means the school district.
 87. "Paper" means newspaper, high-grade office paper, fine paper, bond paper, offset paper, xerographic paper, duplicator paper and related types of cellulosic material containing not more than ten percent by weight or volume of noncellulosic material such as laminates, binders, coatings or saturants.
 88. "Paper product" means paper items or commodities, including paper napkins, towels, corrugated paper and related types of cellulosic products containing not more than ten percent by weight or volume of noncellulosic material such as laminates, binders, coatings or saturates.
 89. "Person" means any corporation, business, individual, union, committee, club, other organization or group of individuals.
 90. "Physician" means a person licensed pursuant to A.R.S. Title 32, Chapters 7, 8, 13, 14, 15.1, 16, or 17.
 91. "Post-consumer material" means a discard generated by a business or residence that has fulfilled its useful life. Post-consumer material does not include discards from industrial or manufacturing processes.
 92. "Posted prices" means the sale price determined by the school district to be fair market value.
 93. "Preconstruction services" means services and other activities during the design phase.
 94. "Pricing data" means information concerning prices, including profit, for materials, services or construction substantially similar to those being procured under a contract or subcontract. In this definition, "prices" refers to offered selling prices, historical selling prices or current selling prices of the items being purchased.
 95. "Prime contractor" means a general contractor, who contracts with a property owner and, in turn, employs a subcontractor, or subcontractors, to perform some or all of the work.
 96. "Procurement" means buying, purchasing, renting, leasing or otherwise acquiring any materials, services, construction or construction services. Procurement also includes all functions that pertain to the obtaining of any material, service, construction, or construction services, including description of requirements, selection and solicitation of sources, preparation and award of contract, and all phases of contract administration.
 97. "Procurement file" means the official procurement records of the school district containing the following:
 - a. List of notified vendors.
 - b. Procurement disclosure statements.
 - c. Final solicitation.
 - d. Solicitation amendments.
 - e. Bids and offers.
 - f. Offer revisions and best and final offers.
 - g. Discussions.
 - h. Clarifications.
 - i. Final evaluation reports.
 - j. Additional information, as necessary.
 98. "Proposal" means a response to a request for proposals and includes an offer to contract with the school district.
 99. "Proprietary specification" means a specification that describes a material made and marketed by a person having the exclusive right to manufacture and sell such mate-

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- rial and excludes other material with similar quality, performance or functional characteristics from being responsive to the solicitation.
100. "Public procurement unit" means either a local public procurement unit, the Arizona Department of Administration, any other state or an agency of the United States.
101. "Public service corporation" means all corporations other than municipal engaged in furnishing gas, electricity, or water and subject to regulation as a utility by the Arizona Corporation Commission.
102. "Purchase description" means the words used in a solicitation to describe the materials, services or construction for purchase and includes specifications attached to, or made a part of, the solicitation.
103. "Purchase requisition" means that document, or electronic transmission, whereby a school district requests that a contract be entered into for a specific need, and may include, but is not limited to, the description of the requested item, delivery schedule, transportation data, criteria for evaluation, suggested source of supply and information supplied for the making of any written determination required by Articles 10 and 11.
104. "Qualified products list" means an approved list of materials or construction items described by model or catalog numbers that, prior to competitive solicitation, the governing board has determined will meet the applicable specification requirement.
105. "Qualified select bidders list" means a selection process for establishing a list of best-qualified prime contractors or construction material suppliers for a specific, single project. The selection process is based upon listed evaluation criteria and conducted through a request for qualifications. Once the selection process is complete, the qualified bidders are invited to submit a sealed competitive bid based upon architectural/engineering plans and specifications or material specifications.
106. "Reasonably susceptible of being awarded a contract" means those proposals that the school district determines are subject to award after the initial review of all original proposals.
107. "Recycled paper" means paper products which have been manufactured from materials otherwise destined for the waste stream and which contain at least forty percent recovered wastepaper with ten percent of that being post-consumer material.
108. "Regional award" means an award of portions of the total requirement by geographic region.
109. "Request for information" means all documents issued to vendors for the sole purpose of seeking information about the availability in the commercial marketplace of materials or services.
110. "Request for proposals" means all documents, whether attached or incorporated by reference, which are used for soliciting proposals in accordance with procedures prescribed in R7-2-1042.
111. "Request for qualifications" means all documents, whether attached or incorporated by reference, which are used for soliciting statements of qualifications in accordance with procedures prescribed in R7-2-1101, R7-2-1106, R7-2-1108 or R7-2-1117.
112. "Residual value" means the guaranteed minimum market value of the earth-moving, material-handling, road maintenance and construction equipment at the end of the life cycle of the equipment being procured, as determined by a guaranteed minimum value offered by the vendor or other parties in its bid.
113. "Responsible bidder or offeror" means a person who at the time of contract award has the capability to perform the contract requirements and the integrity and reliability which will assure good faith performance.
114. "Responsive bidder or offeror" means a person who submits a bid or proposal which conforms in all material respects to the invitation for bids or request for proposals.
115. "Reverse auction" means a procurement method in which bidders are invited to bid on supplying specified materials over the Internet in a real-time competitive bidding event.
116. "School district" has the meaning defined in A.R.S. § 15-101, whose authority is exercised by the governing board or its designee.
117. "Services" means the furnishing of labor, time or effort by a contractor or subcontractor that does not involve the delivery of a specific end product other than required reports and performance. Services does not include employment agreements or collective bargaining agreements.
118. "Shall" denotes the imperative.
119. "Solicitation" means an invitation for bids, an invitation to submit technical offers, a request for proposals, a request for qualification, or any other invitation or request by which the school district invites a person to participate in a procurement.
120. "Specification" means any description of the physical or functional characteristics, or of the nature of a material, service or construction item. Specification may include a description of any requirement for inspecting, testing or preparing a material, service or construction item for delivery.
121. "Specified professional services" means services of an architect, engineer, land surveyor, assayer, geologist and landscape architect and any combination of those services.
122. "Standard commercial material" means material that, in the normal course of business, is customarily maintained in stock or readily available by a manufacturer, distributor or dealer for the marketing of such material.
123. "Statement of qualifications" means a response to a request for qualifications issued pursuant to R7-2-1101, R7-2-1106, R7-2-1108 or R7-2-1117, or unsolicited qualifications submitted pursuant to R7-2-1062 or R7-2-1122, and does not include an offer to contract with the school district.
124. "Subcontractor" means a person who contracts to perform work or render service to a contractor or to another subcontractor as a part of a contract with a school district.
125. "Subconsultant" means any person, firm, partnership, corporation, association or other organization or a combination of any of them, that has a direct contract with a design professional or another subconsultant to perform a portion of the work under a design professional service contract.
126. "Surplus materials" means any materials that no longer have any use to the school district or materials acquired from the United States government. This includes obsolete materials, scrap materials and nonexpendable materials that have completed their useful life.
127. "Suspension" means an action taken by the governing board under R7-2-1168 temporarily disqualifying a person from participating in school district procurements.

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128. "Technical offer" means unpriced written information from a prospective contractor stating the manner in which the prospective contractor intends to perform certain work, its qualifications and its terms and conditions.
129. "Total life cycle cost" means total school district costs and financing costs throughout the life cycle of the earth-moving, material-handling, road maintenance and construction equipment being purchased less residual value.
130. "Total school district costs" means costs to the school district for the earth-moving, material-handling, road maintenance and construction equipment, including repair costs, present value of monies, vendor charges, and all other identifiable school district costs that may be incurred.
131. "Unit price" means the price published in the unit price book for a specific construction or construction related task. Each unit price is comprised of labor, equipment, or material costs to accomplish a specific task, and shall be defined in the contract.
132. "Unit price book" means a comprehensive listing of specific construction related tasks together with a specific unit of measurement and a unit price.
133. "Vendor charges" means the costs of all vendor support, materials, transportation, and all other identifiable costs associated with the vendor's proposal or bid.
134. "Vendor support" means services provided by the vendor for items such as consulting, education and training.
135. "Wastepaper" means recyclable paper and paperboard, including high-grade office paper, computer paper, fine paper, bond paper, offset paper, xerographic paper, duplicator paper and corrugated paper.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
 Amended effective March 21, 1991 (Supp. 91-1).
 Amended effective October 22, 1992 (Supp. 92-4).
 Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1). Amended by final exempt rulemaking at 27 A.A.R. 2342, (October 22, 2021) effective September 27, 2021 (Supp. 21-4).

R7-2-1002. Applicability

- A. Articles 10 and 11 apply to every expenditure of public monies, including federal assistance monies and grants, by a school district as specified in A.R.S. § 15-213(A) for the procurement of all construction, materials and services when the total procurement cost exceeds the aggregate dollar amount specified in A.R.S. § 41-2535(A). If procurement involves the expenditure of federal assistance or contract monies, the school district shall comply with federal law and authorized regulations which are mandatorily applicable and which are not presently reflected in Articles 10 and 11.
- B. Articles 10 and 11 apply to the disposal of school district materials regardless of value.
- C. Articles 10 and 11 do not apply to:
 1. Agreements for providing career and technological education and vocational education pursuant to A.R.S. § 15-789;
 2. Contracts between a school district and other governments, including intergovernmental agreements and contracts pursuant to A.R.S. § 11-952, except as provided by R7-2-1191 through R7-2-1196. This exemption also

includes the purchase of a fee or license from a local, state or federal public entity required by law to collect said fees;

3. Purchases for amounts not exceeding the aggregate dollar amount specified in A.R.S. § 41-2535(A). Such procurements shall comply with the guidelines prescribed by the Auditor General in the Uniform System of Financial Records pursuant to A.R.S. § 15-271;
 4. Contracts for professional witnesses if the purpose of such contracts is to provide for professional services or testimony relating to an existing or probable judicial or administrative proceeding in which the school district is or may become a party;
 5. Agreements negotiated by legal counsel representing the school district in settlement of litigation or threatened litigation;
 6. Expenditures from student activity monies as defined in A.R.S. § 15-1121, if no district funds are involved;
 7. Expenditures for governing board adopted textbooks as defined in A.R.S. § 15-721 and A.R.S. § 15-722, if purchased from the publisher;
 8. The placement of a pupil in a private school that provides special education services if such placement is prescribed in the pupil's individualized education program and the private school has been approved by the Department of Education Division of Special Education pursuant to A.R.S. § 15-765;
 9. Purchases of any products, materials and services directly from certified nonprofit agencies that serve individuals with disabilities as defined in A.R.S. § 41-2636, and Arizona Correctional Industries if the delivery and quality of the products, materials or services meet the school district's reasonable requirements;
 10. The decision to participate in programs pursuant to A.R.S. § 15-382. A program authorized by A.R.S. § 15-382 is not required to engage in competitive bidding for the services necessary to administer the program or for the purchase of insurance or reinsurance;
 11. The purchase of water, gas or electric utilities from a public service corporation. This exemption expressly does not apply to guaranteed energy cost savings contracts and guaranteed energy production contracts subject to A.R.S. § 15-213.01 and A.R.S. § 15-213.03;
 12. Purchases of professional certifications, professional memberships, conference registrations, conference hotels and airfare that meets Arizona Department of Administration General Travel Principles and Policies;
 13. Purchases, sales or leases of real estate. This exemption expressly does not apply to the services of a real estate broker as defined in A.R.S. § 32-2101;
 14. Purchases of surplus property from the state or United States Federal Government in accordance with R7-2-1132;
 15. Purchases in compliance with the terms and conditions of any grant, gift, bequest or cooperative agreement; and
 16. The cost of special elections, including the preparation of ballots in accordance with A.R.S. § 15-406.
- D. Unless displaced by the particular provisions of Articles 10 and 11, the principles of law and equity, including the Uniform Commercial Code of this state, the common law of contracts as applied in this state and law relative to agency, fraud, misrepresentation, duress, coercion, and mistake supplement the provisions of Articles 10 and 11.

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Adopted effective December 17, 1987 (Supp. 87-4).
 Amended effective March 21, 1991 (Supp. 91-1).
 Amended effective March 6, 1997 (Supp. 97-1).
 Amended effective December 4, 1998 (Supp. 98-4).
 Amended by final exempt rulemaking at 21 A.A.R. 1491, effective October 28, 2013 (Supp. 15-3). Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1003. General Provisions

- A. The school district shall not award a contract or incur an obligation on behalf of the school district unless it is reasonable to believe sufficient funds will be available for the procurement. If sufficient funds are not available when a solicitation is issued, the solicitation shall include a statement that funds are not currently available and that any contract awarded will be conditioned upon the availability of funds.
- B. Projects and purchases shall not be divided or sequenced into separate projects or purchases in order to avoid the limits prescribed in Articles 10 and 11.
- C. Any bid or proposal that is conditioned upon award to the bidder or offeror of both the particular contract being solicited and another school district contract shall be deemed nonresponsive or unacceptable.
- D. Except by mutual consent of the parties to the contract, rules in Articles 10 and 11 shall not change any commitment, right or obligation of a school district or of a contractor under a contract in existence on the effective date of the Section.
- E. If a contractor requests to change the name in which it holds a school district contract, the school district may, upon receipt of a document indicating the name change, enter into a contract modification with the contractor to effect the name change. The contract modification shall provide that no other terms and conditions of the contract are changed.
- F. The school district may allow electronic media transactions, including an electronic record or electronic signature, if consistent with state law and advantageous to the school district.
- G. Rights and duties arising from a school district contract may only be transferred, waived or assigned upon the express written consent of both parties.
- H. School district employees and public officers shall not purchase construction, materials or services for their own personal or business use from contracts entered into by the school district.
- I. A person who supervises or participates in contracts, purchases, payments, claims or other financial transactions, or who supervises or participates in the planning, recommending, selecting or contracting for materials, services, goods, construction, or construction services of a school district or school purchasing cooperative is subject to the penalties prescribed in A.R.S. § 15-213(N) if the person solicits, accepts or agrees to accept any personal gift or benefit from a person or vendor that has secured or has taken steps to secure a contract, purchase, payment, claim or financial transaction with a school district or school purchasing cooperative.
- J. Any person or vendor that has secured or has taken steps to secure a contract, purchase, payment, claim or financial transaction with a school district or school purchasing cooperative that offers, confers or agrees to confer any personal gift or benefit on a person who supervises or participates in contracts, purchases, payments, claims or other financial transactions, or on a person who supervises or participates in planning, recom-

mending, selecting or contracting for materials, services, goods, construction or construction services of a school district or school purchasing cooperative is subject to the penalties prescribed in A.R.S. § 15-213(O).

- K. A person who serves on an evaluation committee for a procurement is subject to A.R.S. § 41-2616(C).
- L. A person who contracts for or purchases materials, services, goods, construction or construction services shall be subject to the penalties prescribed in A.R.S. § 15-213 and A.R.S. § 41-2616 for violations of and attempts to avoid Articles 10 and 11.
- M. Pursuant to A.R.S. § 15-213 and A.R.S. Title 41, Chapter 23, the Attorney General shall enforce the provisions of Articles 10 and 11 and may take action prescribed therein.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
 Amended effective March 21, 1991 (Supp. 91-1).
 Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 24 A.A.R. 3283, effective October 22, 2018 (Supp. 18-4). Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1). The word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-1004. Written Determinations

- A. Written determinations required by Articles 10 and 11, including for any specified professional services, construction, construction services or materials to an entity selected from a qualified select bidders list or through a school purchasing cooperative, shall specify the reasons for the determination, including how the determination was made.
- B. The school district is authorized to prescribe methods and operational procedures to be used in preparing written determinations.
- C. The school district shall place the written determination into the school district's procurement file.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
 Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 24 A.A.R. 3283, effective October 22, 2018 (Supp. 18-4).

R7-2-1005. Change orders and contract modifications

Any change order or contract modification that exceeds \$100,000 or five percent, whichever is greater, may be executed only if the governing board determines in writing that the change order or contract modification is advantageous to the school district and the price is determined to be fair and reasonable.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1006. Confidential Information

- A. If a person believes that a bid, proposal, response to a request for information, technical offer, statement of qualifications, specification, or protest contains confidential trade secrets or other proprietary data not to be disclosed as otherwise required by A.R.S. § 39-121, a statement advising the school district of

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this fact shall accompany the submission and the information shall be so identified wherever it appears. Contract terms and conditions, pricing, and information generally available to the public are not considered confidential information under this Section.

- B. Until a determination is made under subsection (C), the school district shall not disclose information designated as confidential under subsection (A) except to school district personnel having a legitimate interest in, or persons assisting the school district in evaluation of, the bid, proposal, response to a request for information, technical offer, statement of qualifications, specification, or protest.
- C. Upon receipt of a submission designating information as confidential, the school district shall make one of the following written determinations:
 - 1. The designated information is confidential and the school district shall not disclose the information except to school district personnel having a legitimate interest in, or persons assisting the school district in evaluation of, the bid, proposal, response to a request for information, technical offer, statement of qualifications, specification, or protest.
 - 2. The designated information is not confidential.
- D. The school district may request additional information, if necessary to make the determination required by subsection (C).
- E. If the school district determines that information submitted is not confidential, the person who made the submission shall be notified in writing. The notice shall specify that a request for review of the district representative's determination may be filed within 10 days of the date of the district representative's determination.
- F. A request for review of the district representative's determination shall be filed in writing with the district representative. The request for review shall state the precise legal or factual errors in the district representative's decision. If a request for review is received:
 - 1. The district representative shall consider the alleged legal or factual errors in the request for review of the district representative's determination and issue a final written determination to the person filing the request.
 - 2. Until the final determination is made under subsection (C)(2), the school district shall not disclose information designated as confidential under subsection (A) except to school district personnel having a legitimate interest in, or persons assisting the school district in evaluation of, the bid, proposal, response to a request for information, technical offer, statement of qualifications, specification, or protest.
- G. The school district may release information determined to not be confidential under subsection (C)(2) if:
 - 1. A request for review is not received by the district representative within the time period specified in the notice; or
 - 2. The district representative issues a final written determination under subsection (F)(1) that the designated information is not confidential.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended effective March 21, 1991 (Supp. 91-1). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1007. Delegation of Procurement Authority

- A. The governing board may, in a public meeting held in conformity with A.R.S. Title 38, Chapter 3, Article 3.1, delegate pro-

curement authority to a designee. Any delegation shall be accomplished by adopting a governing board policy for this purpose.

- 1. Delegated procurement authority may include, but is not limited to the following:
 - a. Authority to make determinations required by Articles 10 and 11;
 - b. Authority to award contracts;
 - c. Authority to make sole source and emergency procurements; and
 - d. Authority to approve change orders and contract modifications.
- 2. Delegated activities and functions shall be adequately separated among individuals so that one individual does not have complete authority over an entire procurement.
- B. Any delegation shall specify:
 - 1. The title of the school district employee or employees to whom authority is delegated;
 - 2. The activity or function authorized;
 - 3. Any limits or restrictions on the exercise of the delegated authority, including the maximum cost of any procurement;
 - 4. Whether the authority may be further delegated;
 - 5. The duration of the delegation; and
 - 6. The conditions and procedures for revocation and modification of the delegation.
- C. No person delegated such authority may participate in any aspect of a specific procurement if the person would receive any benefit directly or indirectly from a contract for such procurement. Violation of this prohibition may result in termination or other disciplinary action.
- D. Delegation of procurement authority does not abrogate the responsibility of the governing board to ensure compliance with Articles 10 and 11 notwithstanding the fact that school district personnel were authorized to make procurement decisions.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1008. Procurement Consultants and Procurement Advisory Groups

- A. The school district may contract with a procurement consultant to assist in drafting specifications, in the development of solicitations, or in the management of the procurement process. A procurement consultant may provide guidance or advice to a procurement evaluation committee, but shall not serve as a voting member of such committee. For the purposes of this Section, a school district employee or a contracted business manager or purchasing director for the school district is not a procurement consultant.
- B. The school district may appoint procurement advisory groups or evaluation committees to assist with respect to specifications, solicitation evaluations or procurement in specific areas. Members of such procurement advisory groups or evaluation committees are not procurement consultants as set forth in this Section. Non-school district employees serving on such procurement advisory groups or evaluation committees are not eligible to receive compensation but are eligible for reimbursement of expenses consistent with the school district's travel policy adopted pursuant to A.R.S. § 15-342(5).

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- C. A procurement consultant, a member of a procurement advisory group, or a member of an evaluation committee who participates in any aspect of a specific procurement shall be prohibited from receiving any benefit directly or indirectly from a contract for such procurement, and shall sign a procurement disclosure statement that the person has no interest in the procurement other than that of a disclosed remote interest, as defined in A.R.S. § 38-502, will have no contact with any representative of a competing vendor related to the particular procurement except those contacts specifically authorized by these rules, and has not accepted any personal gift or benefit from a person or vendor that has secured or has taken steps to secure a contract, purchase, payment, claim or financial transaction with the school district or school purchasing cooperative. The procurement disclosure statements shall be retained in the procurement file.
- D. Specifications prepared by a procurement consultant or a procurement advisory group shall comply with R7-2-1010 through R7-2-1016.
- E. The school district shall not delegate to a procurement consultant, a procurement advisory group, or an evaluation committee the authority for the award or administration of any particular contract, or over any dispute, claim or litigation pertaining thereto, and a procurement consultant or a procurement advisory group shall not be authorized to obligate the school district in any manner.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1009. Repealed**Historical Note**

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

PART II. SPECIFICATIONS**R7-2-1010. Preparation of Specifications**

- A. Specifications shall be prepared only by the school district or by contract pursuant to R7-2-1014 and R7-2-1015. Regardless of who prepares the specifications, the governing board retains the authority to disapprove all specifications.
- B. In an emergency under R7-2-1055, any necessary specifications may be utilized by the person designated in R7-2-1055 (C) without regard to the provisions of this Section.
- C. Content of specifications.
1. A specification may provide alternate descriptions of materials, services, or construction items where two or more design, functional, or performance criteria will satisfactorily meet the school district's requirements.
 2. To the extent practicable, a specification shall not include any solicitation term or condition or any contract term or condition.
 3. If a specification for a common or general use item has been developed in accordance with R7-2-1011(A) or a qualified products list has been developed in accordance with R7-2-1011(D) for a particular material, service, or construction item, it shall be used unless the school district makes a written determination that its use is not

advantageous to the school district and that another specification shall be used.

4. To the extent practicable, specifications shall emphasize functional or performance criteria. To facilitate the use of such criteria, the school district shall use reasonable efforts to include the principle functional or performance requirements as a part of their purchase requisitions.
5. All procurement solicitations for volatile organic compound containing commodities shall include a request for substitute commodities with lower or no volatile organic content. Substitute products shall not have increased toxicity compared to the original commodity.

Historical Note

Adopted effective October 22, 1992 (Supp. 92-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1011. Types of Specifications

- A. Specification for common or general use items. To the extent practicable, a specification for common or general use item shall be prepared and utilized when:
1. A material, service or construction item is used repeatedly by the school district, and the characteristics of the material, service, or construction item, as commercially produced or provided, remain relatively stable while the frequency or volume of procurements is significant;
 2. The school district's recurring needs require uniquely designed or specially produced items; or
 3. The school district finds it to be advantageous to the school district.
- B. Brand name or equal specification. A brand name or equal specification may be used when the school district determines that use of a brand name or equal specification is advantageous to the school district.
- C. Brand name specification. A brand name specification may be prepared and utilized only if the school district makes a determination that only the identified brand name item will satisfy the school district's needs. If only one source can supply the requirement, the procurement shall be made pursuant to R7-2-1053.
- D. Qualified products list. A qualified products list may be prepared and utilized when:
1. The school district determines that testing or examination of the materials or construction items prior to issuance of the solicitation is desirable or necessary in order to best satisfy the school district's requirements.
 2. The school district shall solicit as many potential suppliers as practicable to submit products for testing and examination to determine acceptability for inclusion on a qualified products list. Any potential supplier, even though not solicited, may offer its products for consideration in accordance with the schedule or procedure established for this purpose. The qualified products list shall not be modified after the solicitation is issued.
 3. Inclusion on a qualified products list shall be based on results of tests or examinations conducted in accordance with requirements established by the school district.

Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1012. Proprietary Specifications

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The school district shall not use specifications in any way proprietary to one supplier unless the specification includes a statement of the reasons why no other specification is practicable, a description of the essential characteristics of the specified product and a statement specifically permitting an acceptable alternative product to be supplied.

Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1013. Recycled Products Use

- A. If the price of a recycled paper product that conforms to specifications is within five percent of a low bid product that is not recycled and the recycled product bidder is otherwise the lowest responsible and responsive bidder, the award shall be made to the bidder offering the recycled product. The governing board may adopt rules requiring a five percent preference for other products made from recycled materials.
- B. Specifications shall emphasize functional or performance criteria which, to the extent practicable, do not discriminate against the use of recycled materials.

Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1014. Maximum Practicable Competition

- A. Procurement of any materials, services, goods, construction or construction services pursuant to Article 10 or Article 11, shall seek to achieve maximum practicable competition.
- B. All specifications, including those prepared by architects, engineers, consultants and others for public contracts, shall seek to promote overall economy for the purposes intended and encourage competition in satisfying the school district's needs and shall not be unduly restrictive.
- C. Unless otherwise permitted by R7-2-1010 through R7-2-1016, all specifications shall describe the school district's requirements in a manner that does not unreasonably exclude a material, service, or construction item. Proprietary specifications shall be used only as provided in R7-2-1012.
- D. To the extent practicable, the school district shall use accepted commercial specifications and shall procure standard commercial materials.
- E. Contracts for the preparation of specifications by persons other than the school district shall require the specification writer to adhere to R7-2-1010 through R7-2-1016.

Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 24 A.A.R. 3283, effective October 22, 2018 (Supp. 18-4).

R7-2-1015. Conflict of Interest

- A. No person preparing specifications pursuant to R7-2-1014 shall receive any direct or indirect benefit from the utilization of such specifications.
- B. The governing board may contract for the preparation of specifications with persons, including, but not limited to, consultants, architects, engineers, designers, and other draftsmen of specifications.

- C. If a person prepares a specification pursuant to subsection (B) of this Section, such person shall comply with the requirements of R7-2-1010 through R7-2-1016.

Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1016. Confidentiality

- A. Specifications and any written determination or other document generated or used in the development of a specification shall be available for public inspection pursuant to A.R.S. § 39-121, except to the extent that the withholding of such information is permitted or required by law.
- B. If the supplier believes that the specifications contain confidential trade secrets, test data, or similar information, a statement advising the school district of this fact shall accompany the specification in accordance with R7-2-1006.
- C. Qualified products lists test results shall be made available in a manner to protect the identity of the supplier.

Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1017. Reserved

PART III. REVERSE AUCTIONS

R7-2-1018. Reverse Auctions

- A. Using reverse auctions
 - 1. If a governing board determines in writing that use of reverse auctions is more advantageous to the school district than other procurement methods prescribed by Articles 10 and 11, the school district may use reverse auctions for the purchase of materials.
 - 2. The written determination shall include, but is not limited to the following information:
 - a. An estimate of the number of prospective bidders;
 - b. An explanation of how reverse auctions will foster competition;
 - c. An explanation of why reverse auctions is more advantageous to the school district than other prescribed procurement methods; and
 - d. The scope and estimated total dollar value of the proposed procurement.
- B. Reverse auction procedures
 - 1. The school district shall develop and implement procedures prior to conducting procurement via reverse auctions. The procedures shall include:
 - a. The method or methods to ensure the integrity and security of the reverse auctions;
 - b. The method or methods for registering bidders for reverse auctions;
 - c. The method or methods for notifying vendors of reverse auction opportunities;
 - d. The method or methods for receiving reverse auction bids; and
 - e. The school district official or officials authorized to conduct reverse auctions.
 - 2. School districts may require bidders to register before the date and time for opening the reverse auction for submission of bids and, as part of that registration, require bidders to agree to any terms, conditions or other requirements of the invitation for bids.

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3. Notice of a reverse auction shall be issued at least 14 days before the date and time for opening the reverse auction for submission of bids, unless a shorter time is determined necessary by the school district. If a shorter time is necessary, the school district shall document the specific reasons in the procurement file. The reverse auction notice shall include:
 - a. The school district's requirements for registering prior to the opening date and time, if any;
 - b. The designated site on the Internet for bidder registration and bid submission;
 - c. A link to the designated site on the Internet;
 - d. The scheduled date and time for opening the reverse auction for bid submission; and
 - e. The scheduled date and time for closing the reverse auction for bid submission.
 4. The school district shall issue the notice of reverse auction as follows:
 - a. Mail or otherwise furnish the notice of reverse auctions to all prospective bidders registered with the school district for the specific material being solicited.
 - b. Notice of reverse auction shall be given by the school district pursuant to R7-2-1022.
 - c. In addition to the notice provided in subsections (B)(4)(a) and (b), the school district may give such additional notice as the school district deems appropriate, including posting on a designated site on the Internet.
 5. The school district shall prepare an invitation for bids that includes:
 - a. Notice that all information submitted by bidders will be made available for public inspection following the award of the contract, except for bid prices which will be made available to other bidders and the public when submitted by the bidder;
 - b. Information for submitting bids, including:
 - i. The date and time for opening the reverse auction for bid submission;
 - ii. The date and time for closing the reverse auction for bid submission;
 - iii. The provisions for extending the period for bid submission, if any;
 - iv. Instructions for submitting bids and other required information, including the designated site on the Internet for submitting bids;
 - v. Notice that bids shall be accepted electronically at the time and in the manner designated in the invitation for bids;
 - vi. Notice that bidders' prices shall be disclosed electronically to other bidders and the public on a real time basis;
 - vii. Notice that bidders may submit multiple prices and may reduce their bid prices until the reverse auction bidding is closed;
 - viii. Notice that the lowest price offered shall become the official bid price;
 - ix. Notice that the bidder is required to certify that submission of the bid did not involve collusion or other anticompetitive practices;
 - x. Notice that the bidder is required to declare whether the bidder has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity, including, but not limited to, being disapproved as a subcontractor of any public procurement unit or other governmental body;
 - c. The purchase description, specifications, delivery or performance schedule, and inspection and acceptance requirements, as applicable. If a brand name or equal specification is used, instructions that use of a brand name is for the purpose of describing the standard of quality, performance, and characteristics needed to meet the school district's requirements and is not intended to limit or restrict competition. The invitation for bids shall state that products substantially equivalent to the brands designated qualify for consideration;
 - d. The factors to be used in bid evaluations, including criteria to determine acceptability such as inspection, testing, quality, workmanship, delivery and suitability for a particular purpose. Only objectively measurable evaluation criteria shall be included in the invitation for bids. Examples of such criteria include, but are not limited to, transportation cost, energy cost, ownership cost and other identifiable costs. Evaluation factors need not be precise predictors, but to the extent possible the evaluation factors shall be reasonable estimates based upon information the school district has available concerning future use.
 - e. The contract terms and conditions, including:
 - i. Warranty and bonding or other security requirements, as applicable;
 - ii. The length of the contract and whether the contract will include an option for extension; and
 - iii. Any other contract terms and conditions;
 - f. The name of the district representative or district representatives;
 - g. The manner by which the bidder is required to acknowledge amendments;
 - h. The minimum required information in the bid;
 - i. The specific requirements for designating trade secrets and other proprietary data as confidential;
 - j. Any specific responsibility criteria;
 - k. A statement specifying where documents incorporated by reference may be obtained;
 - l. A statement that the school district may cancel the solicitation or reject a bid in whole or in part if deemed advantageous to the school district;
 - m. The date, time and location of bid opening;
 - n. A description of all information that will be recorded and available for public inspection at bid opening; and
 - o. Procurement of earth-moving, material-handling, road maintenance and construction equipment shall include as price evaluation criteria the total life cycle cost including residual value of the earth-moving, material-handling, road maintenance and construction equipment and, to the extent practicable, outright purchase.
6. Amendments to invitations for bids shall be made in accordance with R7-2-1026.
- C. The school district shall accept reverse auction bids as follows:
1. At the date and time for opening the reverse auction for bid submission, the school district shall begin accepting on-line bids and shall continue accepting bids until the reverse auction is officially closed.

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2. Bids shall be accepted electronically in the manner designated in the invitation for bids.
 3. All reverse auction on-line bids shall be posted electronically and updated on a real-time basis. Bidders' prices shall be disclosed to other bidders and the public.
 4. The identity of competing bidders shall not be disclosed until the reverse auction bidding is closed.
 5. Bidders shall have the opportunity to submit multiple prices and to reduce their bid prices.
 6. The lowest price offered shall become the official bid price.
- D.** Bids made through a reverse auction are considered to be opened when a computer generated record of the information contained in all bids that were received by the designated site on the Internet not later than the scheduled or final closing date and time are reviewed publicly by the school district in the presence of one or more witnesses at the time and place designated in the invitation for bids. Bid opening shall not be later than 24 hours after the scheduled or final closing date and time.
- E.** The contract shall be awarded to the lowest responsible and responsive bidder whose bid conforms in all material respects to the requirements and evaluation criteria set forth in the invitation for bids. No criteria may be used in bid evaluation that are not set forth in the invitation for bids. The amount of any applicable transaction privilege or use tax of a political subdivision of this state is not a factor in determining the lowest bidder.
- F.** The school district shall not modify evaluation criteria after the closing date and time.
- G.** In the event that multiple bidders submit identical prices for the same materials, bids will be considered in the order received with the first being considered to be the lowest bid.
- H.** If only one bid is received in response to an invitation for bids, the school district shall proceed according to R7-2-1032.
- I.** The date and time for closing a reverse auction for bid submission may be fixed or remain open depending on the materials being bid.
- J.** After the reverse auction bidding has closed, a bidder may withdraw a bid or correct a mistake in accordance with R7-2-1030. Withdrawal of bids shall also be permitted as provided in R7-2-1028.
- K.** The school district shall notify all bidders of an award.
- L.** A copy of the invitation for bids shall be made available for public inspection at the school district office.
- M.** A record of the bid prices received and the name of each bidder shall be open to public inspection following bid opening.
- N.** A record of the reverse auction shall be maintained by the school district that will include all prices offered by all bidders. This record will become part of the procurement file.
- O.** Within 10 days after a contract is awarded, the school district shall make the procurement file, including all bids, available for public inspection.
1. If the procurement file contains information that is confidential under R7-2-1006, a copy of the applicable documents with the confidential information redacted shall be placed in the procurement file for the purpose of public inspection.
 2. The unredacted original copy of the confidential information shall be placed in a sealed envelope or other appropriate container, identified as confidential information, and maintained in the procurement file.

Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1019. Reserved**R7-2-1020. Reserved****PART IV. COMPETITIVE SEALED BIDDING****R7-2-1021. Method of Source Selection**

- A.** Unless otherwise authorized by law, all school district contracts shall be awarded by competitive sealed bidding as provided in R7-2-1021 through R7-2-1032, except as provided in R7-2-1018, R7-2-1033 through R7-2-1068, R7-2-1100 through R7-2-1123, and R7-2-1196.
- B.** A school district may conduct competitive sealed bidding electronically, provided that the electronic competitive sealed bidding process complies with the requirements of R7-2-1021 through R7-2-1032. A determination that conducting competitive sealed bidding electronically is advantageous to the school district shall be in writing and retained in the procurement file.
- C.** When using electronic competitive sealed bidding, the school district shall determine whether electronic submission of bids is required or optional and state the electronic submission requirements in the public notice and the invitation for bids.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended effective October 22, 1992 (Supp. 92-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1022. Notice of Competitive Sealed Bidding

- A.** Adequate public notice of the invitation for bids shall be given as provided in R7-2-1024. Notice also may be given as provided in subsection (B). In the event there are four or fewer prospective bidders on the bidders list, then notice also shall be given as provided in subsection (B). If the invitation for bids is for the procurement of services other than those described in R7-2-1061 through R7-2-1068 and R7-2-1100 through R7-2-1123, notice also shall be given as provided in subsection (B).
- B.** If required by subsection A, the notice shall include publication in the official newspaper of the county, within which the school district is located, as prescribed in A.R.S. § 11-255. The publication, shall occur in a reasonable time before bid opening, which shall not be less than 14 days before bid opening. The time of publication may be altered if deemed necessary pursuant to R7-2-1024(A).
- C.** In addition to the notice provided in subsections (A) and (B), the school district may give such additional notice as the school district deems appropriate, including posting on a designated site on the Internet.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1023. Prospective Bidders Lists

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- A. The school district shall compile and maintain a prospective bidders list. Inclusion of the name of a person shall not indicate whether the person is responsible concerning a particular procurement or otherwise capable of successfully performing a school district contract.
 - B. Persons desiring to be included on the prospective bidders list shall notify the school district. Upon notification, the school district shall mail or otherwise provide the person with the school district procedures for inclusion on the bidders list. Within 30 days after receiving the required information, the school district shall add the person to the prospective bidders list unless the school district makes a determination that inclusion is not advantageous to the school district.
 - C. Persons who fail to respond to invitations for bids for two consecutive procurements of similar items may be removed from the applicable bidders list after notifying the person in writing. This notice shall not be required if the two invitations for bids which were not responded to both contained the notice that bidders' names may be removed from the bidders list if they fail to respond to invitations for bids for two consecutive procurements of similar items. Persons may be reinstated upon request.
 - D. Prospective bidders lists shall be available for public inspection, unless the school district makes a written determination that it is advantageous to the school district that they be kept confidential or private and should not be open for inspection pursuant to A.R.S. § 39-121.
- e. The basis for determining the lowest bidder or bidders;
 - f. Procurement of earth-moving, material-handling, road maintenance and construction equipment shall include as price evaluation criteria the total life cycle cost including residual value of the earth-moving, material-handling, road maintenance and construction equipment and, to the extent practicable, the cost of outright purchase;
 - g. The purchase description, specifications, delivery or performance schedule, and inspection and acceptance requirements, as applicable. If a brand name or equal specification is used, instructions that use of a brand name is for the purpose of describing the standard of quality, performance, and other characteristics needed to meet the school district's requirements and is not intended to limit or restrict competition. The invitation for bids shall state that products substantially equivalent to the brands designated qualify for consideration;
 - h. The factors to be used in bid evaluations, including criteria to determine acceptability such as inspection, testing, quality, workmanship, delivery and suitability for a particular purpose. Only objectively measurable evaluation criteria shall be included in the invitation for bids. Examples of such criteria include, but are not limited to, transportation cost, energy cost, ownership cost and other identifiable costs. Evaluation factors need not be precise predictors, but to the extent possible the evaluation factors shall be reasonable estimates based upon information the school district has available concerning future use;

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
 Amended by final exempt rulemaking at 21 A.A.R. 1525,
 effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1024. Invitation for Bids

- A. Invitation for bids shall be issued at least 14 days before the due date and time in the invitation for bids unless a shorter time is deemed necessary for a particular procurement as determined by the school district. If a shorter time is necessary, the school district shall document the specific reasons in the procurement file.
 - B. Content.
 - 1. The invitation for bids shall include the following:
 - a. Notice that all information and bids submitted by bidders will be made available for public inspection following the award of the contract;
 - b. Instructions and information to bidders concerning bid submission requirements, including the means for bid submission such as, hand delivery, U.S. mail, electronic mail, facsimile, or other acceptable means, the bid due date and time, the address of the office at which bids or other documents are to be received, the bid acceptance period, and any other special information or requirements;
 - c. Whether the school district will consider partial bids for award of a contract;
 - d. Notification of whether the school district may award multiple contracts and the school district's basis for determining whether to award multiple contracts. If multiple contracts may be awarded, the invitation for bids shall include the criteria the school district will use for selecting vendors for each contract under the multiple award, including, as applicable, whether contracts will be awarded by individual line items, groups of line items, or categories, whether contracts will be awarded incrementally, and whether contracts will be awarded by designated regions or locations;
- i. The contract terms and conditions, including:
 - i. Warranty and bonding or other security requirements, as applicable;
 - ii. The length of the contract and whether the contract will include an option for extension; and
 - iii. Any other contract terms and conditions;
 - j. The name of the district representative or district representatives;
 - k. The manner by which the bidder is required to acknowledge amendments;
 - l. The minimum information required in the bid;
 - m. The specific requirements for designating trade secrets and other proprietary data as confidential;
 - n. Any specific responsibility criteria;
 - o. A statement specifying where documents incorporated by reference may be obtained;
 - p. A statement that the school district may cancel the solicitation or reject a bid in whole or in part if deemed advantageous to the school district;
 - q. Notice that the bidder is required to certify that submission of the bid did not involve collusion or other anticompetitive practices and that the bidder has taken steps and exercised due diligence to ensure that no violation of A.R.S. § 15-213(O) has occurred;
 - r. Notice that the bidder is required to declare whether the bidder has been debarred, suspended, or otherwise lawfully prohibited from participating in any

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public procurement activity, including, but not limited to, being disapproved as a subcontractor of any public procurement unit or other governmental body;

- s. Any bid security required;
 - t. A description of all information that will be recorded and available for public inspection at bid opening; and
 - u. The date, time and location of any pre-bid conference.
2. When using electronic competitive sealed bidding, the invitation for bids shall specify whether electronic submission of bids is required or optional, the electronic submission requirements, and the electronic signature requirements.
- C. The school district shall mail or otherwise furnish invitation for bids or notices of the availability of invitation for bids to all prospective bidders registered with the school district for the specific material, service or construction being bid.
- D. A copy of the invitation for bids shall be made available for public inspection at the school district office.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

Amended effective October 22, 1992 (Supp. 92-4).

Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1025. Pre-bid Conferences

- A. The school district may conduct a pre-bid conference to explain the procurement requirements.
- B. If a pre-bid conference is conducted, it shall be not less than seven days before the bid due date and time, unless the school district makes a written determination that the specific needs of the procurement justify a shorter time. Statements made during a pre-bid conference are not amendments to the solicitation.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1026. Amendments to Invitation for Bids

- A. An amendment to an invitation for bids shall be issued if necessary to:
 - 1. Make changes in the invitation for bids;
 - 2. Correct defects or ambiguities;
 - 3. Furnish to other bidders information given to one bidder if the information will assist the other bidders in submitting bids or if the lack of the information will prejudice the other bidders;
 - 4. Provide additional information or instructions; or
 - 5. Set a later bid due date and time if the school district determines that an extension is advantageous to the school district.
- B. Amendments to an invitation for bids shall be so identified and the school district shall ensure that the amendments are distributed or made available to all persons to whom the original invitation for bids was distributed or made available. The school district shall make a copy of the amendments to an invitation for bids available for public inspection at the school district office. If the school district posted the invitation for bids

or a notice of the availability of an invitation for bids on a designated site on the Internet, then the school district shall post any amendments to the invitation for bids on the same designated site on the Internet. The school district shall also do one or more of the following:

- 1. Distribute the amendment, by any method reasonably calculated to ensure delivery, to all prospective bidders to whom the invitation for bids was distributed;
 - 2. Make the amendment available and issue a notice of amendment which contains instructions for obtaining copies of the amendment. The notice of amendment shall be distributed, by any method reasonably calculated to ensure delivery, to all prospective bidders to whom the invitation for bids was distributed. Upon receipt of such notice of amendment, it is the responsibility of the prospective bidder to obtain the amendment.
- C. Amendments to invitation for bids shall be issued within a reasonable time before bid opening to allow prospective bidders to consider them in preparing their bids. If the school district determines that the bid due date and time does not permit sufficient time for bid preparation, the bid due date and time shall be extended in the amendment or, if necessary, by telephone, facsimile, email, or other communications methods, and confirmed in the amendment.
- D. A bidder shall acknowledge receipt of an amendment in the manner specified in the invitation for bids or the amendment on or before the bid due date and time.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1027. Pre-opening Modification or Withdrawal of Bids

- A. A bidder may modify or withdraw a bid in writing at any time before bid opening if the modification or withdrawal is received before the bid due date and time at the location designated in the invitation for bids for receipt of bids.
- B. All documents concerning a modification or withdrawal of a bid shall be retained in the procurement file.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1028. Late Bids, Late Withdrawals and Late Modifications

- A. A bid, modification or withdrawal is late if it is received at the location designated in the invitation for bids for receipt of bids after the bid due date and time.
- B. A late bid, late modification, or late withdrawal shall be rejected, unless the late bid, late modification, or late withdrawal would have been timely received but for the action or inaction of school district personnel and is received before contract award.
- C. Upon receiving a late bid, late modification, or late withdrawal, the school district shall record the time and date of receipt and promptly send written notice of late receipt to the bidder. The school district may discard the document 30 days after the date on the notice unless the bidder requests and provides funding for the document to be returned.

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- D.** All documents concerning acceptance of a late bid, late modification, or late withdrawal shall be retained in the procurement file.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1029. Receipt, Opening and Recording of Bids

- A.** A school district shall maintain a record of bids and modifications received for each invitation for bids, shall record the time and date when each bid or modification is received, and shall store each unopened bid or modification in a secure place until the bid due date and time.
1. If required to confirm a vendor's inquiry regarding receipt of its bid prior to the due date and time, a school district may open a bid to identify the vendor. If this occurs, the school district shall record the reason for opening the bid, the date and time the bid was opened, and the solicitation number. The school district shall secure the bid and retain it for public opening.
 2. One or more witnesses shall be present for the opening of a bid under subsection (A)(1).
- B.** Bids and modifications shall be opened publicly at the date, time and place designated in the invitation for bids in the presence of one or more witnesses. The name of each bidder, the amount of each bid, and other relevant information deemed appropriate by the school district shall be recorded. The person opening the bids and all witnesses shall sign the record.
1. The record created in subsection (B) shall be available for public inspection.
 2. The bids shall not be open for public inspection until after a contract is awarded.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1030. Mistakes in Bids

- A.** If an apparent mistake in a bid, relevant to the award determination, is discovered after opening and before award, a school district shall contact the bidder for written confirmation of the bid. If the bidder fails to act, the bidder is considered nonresponsive and the school district shall place a written determination that the bidder is nonresponsive in the procurement file. The school district shall designate a time-frame within which the bidder shall either:
1. Confirm that no mistake was made and assert that the bid stands as submitted; or
 2. Acknowledge that a mistake was made and include all of the following in a written response:
 - a. An explanation of the mistake and any other relevant information;
 - b. A request for correction including the corrected bid or a request for withdrawal; and
 - c. The reasons why correction or withdrawal is consistent with fair competition and advantageous to the school district.
- B.** A bidder who discovers a mistake in its bid after bid opening and before award, may request correction or withdrawal in

writing and shall include all of the following in the written request:

1. An explanation of the mistake and any other relevant information;
 2. A request for correction including the corrected bid or a request for withdrawal; and
 3. The reasons why correction or withdrawal is consistent with fair competition and advantageous to the school district.
- C.** After bid opening and before award, a bid mistake based on an error in judgment may not be corrected or withdrawn. Other bid mistakes may be corrected or withdrawn pursuant to subsections (D) through (F).
- D.** After bid opening and before award, the school district shall either waive minor informalities in a bid or allow the bidder to correct them if correction is advantageous to the school district.
- E.** After bid opening and before award, the bid may not be withdrawn and shall be corrected to the intended bid if a bid mistake and the intended bid are evident on the face of the bid.
- F.** After bid opening and before award, the school district may permit a bidder to withdraw a bid if:
1. A nonjudgmental mistake is evident on the face of the bid but the intended bid is not evident; or
 2. The bidder establishes by clear and convincing evidence that a nonjudgmental mistake was made.
- G.** If correction or withdrawal of a bid after bid opening is permitted or denied under subsections (D), (F) and (J), the school district shall prepare a written determination showing that the relief was permitted or denied under this Section.
- H.** Notwithstanding other provisions of this Section, after bid opening and before award, no corrections in bid prices or other provisions of bids prejudicial to the interest of the school district or fair competition shall be permitted.
- I.** If a mistake in the bid is discovered after the award, the bidder may request withdrawal or correction in writing and shall include all of the following in the written request:
1. An explanation of the mistake and any other relevant information;
 2. A request for correction including the corrected bid or a request for withdrawal; and
 3. The reasons why correction or withdrawal is consistent with fair competition and advantageous to the school district.
- J.** Based on the considerations of fair competition and the best interest of the school district, the school district may take one of the following actions regarding a bid mistake discovered after the award:
1. Allow correction of the mistake, if the corrected bid amount is less than the next lowest bid;
 2. Cancel all or part of the award; or
 3. Deny correction or withdrawal.
- K.** After cancellation of all or part of an award in accordance with subsection (J)(2), if the bid acceptance period has not expired, the school district may award all or part of the contract to the next lowest responsible and responsive bidder, based on the considerations of fair competition and the best interest of the school district.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,

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effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1031. Bid Evaluation and Award

- A.** As provided in subsection (C), the contract or contracts shall be awarded to the lowest responsible and responsive bidder or bidders whose bid or bids conform in all material respects to the requirements and evaluation criteria set forth in the invitation for bids. No criteria may be used in bid evaluation that are not set forth in the invitation for bids. The amount of any applicable transaction privilege or use tax of a political subdivision of this state is not a factor in determining the lowest bidder.
- B.** A product acceptability evaluation shall be conducted solely to determine whether a bidder's product is acceptable as set forth in the invitation for bids and not whether one bidder's product is superior to another bidder's product. Any bidder's offering that does not meet the acceptability requirements shall be rejected as nonresponsive.
- C.** The school district shall award the contract to the single lowest responsible and responsive bidder for all materials or services, except that the school district may make a multiple award if the invitation for bids included notification that multiple contracts may be awarded, the school district's basis for determining whether to award multiple contracts, and the criteria for selecting vendors for the multiple contracts.
- D.** Before making a multiple award, the school district shall determine in writing that a multiple award is necessary and is advantageous to the school district and shall establish procedures for the use of the multiple awarded contracts to ensure that purchases are made from the contracts determined by the school district to offer the lowest cost in satisfying the school district's requirements. A multiple award shall be limited to the least number of suppliers the school district determines in writing to be necessary to meet the school district's requirements, and may include the following types of awards:
 1. Awards to the lowest responsible and responsive bidder for individual line items, groups of line items, or categories.
 2. Awards to the lowest responsible and responsive bidders for similar or identical line items, groups of line items, or categories only if the school district determines in writing that such awards are necessary to obtain the required quantity or delivery, and the awards are limited to the least number of bidders necessary to meet the school district's requirements.
 3. An incremental award only if the school district determines in writing that such an award is necessary to obtain the required quantity or delivery. The award shall be made to the lowest responsible and responsive bidder, then the next lowest responsible and responsive bidder or bidders until the total definite quantity required is awarded.
 4. A regional award to the lowest responsible and responsive bidder in designated regions or locations only if the school district determines in writing that such an award is necessary to obtain the required quantity or delivery over widely scattered locations or a particular requirement is of a local nature.
- E.** The procurement file shall contain the basis on which the award or awards are made.
- F.** The school district shall not modify evaluation criteria after the bid due date and time.
- G.** A school district may appoint an evaluation committee to assist in the evaluation of bids. If bids are evaluated by an evaluation committee, the evaluation committee shall prepare an evaluation report for the school district. The school district may:
 1. Accept the findings of the evaluation committee;
 2. Request additional information from the evaluation committee; or
 3. Reject the findings of the evaluation committee, in which case the school district shall appoint a new evaluation committee to evaluate the existing bids or cancel the solicitation.
- H.** The school district may contact a bidder to confirm the school district's understanding of the bid. Such contact shall be prior to award. The school district shall obtain written confirmation from the bidder and shall retain the confirmation in the procurement file.
- I.** The contract or contracts shall be awarded during the bid acceptance period. If the bid acceptance period expires prior to award of the contract or contracts, the procurement shall be canceled, unless the bid acceptance period is extended in accordance with subsection (J).
- J.** To extend the bid acceptance period, a school district shall notify all bidders in writing of an extension and request written concurrence from each bidder. To be eligible for a contract award, a bidder shall submit a written concurrence to the extension. The school district shall reject a bid as nonresponsive if written concurrence is not provided as requested.
- K.** A contract may not be awarded to a bidder submitting a higher quality item than that designated in the invitation for bids unless the bidder is also the lowest bidder as determined under subsection (A). This Section does not permit negotiations with any bidder, except as provided in subsection (L).
- L.** If all bids for a construction project exceed available monies as certified by the school district, and the lowest responsive bid from a responsible bidder does not exceed such monies by more than five percent, the school district may in situations in which time or economic considerations preclude resolicitation of work of a reduced scope, negotiate an adjustment of the bid price, including changes in the bid requirements, with the lowest responsible and responsive bidder, to bring the bid within the amount of available monies.
- M.** If there are two or more low responsive bids from responsible bidders that are identical in price and that meet all the requirements and criteria set forth in the invitation for bids, award shall be made by drawing lots in the presence of one or more witnesses.
- N.** A record showing the basis for determining the successful bidder shall be retained in the procurement file.
- O.** The school district shall notify all bidders of an award.
- P.** After a contract is awarded, the school district shall return any bid security provided by unsuccessful bidders.
- Q.** Upon execution of the contract, if performance and payment bonds were not required, or upon receipt of the specified bonds, if performance and payment bonds were required, the school district shall return any bid security provided by the successful bidder.
- R.** Within 10 days after a contract is awarded, the school district shall make the procurement file, including all bids, available for public inspection.
 1. If the procurement file contains information that is confidential under R7-2-1006, a copy of the applicable documents with the confidential information redacted shall be placed in the procurement file for the purpose of public inspection.

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2. The unredacted original copy of the confidential information shall be placed in a sealed envelope or other appropriate container, identified as confidential information, and maintained in the procurement file.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

Amended effective October 22, 1992 (Supp. 92-4).

Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1032. Only One Bid Received

If only one responsive bid is received in response to an invitation for bids, an award may be made to the single bidder if the school district determines in writing that the bidder is responsible, that the price submitted is fair and reasonable, and that either other prospective bidders had reasonable opportunity to respond, or there is not adequate time for resolicitation. Otherwise the bid may be rejected in whole or in part as may be specified in the invitation for bids if it is advantageous to the school district. The reasons for cancellation or rejection shall be made part of the procurement file and:

1. New bids may be solicited;
2. The proposed procurement may be canceled; or
3. If the school district determines that the need for the material or service continues and the acceptance of the one bid is not advantageous to the school district, the procurement may then be conducted as follows:
 - a. The school district may follow the sole source procurement procedure if R7-2-1053 applies.
 - b. Notwithstanding any other provision of Articles 10 and 11, the school district may make emergency procurements pursuant to R7-2-1055 and R7-2-1056 if an emergency condition exists pursuant to R7-2-1055.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1033. Simplified School Construction Procurement Program

- A. The simplified school construction procurement program is applicable to construction projects which do not exceed the maximum amount specified in A.R.S. § 15-213(A)(2).
- B. To participate in the simplified school construction procurement program:
 1. Each county school superintendent shall maintain a prospective bidders list of persons who desire to receive solicitations to bid on school district construction projects within that county. The prospective bidders list shall be maintained in accordance with R7-2-1023;
 2. The prospective bidders list maintained pursuant to subsection (B)(1) shall be available for public inspection;
 3. A performance bond and a payment bond, as required by A.R.S. § 34-222, shall be provided for contracts for construction by contractors;
 4. All bids for construction shall be opened at a public opening and the bids shall remain confidential until the public opening;
 5. All persons desiring to submit bids shall be treated equitably and the information related to each project shall be available to all eligible persons; and

6. Competition for construction projects under the simplified school construction procurement program shall be encouraged to the maximum extent possible. School districts shall submit information on each project to all persons listed on the prospective bidders list maintained by the county school superintendent pursuant to subsection (B)(1).

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4).

Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1034. Reserved**PART V. MULTISTEP SEALED BIDDING****R7-2-1035. Multistep Sealed Bidding**

- A. The multistep sealed bidding method may be used if:
 1. Available specifications or purchase descriptions are not sufficiently complete to permit full competition without technical evaluations and discussions to ensure mutual understanding between each bidder and the school district;
 2. Definite criteria exist for evaluation of technical offers;
 3. More than one technically qualified source is expected to be available; and
 4. A fixed-price contract will be used.
- B. The multistep sealed bidding method may not be used for construction contracts.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1036. Phase 1 of Multistep Sealed Bidding

- A. Multistep sealed bidding shall be initiated by the issuance of an invitation to submit technical offers. The invitation to submit technical offers shall be issued according to R7-2-1022 and R7-2-1024(A).
- B. The invitation to submit technical offers shall include the following information:
 1. Notice that the procurement shall be conducted in two phases;
 2. The best description of the material or services desired;
 3. A statement that unpriced technical offers only shall be considered in phase 1;
 4. The requirements for the technical offers, such as drawings and descriptive literature;
 5. The criteria for evaluating technical offers;
 6. The due date and time for receipt of technical offers and the location where technical offers shall be delivered or mailed;
 7. A statement that discussions may be held;
 8. A statement that only bids based on technical offers determined to be acceptable in phase 1 shall be considered for award;
 9. The name of the district representative or district representatives;
 10. Notice that all technical offers submitted will be made available for public inspection following the award of the contract; and
 11. The date, time and location of any pre-technical offer conference.

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- C. A school district may conduct a pre-technical offer conference open to all persons. If a pre-technical offer conference is conducted, it shall be not less than seven days before the technical offer due date and time, unless the school district makes a written determination that the specific needs of the procurement justify a shorter time. Statements made during the pre-technical offer conference shall not be considered modifications to the invitation to submit technical offers.
- D. The invitation to submit technical offers may be amended before or after the submission of the unpriced technical offers. Amendments to an invitation to submit technical offers shall be so identified and the school district shall ensure that the amendments are distributed or made available to all persons to whom the original invitation to submit technical offers was distributed or made available. The school district shall make a copy of the amendments to an invitation to submit technical offers available for public inspection at the school district office. If the school district posted the invitation to submit technical offers or a notice of the availability of an invitation to submit technical offers on a designated site on the Internet, then the school district shall post any amendments to the invitation to submit technical offers on the same designated site on the Internet. The school district shall also do one or more of the following:
 - a. Distribute the amendment, by any method reasonably calculated to ensure delivery, to all persons to whom the invitation to submit technical offers was distributed;
 - b. Make the amendment available and issue a notice of amendment which contains instructions for obtaining copies of the amendment. The notice of amendment shall be distributed, by any method reasonably calculated to ensure delivery, to all persons to whom the invitation to submit technical offers was distributed. Upon receipt of such notice of amendment, it is the responsibility of the person to obtain the amendment.
- 2. Amendments shall be issued within a reasonable time before technical offer opening to allow persons to consider them in preparing their technical offers. If the school district determines that the technical offer due date and time does not permit sufficient time for technical offer preparation, the technical offer due date and time shall be extended in the amendment or, if necessary, telephone, facsimile, email, or other communications methods, and confirmed in the amendment.
- 3. A person shall acknowledge receipt of an amendment in the manner specified in the invitation to submit technical offers or the amendment on or before the technical offer due date and time.
- E. Unpriced technical offers shall not be opened publicly, but shall be opened in the presence of two or more district officials designated by the school district. The contents of unpriced technical offers shall not be disclosed to unauthorized persons. Late technical offers shall not be considered except under the circumstances set forth in R7-2-1028(B).
- F. Unpriced technical offers shall be evaluated solely in accordance with the criteria set forth in the invitation to submit technical offers and shall be determined to be either acceptable for further consideration or unacceptable. A determination that an unpriced technical offer is unacceptable shall be in writing, state the basis for the determination and be retained in the procurement file. If the school district determines a person's unpriced technical offer is unacceptable, the school district

shall notify that person of the determination and that the person shall not be afforded an opportunity to amend the technical offer.

- G. The school district may conduct discussions with any person who submits an acceptable or potentially acceptable technical offer. During discussions, the school district shall not disclose any information derived from one unpriced technical offer to any other person. After discussions, the school district shall establish a due date and time for receipt of final technical offers and shall notify, in writing, persons submitting acceptable or potentially acceptable technical offers of the due date and time. The school district shall keep a detailed record of all discussions.
- H. At any time during phase 1, technical offers may be withdrawn.
- I. A copy of the invitation to submit technical offers shall be made available for public inspection at the school district office.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1037. Phase 2 of Multistep Sealed Bidding

- A. Upon completion of phase 1, the school district shall issue an invitation for bids and conduct phase 2 under R7-2-1024 through R7-2-1032 as a competitive sealed bidding procurement, except that the invitation for bids shall be issued only to persons whose technical offers were determined to be acceptable in phase 1.
- B. Unpriced technical offers of unsuccessful persons shall be open to public inspection after contract award, except to the extent set forth in R7-2-1006.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1038. Reserved**R7-2-1039. Reserved****R7-2-1040. Reserved****PART VI. COMPETITIVE SEALED PROPOSALS****R7-2-1041. Competitive Sealed Proposals**

- A. This Section does not apply to procurement of services of clergy, certified public accountants, physicians, dentists, and legal counsel, construction, construction services, or specified professional services. Services of clergy, certified public accountants, physicians, dentists and legal counsel shall be procured pursuant to R7-2-1061 through R7-2-1068. Construction and construction services shall be procured as provided in R7-2-1100. Specified professional services shall be procured pursuant to R7-2-1117 through R7-2-1123.
- B. As an alternative to competitive sealed bidding, competitive sealed proposals may be used in order to:
 - 1. Use a contract other than a fixed-price type;
 - 2. Conduct oral or written discussions with offerors concerning technical and price aspects of their proposals;
 - 3. Afford offerors an opportunity to revise their proposals;
 - 4. Compare the different price, quality, and contractual factors of the proposals submitted; or

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5. Award a contract in which price is not the determining factor.
- C. A school district may conduct competitive sealed proposals electronically, provided that the electronic competitive sealed proposals process complies with the requirements of R7-2-1041 through R7-2-1050. A determination that conducting competitive sealed proposals electronically is advantageous to the school district shall be in writing and retained in the procurement file.
- D. When using electronic competitive sealed proposals, the school district shall determine whether electronic submission of proposals is required or optional and state the electronic submission requirements in the public notice and the request for proposals.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

Amended effective March 21, 1991 (Supp. 91-1).

Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1042. Request for Proposals

- A. Competitive sealed proposals shall be solicited through a request for proposals. A request for proposals shall include the following:
 1. Instructions to offerors, including:
 - a. Instructions and information to offerors concerning proposal submission requirements, including the means for proposal submission such as, hand delivery, U.S. mail, electronic mail, facsimile, or other acceptable means, the proposal due date and time, the address of the office at which proposals or other documents are to be received, the proposal acceptance period, and any other special information or requirements;
 - b. The manner by which the offeror is required to acknowledge amendments;
 - c. Notification of whether the school district may award multiple contracts and the school district's basis for determining whether to award multiple contracts. If multiple contracts may be awarded, the request for proposals shall include the criteria the school district will use for selecting vendors for each contract under the multiple award, including as applicable, whether contracts will be awarded by individual line items, groups of line items, or categories, whether contracts will be awarded incrementally, and whether contracts will be awarded by designated regions or locations;
 - d. The minimum information required in the proposal;
 - e. The specific requirements for designating trade secrets and other proprietary data as confidential;
 - f. Any specific responsibility criteria;
 - g. Whether the offeror is required to submit samples, descriptive literature, and technical data with the proposal;
 - h. Evaluation factors and the relative importance of price and other evaluation factors. Specific numerical weighting is not required;
 - i. Procurement of earth-moving, material-handling, road maintenance and construction equipment shall include as evaluation factors the total life cycle cost including residual value of the earth-moving, material-handling, road maintenance and construction equipment and, to the extent practicable, the cost of outright purchase;
 2. Specifications, including:
 - a. The purchase description, delivery or performance schedule, and inspection and acceptance requirements, as applicable;
 - b. If a brand name or equal specification is used, instructions that the use of a brand name is for the purpose of describing the standard of quality, performance, and other characteristics needed to meet the school district's requirements and is not intended to limit or restrict competition. The solicitation shall state that products substantially equivalent to those brands designated shall qualify for consideration; and
 - c. Any other specification requirements specific to the solicitation.
 3. Contract terms and conditions, including:
 - a. Warranty and bonding or other security requirements, as applicable;
 - b. The length of the contract and whether the contract will include an option for extension; and
 - c. Any other contract terms and conditions.
 4. When using electronic competitive sealed proposals, the request for proposals shall specify whether electronic submission of proposals is required or optional, the electronic submission requirements, and the electronic signature requirements.
 - j. A statement specifying where documents incorporated by reference may be obtained;
 - k. A statement that the school district may cancel the solicitation or reject a proposal in whole or in part if deemed advantageous to the school district;
 - l. Notice that the offeror is required to certify that submission of the proposal did not involve collusion or other anticompetitive practices and that the offeror has taken steps and exercised due diligence to ensure that no violation of A.R.S. § 15-213(O) has occurred;
 - m. Notice that the offeror is required to declare whether the offeror has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity, including, but not limited to, being disapproved as a subcontractor of any public procurement unit or other governmental body;
 - n. Any bid security required;
 - o. Any cost or pricing data required;
 - p. The type of contract to be used;
 - q. A statement that discussions may be conducted with offerors who submit proposals determined to be reasonably susceptible of being awarded a contract;
 - r. The date, time and location of any pre-proposal conference;
 - s. The name of the district representative or district representatives;
 - t. A description of all information that will be recorded and available for public inspection at proposal opening;
 - u. Notice that all information and proposals submitted by offerors will be made available for public inspection following the award of the contract; and
 - v. Whether the school district will consider partial proposals for award of a contract.

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- B. A request for proposals shall be issued at least 14 days before the due date and time for receipt of proposals unless a shorter time is determined necessary by the school district. If a shorter time is necessary, the school district shall document the specific reasons in the procurement file.
- C. Notice of the request for proposals shall be given by the school district pursuant to R7-2-1022 and R7-2-1024(C).
- D. Before submission of initial proposals, amendments to requests for proposals shall be made in accordance with R7-2-1026. After submission of proposals, amendments may be made in accordance with R7-2-1036(D).
- E. A copy of the request for proposals shall be made available for public inspection at the school district office.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
 Amended effective October 22, 1992 (Supp. 92-4).
 Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1043. Pre-proposal Conferences

Pre-proposal conferences may be convened in accordance with R7-2-1025.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

R7-2-1044. Late Proposals, Modifications or Withdrawals

- A. An offeror may modify or withdraw a proposal in writing at any time before proposal opening if the modification or withdrawal is received before the proposal due date and time at the location designated in the request for proposals for receipt of proposals.
- B. Withdrawal of a proposal after proposal opening is permissible only in accordance with R7-2-1049.
- C. A proposal received after the due date and time for receipt of proposals is late and shall not be considered except under the circumstances set forth in R7-2-1028(B). A best and final offer received after the due date and time for receipt of best and final offers is late and shall not be considered except under the circumstances set forth in R7-2-1028(B).
- D. A modification of a proposal received after the due date and time for receipt of proposals is late and shall not be considered except under the circumstances set forth in R7-2-1028(B).
- E. A modification of a proposal resulting from an amendment issued after the due date and time for receipt of proposals or a modification of a proposal resulting from discussions shall be considered if received by the due date and time set forth in the amendment or by the due date and time for submission of best and final offers, whichever is applicable. If the modifications described in this subsection are received after the respective date and time described in this subsection, the modifications are late and shall not be considered except under the circumstances set forth in R7-2-1028(B).
- F. Upon receiving a late proposal, late modification, or late withdrawal, the school district shall record the time and date of receipt and promptly send written notice of late receipt to the offeror. The school district may discard the document 30 days after the date on the notice unless the offeror requests and provides funding for the document to be returned.
- G. All documents concerning acceptance of a late proposal, late modification, or late withdrawal shall be retained in the procurement file.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
 Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1045. Receipt, Opening and Recording of Proposals

- A. A school district shall maintain a record of proposals and modifications received for each solicitation, shall record the time and date when each proposal or modification is received, and shall store each unopened proposal or modification in a secure place until the proposal due date and time.
 - 1. If required to confirm a vendor's inquiry regarding receipt of its proposal prior to the due date and time, a school district may open a proposal to identify the vendor. If this occurs, the school district shall record the reason for opening the proposal, the date and time the proposal was opened, and the solicitation number. The school district shall secure the proposal and retain it for public opening.
 - 2. One or more witnesses shall be present for the opening of a proposal under subsection (A)(1).
- B. Proposals and modifications shall be opened publicly at the date, time and place designated in the request for proposals in the presence of one or more witnesses. The name of each offeror and other relevant information deemed appropriate by the school district shall be recorded. The person opening the proposals and all witnesses shall sign the record. All other information contained in the proposals shall be confidential so as to avoid disclosure of contents prejudicial to competing offerors during the evaluation of proposals. Proposals and modifications shall be shown only to school district personnel having a legitimate interest in them or persons assisting the school district in evaluation.
 - 1. The record created in subsection (B) shall be available for public inspection.
 - 2. The proposals shall not be open for public inspection until after a contract is awarded.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
 Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1046. Evaluation of Proposals

- A. Evaluation of proposals and best and final offers shall be based on the evaluation factors set forth in the request for proposals. Specific numerical weighting may be used.
 - 1. If only one proposal is received in response to a request for proposals, the school district shall proceed according to R7-2-1032.
 - 2. The school district shall not modify evaluation factors or the relative importance of price and other evaluation factors after the proposal due date and time.
 - 3. A school district may appoint an evaluation committee to assist in the evaluation of proposals. If proposals are evaluated by an evaluation committee, the evaluation committee shall prepare an evaluation report for the school district. The school district may:
 - a. Accept the findings of the evaluation committee;
 - b. Request additional information from the evaluation committee; or
 - c. Reject the findings of the evaluation committee, in which case the school district shall appoint a new

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evaluation committee to evaluate the existing proposals or cancel the solicitation.

- B. As part of its initial evaluation, the school district may contact an offeror to confirm the school district's understanding of the proposal. Such contact shall be prior to the determination that a proposal is acceptable for further consideration. The school district shall obtain written confirmation from the offeror and shall retain the confirmation in the procurement file.
- C. The contract or contracts shall be awarded during the proposal acceptance period. If the proposal acceptance period expires prior to award of the contract or contracts, the procurement shall be canceled, unless the proposal acceptance period is extended in accordance with subsection (D).
- D. To extend the proposal acceptance period, a school district shall notify all offerors in writing of an extension and request written concurrence from each offeror. To be eligible for a contract award, an offeror shall submit a written concurrence to the extension. The school district shall reject a proposal as nonresponsive if written concurrence is not provided as requested.
- E. For the purpose of conducting discussions, the school district shall determine that proposals are either acceptable for further consideration or unacceptable.
- F. A proposal is acceptable if it is determined to be reasonably susceptible of being awarded a contract in accordance with the evaluation criteria and a comparison and ranking of original proposals. Proposals to be considered reasonably susceptible of being awarded a contract shall, at a minimum, demonstrate the following:
 - 1. Affirmative compliance with mandatory requirements designated in the solicitation.
 - 2. An ability to deliver goods or services on terms advantageous to the school district sufficient to be entitled to continue in the competition.
 - 3. That the proposal is technically acceptable as submitted.
- G. A proposal is unacceptable if it is determined to not be reasonably susceptible of being awarded a contract. Those proposals that have no reasonable chance for award when compared on a relative basis with more highly ranked proposals will not be reasonably susceptible of being awarded a contract. The determination shall be in writing, state the basis for the determination and be retained in the procurement file. When there is doubt as to whether a proposal is reasonably susceptible of being awarded a contract, the proposal shall be considered acceptable.
- H. If the school district determines an offeror's proposal is unacceptable, the school district shall notify that offeror of the determination and that the offeror shall not be afforded an opportunity to amend its proposal.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,
effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1047. Discussions with Individual Offerors

- A. Discussions may be conducted with responsible offerors who submit proposals determined to be acceptable for further consideration. Discussions may be conducted to assure full understanding of the proposal in order to obtain the most advantageous contract for the school district based upon the requirements and evaluation factors in the request for proposals. Offerors shall be afforded fair treatment with respect to any opportunity for discussion and revision of proposals.

- B. A school district shall establish procedures and schedules for conducting discussions. The school district shall ensure there is no disclosure of one offeror's price or any information derived from competing proposals to another offeror.
- C. Discussions may be conducted orally or in writing. If oral discussions are conducted, the offeror shall confirm the discussions in writing.
- D. If discussions are conducted, they shall be conducted with all offerors who submit proposals determined to be acceptable for further consideration. Proposals may not be revised during discussions.
- E. The school district shall keep a detailed record of all discussions in the procurement file.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,
effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1048. Best and Final Offers

- A. Only if discussions are conducted pursuant to R7-2-1047, the school district shall issue a written request for best and final offers to all offerors who submitted proposals determined to be acceptable pursuant to R7-2-1046(E). The request shall set forth the date, time and place for the submission of best and final offers.
- B. Best and final offers shall be requested only once, unless the school district makes a determination that it is advantageous to the school district to conduct further discussions or change the school district's requirements.
- C. The request for best and final offers shall inform offerors that, if they do not submit a notice of withdrawal or a best and final offer, their immediate previous offer will be construed as their best and final offer.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,
effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1049. Mistakes in Proposals

- A. Prior to the due date and time for receipt of best and final offers, any offeror may withdraw a proposal in writing or correct any mistake by modifying the proposal.
- B. After receipt of best and final offers, an offeror may withdraw a proposal or correct a mistake in accordance with R7-2-1030.
- C. The offeror shall withdraw or correct its proposal in writing. The school district shall retain the written withdrawal or correction in the procurement file.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,
effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1050. Contract Award

- A. As provided in subsection (B), the school district shall award a contract or contracts to the responsible offeror or offerors whose proposal or proposals are determined in writing to be most advantageous to the school district based on the factors set forth in the request for proposals. No factors or criteria may be used in proposal evaluation that are not set forth in the request for proposals. The amount of any applicable transac-

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tion privilege or use tax of a political subdivision of this state is not a factor in determining the most advantageous proposal.

- B. The school district shall award the contract to the offeror whose proposal is deemed most advantageous to the school district for all materials or services, except that the school district may make a multiple award if the request for proposals included notification that multiple contracts may be awarded, the school district's basis for determining whether to award multiple contracts, and the criteria for selecting vendors for the multiple contracts.
- C. Before making a multiple award, the school district shall determine in writing that a multiple award is necessary and is advantageous to the school district and shall establish procedures for the use of the multiple awarded contracts to ensure that purchases are made from the contracts determined by the school district to be most advantageous to the school district in satisfying the school district's requirements. A multiple award shall be limited to the least number of contracts the school district determines in writing to be necessary to meet the school district's requirements, and may include the following types of awards:
 1. Awards to the offerors most advantageous to the school district for individual line items, groups of line items, or categories.
 2. Awards to the offerors most advantageous to the school district for similar or identical line items, groups of line items, or categories only if the school district determines in writing that such awards are necessary to obtain the required quantity or delivery, and the awards are limited to the least number of offerors necessary to meet the school district's requirements.
 3. An incremental award only if the school district determines in writing that such an award is necessary to obtain the required quantity or delivery. The award shall be made to the offeror whose proposal is determined to be the most advantageous to the school district, then to the offeror with the next most advantageous proposal, etc., until the total definite quantity required is reached.
 4. Regional awards to the offerors most advantageous to the school district in designated regions or locations only if the school district determines in writing that such awards are necessary to obtain the required quantity or delivery over widely scattered locations or a particular requirement is of a local nature.
- D. The school district shall notify all offerors of an award.
- E. The procurement file shall contain the basis on which the award or awards are made.
- F. After a contract is awarded, the school district shall return any bid security provided by the unsuccessful offerors.
- G. Upon execution of the contract, if performance and payment bonds were not required, or upon receipt of the specified bonds, if performance and payment bonds were required, the school district shall return any bid security provided by the successful offeror.
- H. Within 10 days after a contract is awarded, the school district shall make the procurement file, including all proposals, available for public inspection.
 1. If the procurement file contains information that is confidential under R7-2-1006, a copy of the applicable documents with the confidential information redacted shall be placed in the procurement file for the purpose of public inspection.
 2. The unredacted original copy of the confidential information shall be placed in a sealed envelope or other appro-

priate container, identified as confidential information, and maintained in the procurement file.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

Amended effective October 22, 1992 (Supp. 92-4).

Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1051. Reserved

R7-2-1052. Reserved

PART VII. SOLE SOURCE PROCUREMENTS**R7-2-1053. Sole Source Procurements**

- A. A contract may be awarded for a material, service or construction item without competition if the governing board determines in writing that there is only one source for the required material, service or construction item. The school district may require the submission of cost or pricing data in connection with an award under this Section. Sole source procurement shall be avoided, except when no reasonable alternative source exists.
- B. The governing board's determination shall be made before entering the contract and shall include the following information:
 1. A description of the procurement need and the reason why there is only a single source available or why no reasonable alternative exists;
 2. The name of the proposed supplier;
 3. The duration and estimated total dollar value of the proposed procurement;
 4. Documentation that the price submitted is fair and reasonable; and
 5. A description of efforts made to seek other sources.
- C. The school district shall, to the extent practicable, negotiate with the single supplier a contract advantageous to the school district.
- D. A copy of the written determination of the basis for the sole source procurement and any cost or pricing data shall be retained in the procurement file by the school district. The school district shall keep a record of all sole source procurements pursuant to R7-2-1086.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1054. Reserved

PART VIII. EMERGENCY PROCUREMENTS**R7-2-1055. Emergency Procurement Procedure**

- A. An emergency condition creates an immediate and serious need for materials, services, or construction that cannot be met through normal procurement methods and seriously threatens the functioning of the school district, the preservation or protection of property or the public health, welfare or safety. Some examples of emergency conditions are floods, epidemics, or other natural disasters, riots, fire or equipment failures.
- B. An emergency procurement shall be limited to the materials, services, or construction necessary to satisfy the emergency need.

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- C. The governing board shall designate a board member or members or school district official or officials authorized to make emergency procurements, and may prescribe limiting factors including maximum spending limits with regard to emergency procurements.
- D. The designated board member or district official shall:
1. Select the contractor to perform the emergency work with as much competition as practicable under the circumstances;
 2. Obtain a price that is fair and reasonable under the circumstances;
 3. Prepare a written statement documenting the basis for the emergency, the basis for the selection of the particular contractor, and why the price paid was fair and reasonable. The statement shall be signed by the designated governing board member or district official authorized to initiate emergency procurements; and
 4. Convene a meeting of the governing board to approve the emergency procurement, unless the nature of the emergency requires that the procurement be made prior to governing board approval.
- B. Responses to a request for information are not offers and cannot be accepted to form a binding contract.
- C. Information contained in a response to a request for information may be withheld from public inspection until the subsequent procurement is awarded or terminated, two years from the date of the vendor's response, or upon commencement of a new procurement, whichever occurs first.
- D. There is no required format to be used for requests for information.

Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1059. Reserved**R7-2-1060. Reserved****PART X. SERVICES OF CLERGY, CERTIFIED PUBLIC ACCOUNTANTS, PHYSICIANS, DENTISTS AND LEGAL COUNSEL****R7-2-1061. Competitive Selection Procedures for Clergy, Certified Public Accountants, Physicians, Dentists and Legal Counsel**

- A. The services of clergy, certified public accountants, physicians, dentists, or legal counsel shall be procured in accordance with R7-2-1061 through R7-2-1068, except as authorized pursuant to R7-2-1002, R7-2-1053, or R7-2-1055.
- B. Pursuant to A.R.S. § 15-914, contracts for financial and compliance audits and completed audits shall be approved by the Auditor General as provided in A.R.S. § 41-1279.21.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1062. Statement of Qualifications

- A. If the services specified in R7-2-1061(A) are needed, persons may submit and the school district may solicit persons engaged in providing the services to submit statements of qualifications on a prescribed form that shall include the following information:
1. Technical education and training;
 2. General or special experience, certifications, licenses, and memberships in professional associations, societies, or boards;
 3. An expression of interest in providing a particular service; and
 4. Any other pertinent information requested by the school district.
- B. Persons who have submitted statements of qualifications may amend those statements at any time by filing a new statement.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1063. Request for Proposals

- A. Adequate notice of the need for services specified in R7-2-1061(A) shall be given by the school district through a request

R7-2-1056. Emergency Procurement Reporting

- A. If the nature of the emergency does not permit convening a meeting of the governing board to approve the emergency procurement, the designated board member or district official who makes an emergency procurement shall, at the first scheduled governing board meeting following the procurement, provide to the governing board a report concerning the emergency procurement including the following information:
1. The written statement documenting the basis for the emergency, the basis for the selection of the particular contractor, and why the price paid was fair and reasonable; and
 2. Why it was impracticable to convene a meeting of the governing board.
- B. The information and documentation required in this Section shall be included in the procurement file.
- C. The school district shall keep a record of all emergency procurements pursuant to R7-2-1086.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1057. Repealed**Historical Note**

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

PART IX. REQUEST FOR INFORMATION**R7-2-1058. Request for Information**

- A. The school district may issue a request for information to obtain data about services or materials available to meet a specific need. Notice of the request for information shall be issued in accordance with R7-2-1024(A) and R7-2-1024(C).

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for proposals. The request for proposals shall be in accordance with R7-2-1042.

- B. In addition to providing notice of the request for proposals pursuant to R7-2-1022 and R7-2-1024(C), the school district shall provide notice to all persons who submitted statements of qualifications for the particular services solicited.
- C. If required to evaluate proposals, the request for proposals shall require all offerors who have not already done so to submit a statement of qualifications pursuant to R7-2-1062.
- D. Pre-proposal conferences may be convened in accordance with R7-2-1025.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1064. Receipt of Proposals

Proposals shall be received and opened in accordance with R7-2-1045. Late proposals, modifications, or withdrawals shall be considered in accordance with R7-2-1044.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

R7-2-1065. Evaluation of Proposals

Proposals shall be evaluated in accordance with R7-2-1046.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

R7-2-1066. Discussions with Individual Offerors

- A. As part of its initial evaluation, the school district may contact an offeror to confirm the school district's understanding of the proposal. Such contact shall be prior to the determination that a proposal is acceptable for further consideration. The school district shall obtain written confirmation from the offeror and shall retain the confirmation in the procurement file.
- B. The school district may conduct discussions with any offeror in accordance with R7-2-1047. If such discussions are conducted, the school shall issue a request for best and final offers pursuant to R7-2-1048.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1067. Mistakes in Proposals

Mistakes in proposals shall be addressed pursuant to R7-2-1049.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1068. Contract Award

- A. As provided in subsection (B), the school district shall award a contract or contracts to the responsible offeror or offerors best qualified based on the evaluation factors set forth in the request for proposal and after making a written determination that the price is fair and reasonable. The school district shall not award a contract based solely on price. No factors or criteria may be used in proposal evaluation that are not set forth in the request for proposals.

- B. The school district shall award the contract to the best qualified offeror whose price is determined to be fair and reasonable for all services, except that the school district may make a multiple award if the request for proposals included notification that multiple contracts may be awarded, the school district's basis for determining whether to award multiple contracts, and the criteria for selecting vendors for the multiple contracts.

- C. Before making a multiple award, the school district shall determine in writing that a multiple award is necessary and is advantageous to the school district and shall establish procedures for the use of the multiple awarded contracts to ensure that purchases are made from the contracts determined by the school district to be most advantageous to the school district in satisfying the school district's requirements. A multiple award shall be limited to the least number of contracts the school district determines in writing to be necessary to meet the school district's requirements, and may include the following types of awards:

1. Award to the best qualified offeror whose price is determined to be fair and reasonable for individual line items, groups of line items, or categories.
2. Awards to the best qualified offerors whose prices are determined to be fair and reasonable for similar or identical line items, groups of line items, or categories only if the school district determines in writing that such awards are necessary to obtain the required quantity or delivery, and the awards are limited to the least number of offerors necessary to meet the school district's requirements.
3. An incremental award only if the school district determines in writing that such an award is necessary to obtain the required quantity or delivery. The award shall be made to the best qualified person whose price is determined to be fair and reasonable, then to the next best qualified person whose price is determined to be fair and reasonable, etc., until the total definite quantity required is reached.
4. Regional awards to the best qualified offerors whose prices are determined to be fair and reasonable in designated regions or locations only if the school district determines in writing that such an award is necessary to obtain the required quantity or delivery over widely scattered locations or a particular requirement is of a local nature.

- D. The school district shall notify all offerors of an award.

- E. The procurement file shall contain the basis on which the award or awards are made.

- F. Within 10 days after a contract is awarded, the school district shall make the procurement file, including all proposals, available for public inspection.

1. If the procurement file contains information that is confidential under R7-2-1006, a copy of the applicable documents with the confidential information redacted shall be placed in the procurement file for the purpose of public inspection.
2. The unredacted original copy of the confidential information shall be placed in a sealed envelope or other appropriate container, identified as confidential information, and maintained in the procurement file.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

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Amended by final exempt rulemaking at 26 A.A.R. 597,
effective July 1, 2020 (Supp. 20-1).

PART XI. GUARANTEED ENERGY CONTRACTS

R7-2-1069. Guaranteed Energy Cost Savings Contracts

- A.** A school district may procure a guaranteed energy cost savings contract with a qualified provider through competitive sealed proposals in accordance with R7-2-1041 through R7-2-1050.
1. The request for proposal evaluation factors required by R7-2-1042(A)(1)(h) shall include objective criteria for selecting the qualified provider, including the cost of the contract, the energy cost savings, the net projected energy savings, the quality of the technical approach, the quality of the project management plan, the financial solvency of the qualified provider and the experience of the qualified provider with projects of similar size and scope.
 2. Notwithstanding R7-2-1042(A)(1)(h), the request for proposals shall set forth the respective numerical weighting for each evaluation criterion.
 3. At the qualified provider's expense, the proposal shall include an independent third-party validation of cost savings calculations associated with each proposed energy cost savings measure by a licensed, registered professional engineer, with credentials from the national association of energy engineers, who has demonstrated experience in energy analysis. The school district shall approve the selection of the independent third party.
 4. A school district may enter into a guaranteed energy cost savings contract with a qualified provider if the school district determines that the energy savings project will pay for itself within the expected life of the energy cost savings measures implemented (according to the manufacturer's equipment standards), the term of the financial agreement or 25 years, whichever is shortest, if the recommendations in the proposal are followed. Notwithstanding this subsection, a school district may elect to use a shorter capital cost repayment schedule than required pursuant to this subsection. The school district shall retain the cost savings achieved by a guaranteed energy cost savings contract, and these cost savings may be used to pay for the contract and project implementation.
 5. A qualified provider is a person that is experienced in designing, implementing or installing energy cost savings measures, that has a record of established projects or measures of similar size and scope, that has demonstrated technical, operational, financial and managerial capabilities to design and operate cost savings measures and projects and that has the financial ability to satisfy guarantees for energy cost savings.
- B.** In selecting a contractor to perform any construction work related to performing the guaranteed energy cost savings contract, the qualified provider may:
1. Develop and use a prequalification process for contractors.
 2. Require the contractor to demonstrate that the contractor is adequately bonded to perform the work and that the contractor has not failed to perform on a prior job.
- C.** A study shall be performed by the selected qualified provider in order to establish the exact scope of the guaranteed energy cost savings contract, the fixed cost savings guarantee amount and the methodology for determining actual savings. The selected qualified provider will provide the school district with a final study report which validates that the fixed cost savings guarantee amount will meet or exceed the cost savings calculations contained within the original proposal. The study report shall be reviewed and approved by the school district before the actual installation of any equipment. The qualified provider shall transmit a copy of the approved study report to the division of school facilities within the department of administration and the governor's office.
- D.** The information to develop the energy baseline shall be derived from historical energy costs or actual energy measurements or shall be calculated from energy measurements at the facility where energy cost savings measures are to be installed or implemented. The baseline shall be established before the installation or implementation of energy cost savings measures.
- E.** One or more school districts may enter into a financing agreement with a qualified provider or a financial institution, trustee or paying agent for the purchase and installation or implementation of energy cost savings measures. Any required financing may be obtained as part of the original competitive sealed proposal process from the qualified provider, or from a third-party financing institution that is procured separately in accordance with Articles 10 and 11.
- F.** The selected qualified provider shall provide a performance bond in accordance with R7-2-1103(A)(1)(c).
- G.** The selected qualified provider shall make public the information in the subcontractor's bids.
- H.** The guaranteed energy cost savings contract shall include the following:
1. A requirement that, in determining whether the projected energy savings calculations have been met, the energy savings shall be computed by comparing the energy baseline before installation or implementation of the energy cost savings measures with the energy consumed after installation or implementation of the energy cost savings measures. The qualified provider and the school district may agree to make modifications to the energy baseline only for any of the following:
 - a. Changes in utility rates.
 - b. Changes in the number of days in the utility billing cycle.
 - c. Changes in the square footage of the facility.
 - d. Changes in the operational schedule of the facility.
 - e. Changes in facility temperature.
 - f. Significant changes in the weather.
 - g. Significant changes in the amount of equipment or lighting used in the facility.
 - h. Significant changes in the nature or intensity of energy use such as the change of classroom space to laboratory space.
 2. A payment schedule, with payments over a period of not more than the expected life of the energy cost savings measures implemented (according to the manufacturer's equipment standards), the term of the financial agreement or 25 years, whichever is shortest, except a school district may elect to use a shorter capital cost repayment schedule than required pursuant to this subsection.
 3. A requirement that all payments, except obligations on termination of the contract before its expiration, be made pursuant to the terms of the financing agreement.
 4. A written guarantee from the qualified provider that the energy savings will meet or exceed the costs of the energy cost savings measures over the expected life of the energy cost savings measures implemented (according to the manufacturer's equipment standards), the term of the

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financial agreement or 25 years, whichever is shortest, except a school district may elect to use a shorter capital cost repayment schedule than required pursuant to this subsection. The school district shall ensure that the contractor:

- a. For the term of the guaranteed energy cost savings contract, prepares a measurement and verification report on an annual basis in addition to an annual reconciliation of savings.
 - b. Reimburses the school district for any shortfall of guaranteed energy cost savings on an annual basis.
 - c. Uses the international performance and measurement and verification protocol standards or the federal energy management program standards to validate the savings guarantee.
- I.** A school district may use a simplified energy performance contract for projects that are less than \$500,000. Simplified energy performance contracts are not required to include an energy savings guarantee and shall comply with all requirements in this Section except for subsections (D), (H)(1)(a) through (h) and (H)(4)(a) through (c).
- J.** This Section does not apply to the construction of new buildings.
- K.** For all projects under this Section, the school district shall report to the division of school facilities within the department of administration and the governor's office:
1. The name of the project.
 2. The name of the qualified provider.
 3. The total cost of the project.
 4. The expected energy cost savings and relevant escalators.
 5. The agreed-on baseline in the measurement and verification agreement in both kilowatt hours and dollars.

Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1). Amended by final exempt rulemaking at 27 A.A.R. 2342 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-1070. Guaranteed Energy Production Contracts

- A.** A school district may procure a guaranteed energy production contract with a qualified provider through competitive sealed proposals in accordance with R7-2-1041 through R7-2-1050.
1. The request for proposals evaluation factors required by R7-2-1042(A)(1)(h) shall include objective criteria for selecting the qualified provider, including the guaranteed energy price, the guaranteed energy production, the quality of the technical approach, the quality of the project management plan, the financial solvency of the qualified provider and the experience of the qualified provider with projects of similar size and scope.
 2. Notwithstanding R7-2-1042(A)(1)(h), the request for proposals shall set forth the respective numerical weighting for each evaluation criterion.
 3. The school district may obtain any required financing as part of the original competitive sealed proposal process from the qualified provider, or from a third-party financing institution procured separately in accordance with Articles 10 and 11.
 4. When submitting a proposal for the installation of equipment, the qualified provider shall include information containing the guaranteed energy production associated

with each proposed energy production measure. The school district shall review and approve this guarantee before the actual installation of any equipment. The qualified provider shall transmit a copy of the approved guarantee to the division of school facilities within the department of administration and the governor's office.

5. A qualified provider is a person that is experienced in designing, implementing or installing energy cost savings measures, that has demonstrated technical, operational, financial and managerial capabilities to design and operate cost savings measures and projects and that has the financial ability to satisfy guarantees for guaranteed energy production, financial solvency and experience for projects of similar size and scope.
- B.** In selecting a contractor to perform any construction work related to performing the guaranteed energy production contract, the qualified provider may:
1. Develop and use a prequalification process for contractors.
 2. Require the contractor to demonstrate that the contractor is adequately bonded to perform the work and that the contractor has not failed to perform on a prior job.
- C.** A guaranteed energy production contract shall include a guaranteed energy price, and a written guaranteed energy production as measured on an annual basis over the expected life of the energy production measures implemented or within 25 years, whichever is shorter. The school district shall ensure that the contractor:
1. Prepares a measurement and verification report on an annual basis in addition to an annual reconciliation of any guaranteed energy production shortfall.
 2. Reimburses the school district for any guaranteed energy production shortfall on an annual basis by multiplying any energy production shortfall by either the difference between the guaranteed energy price and the effective utility rate, or an alternative method as mutually agreed on by the school district and the qualified provider.
- D.** The selected qualified provider shall provide a performance bond in accordance with R7-2-1103(A)(1)(c).
- E.** The selected qualified provider shall make public information in the subcontractor's bids.
- F.** For all projects under this Section, the school district shall report to the governor's office and the division of school facilities within the department of administration:
1. The name of the project.
 2. The name of the qualified provider.
 3. The total cost of the project.
 4. The expected guaranteed energy production and guaranteed energy price, including relevant escalators, if applicable, over the term of the guaranteed energy production contract.
- G.** For all projects under this Section, the school district shall annually report the actual energy production and guaranteed energy price to the division of school facilities within the department of administration no later than October 15.

Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 27 A.A.R. 2342 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

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PART XII. GENERAL CONTRACT REQUIREMENTS

R7-2-1071. Reserved**R7-2-1072. Cancellation of Solicitations; Rejection of Bids and Proposals**

Each solicitation issued by the school district shall state that the solicitation may be canceled or bids or proposals rejected if it is advantageous to the school district.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

R7-2-1073. Cancellation of Solicitation Before the Due Date and Time

- A. Before the due date and time, a solicitation may be canceled in whole or in part if the school district determines that cancellation is advantageous to the school district. The reasons for the cancellation shall be made part of the procurement file.
- B. The school district shall notify in writing all persons to whom the original notice or solicitation was distributed by the school district. Notice shall be in the same manner as the original notice or solicitation, including posting on a designated site on the Internet, as applicable.
- C. The school district shall not open bids or proposals after cancellation. The school district may discard the bid or proposal 30 days after notice is given in accordance with subsection (B), unless the bidder or offeror requests the bid or proposal be returned.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,
effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1074. Cancellation of Solicitation After Bid or Proposal Opening and Before Award

- A. After opening of bids or proposals but before award, a solicitation may be canceled in whole or in part if the school district determines that cancellation is advantageous to the school district. The reasons for the cancellation shall be made part of the procurement file.
- B. The school district shall notify bidders or offerors of the cancellation in writing.
- C. The school district shall retain bids or proposals received under the canceled solicitation in the procurement file. If the school district intends to issue another solicitation within six months after cancellation of the procurement, the school district shall withhold the bids or proposals from public inspection. After award of a contract under the subsequent solicitation, the school district shall make bids or proposals submitted in response to the canceled solicitation available for public inspection except for information determined to be confidential pursuant to R7-2-1006.
- D. In the event of cancellation, the school district shall promptly return any bid security provided by a bidder or offeror.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,
effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1075. Rejection of Individual Bids and Proposals

- A. A bid or proposal may be rejected in whole or in part if:
 1. The person responding to the solicitation is determined to be nonresponsive pursuant to R7-2-1076;

2. It is nonresponsive or unacceptable;
 3. The proposed price is unreasonable; or
 4. It is otherwise not advantageous to the school district.
- B. Bidders or offerors whose bids or proposals are rejected shall be notified. A record of the rejection shall be retained in the procurement file.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,
effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1076. Responsibility of Bidders and Offerors

- A. The school district shall make a written determination that a bidder or offeror is responsible before awarding a contract to that bidder or offeror.
- B. If the school district determines a bidder or offeror is nonresponsive, the school district shall promptly send a determination to the bidder or offeror stating the basis for the determination. The school district shall file a copy of the determination in the procurement file.
- C. A finding of nonresponsibility shall not be construed as a violation of the rights of any person.
- D. If the school district included specific responsibility criteria in the solicitation, such criteria shall be considered in determining if a bidder or offeror is responsible.
- E. Factors to be considered in determining if a bidder or offeror is responsible may include:
 1. The bidder or offeror's financial, material, personnel or other resources, including subcontracts;
 2. The bidder or offeror's record of performance and integrity;
 3. Whether the bidder or offeror has been debarred or suspended; and
 4. Whether the bidder or offeror is qualified legally to contract with the school district.
- F. The unreasonable failure of a bidder or offeror to promptly supply information in connection with an inquiry with respect to responsibility shall be grounds for a determination of nonresponsibility with respect to the bidder or offeror.
- G. As required by A.R.S. § 41-2540(B), information furnished by a bidder or offeror pursuant to this Section shall not be disclosed outside of the school district without prior written consent by the bidder or offeror except to law enforcement agencies.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,
effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1077. Prequalification of Contractors for Materials, Services and Construction

- A. Prospective contractors may be prequalified for particular types of materials, services and construction. Prospective contractors have a continuing duty to provide the school district with information on any material change affecting the basis of prequalification. Solicitation mailing lists of prospective contractors shall include the prequalified contractors.
- B. A prospective contractor need not be prequalified to be awarded a contract. Prequalification does not represent a determination of responsibility.

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- C. The existence of a qualified product list pursuant to R7-2-1011(D) does not constitute prequalification of any prospective supplier of that product.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,
effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1078. Bid and Contract Security

- A. Bid and performance bonds or other security may be required for material or service contracts to guarantee faithful bid and contract performance if the governing board determines that such requirement is advantageous to the school district. In determining the amount and type of security required for each contract, the governing board shall consider the nature of the performance and the need for future protection to the school district. The requirement for bonds or other security shall be included in the solicitation.
- B. Bid or performance bonds shall not be used as a substitute for a determination of bidder or offeror responsibility.
- C. If a bid or proposal is withdrawn at any time before bid or proposal opening, any bid security shall be returned to the bidder or offeror.
- D. After the contract is awarded, any bid security shall be returned to the unsuccessful bidders or offerors. Upon execution of the contract, if performance bonds or other security were not required, or upon receipt of the specified bonds, if performance bonds or other security were required, the school district shall return any bid security provided by the successful bidder or offeror.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,
effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1079. Cost or Pricing Data

- A. The submission of current cost or pricing data may be required in connection with an award in situations in which analysis of the proposed price is essential to determine that the price is fair and reasonable. A contractor shall, except as provided in subsection (C), submit current cost or pricing data and shall certify that, to the best of the contractor's knowledge and belief, the cost or pricing data submitted is accurate, complete and current as of a mutually determined specified date before the date of either:
1. The pricing of any contract awarded by competitive sealed proposals or pursuant to the sole source procurement authority, if the total contract price is expected to exceed \$100,000.
 2. The pricing of any change order or contract modification which is expected to increase the total contract price which will then exceed \$100,000.
- B. Any contract, change order or contract modification for which certified cost or pricing data is required shall contain a provision that the price to the school district shall be adjusted to exclude any significant amounts by which the school district finds that the price was increased because the contractor-furnished cost or pricing data was inaccurate, incomplete or not current as of the date agreed on between the parties. Such adjustment by the school district may include profit or fee. The school district may reduce the contract price pursuant to R7-2-1081.

- C. The requirements of this Section may be waived if any of the following apply:

1. The contract price is based on adequate price competition.
2. The contract price is based on established catalog prices or market prices.
3. Contract prices are set by law or regulation.
4. It is determined in writing by the school district that the waiver is advantageous to the school district. The determination shall include the reasons why the waiver is advantageous to the school district.

- D. When applicable, the solicitation shall include a notice that certified cost or pricing data shall be submitted.
- E. In an emergency, cost or pricing data may be submitted at a reasonable time after the contract is awarded.
- F. A copy of all determinations by the school district that pertain to the submission of cost or pricing data shall be retained in the procurement file.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,
effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1080. Refusal to Submit Cost or Pricing Data

- A. If the offeror fails to submit cost or pricing data in the required form, the school district may reject the proposal.
- B. If a contractor fails to submit data to support a price adjustment in the form required, the school district may:
1. Reject the price adjustment; or
 2. Set the amount of the price adjustment subject to the contractor's rights under R7-2-1141 through R7-2-1185.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,
effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1081. Defective Cost or Pricing Data

- A. The school district may reduce the contract price if, upon determination, the cost or pricing data are defective.
- B. The contract price shall be reduced in the amount of the defect plus related overhead and profit or fee if the school district relied upon the defective data in awarding the contract.
- C. Any dispute as to the existence of defective cost or pricing data or the amount of an adjustment due to defective cost or pricing data may be appealed as a contract controversy under R7-2-1141 through R7-2-1185. Pending appeal, the adjusted contract price shall remain in effect.
- D. If certification of either current cost or pricing data is required, the awarded contract shall include notice of the right of the school district to a reduction in price if certified cost or pricing data are subsequently determined to be defective.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,
effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1082. Right to Inspect Plant

The school district may at reasonable times inspect the part of the plant or place of business of a contractor or any subcontractor which is related to the performance of any contract awarded or to be awarded by the school district.

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Adopted effective December 17, 1987 (Supp. 87-4).

R7-2-1083. Right to Audit Records

- A. The school district may, at reasonable times and places, audit the books and records of any person who submits cost or pricing data as provided in R7-2-1079 to the extent that the books and records relate to the cost or pricing data. Any person who receives a contract, change order or contract modification for which cost or pricing data is required shall maintain the books and records that relate to the cost or pricing data for five years after completion of the contract.
- B. The school district is entitled to audit the books and records of a contractor or any subcontractor under any contract or subcontract to the extent that the books and records relate to the performance of the contract or subcontract. The books and records shall be maintained by the contractor for a period of five years after completion of the contract and by the subcontractor for a period of five years after completion of the subcontract.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1084. Anticompetitive Practices

- A. If for any reason collusion or other anticompetitive practices are suspected among any bidders or offerors, a notice or the relevant facts shall be transmitted to the governing board and the attorney general. This Section does not require a law enforcement agency conducting an investigation into such practices to convey such notice to the school district.
- B. Upon submitting a bid or proposal, the bidder or offeror shall certify on a form prescribed by the school district that the submission of the bid or proposal did not involve collusion or other anticompetitive practices.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1085. Retention of Procurement Records

All procurement records shall be retained and disposed of in accordance with records retention guidelines and schedules approved by the Arizona State Library, Archives and Public Records.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1086. Record of Procurement Actions

- A. The school district shall maintain a record listing all contracts made under R7-2-1053, Sole source procurements, or R7-2-1055, Emergency procurements, for a minimum of five years. The record shall contain:
 1. Each contractor's name.
 2. The amount and type of each contract.
 3. A listing of the materials, services or construction procured under each contract.
- B. The record shall be available for public inspection.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1087. Contract Clauses

- A. The school district shall include in solicitations and contracts all contract clauses necessary to ensure the school district's interests are addressed. The school district may modify clauses for inclusion in any particular school district contract, provided that any variations are supported by a written determination that states the circumstances justifying the variation and provided that notice of any material variation is stated in the solicitation.
- B. All contract clauses shall be consistent with the provisions of Articles 10 and 11.
- C. The school district may permit or require the inclusion of clauses providing for appropriate remedies, adjustments in prices, time of performance or other contract provisions.
- D. A contract for the procurement of construction or construction services shall include a provision for the recovery of damages related to expenses incurred by the contractor for a delay for which the school district is responsible, that is unreasonable under the circumstances and that was not within the contemplation of the parties to the contract. This subsection does not void any provision in the contract that requires notice of delays, provides for arbitration or any other procedure for settlement or provides for liquidated damages.
- E. A provision, covenant, clause or understanding in, collateral to or affecting a construction contract or design professional service contract that makes the contract subject to the laws of another state or that requires any litigation, arbitration or other dispute resolution proceeding arising from the contract to be conducted in another state is against the public policy of this state and is void and unenforceable.
- F. A provision or clause for contract termination in accordance with A.R.S. § 38-511. The school district may cancel the Contract within three years after Contract execution without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting, or creating the Contract on behalf of the school district is or becomes at any time while the Contract, or an extension of the Contract is in effect an employee of or a consultant to any party to the Contract with respect to the subject matter of the Contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time.
- G. A provision or clause for contract termination if it appears that any person has not complied with A.R.S. § 15-213(O). The school district or school purchasing cooperative may, by written notice, terminate the Contract, in whole or in part, if the school district or school purchasing cooperative determines that any person or vendor has offered, conferred or agreed to confer any personal gift or benefit on any employee of the school district or school purchasing cooperative who supervised or participated in the planning, recommending, selecting or contracting of the Contract.
- H. A provision or clause for contract termination for gratuities. The school district or school purchasing cooperative may, by written notice, terminate the Contract in whole or in part, if the school district or school purchasing cooperative determines that employment or a gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the school district or school purchasing cooperative.

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tive for the purpose of influencing the outcome of the procurement or securing the Contract, an amendment to the Contract, or favorable treatment concerning the Contract, including making of any determination or decision about contract performance.

- I. A covenant, clause or understanding in, collateral to or affecting a construction contract or subcontract or a design professional services contract or subcontract that purports to indemnify, to hold harmless or to defend the promisee of, from or against liability for loss or damage resulting from the negligence of the promisee or the promisee's agents, employees or indemnitee is against the public policy of this state and is void.
- J. If a design professional provides work, services, studies, planning, surveys or other preparatory work in connection with a public building or improvement, the school district or property owner may require that the design professional services contract or subcontract require the design professional to indemnify and hold harmless the school district or property owner, and its officers and employees, from liabilities, damages, losses and costs, including reasonable attorney fees and court costs, but only to the extent caused by the negligence, recklessness or intentional wrongful conduct of such design professional or other persons employed or used by such design professional in the performance of the contract or subcontract.
- K. A design professional services subcontract entered into in connection with a public building or improvement may also require any design professional to indemnify and hold harmless the school district or property owner and the indemnified design professional who executed the subcontract, and their respective owners, officers and employees, from liabilities, damages, losses and costs, including reasonable attorney fees and court costs, but only to the extent caused by the negligence, recklessness or intentional wrongful conduct of such design professional, or persons employed or used by the indemnifying design professional in connection with the subcontract.
- L. Nothing in this Section shall prohibit the requirement of insurance coverage that complies with this Section, including the designation of the school district or property owner as an additional insured on a general liability insurance policy or as a designated insured on an automobile liability policy provided in connection with a construction contract or subcontract or design professional services contract or subcontract.
- M. Notwithstanding subsection (I), a contractor who is responsible for the performance of a construction contract or subcontract may fully indemnify a person, firm, corporation, state or other agency for whose account the construction contract or subcontract is not being performed and that, as an accommodation, enters into an agreement with the contractor that permits the contractor to enter on or adjacent to its property to perform the construction contract or subcontract for others.
- N. Except as provided in subsections (J), (K) and (L), a design professional services contract or subcontract entered into in connection with a public building or improvement shall not require that a design professional defend, indemnify, insure or hold harmless the school district or property owner or its employees, officers, directors, agents, contractors or subcontractors from any liability, damage, loss, claim, action or proceeding, and any contract provision that is not permitted by subsections (J), (K) and (L) is against the public policy of this state and is void.
- O. If any provision or condition contained in this Section conflicts with any provision of a contract between the school district and the federal government, such provision shall not

apply to any construction contract or subcontract, or design professional services contract or subcontract to the extent such conflict exists, but all provisions of this Section with which there is no such conflict, shall apply.

P. In this Section:

- 1. "Construction contract or subcontract" means a written or oral agreement relating to the construction, alteration, repair, maintenance, relocation, moving, demolition or excavation of a structure, street or roadway, appurtenance, facility, development, or other improvement to land.
- 2. "Design professional services" means architect services, engineer services, land surveying services, geologist services or landscape architect services or any combination of those services performed by or under the supervision of a design professional or any person employed by the design professional.
- 3. "Design professional services contract or subcontract" means a written or oral agreement relating to the planning, design, construction administration, study, evaluation, consulting, inspection, surveying, mapping, material sampling, testing or other professional, scientific or technical services furnished in connection with any actual or proposed study, planning, survey, environmental remediation, construction, improvement, alteration, repair, maintenance, relocation, moving, demolition or excavation of a structure, street or roadway, appurtenance, facility, development or other improvement to land.
- 4. "Other persons employed or used" means a subcontractor to a contractor or design professional in any tier, or any other person or entity who performs work or design professional services, or provides labor, services, materials or equipment in connection with a construction contract or subcontract or design professional service contract or subcontract subject to this Section.

Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1088. Reserved

R7-2-1089. Reserved

R7-2-1090. Reserved

PART XIII. CONTRACT TYPES

R7-2-1091. Repealed

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1092. Authority to Use Contract Types

Subject to the limitations of this Section, any type of contract that would be advantageous to the school district may be used, except that the use of a cost-plus-a-percentage-of-cost contract is prohibited.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section amended by final exempt

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rulemaking at 21 A.A.R. 1525, effective July 1, 2014
(Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1093. Multiterm Contracts

- A. Unless otherwise provided by law, multiterm contracts for materials or services and contracts for job-order-contracting construction services may be entered into if the duration of the contract and the conditions of renewal or extension, if any, are included in the invitation for bids or the request for proposals and if monies are available for the first fiscal period at the time the contract is executed. The duration of contracts for materials or services and contracts for job-order-contracting construction services shall be limited to no more than five years unless the governing board determines in writing before the procurement solicitation is issued that a contract of longer duration would be advantageous to the school district. Payment and performance obligations for succeeding fiscal periods are subject to the availability and appropriation of monies.
- B. Before the use of a multiterm contract, it shall be determined in writing by the governing board that:
 - 1. Estimated requirements cover the period of the contract and are reasonable and continuing.
 - 2. Such a contract will be advantageous to the school district by encouraging effective competition or otherwise promoting economies in school district procurement.
- C. The school district shall include in all multiterm contracts a clause specifying that the contract shall be canceled if monies are not appropriated or otherwise made available to support the continuation of performance in a subsequent fiscal year.
- D. If monies are not appropriated or otherwise made available to support continuation of performance in a subsequent fiscal period, the contract shall be canceled and the contractor may only be reimbursed for the reasonable value of any nonrecurring costs incurred but not amortized in the price of the materials or services delivered under the contract or which are otherwise not recoverable. The cost of cancellation may be paid from any appropriations available for such purposes.
- E. A contract for specified professional services shall have a term not to exceed five years after the date of contract award by the school district of the first contract under the procurement, except that the contract may continue in effect after the five year term for projects on which the rendering of specified professional services commences within the five year term.
- F. Notwithstanding this Section, contracts for auditors and auditing firms shall have a term as prescribed in A.R.S. § 15-213.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 24 A.A.R. 3283, effective October 22, 2018 (Supp. 18-4).

R7-2-1094. Reserved**R7-2-1095. Reserved****R7-2-1096. Reserved****R7-2-1097. Reserved****R7-2-1098. Reserved****R7-2-1099. Reserved****ARTICLE 11. SCHOOL DISTRICT PROCUREMENT (CONTINUED)****PART XIV. PROCUREMENT OF CONSTRUCTION****R7-2-1100. Construction Project Delivery Methods**

- A. For the design-bid-build project delivery method, the school district shall procure:
 - 1. Design services pursuant to R7-2-1117 through R7-2-1123, except as authorized by R7-2-1053 and R7-2-1055.
 - 2. Construction by competitive sealed bidding pursuant to R7-2-1021 through R7-2-1032 and R7-2-1102 through R7-2-1105, except as authorized by R7-2-1033, R7-2-1053, R7-2-1055, and R7-2-1101.
- B. For construction-manager-at-risk, design-build and job-order-contracting project delivery methods, the school district shall procure construction services pursuant to R7-2-1102 through R7-2-1115.
- C. For construction-manager-at-risk project delivery method, the school district shall purchase design services pursuant to R7-2-1117 through R7-2-1123.
- D. For job-order-contracting project delivery method, the school district may include design services in the job-order-contracting construction services contract, but if the school district does not include design services in the contract, the school district shall procure any design services relating to construction services projects under the contract pursuant to R7-2-1117 through R7-2-1123.

Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1101. Qualified Select Bidders List

- A. The school district may use the qualified select bidders list method to determine the vendors who receive the notice of competitive sealed bidding for a construction contract. The qualified select bidders list shall be determined in accordance with this Section.
- B. Sealed prime contractor or construction materials supplier statements of qualifications shall be solicited through requests for qualifications.
 - 1. Notice of the request for qualifications shall be given by the school district pursuant to R7-2-1022 and R7-2-1024(C).
 - 2. Requests for qualifications shall be issued at least 21 days before the due date and time for submission.
 - 3. Use of the qualified select bidders list shall be restricted to the specific project identified in the request for qualifications.
 - 4. The qualified select bidders list shall consist of at least three prime contractors when a contractor is solicited or three construction material suppliers when material suppliers are solicited.
 - 5. The qualified select bidders list for any specific project is valid for one year but may be extended for an additional year, at the option of the school district.
- C. The request for qualifications shall include the following:
 - 1. Notice that all information and statements of qualifications submitted by persons will be made available for public inspection following the establishment of a qualified select bidders list.
 - 2. Instructions and information to persons concerning the statement of qualifications submission requirements, including the due date and time for submission, the address of the office at which the statements of qualifica-

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tions are to be received, and any other special information.

3. The anticipated evaluation period and selection of a qualified select bidders list.
 4. General information on the project site or sites, scope of work, schedule, evaluation criteria, project design and construction budget, or life cycle budget for a procurement that includes maintenance, operations, and finance services.
 5. The weight prescribed by the school district for each of the criteria to be used in making the evaluation.
 6. The criteria to be used in making the evaluation, which shall include at a minimum:
 - a. Person's capabilities and qualifications for performing the scope of work;
 - b. Person's project team, and key members' education, training and qualifications;
 - c. Method of approach, including subcontractor plan, safety plan;
 - d. Safety record and worker's compensation rate;
 - e. Projected construction schedule;
 - f. Current workload;
 - g. Five most recent representative examples of similar work along with references for each example;
 - h. Current bonding availability and capacity;
 - i. Any judgment or liens against the person within the last three years;
 - j. Any current unresolved bond claims against the person;
 - k. Any deficiency orders issued against the prime contractor by the Arizona Registrar of Contractors within the last three years; and
 - l. Any filing under the United States Bankruptcy Code, assignments for the benefit of creditors, or other measures taken for the protection against creditors during the last three years.
 7. The type of contract to be used.
 8. The name of the district representative or district representatives.
 9. The expiration date of the qualified select bidders list if less than one year.
 10. A statement that the school district reserves the right to conduct interviews as part of the evaluation process.
 11. The date, time and location of any pre-submittal conference.
- D.** The school district may conduct a pre-submittal conference not less than 14 days prior to the statement of qualifications due date and time for the purposes of explaining the requirements of the request for qualifications.
- E.** Amendments to request for qualifications.
1. An amendment to a request for qualifications shall be issued if necessary to do any of the following:
 - a. Make changes in the request for qualifications;
 - b. Correct defects or ambiguities;
 - c. Furnish to persons information given to any other person, if the information will assist the persons in submitting their statements of qualifications or if the lack of the information will prejudice the persons;
 - d. Provide additional information or instructions; or
 - e. Extend the due date and time if the school district determines that an extension is advantageous to the school district.
 2. Amendments to a request for qualifications shall be so identified and the school district shall ensure that the

amendments are distributed or made available to all persons to whom the original request for qualifications was distributed or made available. The school district shall make a copy of the amendments to a request for qualifications available for public inspection at the school district office. If the school district posted the request for qualifications or a notice of the availability of a request for qualifications on a designated site on the Internet, then the school district shall post any amendments to the request for qualifications on the same designated site on the Internet. The school district shall also do one or more of the following:

- a. Distribute the amendment, by any method reasonably calculated to ensure delivery, to all persons to whom the request for qualifications was distributed;
 - b. Make the amendment available and issue a notice of amendment which contains instructions for obtaining copies of the amendment. The notice of amendment shall be distributed, by any method reasonably calculated to ensure delivery, to all persons to whom the request for qualifications was distributed. Upon receipt of such notice of amendment, it is the responsibility of the person to obtain the amendment.
3. Amendments to request for qualifications shall be issued within a reasonable time before the due date and time to allow persons to consider them in preparing their statements of qualifications. If the school district determines that the due date and time in the request for qualifications does not permit sufficient time for statement of qualifications preparation, the due date and time shall be extended in the amendment or, if necessary, by telephone, facsimile, email, or other communications methods, and confirmed in the amendment.
 4. A person shall acknowledge receipt of an amendment in the manner specified in the request for qualifications or the amendment on or before the due date and time.
- F.** Pre-submittal modification or withdrawal of statements of qualifications
1. A person may modify or withdraw a statement of qualifications in writing at any time before the prescribed due date and time if the modification or withdrawal is received before the due date and time at the location designated in the request for qualifications for receipt of statements of qualifications.
 2. All documents concerning a modification or withdrawal of a statement of qualifications shall be retained in the procurement file.
- G.** Late statements of qualifications, late withdrawals and late modifications
1. A statement of qualifications, modification or withdrawal is late if it is received at the location designated in the request for qualifications for receipt of statements of qualifications after the due date and time.
 2. A late statement of qualifications, late modification, or late withdrawal shall be rejected, unless the statement of qualifications, modification or withdrawal would have been timely received but for the action or inaction of school district personnel and is received before the qualified select bidders list is established.
 3. Upon receiving a late statement of qualifications, late modification, or late withdrawal, the school district shall record the time and date of receipt and promptly send notice of late receipt to the person. The school district

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may discard the document 30 days after the date on the notice unless the person requests the document be returned.

4. All documents concerning acceptance of a late statement of qualifications, late modification, or late withdrawal shall be retained in the procurement file.

H. Receipt, opening and recording statements of qualifications

1. A school district shall maintain a record of statements of qualifications and modifications received for each solicitation, shall record the time and date when each statement of qualifications or modification is received, and shall store each unopened statement of qualifications or modification in a secure place until the due date and time.
 - a. If required to confirm a vendor's inquiry regarding receipt of its statement of qualifications prior to the due date and time, a school district may open a statement of qualifications to identify the vendor. If this occurs, the school district shall record the reason for opening the statement of qualifications, the date and time the statement of qualifications was opened, and the solicitation number. The school district shall secure the statement of qualifications and retain it for public opening.
 - b. One or more witnesses shall be present for the opening of a statement of qualifications under subsection (H)(1)(a).
2. Statements of qualifications and modifications shall be opened publicly at the date, time and location designated in the request for qualifications in the presence of one or more witnesses. The name of each person and any other relevant information deemed appropriate by the school district shall be recorded. The person opening the statements of qualifications and all witnesses shall sign the record.
 - a. The record created in subsection (H)(2) shall be available for public inspection.
 - b. The statements of qualifications shall not be open for public inspection until after the qualified select bidders list has been established.

I. Establishing the qualified select bidders list.

1. The qualified select bidders list shall be established by determining the highest rated persons from the statements of qualifications received. This will be a minimum of three and a maximum of five.
2. For each qualified select bidders list process there will be established by the school district an evaluation committee composed of five members. These members shall include the project designer or construction material specifier, one member from the prime contracting or construction material supplier community that performs commensurate level work and is disinterested in this project, a school district facilities representative and two other members as designated by the school district.
3. The evaluation committee shall review and score each statement of qualifications received according to the established evaluation criteria. The committee shall rank the statements of qualifications in accordance with the scores.
4. The committee may conduct interviews before making the final determination of the qualified select bidders list. The committee shall document the interviews in writing.
5. The committee shall select at least three and not more than five of the highest scoring persons for the qualified select bidders list.

6. The district representative shall review the committee's qualified select bidders list. The district representative shall:
 - a. Accept the list as submitted;
 - b. Return the list for additional committee review;
 - c. Reject the list and terminate the process.

7. A one-year eligibility period for the qualified select bidders list shall begin on the date the district representative accepts it. The qualified select bidders list may be extended one year at the option of the school district.
8. Once the qualified select bidders list is established, a written notice of the selected persons shall be sent to all the persons that submitted statements of qualifications.
9. After the establishment of the qualified select bidders list, a written record showing the basis for determining the qualified select bidders list shall be prepared by the district representative and retained in the procurement file. Within 10 days after the qualified select bidders list has been established, the school district shall make the procurement file, including all statements of qualifications, available for public inspection.
 - a. If the procurement file contains information that is confidential under R7-2-1006, a copy of the applicable documents with the confidential information redacted shall be placed in the procurement file for the purpose of public inspection.
 - b. The unredacted original copy of the confidential information shall be placed in a sealed envelope or other appropriate container, identified as confidential information, and maintained in the procurement file.
10. The qualified select bidders shall be provided an invitation for bids in accordance with R7-2-1024 to R7-2-1032. For any projects not identified in the request for qualifications, the school district may not solicit bids on those projects under the qualified select bidders list either in the initial one-year period or the one-year extension period.
11. The project identified in the request for qualifications shall have invitation for bids issued within the initial one-year period, or in the one-year extension period, to be awarded a contract under that qualified select bidders list.

J. Terminating the process for insufficient response or selection

1. In the event that less than three statements of qualifications are received, this procurement process shall cease and the school district may elect to reissue the request for qualifications or pursue other procurement methods.
2. In the event that less than three persons are identified by the selection committee as being the most highly qualified, this procurement process shall cease and the school district may elect to reissue the request for qualifications or pursue other procurement methods.

- K.** A copy of the request for qualifications shall be made available for public inspection at the school district office.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1102. Bid Security

- A.** Bid security shall be required for all competitive sealed bidding for construction contracts, and for all competitive sealed

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proposals for design-build construction services or job-order-contracting construction services procured pursuant to R7-2-1111, if the price, excluding the cost of any finance services, maintenance services, operations services, design services, preconstruction services, or other related services included in the contract, is estimated by the school district to exceed the amount established by R7-2-1002(A).

B. Invitations for bid on school district construction contracts and requests for proposals for design-build construction services or job-order-contracting construction services, shall require submission of bid security as follows:

1. For design-bid-build construction services, ten percent of the contractor's bid.
2. For design-build construction services awarded by competitive sealed proposals pursuant to R7-2-1111, ten percent of the school district's construction budget for the project as stated in the request for proposals, excluding finance services, maintenance services, operations services, design services, preconstruction services or any other related services included in the contract.
3. For job-order-contracting construction services awarded by competitive sealed proposals pursuant to R7-2-1111, the amount prescribed by the school district in the request for proposals, but not more than ten percent of the school district's reasonably estimated budget for construction that the school district believes is likely to actually be done during the first year under the contract, excluding any finance services, maintenance services, operations services, design services, preconstruction services or other related services included in the contract.

C. Acceptable bid security shall be limited to:

1. An annual or one-time bid bond executed and furnished as required by A.R.S. Title 34, Chapter 2 or 6, as applicable; or
2. A certified check.

D. The school district may issue a written determination to accept the bid security if the bid security fails to comply in a nonsubstantial manner when:

1. Only one bid or proposal is received and there is not sufficient time to rebid or resolicit proposals;
2. The amount of the bid security submitted, although less than the amount required by the invitation for bids or request for proposals, is equal to or greater than the difference between the apparent low bid or highest scoring proposal and the next higher acceptable bid or next highest scoring proposal; or
3. The bid security is inadequate as a result of modifying or correcting a bid in accordance with R7-2-1027 or R7-2-1030, if the bidder increases the amount of security to required limits within two days after notification.

E. After the bids and proposals are opened, they are irrevocable for the period specified in the invitation for bids or request for proposals, except as provided in R7-2-1030. If a bidder or offeror is permitted to withdraw its bid before award, no action may be had against the bidder or offeror or the bid security.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1103. Contract Performance and Payment Bonds

A. The following bonds or security is required and is binding on the parties to the contract if the value of a construction or construction services award exceeds the amount established by R7-2-1002(A):

1. A performance bond that is executed and furnished as required under Arizona Revised Statutes Title 34, Chapter 2, Article 2 or Chapter 6, as applicable, in an amount equal to 100 percent of the price specified in the contract conditioned on the faithful performance of the contract in accordance with the plans, specifications and conditions of the contract, except that:

a. For job-order-contracting construction services, the performance bond shall cover the full amount of construction under the job-order-contracting construction services contract, shall not include any design services, preconstruction services, finance services, maintenance services, operations services or other related services included in the contract, may be a single bond for the full term of the contract, a separate bond for each year of a multiyear contract or a separate bond for each job order, as determined by the school district, and, if a single bond for the full term of the contract or a separate bond for each year of a multiyear contract, shall initially be based on the school district's reasonable estimate of the amount of construction that the school district believes is likely to actually be done during the full term of the contract or during the particular year of a multiyear contract, as applicable.

b. For construction-manager-at-risk construction services and design-build construction services, the amount of the performance bond shall be the price of construction and shall not include the cost of any design services, preconstruction services, finance services, maintenance services, operations services and other related services included in the contract. This bond is solely for the protection of the school district. The conditions and provisions of the performance bond regarding the surety's obligations shall follow the form required under A.R.S. § 34-222(G) or A.R.S. § 34-610(G), as applicable.

c. For guaranteed energy cost savings contracts and guaranteed energy production contracts, the amount of the performance bond shall be one hundred percent of the project amount to the school district for its faithful performance of the equipment installment.

2. A payment bond that is executed and furnished as required by Arizona Revised Statutes Title 34, Chapter 2, Article 2 or Chapter 6, as applicable, in an amount equal to one hundred percent of the price specified in the contract for the protection of all persons supplying labor or material to the contractor or its subcontractors for the performance of the construction provided for in the contract, except that:

a. For job-order-contracting construction services, the payment bond shall cover the full amount of construction under the job-order-contracting construction services contract, shall not include any design services, preconstruction services, finance services, maintenance services, operations services or other related services included in the contract, may be a single bond for the full term of the contract, a separate bond for each year of a multiyear contract or a

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separate bond for each job order, as determined by the school district, and, if a single bond for the full term of the contract or a separate bond for each year of a multiyear contract, shall initially be based on the school district's reasonable estimate of the amount of construction that the school district believes is likely to actually be done during the full term of the contract or during the particular year of a multiyear contract, as applicable.

- b. For construction-manager-at-risk construction services and design-build construction services, the amount of the payment bond shall be the price of construction and shall not include the cost of any design services, preconstruction services, finance services, maintenance services, operations services or other related services included in the contract. The conditions and provisions of the payment bond regarding the surety's obligations shall follow the form required under A.R.S. § 34-222(F) or A.R.S. § 34-610(F), as applicable.
- B. For design-bid-build construction, the bonds prescribed in subsection (A) shall be provided on and at the same time as execution of the construction contract. For construction-manager-at-risk, design-build and job-order-contracting construction services, the bonds prescribed in subsection (A) shall be provided only on and at the same time as execution of a contract or contract modification that commits the contractor to provide construction for a fixed price, guaranteed maximum price or other fixed amount within a designated time frame.
- C. If the prime contract or specifications require any persons supplying labor or materials in the prosecution of the work to furnish payment or performance bonds, these bonds shall be executed solely by a surety company or companies holding a certificate of authority to transact surety business in this state issued by the director of the Department of Insurance pursuant to Arizona Revised Statutes Title 20, Chapter 2, Article 1. Notwithstanding the provisions of any other statute, the bonds shall not be executed by an individual surety or sureties, even if the requirements of A.R.S. § 7-101 are satisfied.
- D. If a contractor fails to deliver the required performance bond or payment bond, the contractor's bid shall be rejected, its bid security shall be enforced, and award of the contract shall be made pursuant to Articles 10 and 11.
- E. This Section shall not be construed to limit the authority of the school district to require a performance bond or other security in addition to those bonds or in circumstances other than specified in subsection (A).
- F. Any person who furnishes labor or material to the contractor or its subcontractors for the work provided in the contract, in respect of which a payment bond is furnished under this Section, and who has not been paid in full within 90 days from the date on which the last of the labor was performed or material was supplied by the person for whom the claim is made has the right to sue on the payment bond for any amount unpaid at the time the suit is instituted and to prosecute the action for the amount due the person. However, any person who has a contract with a subcontractor of the contractor, but no express or implied contract with the contractor furnishing the payment bond, has a right of action on the payment bond on giving the contractor, only, a written preliminary 20-day notice as provided for in A.R.S. § 33-992.01, subsection (C)(1), (2), (3), and (4) and subsections (D), (E), and (H), and upon giving written notice to the contractor within 90 days from the date on which the last of the labor was performed or material was sup-

plied by the person for whom the claim is made. The person shall state in the notice the amount claimed and the name of the party for whom the labor was performed or to whom the material was supplied. The notice shall be personally served or sent by registered mail, postage prepaid, in an envelope addressed to the contractor at any place the contractor maintains an office or conducts business.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. The term "one hundred" was changed to "100" to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-1104. Contract Payment Retention and Substitute Security

- A. Ten percent of all construction contract payments shall be retained by the school district as insurance of proper performance of the contract or, at the option of the contractor, a substitute security may be provided by the contractor pursuant to this Section. The contractor is entitled to all interest from any such substitute security. When the contract is fifty percent completed, one-half of the amount retained or securities substituted pursuant to this Section shall be paid to the contractor upon the contractor's request provided the contractor is making satisfactory progress on the contract and there is no specific cause or claim requiring a greater amount to be retained. After the contract is fifty percent completed, no more than five percent of the amount of any subsequent progress payments made under the contract shall be retained providing the contractor is making satisfactory progress on the project, except if at any time the governing board determines satisfactory progress is not being made, ten percent retention shall be reinstated for all progress payments made under the contract subsequent to the determination.
- B. Notwithstanding subsection (A), there shall be no retention for job-order-contracting construction services contracts. The school district may elect to have no retention for construction-manager-at-risk and design-build construction services contracts. If the school district elects to have retention, then payment retention for construction-manager-at-risk and design-build contracts shall be in accordance with this Section.
- C. Retention applies only to amounts payable for construction and does not apply to amounts payable for design services, preconstruction services, finance services, maintenance services, operations services, or any other related services included in the contract.
- D. The form of substitute security is limited to the following:
 1. An assignment of time certificates of deposit by financial institutions licensed by this state;
 2. Share certificate of a financial institution or credit union authorized to transact business in this state; or
 3. Security issued or guaranteed as to principal and interest by:
 - a. The United States;
 - b. The state;
 - c. Counties, municipalities and school districts within this state.
- E. Conditions for use of substitute security.
 1. A contractor may submit substitute security to replace contract payment retention if:
 - a. The use of substitute security is requested of the school district or designee for work performed under

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the contract. The contractor shall have the option of submitting the substitute security:

- i. Prior to each progress payment in an amount of no less than five percent of each progress payment; or
- ii. Once, prior to the first progress payment in an amount no less than five percent of the total contract amount.
- b. The interest earned on such security shall accrue to the benefit of the contractor, but shall be retained until the school district has approved completion and acceptance of all work to be performed under the contract;
- c. The term of such security shall not mature until after the estimated contract completion date; and
- d. The security shall mature no later than one year after the estimated contract completion date.
2. The substitute security shall not be released without written approval by the school district.
3. A contractor may submit a single substitute security for more than one project provided that:
 - a. The amount of such security is sufficient to cover the aggregate retention amount;
 - b. The school district determines that such single substitute security is advantageous to the school district; and
 - c. Such security complies with the requirements of subsection (E)(1).
- F. Any retention shall be paid or substitute security shall be returned to the contractor within 60 days after final completion and acceptance of work under the contract. Retention of payments by a school district longer than 60 days after final completion and acceptance requires a specific written finding by the governing board of the reasons justifying the delay in payment. No school district may retain any monies after 60 days which are in excess of the amount necessary to pay the expenses the governing board reasonably expects to incur in order to pay or discharge the expenses determined in the finding justifying the retention of monies.
- G. The school district shall not accept any substitute security unless accompanied by a signed and acknowledged waiver of any right or power of the obligor to set off any claim against either the school district or the contractor in relationship to the security assigned. In any instance in which the school district accepts substitute security as provided in this Section, any subcontractor undertaking to perform any part of the contract is entitled to provide such security to the contractor.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1105. Progress Payments

- A. Progress payments may be made by the school district to the contractor on the basis of a duly certified and approved estimate of the work performed during the preceding month if the contractor agrees to adhere to the provisions of A.R.S. § 41-2577(B), (D), and (F). Payment shall be made within 14 days after the estimate of the work is certified and approved, except that a percentage of all estimates shall be retained as provided in R7-2-1104. The estimate of the work shall be deemed received by the school district on submission of the estimate of the work to the school district or a person designated by the

school district for the submission, review or approval of the estimate of the work. An estimate of the work submitted under this Section shall be considered approved and certified after seven days from the date of submission unless before that time the school district or designee prepares and issues a specific written finding detailing those items in the estimate of the work that are not approved and certified under the contract or design professional service contract. The school district may withhold an amount from the progress payment sufficient to pay the expenses the school district reasonably expects to incur in correcting the deficiency set forth in the written finding. No contract for construction or design professional service contract may materially alter the rights of any contractor, subcontractor, design professional or material supplier to receive prompt and timely payment as provided under this Section. On completion and acceptance of separate divisions of the contract or design professional service contract on which the price is stated separately in the contract, payment may be made in full including retained percentages, less deductions, unless a substitute security has been provided pursuant to R7-2-1104.

- B. Progress payments pursuant to subsection (A) are authorized for construction services and design professional services contracts. The requirements of subsection (A) apply only to amounts payable in a construction services contract for construction and in a contract for design services and do not apply to amounts payable in a contract for preconstruction services, finance services, maintenance services, operations services or any other related services included in the contract.
- C. A subcontractor or design professional may notify the school district, in writing, requesting that the subcontractor or design professional be notified by the school district in writing within five days from payment of each progress payment made to the contractor. The subcontractor's or design professional's request remains in effect for the duration of the subcontractor's or design professional's work on the project.
- D. If any payment to a contractor is delayed after the date due, interest shall be paid at the rate of one percent per calendar month, or a fraction of a calendar month, on such unpaid balance as may be due.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1106. Procurement of Construction Using Alternative Project Delivery Methods

- A. A school district may use an alternative project delivery method if it determines in writing that such alternative project delivery method is advantageous to the school district. The following factors may be used for such determination:
 1. Cost and cost control method;
 2. Value engineering;
 3. Market conditions;
 4. Schedule;
 5. Required specialized expertise;
 6. Technical complexity of the project; or
 7. Project management.
- B. Use of alternative project delivery methods
 1. Alternative project delivery methods for construction services shall be procured as provided in R7-2-1100.

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2. For design-build construction services and construction-manager-at-risk construction services, the school district is limited to one contract per procurement.
 - a. Alternatively, for construction-manager-at-risk construction services, a school district may elect separate contracts for preconstruction services during the design phase, for construction during the construction phase and for any other construction services.
 - b. Alternatively, for design-build construction services, a school district may elect separate contracts for preconstruction services and design services during the design phase, for construction and design services during the construction phase and for any other construction services.
 - c. If the school district enters into the first contract for preconstruction services or construction services the procurement ends. After execution of that first contract the school district may not use the procurement or the existing final list in the procurement as the basis for entering into a contract with any other person that participated in the procurement.
3. For job-order-contracting construction services, the school district may award a single contract, or multiple contracts for similar job-order-contracting construction services to be awarded to separate persons. If the school district enters into the number of contracts specified under the request for qualifications, the procurement ends. After that time the school district may not use the procurement or any existing final list in the procurement as the basis for entering into a contract with any other person that participated in the procurement.
4. All construction-manager-at-risk construction services or design-build construction services included in a procurement shall be limited to construction services to be performed at a single location, a common location or, if the construction services are all for a similar purpose, multiple locations. For construction-manager-at-risk construction services and design-build construction services to be performed at multiple locations:
 - a. At the time the request for qualifications is issued, the school district shall intend to commence all construction at each location within thirty months after execution of the first contract for preconstruction services or other construction services at any of the locations.
 - b. The request for qualifications shall include the information described in R7-2-1108(B)(2).
5. The school district and the selection committee shall not request or consider fees, price, man-hours or any other cost information at any point in the selection process under this Section and R7-2-1107, R7-2-1108, R7-2-1110, and R7-2-1111, including the selection of persons to be interviewed, the selection of persons to be on the final list, in determining the order of preference of persons on the final list or for any other purpose in the selection process, except as provided in R7-2-1110(D) and R7-2-1111.
6. In determining the persons to participate in any interviews, in determining the persons to be on the final list, and in determining the order on the final list, the selection committee shall use and consider only the criteria and weighting of criteria in the request for qualifications. No other factors or criteria may be used in the evaluation, determinations and other actions.
7. Notwithstanding any other provision specifying the number of persons to be interviewed, the number of persons to be on a final list, or any other numerical specification in R7-2-1106 through R7-2-1115:
 - a. If a smaller number of persons respond to the request for qualifications or if one or more persons drop out of the procurement so there is a smaller number of persons participating in the procurement, the school district, as the school district determines necessary and appropriate, may elect to proceed with the participating persons if there are at least two participating responsive and responsible persons. Alternatively, the school district may elect to terminate the procurement.
 - b. As to a request for qualifications to be negotiated pursuant to R7-2-1110(D), if only one responsive and responsible person responds to the request for qualifications or if one or more persons drop out of the procurement so that only one responsive and responsible person remains in the procurement, the school district may elect to proceed with the procurement with only one person if the governing board determines in writing that the negotiated fee is fair and reasonable and that either other prospective persons had reasonable opportunity to respond or there is not adequate time for a resolicitation.
 - c. If a person on the final list withdraws or is removed from the procurement and the selection committee determines that it is advantageous to the school district, the selection committee may replace that person on the final list with another person that submitted qualifications in the procurement and that is selected as the next most qualified.

Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1107. Selection Committee

- A. The school district shall initiate an appropriately qualified selection committee for each request for qualifications. The school district shall ensure that selection committee members are competent to serve on the selection committee.
- B. Each selection committee shall include at least one school district representative appointed by the school district.
- C. The selection committee shall not have more than seven members and shall include at least one person who is a senior management employee of a licensed contractor and one person who is an architect or an engineer who is registered pursuant to A.R.S. § 32-121.
- D. Non-school district employees serving on a selection committee shall not receive compensation from the school district for performing this service, but the school district may elect to reimburse non-school district members for travel, lodging and other expenses incurred in connection with service on a selection committee.
- E. A person who is a member of a selection committee shall not be a contractor or subcontractor under a contract awarded under the procurement or provide any specified professional services, construction, construction services, materials or other services under the contract.
- F. For the procurement of multiple contracts for job-order-contracting, the same selection committee shall be used for all contracts in the procurement.

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Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1108. Request for Qualifications

- A.** Notice of the need for construction services shall be given by the school district pursuant to R7-2-1022 and R7-2-1024(C). Such notice shall be issued not less than 14 days in advance of when responses shall be received. The notice shall:
1. Contain a statement of the construction services required that adequately describes the procurement and specifies how a request for qualifications containing specific information on the procurement may be obtained;
 2. Specify whether the procurement is for a single contract or, for job-order-contracting construction services only, for multiple contracts; and
 3. If the procurement is for multiple job-order-contracting construction services contracts:
 - a. Specify that multiple contracts may or will be awarded;
 - b. Specify the number of contracts that may or will be awarded; and
 - c. Describe the construction services to be performed under each contract.
- B.** The request for qualifications shall include the following:
1. Instructions and information to persons concerning the statement of qualifications submission requirements, including the due date and time for receipt of statements of qualifications, the address of the office at which the statements of qualifications are to be received, and any other special information.
 2. In a procurement of construction-manager-at-risk construction services or design-build construction services to be performed at multiple locations, include:
 - a. A brief description of the construction services to be performed at each location;
 - b. The estimated budget for the construction services to be performed at each location; and
 - c. A schedule for the construction services to be performed at each location that shows the school district's intent to commence all construction at each location within thirty months after execution of the first contract for preconstruction services or other construction services at any of the locations.
 3. General information on the project site, scope of work, schedule, selection criteria, project design and construction budget, or life cycle budget for a procurement that includes maintenance, operations, and finance services.
 4. The criteria and the weight prescribed by the school district for each of the criteria to be used in making the evaluation.
 - a. All selection criteria shall be factors that demonstrate competence and qualifications for the type of construction services included in the procurement.
 - b. One of the criteria shall be the person's subcontractor selection plan or procedures to implement the school district's subcontractor selection plan.
 - c. If interviews will be held, state the selection criteria and relative weights to be used in selecting the persons to be interviewed. The request for qualifications may state the selection criteria and relative weights to be used in selecting the persons on the final list and in determining their order on the final list. The final list selection criteria and relative weights may be different than the selection criteria and relative weights used to determine the persons to be interviewed. The request for qualifications also shall state whether the school district will select the persons on the final list and their order on the final list solely through the results of the interview process or through the combined results of both the interview process and the evaluation of statements of qualifications and performance data submitted in response to the school district's request for qualifications.
 5. Whether one contract or multiple contracts may or will be awarded.
 - a. For design-build construction services, construction-manager-at-risk construction services, and a single contract for job-order-contracting construction services, state that one person may or will be awarded the contract.
 - b. For multiple contracts for similar job-order-contracting construction services, state the number of contracts that may or will be awarded, the job-order-contracting construction services to be performed under each of the contracts, and that each of the multiple contracts will be awarded to a separate person.
 6. In a procurement where the contract is to be negotiated under R7-2-1110(D):
 - a. State that there will be a single final list of at least three and not more than five persons for a design-build, construction-manager-at-risk, or single job-order-contracting construction services award.
 - b. In a procurement for multiple contracts for similar job-order-contracting construction services to be awarded to separate persons, state that there will be a single final list and the number of persons on the final list, which shall be the sum of the number of contracts that may or will be awarded, plus another number that is determined by the school district and that is not more than five.
 7. In a procurement in which the contract will be awarded under R7-2-1111:
 - a. State that there will be a single final list and that the number of persons on the final list will be three for a design-build or single job-order-contracting construction services award.
 - b. In a procurement for multiple contracts for similar job-order-contracting construction services to be awarded to separate persons, state that there will be a single final list and the number of persons on the final list, which shall be the sum of the number of contracts that may or will be awarded, plus another number that is determined by the school district and that is not more than five.
 8. The type of contract to be used.
 9. The name of the district representative or district representatives and the publicly available location of the school district's protest policy and procedures.
 10. If the school district will hold interviews as part of the selection process:
 - a. State that interviews will be held and that the interviews will be with at least three and not more than

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five persons for a design-build, construction-manager-at-risk, or single job-order-contracting construction services procurement.

- b. In a procurement for multiple contracts for similar job-order-contracting construction services to be awarded to separate persons, state that interviews will be held and that the interviews will be with a specified number of persons. The specified number shall be stated in the request for qualifications, shall be determined by the school district and shall be the sum of the number of contracts that may or will be awarded, plus another number that is determined by the school district and that is not more than five.
11. The manner in which subcontractors shall be selected, either:
 - a. A requirement that each person submit a proposed subcontractor selection plan and a requirement that the proposed subcontractor selection plan shall select subcontractors based on qualifications alone or on a combination of qualifications and price and shall not select subcontractors based on price alone; or
 - b. A subcontractor selection plan adopted by the school district that applies to the person that is selected to perform the construction services and that requires subcontractors to be selected based on qualifications alone or on a combination of qualifications and price and not based on price alone and a requirement that each person shall submit a description of the procedures it proposes to use to implement the school district's subcontractor selection plan.
 12. Notice that all information and statements of qualifications submitted by persons will be made available for public inspection after the school district has entered into a single contract or all of the multiple contracts.
- C. A copy of the request for qualifications shall be made available for public inspection at the school district office.

Historical Note

New Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1109. Receipt and Opening of Statements of Qualifications, Technical Proposals and Price Proposals for Design-build and Job-order-contracting

- A. Statements of qualifications, technical proposals and price proposals shall be received and opened in accordance with R7-2-1045. Late statements of qualifications, proposals, modifications, or withdrawals shall be considered in accordance with R7-2-1044 and R7-2-1049.
- B. A school district may cancel a request for qualifications or a request for proposals, reject in whole or in part any or all statements of qualifications or proposals or determine not to enter into a contract as specified in the solicitation if it is advantageous to the school district. The school district shall make the reasons for cancellation, rejection or determination not to enter into a contract part of the procurement file.

Historical Note

New Section made by exempt rulemaking at 13 A.A.R. 1266, effective February 26, 2007 (Supp. 07-1). Section repealed; new Section made by final exempt rulemaking

at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1110. Committee Evaluation and Contract Award

- A. If interviews are specified in the request for qualifications:
 1. The selection committee shall determine the persons to be interviewed by evaluating the statements of qualifications and performance data submitted based solely on the selection criteria and relative weights in the request for qualifications to be used to determine the persons to be interviewed.
 2. If the selection criteria and relative weights to be used by the selection committee to select the persons on the final list and to determine their order on the final list are not included in the request for qualifications:
 - a. Before the interviews are held the school district shall distribute to the persons to be interviewed the selection criteria and relative weights to be used to select the persons on the final list and to determine their order on the final list.
 - b. These selection criteria and relative weights may be different than the selection criteria and relative weight used to determine the persons to be interviewed.
 3. The selection committee shall conduct interviews with the number of persons specified in the request for qualifications.
- B. Based solely on the selection criteria and relative weights for selection of the persons on the final list and their order on the final list, the selection committee shall select the persons for the final list and, in the case of a final list for a contract that will be negotiated under subsection (D), rank the persons in order of preference.
- C. The school district shall make the following notifications regarding the final lists:
 1. If the contract will be negotiated under subsection (D) before or at the same time as the school district notifies the highest ranking person on the final list that it is the highest ranking person, the school district shall send actual notice to each of the following that it is not the highest ranking person or that another person is the highest ranking person:
 - a. If interviews were held, the other persons interviewed.
 - b. If interviews were not held, the other persons that made submittals.
 2. If the contract will be awarded under R7-2-1111, before or at the same time as the school district notifies the persons on the final list that they are on the final list, the school district shall send actual notice to each of the following persons that they are not on the final list or that other persons are on the final list:
 - a. If interviews were held, the other persons interviewed.
 - b. If interviews were not held, the other persons that made submittals.
- D. The school district shall conduct negotiations with persons on the final list as follows:
 1. The negotiations shall include consideration of compensation and other contract terms that the school district determines to be fair and reasonable to the school district. In making this decision, the school district shall take into account the estimated value, the scope, the complexity and the nature of the construction services to be rendered.

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2. If the procurement is for a single contract, there is one final list and the school district shall enter into negotiations with the highest qualified person on the final list. If the school district is not able to negotiate a satisfactory contract with the highest qualified person on the final list, at compensation and on other contract terms the school district determines to be fair and reasonable, the school district shall formally terminate negotiations with that person. The school district shall then undertake negotiations with the next most qualified person on the final list in sequence until an agreement is reached or a determination is made to reject all persons on the final list.
3. If the procurement is for multiple contracts for similar job-order-contracting construction services to be awarded to separate persons, there is one final list and the school district shall enter into separate negotiations for contracts with the number of the highest qualified persons on the final list equal to the number of contracts to be awarded. If the school district is not able to negotiate a satisfactory contract with a person with whom the school district has commenced negotiations, the school district shall formally terminate negotiations with that person. The school district shall then undertake negotiations for a contract with the next most qualified person on the final list with whom the school district is not then negotiating and with whom the school district has not previously negotiated in sequence until an agreement is reached for some or all of the multiple contracts included in the request for qualifications or a determination is made to reject all persons on the final list.
4. If the school district terminates negotiations with a person and commences negotiations with another person on the final list, the school district shall not recommence negotiations or enter into a contract for the construction services covered by the final list with any person with whom the school district terminated negotiations.

Historical Note

New Section made by exempt rulemaking at 13 A.A.R. 1266, effective February 26, 2007 (Supp. 07-1). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1111. Alternative Procedure for Design-build or Job-order-contracting Construction Services

- A. As an alternative to R7-2-1110(D), the school district may award a single contract for design-build construction services or a single or multiple contracts for similar job-order-contracting construction services pursuant to this Section.
- B. The school district shall use the selection committee appointed for the request for qualifications pursuant to R7-2-1107.
- C. The school district shall issue a request for proposals to the persons on the final list developed pursuant to R7-2-1110(A) through (C). The request for proposals shall be issued at least 14 days before the due date and time for receipt of proposals unless a shorter time is determined necessary by the school district.
- D. The request for proposals shall include the following:
 1. A statement that the procurement is for a single contract or, for similar job-order-contracting construction services only, for multiple contracts.
 2. If the procurement is for multiple contracts for similar job-order-contracting construction services, the notice shall specify that multiple contracts will be awarded,

shall specify the number of contracts that will be awarded, shall specify the number of offerors to whom contracts will be awarded which shall be the number of contracts in the procurement, and shall describe the job-order-contracting services to be performed under each contract.

3. Instructions and information to persons concerning the proposal submission requirements, including the due date and time for receipt of proposals, the address of the office at which proposals are to be received, the proposal acceptance period, and any other special information.
4. The school district's project schedule and project final budget for design and construction or life cycle budget for a procurement that includes maintenance services or operations services.
5. If a single contract will be awarded, a statement that the contract will be awarded to the person whose proposal receives the highest number of points under a scoring method. If multiple contracts for similar job-order-contracting services will be awarded, a statement that the multiple contracts will be awarded to a specified number of offerors whose proposals receive the highest number of points under a scoring method. The specified number of offerors will be the number of contracts included in the procurement.
6. A description of the scoring method, including a list of the factors in the scoring method and the number of points allocated to each factor.
7. For design-build constructions services only, the design requirements, including the required features, functions, characteristics, qualities and properties, the anticipated schedule, including start, duration and completion, and the estimated budgets applicable to the specific procurement for design and construction and, if applicable, for operation and maintenance. Drawings and other documents illustrating the scale and relationship of the features, functions and characteristics of the project, which shall all be prepared by an architect or engineer, as appropriate, and additional design information or documents specified by the school district, may also be included.
8. A requirement that each offeror submit separately a technical proposal and a price proposal and that the offeror's entire proposal is responsive to the requirements in the request for proposals. For design-build construction services, the price in the price proposal shall be a fixed price or a guaranteed maximum price.
9. A statement that in applying the scoring method, the selection committee will separately evaluate and score the technical proposal before opening, evaluating, and scoring the price proposal.
10. If the school district desires to conduct discussions with offerors, a statement that discussions may be held and a requirement that each offeror submit a preliminary technical proposal before the discussions are held.
11. Type of contract to be used.
12. That offerors may designate as proprietary portions of the proposal.
13. Notice that all information and proposals submitted by offerors, except as stated in subsection (D)(12), will be made available for public inspection after the school district has entered into a single contract or all of the multiple contracts.
14. The contract terms and conditions, including warranty and bonding or other security requirements, as applicable.

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15. The name of the district representative or district representatives.
 16. If the request for proposals incorporates documents by reference, the request for proposals shall specify where such documents may be obtained.
- E.** The factors in the scoring method described in the request for proposals may include:
1. For design-build construction services only, demonstrated compliance with the design requirements.
 2. Offeror qualifications.
 3. Offeror financial capacity.
 4. Compliance with the school district's project schedule.
 5. For design-build construction services only, if the request for proposals specifies that the school district will spend its project budget and not more than its project budget and is seeking the best proposal for the project budget, compliance of the offeror's price or life cycle price for procurements that include maintenance services, operations services or finance services with the school district's budget as prescribed in the request for proposals.
 6. For design-build construction services if the request for proposals does not contain the specifications prescribed in subsection (E)(5) and for job-order-contracting construction services, the price or life cycle price for procurements that include maintenance services, operations services or finance services.
 7. An offeror quality management plan.
 8. Other evaluation factors that demonstrate competence and qualifications for the type of construction services in the request for proposals as determined by the school district, if any.
- F.** If determined by the school district and included in the request for proposals, the selection committee shall conduct discussions with all offerors that submit preliminary technical proposals. Discussions shall be for the purpose of clarification to ensure full understanding of, and responsiveness to, the solicitation requirements. Offerors shall be accorded fair treatment with respect to any opportunity for discussion and for clarification by the school district. Revision of preliminary technical proposals shall be permitted after submission of preliminary technical proposals and before award for the purpose of obtaining best and final proposals. In conducting any discussions, information derived from proposals submitted by competing offerors shall not be disclosed to other competing offerors.
- G.** After completion of any discussions pursuant to subsection (F) or if no discussions are held, each offeror shall submit separately its final technical proposal and its price proposal.
- H.** Before opening any price proposal, the selection committee shall open and evaluate the final technical proposals and score the final technical proposals using the scoring method in the request for proposals. No other factors or criteria may be used in evaluation and scoring.
- I.** After completion of the evaluation and scoring of all final technical proposals, the selection committee shall open, evaluate and score the price proposals, and complete scoring of the entire proposals using the scoring method in the request for proposals. No other factors or criteria may be used in evaluation and scoring.
- J.** The school district shall award the contract to the responsive and responsible offeror whose proposal receives the highest score under the method of scoring in the request for proposals. No other factors or criteria may be used in evaluation and award.
- K.** For procurements of multiple contracts for similar job-order-contracting construction services, the school district may award up to the number of contracts specified in the request for proposals.
- L.** Before or at the same time as the school district notifies the selected offeror of contract award, the school district shall notify all other offerors of the award.
- M.** For design-build construction services only, the school district shall award a stipulated fee equal to a percentage of the school district's project final budget for design and construction, as prescribed in the request for proposals, but not less than two-tenths of one percent of the project final budget for design and construction to each final list offeror who provides a responsive, but unsuccessful, proposal. If the school district does not award a contract, all responsive final list offerors shall receive the stipulated fee based on the school district's project final budget for design and construction as included in the request for proposals. The school district shall pay the stipulated fee to each offeror within 90 days after the award of the initial contract or the decision not to award a contract. In consideration for paying the stipulated fee, the school district may use any ideas or information contained in the proposals in connection with any contract awarded for the project, or in connection with a subsequent procurement, without any obligation to pay any additional compensation to the offerors. Notwithstanding the other provisions of this subsection, an offeror may elect to waive the stipulated fee. If an offeror elects to waive the stipulated fee, the school district may not use ideas and information contained in the offeror's proposal, except that this restriction does not prevent the school district from using any idea or information if the idea or information is also included in a proposal of an offeror that accepts the stipulated fee.
- N.** The procurement file shall contain the basis on which the award is made, including at a minimum the information and documents required under R7-2-1115.
- O.** A copy of the request for proposals shall be made available for public inspection at the school district office.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1112. Contractor Licenses, Contract and Performance Requirements

- A.** Notwithstanding any other Section:
1. The contractor for design-build or job-order-contracting construction services is not required to be registered to perform design services pursuant to A.R.S. Title 32, Chapter 1 if the person actually performing the design services on behalf of the contractor is appropriately registered.
 2. The contractor for construction-manager-at-risk, design-build or job-order-contracting construction services shall be licensed to perform construction pursuant to A.R.S. Title 32, Chapter 10.
 3. The school district shall obtain and maintain a record of proof in the procurement file that a construction or construction services provider that has been awarded a contract with the school district, or through a cooperative purchasing agreement, has a license in good standing to perform construction work pursuant to A.R.S. Title 32, Chapter 10. The license shall be active on the day the contract is awarded. This subsection does not require

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licensure for professions that are not licensed pursuant to A.R.S. Title 32, Chapter 10.

- B. In a procurement for construction-manager-at-risk construction services or design-build construction services, except for design-build contracts awarded pursuant to R7-2-1111, the school district shall enter into a written contract with the contractor for preconstruction services under which the school district shall pay the contractor a fee for preconstruction services in an amount agreed by the school district and the contractor, and the school district shall not request or obtain a fixed price or a guaranteed maximum price for the construction from the contractor or enter into a construction contract with the contractor until after the school district has entered into the written contract for preconstruction services and a preconstruction services fee.
- C. Construction shall not commence under a construction services contract until the school district and contractor agree in writing on either a fixed price that the school district will pay or a guaranteed maximum price for the construction to be commenced. The construction to be commenced may be the entire project or may be one or more phased parts of the project.
- D. For negotiated construction-manager-at-risk and design-build contracts, preconstruction services, general conditions, schedules, construction contingency, and construction fees shall be part of the contract. For design-build contracts awarded pursuant to a request for proposals, the fees shall be included in the vendor's proposal and shall become part of the awarded contract.
- E. For job-order-contracting construction services only:
 - 1. The maximum dollar amount of an individual job order for job-order-contracting construction services shall be one million dollars or a higher or lower amount prescribed by the governing board in a policy adopted in a public meeting held pursuant to A.R.S. Title 38, Chapter 3, Article 3.1. Requirements shall not be artificially divided or fragmented in order to constitute a job order that satisfies the requirements of this subsection.
 - 2. If the contractor subcontracts or intends to subcontract part or all of the work under a job order and if the job-order-contracting construction services contract includes descriptions of standard individual tasks, standard unit prices for standard individual tasks and pricing of job orders based on the number of units of standard individual tasks in the job order:
 - a. The contractor has a duty to deliver promptly to each subcontractor invited to bid a coefficient to the contractor to do all or part of the work under one or more job orders a copy of the descriptions of all standard individual tasks on which the subcontractor is invited to bid and a copy of the standard unit prices for the individual tasks on which the subcontractor is invited to bid.
 - b. If not previously delivered to the subcontractor, the contractor has a duty to promptly deliver to each subcontractor invited to or that has agreed to do any of the work included in any job order a copy of the description of each standard individual task that is included in the job order and that the subcontractor is invited to perform, the number of units of each standard individual task that is included in the job order and that the subcontractor is invited to perform, and the standard unit price for each standard individual task that is included in the job order and that the subcontractor is invited to perform.
- F. For all construction services contracts, the contractor performing the construction services is permitted to self-perform part of the construction work, if and to the extent agreed in writing by the school district and the contractor. The school district may use methods other than competitive bidding to assure itself that the price the school district pays to the contractor for self-performed work is fair and reasonable. Permitted methods to evaluate fairness and reasonableness of the price of self-performed work include evaluation of the contractor's proposed scope of work and price for self-performed work by an estimator who is hired and paid by the school district, who is independent of the contractor and who may be an employee of the school district. Although the school district may elect to so require, nothing in Articles 10 and 11 shall be construed or interpreted to require the school district to require a contractor desiring to self-perform part of the construction work to competitively bid that part of the construction work against other contractors in a bid competition.
- G. For all construction services contracts, the following requirements apply to the construction work to be performed by subcontractors and do not apply to construction work that the school district and the contractor agree in writing will be self-performed by the contractor:
 - 1. The person selected to perform the construction services shall select subcontractors based on qualifications alone or on a combination of qualifications and price and shall not select subcontractors based on price alone. A qualifications and price selection may be a single-step selection based on a combination of qualifications and price or a two-step selection. In a two-step selection, the first step shall be based on qualifications alone and the second step may be based on a combination of qualifications and price or on price alone.
 - 2. The school district shall include in each contract:
 - a. If the school district included its subcontractor selection plan in the request for qualifications, the school district's subcontractor selection plan and the procedures to implement the school district's subcontractor selection plan proposed by the awarded contractor in submitting its qualifications with those modifications to the procedures as the school district and the contractor agree.
 - b. If the school district did not include its subcontractor selection plan in the request for qualifications, the subcontractor selection plan proposed by the awarded contractor in submitting its qualifications with those modifications as the school district and the contractor agree.
 - 3. In making the selection of subcontractors, the contractor shall use the subcontractor selection plan and any procedures included in its contract.
- H. The school district shall include in each contract for construction services the full street or physical address of each separate location at which the construction will be performed and a requirement that the contractor and each subcontractor at any level include in each of its subcontracts the same address information. The contractor and each subcontractor at any level shall include in each subcontract the full street or physical address of each separate location at which construction work will be performed.

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Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 24 A.A.R. 3283, effective October 22, 2018 (Supp. 18-4). The word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-1113. Prohibitions

- A. Notwithstanding any contrary provision of Articles 10 and 11, a school district shall not enter into a contract to provide construction-manager-at-risk construction services, design-build construction services or job-order-contracting construction services.
- B. The prohibitions prescribed in subsection (A) do not prohibit a school district from providing construction for itself as provided by law.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1114. Bid Security, Contract Performance and Payment Bonds, and Payment and Retention

- A. Bid security shall be provided pursuant to R7-2-1102.
- B. Contract performance and payment bonds shall be provided pursuant to R7-2-1103.
- C. Contract payment retention and substitute security shall be in accordance with R7-2-1104.
- D. Progress payments shall be in accordance with R7-2-1105.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Amended effective March 21, 1991 (Supp. 91-1). Amended effective October 22, 1992 (Supp. 92-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1115. Procurement File Contents and Review

- A. At a minimum, the school district shall retain the following for each procurement under R7-2-1106 through R7-2-1114:
 - 1. For each request for qualifications procurement process:
 - a. If interviews were not held:
 - i. The submittal of the person listed first on the final list and the submittal of each person with whom the school district enters into a contract.
 - ii. The final list.
 - iii. A list of the selection criteria and relative weight of selection criteria used to select the persons for the final list and to determine their order on the final list.
 - iv. A list that contains the name of each person that submitted qualifications and that shows the person's final overall rank or score.
 - v. Documents that show the final score or rank on each selection criteria of each person that submitted qualifications and that support the final overall rankings and scores of the persons that submitted qualifications. The school district shall retain the individual scoring sheets for individual selection committee members.
 - b. If interviews were held:

- i. All submittals of the person listed first on the final list and the submittal of each person with whom the school district enters into a contract.
- ii. The final list.
- iii. A list of the selection criteria and relative weight of selection criteria used to select the persons for the final list and to determine their order on the final list.
- iv. A list that contains the name of each person that was interviewed and that shows the person's final overall rank or score.
- v. Documents that show the final score or rank on each selection criteria of each person that was interviewed and that support the final overall rankings and scores of the persons that were interviewed. The school district shall retain the individual scoring sheets for individual selection committee members.
- vi. A list of the selection criteria and relative weight of the selection criteria used to select the persons for the short list to be interviewed.
- vii. A list that contains the name of each person that submitted qualifications and that shows the person's final overall rank or score in the selection of the persons to be on the short list to be interviewed.
- viii. Documents that show the final score or rank on each selection criteria of each person that submitted qualifications and that support the final overall rankings and scores of the persons that submitted qualifications. The school district shall retain the individual scoring sheets for individual selection committee members.

2. For each request for proposals procurement process under R7-2-1111:

- a. The entire proposal submitted by the person that received the highest score in the scoring method in the request for proposals and the entire proposal submitted by each person with whom the school district enters into a contract.
- b. The description of the scoring method, the list of factors in the scoring method and the number of points allocated to each factor, all as included in the request for proposals.
- c. A list that contains the name of each offeror that submitted a proposal and that shows the offeror's final overall score.
- d. Documents that show the final score or rank on each factor in the scoring method in the request for proposals of each offeror that submitted a proposal and that support the final overall scores of the offerors that submitted proposals. The school district shall retain the individual scoring sheets for individual selection committee members.

B. Information relating to each procurement under R7-2-1106 through R7-2-1114 shall be made available to the public as follows:

- 1. Until the school district awards a single contract or all of the multiple contracts or terminates the procurement, only the name of each person on the final list may be made available to the public. All other information received by the school district in response to the request for qualifications shall be confidential in order to avoid

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disclosure of the contents that may be prejudicial to competing respondents during the selection process.

2. After the school district awards a single contract or all of the multiple contracts or terminates the procurement, the school district shall make the contents of the procurement file, except the proposals and statements of qualifications submitted in response to a solicitation and the documents described in subsections (A)(1)(a)(v), (A)(1)(b)(v), (A)(1)(b)(viii), and (A)(2)(d), available to the public.
 3. After the school district has entered into a single contract or all of the multiple contracts or has terminated the procurement, the school district shall make the proposals and statements of qualifications and the documents described in subsections (A)(1)(a)(v), (A)(1)(b)(v), (A)(1)(b)(viii), and (A)(2)(d) available to the public.
 4. To the extent that an offeror designates and the school district concurs, trade secrets and other proprietary data contained in a proposal or statement of qualifications shall remain confidential.
 5. If the procurement file contains information that is confidential under R7-2-1006, a copy of the applicable documents with the confidential information redacted shall be placed in the procurement file for the purpose of public inspection. The unredacted original copy of the confidential information shall be placed in a sealed envelope or other appropriate container, identified as confidential information, and maintained in the procurement file.
- C. The school district shall retain the records of a procurement under R7-2-1106 through R7-2-1114 in accordance with R7-2-1085.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

Amended effective March 21, 1991 (Supp. 91-1).

Amended effective October 22, 1992 (Supp. 92-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1116. Repealed**Historical Note**

New Section made by exempt rulemaking at 13 A.A.R. 1266, effective February 26, 2007 (Supp. 07-1). Section repealed by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

PART XV. PROCUREMENT OF SPECIFIED PROFESSIONAL SERVICES

R7-2-1117. Procurement of Specified Professional Services

- A. Specified professional services, which is defined in R7-2-1001(120), as services of an architect, engineer, land surveyor, assayer, geologist and landscape architect, shall be procured as provided in R7-2-1117 through R7-2-1123, except as authorized in R7-2-1033, R7-2-1053, R7-2-1055, and R7-2-1122.
- B. Prior to public notice of the need for specified professional services, the school district shall determine that the services to be acquired are specified professional services.
- C. In the procurement of specified professional services:
 1. The school district shall specify whether the procurement is for a single contract or for multiple contracts. Multiple contracts may be awarded to separate persons or may be awarded to a single person as specified in the request for qualifications.

2. The school district and the selection committee shall not request or consider fees, price, man-hours or any other cost information at any point in the selection process under this Section and R7-2-1120 or R7-2-1121, including the selection of persons to be interviewed, the selection of persons to be on the final list, in determining the order of preference of persons on a final list or for any other purpose in the selection process except as provided in R7-2-1121.
 3. In determining the persons to participate in any interviews, in determining the persons to be on the final list, and in determining the order on the final list, the selection committee shall use and consider only the criteria and weighting of criteria in the request for qualifications. No other factors or criteria may be used in the evaluation, determinations and other actions.
 4. If the school district enters into the number of contracts specified in the request for qualifications, the procurement ends. After that time the school district may not use the procurement or any final list in the procurement as the basis for entering into a contract with any other person that participated in the procurement.
 5. Notwithstanding any other provision specifying the number of persons to be interviewed, the number of persons to be on a final list, or any other numerical specification in this Section or R7-2-1121:
 - a. If a smaller number of persons respond to the request for qualifications or if one or more persons drop out of the procurement so that there is a smaller number of persons participating in the procurement, the school district, as the school district determines necessary and appropriate, may elect to proceed with the participating persons if there are at least two participating responsive and responsible persons. Alternatively, the school district may elect to terminate the procurement.
 - b. As to a request for qualifications to be negotiated pursuant to R7-2-1121(D), if only one responsive and responsible person responds to the request for qualifications, or if one or more persons drop out of the procurement so that only one responsive and responsible person remains in the procurement, the school district may elect to proceed with the procurement with only one person if the governing board determines in writing that the negotiated fee is fair and reasonable and that either other prospective persons had reasonable opportunity to respond or there is not adequate time for a resolicitation.
 - c. If a person on the final list withdraws or is removed from the procurement and the selection committee determines that it is advantageous to the school district, the selection committee may replace that person on the final list with another person that submitted qualifications in the procurement and that is selected as the next most qualified.
- D. The request for qualifications shall:
1. Provide instructions and information to persons concerning the statement of qualifications submission requirements, including the due date and time for receipt of statements of qualifications, the address of the office at which the statements of qualifications are to be received, and any other special information.
 2. State whether one contract or multiple contracts may or will be awarded.

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- a. If one contract will be awarded, state that one contract may or will be awarded, describe the services to be performed under the contract and state that one person may or will be awarded the contract.
 - b. If multiple contracts may or will be awarded, state the number of contracts that may or will be awarded, the services to be performed under each of the multiple contracts, and either that each contract will be awarded to a separate person or that all of the contracts will be awarded to the same person.
3. State the number of persons to be included on the final list.
 - a. If a single contract will be awarded, state that there will be a single final list of at least three and not more than five persons.
 - b. If multiple contracts will be awarded to a single person, state that there will be a single final list of at least three and not more than five persons.
 - c. In a procurement for multiple contracts for similar specified professional services to be awarded to separate persons, state that there will be a single final list and the number of persons on the final list, which shall be the sum of the number of contracts that may or will be awarded plus another number that is determined by the school district and that is not more than five.
 - d. If multiple contracts for different specified professional services will be awarded to separate persons, state that there will be a separate final list for each type of specified professional services and that the number of persons on each final list will be equal to the number of contracts that may or will be awarded for each type of specified professional services plus a number determined by the school district not to exceed five.
 4. State the selection criteria and relative weight to be used. All selection criteria shall be factors that demonstrate competence and qualifications for the type of specified professional services included in the procurement.
 - a. If interviews will be held, state the selection criteria and relative weights to be used in selecting the persons to be interviewed. The request for qualifications may state the selection criteria and relative weights to be used in selecting the persons on the final list and in determining their order on the final list. The final list selection criteria and relative weights may be different than the selection criteria and relative weights used to determine the persons to be interviewed. The request for qualifications also shall state whether the school district will select the persons on the final list and their order on the final list solely through the results of the interview process or through the combined results of both the interview process and the evaluation of statements of qualifications and performance data submitted in response to the request for qualifications.
 - b. If interviews will not be held, state the selection criteria and relative weights to be used in selecting the persons on the final list and in determining their order on the final list.
 5. State whether interviews will be held.
 - a. If a single contract will be awarded, state that there will be interviews with at least three and not more than five persons.
 - b. If multiple contracts will be awarded to a single person, state that there will be interviews with at least three and not more than five persons.
 - c. In a procurement for multiple contracts for similar specified professional services to be awarded to separate persons, state that interviews will be held and that the interviews will be with a specified number of persons. The specified number shall be stated in the request for qualifications, shall be determined by the school district and shall be the sum of the number of contracts that may or will be awarded, plus another number that is determined by the school district and that is not more than five.
 - d. If multiple contracts for different specified professional services will be awarded to separate persons, state that interviews will be held and that the interviews will be with a specified number of persons. The specified number shall be stated in the request for qualifications, shall be determined by the school district, shall be at least three times the number of contracts that may or will be awarded and shall not be more than five times the number of contracts that may or will be awarded.
 6. The name of the district representative or district representatives and the publicly available location of the school district's protest policy or procedure.
 7. Notice that all information and statements of qualifications submitted by persons will be made available for public inspection after the school district has entered into a single contract or all of the multiple contracts.
- E. Statements of qualifications shall be received and opened in accordance with R7-2-1045. Late statements of qualifications, late modifications, or late withdrawals shall be considered in accordance with R7-2-1044 and R7-2-1049.
 - F. A copy of the request for qualifications shall be made available for public inspection at the school district office.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
 Amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1118. Public Notice of Specified Professional Services

- A. Notice of the need for specified professional services shall be given by the school district pursuant to R7-2-1022 and R7-2-1024(C). Such notice shall be issued not less than 14 days in advance of when responses shall be received.
- B. The notice shall:
 1. Contain a statement of the services required that adequately describes the procurement and specifies how a request for qualifications containing specific information on the procurement may be obtained.
 2. Specify whether the procurement is for a single contract or for multiple contracts; and
 3. If the procurement is for multiple contracts:
 - a. Specify that multiple contracts may or will be awarded;
 - b. Specify the number of contracts that may or will be awarded; and
 - c. Describe the specified professional services to be performed under each contract.

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Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final exempt rulemaking at 21 A.A.R. 1525,
effective July 1, 2014 (Supp. 15-3); effective year cor-
rected in Supp. 18-2.

R7-2-1119. Cancellation or Rejection of the Solicitation

A school district may cancel a request for qualifications, reject in whole or in part any or all statements of qualifications or determine not to enter into a contract as specified in the solicitation if it is advantageous to the school district. The school district shall make the reasons for cancellation, rejection or determination not to enter into a contract part of the procurement file.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Sec-
tion repealed; new Section made by final exempt
rulemaking at 21 A.A.R. 1525, effective July 1, 2014
(Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1120. Specified Professional Services Selection Committee

- A. The school district shall initiate an appropriately qualified selection committee for each request for qualifications. The school district shall ensure that selection committee members are competent to serve on the selection committee.
- B. Each selection committee shall include at least one school district representative appointed by the school district.
- C. The school district shall determine the number and qualifications of the selection committee members. These members may be employees of the school district or non-school district appointees.
- D. Non-school district employees serving on a selection committee shall not receive compensation from the school district for performing this service, but the school district may elect to reimburse non-school district members for travel, lodging and other expenses incurred in connection with service on a selection committee.
- E. A person who is a member of a selection committee shall not be a contractor or subcontractor under a contract awarded under the procurement or provide any specified professional services or other services under the contract.
- F. For the procurement of multiple contracts for specified professional services, the same selection committee shall be used for all contracts in the procurement.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Sec-
tion repealed; new Section made by final exempt
rulemaking at 21 A.A.R. 1525, effective July 1, 2014
(Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1121. Committee Evaluation and Selection

- A. If interviews are specified in the request for qualifications:
 1. The selection committee shall determine the persons to be interviewed by evaluating the statements of qualifications and performance data submitted based solely on the selection criteria and relative weights in the request for qualifications to be used to determine the persons to be interviewed.
 2. If the selection criteria and relative weights to be used by the selection committee to select the persons on the final list or final lists are not included in the request for qualifications:
 - a. Before the interviews are held the school district shall distribute to the persons to be interviewed the

selection criteria and relative weights to be used to select the persons on the final list and to determine their order on the final list.

- b. These selection criteria and relative weight may be different than the selection criteria and relative weight used to determine the persons to be interviewed.
3. The selection committee shall conduct interviews with the number of persons specified in the request for qualifications.
- B. Based solely on the selection criteria and relative weights for selection of the persons on the final list or final lists and their order on the final list or final lists, the selection committee shall select the persons for the final list or final lists and rank the persons on the final list or final lists in order of preference. If the procurement is for multiple contracts for different specified professional services to be awarded to separate persons, and if a person submitted qualifications for more than one type of specified professional services, the person may be on more than one final list.
- C. Before or at the same time as the school district notifies the highest ranking person on the final list or final lists that it is the highest ranking person, the school district shall send actual notice to each of the following that it is not the highest ranking person or that another person is the highest ranking person:
 1. If interviews were held, the other persons interviewed.
 2. If interviews were not held, the other persons that made submittals.
- D. The school district shall conduct negotiations with persons on the final list or final lists as follows:
 1. The school district shall negotiate a contract with the highest qualified person for the required specified professional services at compensation determined in writing to be fair and reasonable to the school district. Contract negotiations shall be directed toward:
 - a. Making certain that the person has a clear understanding of the scope of the work, specifically, the essential requirements involved in providing the required services;
 - b. Determining that the person will make available the necessary personnel and facilities to perform the services within the required time; and
 - c. Agreeing upon compensation that is fair and reasonable.
 2. The negotiations shall include consideration of compensation and other contract terms that the school district determines to be fair and reasonable to the school district. In making this decision, the school district shall take into account the estimated value, the scope, the complexity and the nature of the specified professional services to be rendered.
 3. If the procurement is for a single contract, there is one final list and the school district shall enter into negotiations with the highest qualified person on the final list. If the school district is not able to negotiate a satisfactory contract with the highest qualified person on the final list, at compensation and on other contract terms the school district determines to be fair and reasonable, the school district shall formally terminate negotiations with that person. The school district shall then undertake negotiations with the next most qualified person on the final list in sequence until an agreement is reached or a determination is made to reject all persons on the final list.

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4. If the procurement is for multiple contracts for specified professional services to be awarded to a single person on the final list, there is one final list and the school district shall enter into negotiations with the highest qualified person on the final list. If the school district is not able to negotiate a satisfactory contract with the highest qualified person on the final list, at compensation and on other contract terms the school district determines to be fair and reasonable, the school district shall formally terminate negotiations with that person. The school district shall then undertake negotiations with the next most qualified person on the final list in sequence until an agreement is reached or a determination is made to reject all persons on the final list.
5. If the procurement is for multiple contracts for similar specified professional services to be awarded to separate persons, there is one final list and the school district shall enter into separate negotiations for contracts with the number of the highest qualified persons on the final list equal to the number of contracts to be awarded. If the school district is not able to negotiate a satisfactory contract with a person with whom the school district has commenced negotiations, the school district shall formally terminate negotiations with that person. The school district shall then undertake negotiations for a contract with the next most qualified person on the final list with whom the school district is not then negotiating and with whom the school district has not previously negotiated in sequence until an agreement is reached for some or all of the multiple contracts included in the request for qualifications or a determination is made to reject all persons on the final list.
6. If the procurement is for multiple contracts for different specified professional services to be awarded to separate persons, there is a separate final list for each type of specified professional services and the school district shall enter into separate negotiations for contracts with the number of the highest qualified persons on each final list equal to the number of contracts to be awarded. If the school district is not able to negotiate a satisfactory contract with a person with whom the school district has commenced negotiations, the school district shall formally terminate negotiations with that person. The school district shall then undertake negotiations for a contract with the next most qualified person on the applicable final list with whom the school district is not then negotiating and with whom the school district has not previously negotiated in sequence until an agreement is reached for some or all of the multiple contracts included in the request for qualifications or a determination is made to reject all persons on the final list.
7. If the school district terminates negotiations with a person and commences negotiations with another person on the final list, the school district shall not recommence negotiations or enter into a contract for the specified professional services covered by the final list with any person with whom the school district terminated negotiations.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1122. Specified Professional Services Contracts Not**Exceeding Certain Amounts**

- A. A school district may procure a single contract or multiple contracts for specified professional services under this Section if the contract is for specified professional services by an architect or architect firm and the contract amount is \$250,000 or less or if the contract is for specified professional services by a person other than an architect and the contract amount is \$500,000 or less. For such procurements, the school district shall encourage persons engaged in the lawful practice of the profession to submit annually a statement of qualifications and experience.
- B. For each procurement of specified professional services under this Section, the school district shall establish a selection committee pursuant to R7-2-1120.
- C. The selection committee shall evaluate current statements of qualifications and experience on file with the school district, together with those that may be submitted by other persons regarding the procurement.
- D. The school district and the selection committee shall not request or consider fees, price, man-hours or any other cost information at any point in the selection process under this Section, including the selection of the persons to be interviewed, the selection of persons to be on a final list, in determining the order of preference of persons on a final list or for any other purpose in the selection process, except as provided in subsection (F).
- E. If possible and practicable, the selection committee shall conduct interviews regarding the procurement and the relative methods of furnishing the required specified professional services and, if possible, shall select, in order of preference and based on criteria established and published by the selection committee, one or more final lists of the persons deemed to be the most qualified to provide the specified professional services required. The selection committee shall base the selection of each final list and the order of preference on demonstrated competence and qualifications only.
 1. If the procurement is for a single contract or if the procurement is for multiple contracts to be awarded to a single person, there shall be one final list of three persons.
 2. If the procurement is for multiple contracts for different specified professional services to be awarded to separate persons, there shall be a separate final list of three persons for each contract.
 3. In a procurement for multiple contracts for similar specified professional services to be awarded to separate persons, there shall be one final list and the number of persons on the final list shall be the number of contracts, plus another number that is determined by the school district and that is not more than five.
- F. The school district shall enter into negotiations with the highest qualified person on each final list or, in the case of a single final list for multiple contracts for the same specified professional services to be awarded to separate persons, the school district shall enter into negotiations with a number of the highest qualified persons on the final list equal to the number of contracts that may or will be awarded.
 1. Negotiations shall include consideration of compensation and other contract terms that the school district determines to be fair and reasonable to the school district. In making this determination, the school district shall take into account the estimated value, the scope, the complexity and the nature of the specified professional services to be rendered.

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2. If the school district is unable to negotiate a satisfactory contract with a person with whom the school district is negotiating at a price and on other contract terms the school district determines to be fair and reasonable to the school district, the school district shall formally terminate negotiations with that person.
3. The school district may undertake negotiations with the next most qualified person on the final list in sequence until an agreement is reached or a determination is made to reject all persons on the final list.
4. If the school district terminates negotiations with a person on a final list and commences negotiations with another person on the final list, the school district shall not in that procurement recommence negotiations or enter into a contract or contracts with any person with whom the school district has terminated negotiations.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1123. Procurement File Contents and Review for Procurements Conducted under R7-2-1117 through R7-2-1121

A. At a minimum, the school district shall retain the following for each procurement under R7-2-1117 through R7-2-1121:

1. If interviews were not held:
 - a. The submittal of the person listed first on the final list and the submittal of each person with whom the school district enters into a contract. If the procurement has multiple final lists, the school district shall retain the submittal of the person listed first on the final list and the submittal of each person with whom the school district enters into a contract, for each final list.
 - b. The final list or final lists.
 - c. A list of the selection criteria and relative weight of selection criteria used to select the persons for the final list or final lists and to determine their order on the final list or final lists.
 - d. A list that contains the name of each person that submitted qualifications and that shows the person's final overall rank or score.
 - e. Documents that show the final score or rank on each selection criteria of each person that submitted qualifications and that support the final overall rankings and scores of the persons that submitted qualifications. The school district shall retain the individual scoring sheets for individual selection committee members.
2. If interviews were held:
 - a. All submittals of the person listed first on the final list and the submittal of each person with whom the school district enters into a contract. If the procurement has multiple final lists, the school district shall retain the submittal of the person listed first on the final list and the submittal of each person with whom the school district enters into a contract, for each final list.
 - b. The final list or final lists.
 - c. A list of the selection criteria and relative weight of selection criteria used to select the persons for the

final list or final lists and to determine their order on the final list or final lists.

- d. A list that contains the name of each person that was interviewed and that shows the person's final overall rank or score.
- e. Documents that show the final score or rank on each selection criteria of each person that was interviewed and that support the final overall rankings and scores of the persons that were interviewed. The school district shall retain the individual scoring sheets for individual selection committee members.
- f. A list of the selection criteria and relative weight of the selection criteria used to select the persons for the short list or short lists to be interviewed.
- g. A list that contains the name of each person that submitted qualifications and that shows the person's final overall rank or score in the selection of the persons to be on the short list or short lists to be interviewed.
- h. Documents that show the final score or rank on each selection criteria of each person that submitted qualifications and that support the final overall rankings and scores of the persons that submitted qualifications. The school district shall retain the individual scoring sheets for individual selection committee members.

B. Information relating to each procurement under R7-2-1117 through R7-2-1121 shall be made available to the public as follows:

1. Until the school district awards a single contract or all of the multiple contracts or terminates the procurement, only the name of each person on the final list may be made available to the public. All other information received by the school district in response to the request for qualifications shall be confidential in order to avoid disclosure of the contents that may be prejudicial to competing respondents during the selection process.
2. After the school district awards a single contract or all of the multiple contracts or terminates the procurement, the school district shall make the contents of the procurement file, except the statements of qualifications and the documents described in subsections (A)(1)(e), (A)(2)(e), and (A)(2)(h), available to the public.
3. After the school district has entered into a single contract or all of the multiple contracts or has terminated the procurement, the school district shall make the statements of qualifications and the documents described in subsections (A)(1)(e), (A)(2)(e), and (A)(2)(h) available to the public.
4. To the extent that a person designates and the school district concurs, trade secrets and other proprietary data contained in a statement of qualifications shall remain confidential.
5. If the procurement file contains information that is confidential under R7-2-1006, a copy of the applicable documents with the confidential information redacted shall be placed in the procurement file for the purpose of public inspection. The unredacted original copy of the confidential information shall be placed in a sealed envelope or other appropriate container, identified as confidential information, and maintained in the procurement file.

C. The school district shall retain the records of a procurement under R7-2-1117 through R7-2-1121 in accordance with R7-2-1085.

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Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section repealed; new Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1124. Reserved**PART XVI. COST PRINCIPLES****R7-2-1125. Cost Principles**

The cost principles adopted by the director of the Department of Administration pursuant to A.R.S. § 41-2591 shall be used to determine the allowability of incurred costs for the purpose of reimbursing costs under contract provisions that provide for the reimbursement of costs.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1126. Reserved**R7-2-1127. Reserved****R7-2-1128. Reserved****R7-2-1129. Reserved****R7-2-1130. Reserved****PART XVII. MATERIALS MANAGEMENT****R7-2-1131. Material Management and Disposition**

- A.** The school district shall ascertain or verify that materials, services, or construction items procured by the school district conform to specifications as set forth in the solicitation.
- B.** The school district shall determine the fair market value of excess and surplus material.
- C.** Disposition of surplus materials.
 1. Except as provided in A.R.S. § 15-342(7) related to sales or leases to the state, a county, a city, another school district, or a tribal government agency, and A.R.S. § 15-342(18) related to the disposition of surplus or outdated learning materials, educational equipment and furnishings, surplus materials, regardless of value, shall be offered through competitive sealed bids, public auction, on-line sales, established markets, trade in, posted prices or state surplus property. If unusual circumstances render the above methods impractical, the school district may employ other disposition methods, including appraisal or barter, provided the school district makes a written determination that such procedure is advantageous to the school district. Only United States Postal Money Orders, certified checks, cashiers' checks or cash shall be accepted for sales of surplus material unless otherwise approved by the school district.
 2. Competitive sealed bidding.
 - a. Notice for sale bids shall be publicly available from the school district at least 10 days before the due date set for bids. Notice of the sale bids shall be provided to prospective bidders, including those bidders on lists maintained by the school district pursuant to R7-2-1023. The notice for sale bids shall list the materials offered for sale, their location, availability for inspection, the terms and conditions of sale and instructions to bidders including the bid due date and

time. Bids shall be opened publicly pursuant to the requirements of R7-2-1029.

- b. The award shall be made in accordance with the provisions of the notice for sale bids to the highest responsive and responsible bidder, provided that the price offered by such bidder is acceptable to the school district. If the school district determines that the bid is not advantageous to the school district, the school district may reject the bids in whole or in part and may resolicit bids or the school district may negotiate the sale, provided that the negotiated sale price is higher than the highest responsive and responsible bidder's price.
3. Auctions shall be advertised in the official newspaper of the county as prescribed in A.R.S. § 11-255 or a newspaper of general circulation, in accordance with A.R.S. § 41-2533. The publication shall not be less than 14 days before the auction date. All the terms and conditions of any sale shall be available to the public at least 24 hours prior to the auction date. The school district or any agent acting on the school district's behalf may also advertise the auction in any other manner determined advantageous to the school district.
4. Internet-based on-line sales shall not be subject to the advertisement requirements in subsection (C)(3). For such disposal services, the school district shall post and maintain a notice explaining the use of Internet-based on-line sales on a designated site on the Internet. The notice shall include:
 - a. The name of the on-line sales provider and the designated site on the Internet where potential buyers may obtain information or participate in the on-line auctions;
 - b. A link to the Internet-based on-line sales service;
 - c. A link to the terms and conditions of sale;
 - d. Instructions for bidding on the Internet-based on-line sales site; and
 - e. A period of not less than 14 days for each Internet-based on-line sale during which persons may submit offers to purchase the specified materials.
5. Before surplus materials are disposed of by trade-in to a vendor for credit on an acquisition, the school district shall approve such disposal. The school district shall base this determination on whether the trade-in value is expected to exceed the value realized through the sale or other disposition of such materials.
6. An employee of the school district or a governing board member, or an employee of a school district's agent conducting an auction on behalf of the school district, shall not directly or indirectly purchase or agree with another person to purchase surplus property if said employee or board member is, or has been, directly or indirectly involved in the purchase, disposal, maintenance, or preparation for sale of the surplus material.
7. State surplus property manager. The school district may enter into an agreement with the State Surplus Property Manager for the disposition of materials pursuant to Article 8 of the Arizona Procurement Code (A.R.S. § 41-2601 et seq.) and the rules adopted thereunder.
8. Pursuant to A.R.S. § 15-342(35), a school district may offer to sell outdated learning materials, educational equipment or furnishings at a posted price commensurate with the value of the items to pupils who are currently

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enrolled in that school district before those materials are offered for public sale.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

Amended effective March 21, 1991 (Supp. 91-1).

Amended effective October 22, 1992 (Supp. 92-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1132. State and Federal Surplus Materials Program

- A. The governing board may acquire surplus materials from the state and the United States government.
- B. The governing board may enter into an agreement with the State Surplus Property Manager for the purpose of acquiring surplus materials from the United States government pursuant to A.R.S. § 41-2603 and the rules adopted thereunder.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

Amended effective March 21, 1991 (Supp. 91-1).

R7-2-1133. Authority for Transfer of Material

Notwithstanding any law to the contrary, the governing board may secure the transfer of surplus materials and obligate its monies to the extent necessary to comply with the laws and conditions of such transfers.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1134. Reserved

R7-2-1135. Reserved

R7-2-1136. Reserved

R7-2-1137. Reserved

R7-2-1138. Reserved

R7-2-1139. Reserved

R7-2-1140. Reserved

PART XVIII. BID PROTESTS**R7-2-1141. Resolution of Bid Protests**

- A. Informal resolution of bid protests. Nothing in Articles 10 and 11 are intended to eliminate the informal resolution of problems by school district personnel.
- B. Formal resolution of bid protests. The governing board pursuant to R7-2-1007 shall designate a district representative, as defined in R7-2-1001, to resolve bid protests. All solicitations issued by the school district shall include the name of the district representative and shall indicate that any bid protest shall be filed with the district representative. Appeal from the decision of the district representative may be made to the hearing officer pursuant to R7-2-1147 and R7-2-1181.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt

rulemaking at 27 A.A.R. 2342 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-1142. Filing of a Protest

- A. Any interested party may protest a solicitation issued by the school district, a determination that a proposal is unacceptable, or the proposed award or the award of a school district contract. Protests shall be filed with the district representative.
- B. Content of protest. The protest shall be in writing and shall include the following information:
 1. The name, address and telephone number of the interested party;
 2. The signature of the interested party or the interested party's representative;
 3. Identification of the solicitation or contract number;
 4. A detailed statement of the legal and factual grounds of the protest including copies of relevant documents; and
 5. The form of relief requested.
- C. The interested party shall supply any other information requested by the district representative within 10 days of the request.
- D. The interested party may file a written request with the district representative for an extension of the time limit for providing additional information set forth in subsection (C). The written request shall be filed before the expiration of the time limit set forth in subsection (C) and shall set forth good cause as to the specific reason that the interested party is unable to provide the additional information within the 10 days. The district representative shall approve or deny the request in writing, state the reasons for the determination, and if an extension is granted, set forth a new date for submission of the filing.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1143. Time for Filing Protests

- A. Protests based upon alleged improprieties in a solicitation that are apparent before the due date and time for responses to the solicitation, shall be filed before the due date and time for responses to the solicitation.
- B. In cases other than those covered in subsection (A), the interested party shall file the protest within 10 days after the school district makes the procurement file available for public inspection.
- C. The interested party may file a written request with the district representative for an extension of the time limit for protest filing set forth in subsection (B). The written request shall be filed before the expiration of the time limit set forth in subsection (B) and shall set forth good cause as to the specific action or inaction of the school district that resulted in the interested party being unable to file the protest within the 10 days. The district representative shall approve or deny the request in writing, state the reasons for the determination, and, if an extension is granted, set forth a new date for submission of the filing.
- D. If the interested party shows good cause and it is advantageous to the school district, the district representative may consider any protest that is not filed timely.
- E. The district representative shall immediately give notice of the protest to the successful contractor if award has been made or, if no award has been made, to all interested parties.

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- F. At any time the district representative or hearing officer may refer the protest to the governing board for resolution in accordance with R7-2-1152.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1144. Stay of Procurements During the Protest

The district representative may stay all or part of the procurement or contract if it is determined that there is a reasonable probability the protest will be upheld or that a stay is advantageous to the school district. The district representative shall notify the successful contractor if award has been made or, if no award has been made, all interested parties of the stay in writing no later than the time of issuance of the district representative's decision in accordance with R7-2-1145.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1145. Decision by the District Representative

- A. The district representative shall have the authority granted to the district representative by the governing board to settle and resolve a protest.
- B. The district representative shall issue a written decision within 14 days after a protest has been filed, or after additional information requested by the district representative has been submitted, pursuant to R7-2-1142. The decision shall include:
 1. A statement of the decision of the district representative with supporting rationale; and
 2. A paragraph substantially as follows: "This is the decision of the district representative of the _____ School District. The decision may be appealed to a hearing officer. If you appeal, you must file a written notice of appeal with the district representative within 30 days from the date of the decision."
- C. The district representative shall furnish a copy of the decision to the interested party by any method that provides evidence of receipt.
- D. On agreement of all interested parties, the time limit for decisions set forth in subsection (B) may be extended by the district representative for good cause for a reasonable time not to exceed an additional 30 days. The district representative shall notify the interested party in writing that the time for the issuance of a decision has been extended and the date by which a decision will be issued.
- E. If the district representative fails to issue a decision within the time limits set forth in subsections (B) or (D), the interested party may proceed as if the district representative had issued an adverse decision.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt

rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1146. Remedies

- A. If the district representative sustains the protest in whole or part and determines that a solicitation, a determination that a proposal is unacceptable, proposed contract award, or contract award does not comply with Articles 10 and 11, the school district shall implement an appropriate remedy.
- B. In determining an appropriate remedy, the district representative shall consider all the circumstances surrounding the procurement or proposed procurement including, but not limited to, the seriousness of the procurement deficiency, the degree of prejudice to other interested parties or to the integrity of the procurement system, the good faith of the parties, the extent of performance, costs to the school district, the urgency of the procurement, the impact of the relief on the mission of the school district, and other relevant issues.
- C. An appropriate remedy may include one or more of the following:
 1. Decline to exercise an option to renew under the contract;
 2. Terminate the contract;
 3. Amend the solicitation;
 4. Issue a new solicitation;
 5. Award a contract consistent with procurement statutes and regulations; or
 6. Such other relief as is determined necessary to ensure compliance with Articles 10 and 11.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1147. Appeals to a Hearing Officer

- A. An appeal to a hearing officer from a decision entered or deemed to be entered by the district representative shall be filed with the district representative within 30 days from the date of decision.
- B. Content of appeal. The appeal shall contain:
 1. The information set forth in R7-2-1142(B); and
 2. The precise factual or legal error in the decision of the district representative from which an appeal is taken.
- C. All costs associated with conducting a hearing, including the costs of the hearing officer, shall be paid by the school district. If the hearing officer decides in favor of the school district, the other party shall reimburse the school district for the costs of the hearing within 30 days of receipt of a copy of the hearing officer's invoice.
- D. The Executive Director of the State Board of Education ("Executive Director") shall prepare and maintain a list of individuals who meet the qualifications specified in R7-2-1185 to serve as hearing officers.
- E. A hearing officer may be selected by mutual agreement of both parties. If the parties are unable to mutually agree on a hearing officer, three hearing officers shall be selected randomly by the Executive Director and shall be screened to determine availability and possible bias. Once the Executive Director has selected three hearing officers who are available and show no evidence of bias, the three names shall be provided to both parties. Both parties have the opportunity to strike one name from the list provided, but shall do so within 14 calendar days from the date on which the Executive Director provided the list to the parties. If after the time period for striking a hearing officer has passed and more than one person

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remains on the list, the Executive Director shall select one of the remaining individuals on the list as the hearing officer unless either party objects for cause and provides such reason in writing to the Executive Director. If after the time period for striking a hearing officer has passed and there is only one person remaining on the list, the remaining individual shall be named as the hearing officer unless either party objects for cause and provides such reason in writing to the Executive Director. Objections for cause shall require specific evidence that the individual does not meet the criteria specified in R7-2-1185. The Executive Director shall review the evidence submitted and determine the qualifications of the individual. If the Executive Director determines that the individual is not qualified to serve as the hearing officer, the Executive Director shall repeat the process and select three additional hearing officers to be provided to the parties.

- F. Issuance of a school district purchase order shall constitute the official selection date of the hearing officer.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1148. Notice of Appeal

The district representative shall within three working days give notice of the filing of the appeal to the governing board and the successful contractor if award has been made.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1149. Stay of Procurement During Appeal

If an appeal is filed and the procurement or contract was stayed by the district representative pursuant to R7-2-1144, the filing of an appeal shall automatically continue the stay unless the hearing officer makes a written determination that the award of the contract without delay is necessary to protect substantial interests of the school district. If no such determination is made, the stay shall automatically end upon written decision of the hearing officer pursuant to R7-2-1151 or R7-2-1181.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1150. District Representative's Response

- A. The district representative shall file a complete response to the appeal within 21 days from the date the appeal is filed or within five days after the hearing officer has been selected, whichever is later. At the same time, the district representative shall furnish a copy of the response to the appellant and to any interested party.
- B. The district representative may submit a written request to the hearing officer for an extension of the period for submission of response, identifying the reasons for the extension. The hearing officer shall approve or deny the request in writing, state

the reasons for the determination, and, if an extension is granted, set forth a new date for the submission of filing a response. The hearing officer shall notify the district representative and the interested party of any extension.

- C. The interested party shall file comments on the district representative's response with the hearing officer within 10 days after receipt of the response. The interested party shall provide copies of the comments to the district representative and other interested parties.
- D. The interested party may submit a written request to the hearing officer for an extension of the period for submission of comments, identifying the reasons for the extension. The hearing officer shall approve or deny the request in writing, state the reasons for the determination, and, if an extension is granted, set forth a new date for the submission of filing comments. The hearing officer shall notify the district representative and the interested party of any extension.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1151. Dismissal Before Hearing

- A. The hearing officer shall dismiss, upon a written determination, an appeal before scheduling a hearing if:
1. The appeal does not state a valid basis for protest;
 2. The appeal is untimely pursuant to R7-2-1147(A); or
 3. The appeal attempts to raise issues not raised in the protest.
- B. The hearing officer shall notify the interested party and the district representative in writing of a determination to dismiss an appeal before hearing.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1152. Hearing

Hearings on appeals of bid protest decisions shall be conducted pursuant to R7-2-1181 and A.R.S. § 41-1092.07 as contested cases.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1153. Remedies

If the hearing officer sustains the appeal in whole or part and determines that a solicitation, a determination that a proposal is unacceptable, proposed award, or award does not comply with Articles 10 and 11, remedies shall be implemented pursuant to R7-2-1146.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1154. Reserved

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PART XIX. CONTRACT CLAIMS AND CONTROVERSIES

R7-2-1155. Resolution of Contract Claims and Controversies

- A. The district representative shall have the authority granted to the district representative by the governing board to settle and resolve contract claims and controversies including claims relating to assignees of the contractor.
- B. The district representative shall receive prior written approval of the governing board for the settlement or resolution of a claim exceeding the dollar amount specified in A.R.S. § 41-2535.
- C. Appeals from decisions of the district representative may be made to the hearing officer pursuant to R7-2-1158.
- D. A claimant shall file a contract claim with the district representative within 180 days after the claim arises. The claim shall include the following:
 1. The name, address, and telephone number of the claimant;
 2. The signature of the claimant or claimant's representative;
 3. Identification of the solicitation or contract number;
 4. A detailed statement of the legal and factual grounds of the claim including copies of the relevant documents; and
 5. The form and dollar amount of the relief requested.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1156. District Representative's Decision

- A. If a controversy cannot be resolved by mutual agreement, the district representative shall issue a written decision within no more than 60 days from receipt of the contractor's written request for a decision. Before issuing a written decision, the district representative shall review the facts pertinent to the claim and secure any necessary assistance from legal, fiscal, and other advisors.
- B. Decision of the district representative. The district representative shall furnish a copy of the decision to the contractor by any method that provides evidence of receipt. The decision shall include:
 1. A description of the claim;
 2. A reference to the pertinent contract provision;
 3. A statement of the factual areas of agreement or disagreement;
 4. A statement of the district representative's decision, with supporting rationale; and
 5. A paragraph substantially as follows:

"This is the decision of the district representative of the _____ School District. This decision may be appealed to a hearing officer. If you appeal, you must file a written notice of appeal with the district representative within 30 days from the date of decision."

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Amended by final rulemaking at 6 A.A.R. 3750, effective September 8, 2000 (Supp. 00-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in

Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1157. Issuance of a Timely Decision

- A. On agreement of all interested parties, the time limit for decisions set forth in R7-2-1156(A) may be extended for good cause for a reasonable time not to exceed 14 days. The district representative shall notify the contractor in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.
- B. If the district representative fails to issue a decision within 60 days after the request is filed or within the time prescribed under subsection (A), the contractor may proceed as if the district representative had issued an adverse decision.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1158. Appeals to a Hearing Officer

- A. An appeal from a decision entered or deemed to be entered by the district representative on a contract claim or controversy shall be filed with the district representative within 30 days from the date of decision.
- B. The appeal shall contain the basis for the precise factual or legal error in the decision of the district representative from which an appeal is taken.
- C. The district representative shall file a complete response to the appeal within 21 days from the date the appeal is filed or within five days after the hearing officer has been selected, whichever is later. At the same time, the district representative shall furnish a copy of the response to the appellant and to any interested party.
- D. The district representative may submit a written request to the hearing officer for an extension of the period for submission of response, identifying the reasons for the extension. The hearing officer shall approve or deny the request in writing, state the reasons for the determination, and, if an extension is granted, set forth a new date for the submission of filing a response. The hearing officer shall notify the district representative and the interested party of any extension.
- E. The interested party shall file comments on the district representative's response with the hearing officer within 10 days after receipt of the response. The interested party shall provide copies of the comments to the district representative and other interested parties.
- F. The interested party may submit a written request to the hearing officer for an extension of the period for submission of comments, identifying the reasons for the extension. The hearing officer shall approve or deny the request in writing, state the reasons for the determination, and, if an extension is granted, set forth a new date for the submission of filing comments. The hearing officer shall notify the district representative and the interested party of any extension.
- G. All costs associated with conducting a hearing, including the costs of the hearing officer, shall be paid by the school district. If the hearing officer decides in favor of the school district, the other party shall reimburse the school district for the costs of the hearing within 30 days of receipt of a copy of the hearing officer's invoice.

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- H.** The Executive Director of the State Board of Education ("Executive Director") shall prepare and maintain a list of individuals who meet the qualifications specified in R7-2-1185 to serve as hearing officers.
- I.** A hearing officer may be selected by mutual agreement of both parties. If the parties are unable to mutually agree on a hearing officer, three hearing officers shall be selected randomly by the Executive Director and shall be screened to determine availability and possible bias. Once the Executive Director has selected three hearing officers who are available and show no evidence of bias, the three names shall be provided to both parties. Both parties have the opportunity to strike one name from the list provided, but shall do so within 14 calendar days from the date on which the Executive Director provided the list to the parties. If after the time period for striking a hearing officer has passed and more than one person remains on the list, the Executive Director shall select one of the remaining individuals on the list as the hearing officer unless either party objects for cause and provides such reason in writing to the Executive Director. If after the time period for striking a hearing officer has passed and there is only one person remaining on the list, the remaining individual shall be named as the hearing officer unless either party objects for cause and provides such reason in writing to the Executive Director. Objections for cause shall require specific evidence that the individual does not meet the criteria specified in R7-2-1185. The Executive Director shall review the evidence submitted and determine the qualifications of the individual. If the Executive Director determines that the individual is not qualified to serve as the hearing officer, the Executive Director shall repeat the process and select three additional hearing officers to be provided to the parties.
- J.** Issuance of a school district purchase order shall constitute the official selection date of the hearing officer.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Amended by final rulemaking at 6 A.A.R. 3750, effective September 8, 2000 (Supp. 00-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1159. Hearing

Hearings on appeals of contract claim and controversy decisions shall be conducted pursuant to R7-2-1181 and A.R.S. § 41-1092.07 as contested cases.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1160. Reserved**PART XX. DEBARMENT AND SUSPENSION****R7-2-1161. Authority to Debar or Suspend**

- A.** Except as provided in A.R.S. § 41-1279.21(B), the governing board has the sole authority to debar or suspend a person from participating in school district procurements.
- B.** The causes for debarment or suspension include the following:
1. Conviction of any person or any subsidiary or affiliate of any person for commission of a criminal offense arising out of obtaining or attempting to obtain a public or private contract or subcontract, or in the performance of such contract or subcontract.

2. Conviction of any person or any subsidiary or affiliate of any person under any statute of the federal government, this state or any other state for embezzlement, theft, fraudulent schemes and artifices, fraudulent schemes and practices, bid rigging, perjury, forgery, bribery, falsification or destruction of records, receiving stolen property or any other offense indicating a lack of business integrity or business honesty which affects responsibility as a school district contractor.
3. Conviction or civil judgment finding a violation by any person or any subsidiary or affiliate of any person under state or federal antitrust statutes.
4. Violations of contract provisions of a character which are deemed to be so serious as to justify debarment action, such as either of the following:
 - a. Knowingly fails without good cause to perform in accordance with the specification or within the time limit provided in the contract.
 - b. Failure to perform or unsatisfactory performance in accordance with the terms of one or more contracts, except that failure to perform or unsatisfactory performance caused by acts beyond the control of the contractor shall not be considered to be a basis for debarment.
5. Any other cause deemed to affect responsibility as a school district contractor, including suspension or debarment of such person or any subsidiary or affiliate of such person by another governmental entity for any cause.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1162. Initiation of Debarment

Upon receipt of information concerning a possible cause for debarment, the school district shall investigate the possible cause. If the school district has a reasonable basis to believe that a cause for debarment exists, the school district may propose debarment under R7-2-1164.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

R7-2-1163. Period of Debarment

- A.** The period of time for a debarment shall not exceed three years from the date of the debarment determination.
- B.** If debarment is based solely upon debarment by another governmental agency including another school district, the period of debarment may run concurrently with the period established by that other debarring agency.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

R7-2-1164. Notice

- A.** If the school district proposes debarment, the school district shall notify the person and affected affiliates in writing within seven days of the proposed debarment by any means evidencing receipt, which notice shall indicate that a hearing shall be scheduled, if requested, in accordance with R7-2-1181 as contested cases.
- B.** The notice of debarment shall state:
1. The basis for debarment;

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2. The period, including dates, of the debarment;
3. That bids or proposals shall not be solicited or accepted from the person and, if received, will not be considered; and
4. That the person is entitled to a hearing on the suspension if the person files a written request for a hearing with a designated district representative within 10 days after receipt of the notice.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1165. Notice to Affiliates

- A. If the school district proposes to debar an affiliate, the affiliate shall have a right to appear in any hearing on the proposed debarment to show mitigating circumstances.
- B. The affiliate shall in writing advise the school district within 10 days of receipt of the notice under R7-2-1164 of its intention to appear under subsection (A). Failure to provide written notice of appearance within the 10-day period shall be a waiver of the right to appear in the hearing.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1166. Imputed Knowledge

- A. Improper conduct may be imputed to an affiliate for purposes of debarment where the impropriety occurred in connection with the affiliate's duties for or on behalf of, or with the knowledge, approval, or acquiescence of, the contractor.
- B. The improper conduct of a person or its affiliate having a contract with a contractor may be imputed to the contractor for purposes of debarment where the impropriety occurred in connection with the person's duties for or on behalf of, or with the actual or constructive knowledge, approval, or acquiescence of, the contractor.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1167. Reinstatement

- A. The governing board may at any time reinstate a debarred person or rescind the debarment upon a determination that the cause upon which the debarment is based no longer exists or upon a determination that such reinstatement or rescission is advantageous to the school district. The governing board's determination shall include any limitations on the debarred person's ability to contract with the school district.
- B. Any debarred person may request reinstatement by submitting a petition to the school district supported by documentary evidence showing that the cause for debarment no longer exists or has been substantially mitigated.
- C. The school district may require a hearing on the request for reinstatement.
- D. The school district shall make a written decision on reinstatement within 30 days after the request is filed and specify the factors on which it is based.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1168. Suspension

- A. If adequate grounds for debarment exist, the governing board may suspend a person from participating in any procurement or receiving any award in accordance with the procedures in R7-2-1170.
- B. The governing board shall not suspend a person pending debarment unless compelling reasons require suspension to protect school district interests.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1169. Period and Scope of Suspension

- A. Unless otherwise agreed to by the parties, the period of suspension shall not exceed 35 days without satisfying the notice requirements of R7-2-1170. If the notice requirements are satisfied the period of suspension shall not exceed six months.
- B. For purpose of suspension, a person's conduct may be imputed to an affiliate or another person in accordance with R7-2-1166.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1170. Notice and Hearing

- A. The school district shall notify the person suspended by any means evidencing receipt.
- B. The notice of suspension shall state:
 1. The basis for suspension;
 2. The period, including dates, of the suspension;
 3. That bids or proposals shall not be solicited or accepted from the person and, if received, will not be considered; and
 4. That the person is entitled to a hearing on the suspension if the person files a written request for a hearing, including the basis for the request, with a designated district representative within 10 days after receipt of the notice.
- C. A hearing requested under this Section shall be conducted pursuant to R7-2-1181.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1171. List of Debarments, Suspensions and Voluntary Exclusions

The school district shall maintain a list of debarment, suspensions, and voluntary exclusions. It is recommended that the school district provide notice of any debarments, suspensions and voluntary exclusions to the state purchasing office.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

R7-2-1172. Reserved

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- R7-2-1173. Reserved
- R7-2-1174. Reserved
- R7-2-1175. Reserved
- R7-2-1176. Reserved
- R7-2-1177. Reserved
- R7-2-1178. Reserved
- R7-2-1179. Reserved
- R7-2-1180. Reserved

PART XXI. HEARING PROCEDURES

R7-2-1181. Hearing Procedures

- A. If a hearing is required or permitted under Articles 10 and 11, this Section shall apply. Hearing officers shall be selected pursuant to R7-2-1147(D) and (E) or R7-2-1158(E) and (F).
- B. The Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6) shall apply where the Act is not inconsistent with Articles 10 and 11.
- C. The hearing officer shall arrange for a hearing to be held within 30 days of receiving required responses and comments from both parties and notify the parties in writing of the time and place of the hearing.
- D. The hearing officer may:
 - 1. Hold pre-hearing conferences to settle, simplify, or identify the issues in a proceeding, or to consider other matters that may aid in the expeditious disposition of the proceeding;
 - 2. Require parties to state their positions concerning the various issues in the proceeding;
 - 3. Require parties to produce for examination those relevant witnesses and documents under their control;
 - 4. Rule on motions and other procedural items on matters pending before such officer;
 - 5. Regulate the course of the hearing and conduct of participants;
 - 6. Establish time limits for submission of motions or memoranda;
 - 7. Impose appropriate sanctions against any person failing to obey an order under these procedures, which may include:
 - a. Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;
 - b. Excluding all testimony of an unresponsive or evasive witness; and
 - c. Expelling person from further participation in the hearing;
 - 8. Take official notice of any material fact not appearing in evidence in the record, if the fact is among the traditional matters of judicial notice; and
 - 9. Administer oaths or affirmations.
- E. A transcribed record of the hearing shall be made available at cost to any requesting party.
- F. Decision by the hearing officer. A decision by the hearing officer shall be sent within 30 days after the conclusion of the hearing to all parties by any means evidencing receipt. A decision shall contain:
 - 1. A statement of facts;
 - 2. A statement of the decision with supporting rationale; and

- 3. A statement that the parties may file a motion for rehearing within 15 days from the date a copy of this decision is served upon the party.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
 Amended by final rulemaking at 6 A.A.R. 3750, effective September 8, 2000 (Supp. 00-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2. Amended by final exempt rulemaking at 26 A.A.R. 597, effective July 1, 2020 (Supp. 20-1).

R7-2-1182. Rehearing of Decisions

- A. Procedure; grounds. A decision of the hearing officer may be vacated and new hearing granted on motion of the aggrieved party for any of the following causes materially affecting the party's rights:
 - 1. Irregularity in the proceedings of the hearing officer or prevailing party, or any order or abuse of discretion, whereby the moving party was deprived of a fair hearing.
 - 2. Misconduct of the prevailing party.
 - 3. Accident or surprise not preventable by ordinary prudence.
 - 4. Material evidence, newly discovered, which despite reasonable diligence was not discovered and produced at the hearing.
 - 5. Excessive or insufficient damages or penalties.
 - 6. Error of law occurring at the hearing or during the progress of the proceeding.
 - 7. That the findings of fact or decision is not justified by the evidence or is contrary to law.
- B. Scope. A rehearing may be granted to all or any of the parties and on all or part of the issues in the proceeding for any of the reasons for which rehearings are authorized by law or rule of court. On a motion for a rehearing, the hearing officer may open the decision, take additional testimony, amend findings of fact and conclusions of law or make new findings and conclusions, and direct the entry of a new decision.
- C. Contents of motion; amendment; rulings reviewable.
 - 1. The motion for rehearing shall be in writing, shall specify generally the grounds upon which the motion is based, and may be amended at any time before it is ruled upon by the hearing officer.
 - 2. Upon the general ground that the hearing officer erred in admitting or rejecting evidence, the hearing officer shall review all rulings during the hearing upon objections to evidence.
 - 3. Upon the general ground that the findings of fact or decision are not justified by the evidence, the hearing officer shall review the sufficiency of the evidence.
- D. Time for motion for rehearing. A motion for rehearing shall be filed not later than 15 days after service of the decision upon the party.
- E. Time for serving affidavits. When a motion for rehearing is based upon affidavits they shall be served with the motion. The opposing party has 10 days after such service within which to serve opposing affidavits, which period may be extended for an additional period not exceeding 20 days either by the hearing officer for good cause shown or by the parties by written stipulation. The hearing officer may permit reply affidavits.
- F. On initiative of hearing officer. Not later than 15 days after the date of the decision, the hearing officer may order a rehearing for any reason for which it might have granted a rehearing on

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motion of a party. After giving the parties notice and an opportunity to be heard on the matter, the hearing officer may grant a motion for a rehearing, timely served, for a reason not stated in the motion. In either case, the hearing officer shall specify in the order the grounds therefor.

- G. Questions to be considered in rehearing. A rehearing, if granted, shall be only a rehearing of the question or questions with respect to which the decision is found erroneous, if separable. If a rehearing is ordered because the damages or penalties are excessive or inadequate and granted solely for that reason, the decision shall be set aside only in respect of the damages or penalties, and shall stand in all other respects.
- H. Motion on ground of excessive or inadequate damages. When a motion for rehearing is made upon the ground that the damages or penalties awarded are either excessive or insufficient, the hearing officer may grant the rehearing conditionally upon the filing within a fixed period of time, not to exceed 15 days, of a statement by the party adversely affected by reduction or increase of damages or penalties accepting that amount of damages or penalties which the hearing officer shall designate. If such a statement is filed with the prescribed time, the motion for rehearing shall be regarded as denied as of the date of such filing. If no statement is filed, the motion for rehearing shall be regarded as granted as of the date of the expiration of the time period within which a statement may have been filed. No further written order shall be required to make an order granting or denying the rehearing final. If the conditional order of the hearing officer requires a reduction of or increase in damages or penalties, then the rehearing will be granted in respect of the damages or penalties only and the decision shall stand in all other respects.
- I. Number of motions for rehearing. Not more than two motions for rehearing shall be granted to any party in the same action.
- J. Specifications of grounds of rehearing in order. An order granting a motion for rehearing shall specify with particularity the ground or grounds on which the rehearing is granted.
- K. Final decision.
 1. If a motion for rehearing is denied, the final decision denying the motion for rehearing shall be sent within five days after the denial to all parties by any means evidencing receipt. A final decision shall contain a paragraph substantially as follows: "This is the final decision of the hearing officer in the matter of _____."
 2. If the motion for rehearing was granted, after the rehearing is completed, a final decision shall be made and shall be sent within five days after the conclusion of the rehearing to all parties as required in subsection (K)(1). A final decision shall contain:
 - a. A statement of facts;
 - b. A statement of the decision with supporting rationale; and
 - c. A paragraph substantially as stated in subsection (K)(1).

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).
Amended by final rulemaking at 6 A.A.R. 3750, effective September 8, 2000 (Supp. 00-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1183. Judicial Review

Any final decision made as a result of a hearing held pursuant to Articles 10 and 11 are subject to judicial review in accordance with A.R.S. Title 12, Chapter 7, Article 6.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 3750, effective September 8, 2000 (Supp. 00-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1184. Exclusive Remedy

Articles 10 and 11 (R7-2-1001 et seq.) provide the exclusive procedure for asserting a cause against the school district and its governing board arising in relation to any procurement conducted under Articles 10 and 11.

Historical Note

Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1185. Qualifications for Hearing Officers

- A. A "hearing officer" means a person assigned to preside at a hearing held pursuant to Articles 10 and 11 and whose duty it is to assure that proper procedures are followed and that the rights of the parties are protected.
- B. A hearing officer shall be:
 1. Unbiased - not prejudiced for or against any party in the hearing;
 2. Disinterested - not having any personal or professional interest which would conflict with his/her objectivity in the hearing; and
 3. Independent - may not be an officer, employee or agent of the contractor or governing board, or of any other public agency involved in the dispute to be settled. A person who otherwise qualifies to conduct a hearing is not an employee of the contractor or governing board solely because he or she is paid by the parties to serve as a hearing officer.
- C. A hearing officer shall have:
 1. A minimum of three years of verified experience in the practice of law; or
 2. A minimum of three years of verified experience in school procurement or school facilities management and a minimum of one year of verified experience in conducting hearings. Completion of a course or program in conducting a hearing or arbitration may substitute for the one year of verified experience in conducting hearings.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 3750, effective September 8, 2000 (Supp. 00-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1186. Reserved**R7-2-1187. Reserved****R7-2-1188. Reserved****R7-2-1189. Reserved****R7-2-1190. Reserved****PART XXII. INTERGOVERNMENTAL PROCUREMENTS****R7-2-1191. Cooperative Purchasing Authorized**

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- A.** A school district may either participate in, sponsor, conduct, or administer a cooperative purchasing agreement for the procurement of any materials, services, specified professional services, construction, or construction services with one or more eligible procurement units in accordance with an agreement entered into between the participants. An agreement entered into as provided in R7-2-1191 through R7-2-1195 is exempt from A.R.S. § 11-952(D) and (E). Parties under a cooperative purchasing agreement may:
1. Sponsor, conduct, or administer a cooperative purchasing agreement for the procurement or disposal of any materials, services or construction.
 2. Cooperatively use materials or services.
 3. Commonly use or share warehousing facilities, capital equipment and other facilities.
 4. Provide personnel, except that the requesting public procurement unit shall pay the public procurement unit providing the personnel the direct and indirect cost of providing the personnel, in accordance with the agreement.
 5. On request, make available to other public procurement units informational, technical or other services or software that may assist in improving the efficiency or economy of procurement. The public procurement unit furnishing the informational, technical, or other services or software has the right to request reimbursement for the reasonable and necessary costs of providing such services or software.
- B.** The activities described in subsections (A)(1) through (A)(5) do not limit what parties may do under a cooperative purchasing agreement.
- C.** A nonprofit corporation shall comply with Articles 10 and 11 in any cooperative purchasing agreement the nonprofit corporation administers in which a school district participates.
- D.** Whether administering or purchasing from the agreement, this Section does not abrogate the responsibility of each school district to perform due diligence in order to ensure compliance with Articles 10 and 11 notwithstanding the fact that the cooperative purchase is administered by another eligible procurement unit.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1192. Contract Provisions in a Cooperative Purchasing Agreement

Any contract entered pursuant to R7-2-1191 shall provide that:

1. Payment for materials and services and inspection and acceptance of materials or services ordered by an eligible procurement unit under a cooperative purchasing agreement shall be the exclusive obligation of such procurement unit;
2. The exercise of any rights or remedies by a using eligible procurement unit shall be the exclusive obligation of such procurement unit. The administering public procurement unit, as the contract administrator and without subjecting itself to any liability, may join in the resolution of any controversy;
3. Any school district may terminate without notice any cooperative purchasing agreement if another eligible procurement unit fails to comply with the terms of the contract;

4. Failure of an eligible procurement unit to secure performance from the contractor in accordance with the terms and conditions of its purchase order does not necessarily require any other eligible procurement unit to exercise its own rights or remedies; and
5. An eligible procurement unit shall not use a cooperative purchasing contract as a method for obtaining concessions or reduced prices for non-contract purchases of similar materials or services.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1193. Use of Payments Received by a Supplying Public Procurement Unit

All payments received by a public procurement unit supplying personnel or services shall be available to the supplying public procurement unit to defray the cost of the cooperative program.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4).

R7-2-1194. Public Procurement Units in Compliance with Article Requirements

- A.** If the eligible procurement unit administering a cooperative purchase complies with the requirements of Articles 10 and 11, any public procurement unit participating in such a purchase is deemed to have complied with Articles 10 and 11. Public procurement units may not enter into a cooperative purchasing agreement for the purpose of circumventing Articles 10 and 11.
- B.** A participating public procurement unit using a contract awarded by another eligible procurement unit shall only purchase awarded materials, services, specified professional services, construction, or construction services in compliance with the terms, conditions and prices in the contract.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1195. Contract Controversies

- A.** Under a cooperative purchasing agreement in which a school district is a party, controversies arising between an administering public procurement unit and its bidders, offerors or contractors shall be resolved in accordance with Articles 10 and 11.
- B.** Any local public procurement unit which is not subject to R7-2-1181 through R7-2-1185 may enter into an agreement with a school district to establish procedures or use such school district's existing procedures to resolve controversies with contractors, whether or not such controversy arose from a cooperative purchasing agreement.

Historical Note

Adopted effective December 17, 1987 (Supp. 87-4). Section amended by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1196. General Services Administration Contracts

- A.** The governing board may authorize purchases under a current General Services Administration contract for materials or ser-

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vices without complying with the requirements of Articles 10 and 11 if the governing board determines in writing before proceeding with a General Services Administration contract procurement that all of the following apply:

1. The price for materials or services is equal to or less than the contractor's current federal supply contract price with the General Services Administration and is fair and reasonable.
 2. The contractor has indicated in writing that the contractor is willing to extend the current federal supply contract pricing, terms and conditions to the school district.
 3. The purchase order adequately identifies the federal supply contract on which the order is based, including the name of the contractor, contract number and procurement description.
 4. The purchase contract is cost effective based on price, quality and other relevant factors, and is advantageous to the school district.
- B.** The school district shall only purchase materials or services awarded under the applicable General Services Administration contract.
- C.** The governing board shall comply with all federal requirements applicable to state and local government use of General Services Administration contracts.

Historical Note

Section made by final exempt rulemaking at 21 A.A.R. 1525, effective July 1, 2014 (Supp. 15-3); effective year corrected in Supp. 18-2.

R7-2-1197. Reserved

R7-2-1198. Reserved

R7-2-1199. Reserved

R7-2-1200. Reserved

ARTICLE 12. REPEALED

R7-2-1201. Repealed

Historical Note

Adopted effective April 27, 1989 (Supp. 89-2). Repealed effective February 20, 1997 (Supp. 97-1).

ARTICLE 13. CONDUCT**R7-2-1301. Definitions**

In this Article, unless the context otherwise specifies:

1. "Alleging party" means an individual, partnership, corporation, association, governmental subdivision or unit of a governmental subdivision, a public or private organization of any character or other agency who completes a statement alleging immoral or unprofessional conduct against a certificated individual.
2. "Applicant" means a noncertificated person who has been disciplined by the Board and who has submitted an application requesting reinstatement of the person's legal right to work in a public school, or a person who has submitted an application to the Department requesting an evaluation of the requirements set forth in R7-2-601 et seq., requesting issuance of a certificate pursuant to R7-2-601 et seq., requesting renewal of a certificate issued pursuant to R7-2-601 et seq. or requesting changes of coding to existing files or certificates pursuant to R7-2-601 et seq.
3. "Board" means the State Board of Education.

4. "Certificated individual" means an individual who holds or has held an Arizona certificate issued pursuant to R7-2-601 et seq.
5. "Complaint" means the filing of a charge by the Board against a certificated individual alleging immoral or unprofessional conduct.
6. "Department" means the Arizona Department of Education.
7. "Hearing" means an adjudicative proceeding held pursuant to A.R.S. Title 41, Chapter 6 and R7-2-701 et seq.
8. "Noncertificated individual" means a noncertificated person defined in A.R.S. § 15-505, as determined by the Board.
9. "PPAC" means the Professional Practices Advisory Committee established pursuant to R7-2-205.

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Amended by final exempt rulemaking at 25 A.A.R. 967, effective March 27, 2019 (Supp. 19-1). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-1302. Statement of Allegations

- A.** Any person may file, with the Board, a statement of allegations against a certificated or noncertificated individual on forms provided by the Board.
- B.** A statement of allegations shall state the facts under which a party is alleging immoral or unprofessional conduct and shall be signed and notarized.
- C.** The facts in a statement of allegations shall clearly state the details of the alleged immoral or unprofessional conduct.
- D.** A statement of allegations shall contain the names, addresses and telephone numbers of individuals who can be contacted to provide information regarding the allegations contained in the statement. The list of individuals shall also include a brief summary of the substance and extent of each individual's knowledge regarding the allegations contained in the statement.
- E.** The alleging party may attach written or other evidence to a statement of allegations at the time that the statement is filed with the Board.
- F.** A statement of allegations may be returned to the alleging party if the statement is not complete or not legible.
- G.** The Board shall conduct an investigation of all statements of allegations filed pursuant to this Article.

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Amended by final exempt rulemaking at 25 A.A.R. 967, effective March 27, 2019 (Supp. 19-1). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-1303. Complaint

- A.** Upon completion of an investigation resulting from a statement of allegations, the Board may file a complaint against a certificated or noncertificated individual, may issue or deny certification to an applicant, or may reinstate a noncertificated individual's legal right to work in a public school and matters related to immoral or unprofessional conduct, unfitness to

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teach, and the discipline of noncertificated individuals pursuant to A.R.S. § 15-505.

- B. The Board may, at its own discretion, investigate any matter and file a complaint against a certificated or noncertificated individual upon receiving any information, from any source, indicating immoral or unprofessional conduct has occurred.
- C. A hearing shall be held on a complaint before the PPAC.

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4). Section R7-2-1303 renumbered to R7-2-1304; new Section R7-2-1303 renumbered from R7-2-1304 and amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Amended by final exempt rulemaking at 25 A.A.R. 967, effective March 27, 2019 (Supp. 19-1). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-1304. Notification; Investigation

The certificated or noncertificated individual shall have 20 days from service by U.S. mail and email of the notice of investigation to file a written response with the Board.

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4). Section R7-2-1304 renumbered to R7-2-1303; new Section R7-2-1304 renumbered from R7-2-1303 and amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Amended by final exempt rulemaking at 23 A.A.R. 725, effective January 23, 2017 (Supp. 17-1). Amended by final exempt rulemaking at 25 A.A.R. 967, effective March 27, 2019 (Supp. 19-1). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-1305. Investigation

- A. Applicants shall certify on forms that are provided by the Department whether the applicant:
 - 1. Has ever received any disciplinary action, including revocation, suspension or reprimand, involving any professional certification or license;
 - 2. Is currently under investigation or has ever been the subject of any investigation by the Department of Child Safety or a similar department in this state or another jurisdiction;
 - 3. Has ever been convicted of a felony offense;
 - 4. Has ever been arrested, cited and released, or received a criminal summons for any offense, regardless if eventually convicted of a crime or if a conviction was set aside or expunged; or
 - 5. Has ever been arrested, cited and released, or received a criminal summons for any offense involving a child, regardless if eventually convicted of a crime or if a conviction was set aside or expunged.
- B. Upon receipt of notification that an applicant, certificated, or noncertificated individual has engaged in unprofessional or immoral conduct pursuant to R7-2-1308, conduct that would warrant disciplinary action if the person had been certified at the time that the alleged conduct occurred, or conduct listed in subsections (A)(1) through (5), the Board shall initiate an investigation.
- C. Applicants, certificated, and noncertificated individuals who are alleged to have engaged in unprofessional or immoral conduct pursuant to R7-2-1308, conduct that would warrant disciplinary action if the person had been certified at the time that

the alleged conduct occurred, or conduct listed in subsections (A)(1) through (5) shall provide the Board with copies of court records and law enforcement reports pertaining to the offense.

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Amended by final exempt rulemaking at 25 A.A.R. 967, effective March 27, 2019 (Supp. 19-1). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-1306. Repealed**Historical Note**

Adopted effective December 4, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Repealed by final exempt rulemaking at 25 A.A.R. 967, effective March 27, 2019 (Supp. 19-1).

R7-2-1307. Criminal Offenses

- A. The Board shall revoke, not issue, or not renew the certification of a person who has been convicted of committing or attempting, soliciting, facilitating or conspiring to commit any of the following criminal offenses in this state or similar offenses in another jurisdiction:
 1. Sexual abuse of a minor;
 2. Incest;
 3. First-degree murder;
 4. Second-degree murder;
 5. Manslaughter;
 6. Sexual assault;
 7. Sexual exploitation of a minor;
 8. Commercial sexual exploitation of a minor;
 9. A dangerous crime against children as defined in A.R.S. § 13-705;
 10. Armed robbery;
 11. Aggravated assault;
 12. Sexual conduct with a minor;
 13. Molestation of a child;
 14. Exploitation of minors involving drug offenses;
 15. Sexual abuse of a vulnerable adult;
 16. Sexual exploitation of a vulnerable adult;
 17. Commercial sexual exploitation of a vulnerable adult;
 18. Child sex trafficking as prescribed in A.R.S. § 13-3212;
 19. Child abuse;
 20. Abuse of a vulnerable adult;
 21. Molestation of a vulnerable adult;
 22. Taking a child for the purpose of prostitution as prescribed in A.R.S. § 13-3206;
 23. Neglect or abuse of a vulnerable adult;
 24. Sex trafficking;
 25. Sexual abuse;
 26. Production, publication, sale, possession and presentation of obscene items as prescribed in A.R.S. § 13-3502;
 27. Furnishing harmful items to minors as prescribed in A.R.S. § 13-3506;
 28. Furnishing harmful items to minors by internet activity as prescribed in A.R.S. § 13-3506.01;
 29. Obscene or indecent telephone communications to minors for commercial purposes as prescribed in A.R.S. § 13-3512;
 30. Luring a minor for sexual exploitation;
 31. Enticement of persons for purposes of prostitution;

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32. Procurement by false pretenses of person for purposes of prostitution;
 33. Procuring or placing persons in a house of prostitution;
 34. Receiving earnings of a prostitute;
 35. Causing one's spouse to become a prostitute;
 36. Detention of persons in a house of prostitution for debt;
 37. Keeping or residing in a house of prostitution or employment in prostitution;
 38. Pandering;
 39. Transporting persons for the purpose of prostitution, polygamy and concubinage;
 40. Portraying adult as a minor as prescribed in A.R.S. § 13-3555;
 41. Admitting minors to public displays of sexual conduct as prescribed in A.R.S. § 13-3558;
 42. Unlawful sale or purchase of children;
 43. Child bigamy; or
 44. Trafficking of persons for forced labor or services.
- B.** Upon notification by the clerk of the court, magistrate or court of competent jurisdiction, the Board shall immediately and permanently revoke the certificate of a person who has been convicted of any of the following offenses:
1. A dangerous crime against children as defined in A.R.S. § 13-705;
 2. Sexual abuse as prescribed in A.R.S. § 13-1404 in which the victim was a minor;
 3. Sexual assault as prescribed in A.R.S. § 13-1406 in which the victim was a minor;
 4. Sexual conduct with a minor as prescribed A.R.S. § 13-1405;
 5. A preparatory offense as prescribed in A.R.S. § 13-1001 of any of the offenses listed in subsections (B)(1), (2), (3), or (4);
 6. Any crime that requires the person to register as a sex offender; or
 7. An act committed in another state or territory that if committed in this state would have been one of the offenses listed in subsections (B)(1), (2), (3), or (4).
- C.** If the Board takes disciplinary action against a noncertificated individual, does not issue, does not renew, or revokes a certificate due to a person's conviction or admission of an offense listed in subsections (A)(1) through (44), but which is not an offense listed in subsections (B)(1) through (7), the notice of non-issuance, non-renewal or revocation shall inform the person of that person's right to request a hearing within 20 days of service of the notice.
- D.** The Board shall prohibit from employment at a public school a noncertificated individual who has been convicted of committing or attempting, soliciting, facilitating or conspiring to commit any of the criminal offenses in this state or similar offenses in another jurisdiction listed in subsections (A)(1) through (44).
- E.** Upon notification by the clerk of the court, magistrate or court of competent jurisdiction, the Board shall immediately and permanently prohibit a noncertificated individual from employment at a public school if the individual has been convicted of any offense listed in subsections (B)(1) through (7).

Historical Note

Adopted effective December 4, 1998 (Supp. 98-4).
 Amended by final exempt rulemaking at 23 A.A.R. 725, effective January 23, 2017 (Supp. 17-1). Amended by final rulemaking at 6 A.A.R. 1132, effective March 10, 2000 (Supp. 00-1). Amended by final exempt rulemaking at 25 A.A.R. 967, effective March 27, 2019 (Supp. 19-1).

The phrase "paragraphs one, two, three or four" was changed to "subsections (B)(1), (2), (3) or (4)" to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-1308. Unprofessional and Immoral Conduct

- A.** Noncertificated individuals and individuals holding certificates issued by the Board pursuant to R7-2-601 et seq. and individuals applying for certificates issued by the Board pursuant to R7-2-601 et seq. shall:
1. Make reasonable efforts to protect pupils from conditions harmful to learning, health, or safety;
 2. Account for all funds collected from pupils, parents, or school personnel;
 3. Adhere to provisions of the Uniform System of Financial Records related to use of school property, resources, or equipment; and
 4. Abide by copyright restrictions, security, or administration procedures for a test or assessment.
- B.** Noncertificated individuals and individuals holding certificates issued by the Board pursuant to R7-2-601 et seq. and individuals applying for certificates issued by the Board pursuant to R7-2-601 et seq. shall not:
1. Discriminate against or harass any pupil or school employee on the basis of race, national origin, religion, sex, including sexual orientation, disability, color or age;
 2. Deliberately suppress or distort information or facts relevant to a pupil's academic progress;
 3. Misrepresent or falsify pupil, classroom, school, or district-level data from the administration of a test or assessment;
 4. Engage in a pattern of conduct for the sole purpose or with the sole intent of embarrassing or disparaging a pupil;
 5. Use professional position or relationships with pupils, parents, or colleagues for improper personal gain or advantage;
 6. Falsify or misrepresent documents, records, or facts related to professional qualifications or educational history or character;
 7. Assist in the professional certification or employment of a person the certificate holder knows to be unqualified to hold a position;
 8. Accept gratuities or gifts that influence judgment in the exercise of professional duties;
 9. Possess, consume, or be under the influence of alcohol on school premises or at school-sponsored activities;
 10. Illegally possess, use, or be under the influence of marijuana, dangerous drugs, or narcotic drugs, as each is defined in A.R.S. § 13-3401;
 11. Make any sexual advance towards a pupil or child, either verbal, written, or physical;
 12. Engage in sexual activity, a romantic relationship, or dating of a pupil or child;
 13. Submit fraudulent requests for reimbursement of expenses or for pay;
 14. Use school equipment to access pornographic, obscene, or illegal materials; or
 15. Engage in conduct which would discredit the teaching profession.
- C.** Individuals found to have engaged in unprofessional or immoral conduct shall be subject to, and may be disciplined by, the Board.

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- D. Procedures for making allegations, complaints, and investigation of unprofessional or immoral conduct shall be as set forth in this Article.
- E. Application forms and certificates shall include the rules and statutes related to unprofessional and immoral conduct, including resignation from a contracted position without authorization and duties to report as required by law.
- F. Individuals applying for certificates issued by the Board pursuant to R7-2-601 et seq shall certify:
 1. That they have read and understood the rules and statutes related to unprofessional and immoral conduct, including resignation from a contracted position without authorization and duties to report as required by law; and
 2. Whether they have been disciplined or are under investigation in another state for engaging in conduct that is immoral or unprofessional.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 1544, effective June 28, 2003 (Supp. 03-2). Amended by final exempt rulemaking at 23 A.A.R. 725, effective January 23, 2017 (Supp. 17-1). Amended by final exempt rulemaking at 27 A.A.R. 2353 (October 22, 2021), effective September 27, 2021 (Supp. 21-4).

R7-2-1309. Summary Suspension

- A. If a certificate holder is arrested, cited and released, or received a criminal summons for an offense listed in R7-2-1307 and if the Board finds the public health, safety or welfare imperatively requires emergency action, the Board may proceed under A.R.S. § 41-1064(C) ordering a summary suspension of a certificate while other proceedings are pending. The Board shall provide notice to the certificate holder of the meeting pursuant to R7-2-703 and R7-2-704.
- B. Summary suspensions issued by the Board shall remain in effect pending a public hearing and final decision by the Board pursuant to Article 7.

Historical Note

New Section made by final exempt rulemaking at 26 A.A.R. 66, effective December 13, 2019 (Supp. 19-4).

R7-2-1400. Reserved**ARTICLE 14. CHARTER SCHOOLS****R7-2-1401. Definitions**

For the purpose of this Article the following definitions shall apply:

1. "Applicant" means a person, public body, or private organization that has applied to the State Board of Education to establish a charter school under the provisions of A.R.S. § 15-181 et seq.
2. "Background check" means a report received related to an applicant and the identified governing board members regarding the status of each person's credit and credit history, and any criminal activity identified by the law enforcement agency processing the applicant and governing board member's fingerprints.
3. "Committee" means the Charter School Committee established pursuant to this Article.
4. "Charter School" means a school chartered pursuant to A.R.S. § 15-181 et seq. and sponsored by the Board of Education.
5. "Contract" means a document outlining the terms and conditions of an agreement between the parties.

6. "Governing board" means the governing body responsible for the policy and operational decisions of the charter school formed pursuant to A.R.S. § 15-183 et seq.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 3211, effective August 24, 1999 (Supp. 99-4).

R7-2-1402. Charter School Committee

- A. The Board of Education shall establish a Charter School Committee that shall have the responsibility of reviewing applications and preparing a recommendation for the Board of Education's consideration.
- B. The Board of Education shall appoint the members of the committee. The committee shall consist of seven members as follows:
 1. An individual knowledgeable in building construction or renovation;
 2. An individual knowledgeable in finance and accounting and in generally accepted accounting practices;
 3. An individual representing a city in this state who is knowledgeable about zoning and operating permit requirements;
 4. An individual knowledgeable about elementary and high school curricula and the development and evaluation of curricula;
 5. An individual knowledgeable about assessments and the administration of assessments;
 6. An individual representing the Board of Education;
 7. A current operator of a charter school sponsored by the Board of Education.
- C. Terms of each member of the committee shall be for three years. Members may be appointed for subsequent terms upon approval by the Board of Education.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 3211, effective August 24, 1999 (Supp. 99-4).

R7-2-1403. Application

- A. Interested parties or individuals may submit an application for approval by the Board of Education pursuant to A.R.S. § 15-181 et seq. Applications shall be on forms approved by the Board of Education.
- B. Applications shall be evaluated by the committee. The committee shall prepare a recommendation for the Board of Education's consideration. The recommendation shall be based upon a review of all aspects of the application, including, for example, completeness of the application, the viability of the school including the financial viability, the projected funding sources, the number and population to be served, including school-aged students who are deemed to be unserved or underserved.
 1. The committee may request additional information as needed to assist in evaluating the application and preparing a recommendation for the Board of Education's consideration.
 2. Recommendations of the committee to the Board of Education may include approval of the application, denial of the application, or deferral of the application pending further information or clarification.
 3. Applicants shall be notified in writing at least 10 days prior to the Board of Education meeting of the date, time, and place of the meeting at which the Board of Education shall consider the charter school committee's recommendation related to the application.

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4. Action by the Board of Education may include approval of the application, denial of the application, or deferral of the application pending further information or clarification. The Board of Education shall state the reasons for denial or deferral of the application.
5. Applicants shall be notified in writing of the decision of the Board of Education. Written notification that the Board of Education has denied an application shall include reasons for denial. Written notification shall be provided to applicants within 15 days following a decision of the Board of Education.
- C. An approved application does not constitute an approved contract, and approval of an application shall not be construed to imply that a contract will be issued.
2. Certificate of Occupancy or a written exemption from the local municipality or county that the certificate is not required for operation of a public school. A set of architectural plans approved by the local planning and zoning office may be submitted in lieu of a certificate of occupancy for the purposes of this subsection for construction of new buildings or renovation of existing buildings. A certificate of occupancy will be required to be submitted prior to opening of the school.
3. A lease agreement or proof of building availability;
4. Executed statement of assurances;
5. Written verification that the facility meets the requirements established by the state and local fire marshal;
6. Written verification from an insurance company authorized to do business in the state of Arizona that arrangements have been finalized to provide the required amount of insurance;
7. Proof of local County Health Department approval.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 3211, effective August 24, 1999 (Supp. 99-4).

R7-2-1404. Contract

- A. A contract shall be on forms approved by the Board of Education.
- B. At least once per year, the Board of Education shall consider issuance of a contract to approved applicants.
- C. Upon review and recommendation from the committee, the Board of Education may approve the issuance of a contract, approve the issuance of a contract pending receipt of specific information or completion of requirements, defer the issuance of a contract, or deny the issuance of a contract. The Board of Education shall state the reasons for denial or deferral of issuance of a contract.
- D. Applicants shall be notified in writing at least 10 days prior to the Board of Education meeting of the date, time, and place of the meeting at which the Board of Education shall consider the charter school committee's recommendation related to issuance of a charter.
- E. Applicants shall be notified in writing of the decision of the Board of Education. Written notification that the Board of Education has denied issuance of a contract shall include reasons for denial. Written notification shall be provided to applicants within 15 days following a decision of the Board of Education.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 3211, effective August 24, 1999 (Supp. 99-4).

R7-2-1405. Execution of a Contract

- A. Contracts shall be signed by the applicant, or a person with signatory authority for the applicant, within six months from the date of approval of issuance of the contract by the Board of Education, unless an extension of time is granted by the Board of Education. If issuance of a contract was approved by the Board of Education pending receipt of additional information, the contract shall be signed by the applicant or a person with signatory authority for the applicant within six months of receipt of the additional information by the Board of Education.
- B. Contracts which have not been signed pursuant to this Section shall require reapplication and approval during a subsequent application cycle.
- C. The following items shall be submitted to the Board of Education prior to signing of a contract:
 1. Background check, including fingerprint clearance for all authorized signatories and all governing board members approved;

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 3211, effective August 24, 1999 (Supp. 99-4). The word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-1406. Amendments to a Contract

- A. Any changes to the contract shall be submitted on forms approved the Board of Education.
- B. All amendments to the contract shall be accompanied by a signed governing board resolution or an official copy of the minutes of a governing board meeting that the amendment was approved by the governing board.
- C. No amendment shall be effective or implemented prior to being approved by the governing board, submitted to and approved by the Board of Education.
- D. Amendments requesting a change in the membership of the governing board shall, in addition to the requirements specified in subsection (B), include a completed fingerprint application and a signed affidavit authorizing a background check.
- E. If an extension of time was granted pursuant to R7-2-1405(A), amendments to update the application shall be submitted at the time the contract is executed.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 3211, effective August 24, 1999 (Supp. 99-4).

R7-2-1407. Revocation of a Contract

- A. The Board of Education may issue a Notice of Intent to Revoke a Contract and Notice of Hearing to any contract holder who is alleged to be in violation of the contract and the governing board.
- B. Within 10 days of receipt of a Notice of Intent to Revoke a Contract and Notice of Hearing, the governing board shall:
 1. Notify the parents or guardians of the students enrolled in the charter school that a Notice of Intent to Revoke a Contract and Notice of Hearing has been received;
 2. Hold a public meeting to inform the public and discuss the specific charges outlined in the Notice of Intent to Revoke a Contract;
 3. Provide the Board of Education with copies of all correspondence and communications used to comply with subsection (B)(1) and minutes of the meeting as evidence of compliance with subsection (B)(2);
 4. Provide the Board of Education with the names and mailing addresses of parents or guardians of all students

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enrolled in the charter school at the time the Notice of Intent to Revoke a Contract and Notice of Hearing was received.

- C. Hearings held pursuant to a Notice of Intent to Revoke a Contract and Notice of Hearing shall be held in accordance with Sections R7-2-701 through R7-2-709.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 3211, effective August 24, 1999 (Supp. 99-4). The word “above” was removed from subsection (3) to reflect current standards in Chapter style and format (Supp. 21-2).

R7-2-1408. Renewal of Contract

When considering renewal of a contract, the following, as a minimum, shall be provided to the Board of Education:

1. Assessment results, including scores of the norm-referenced achievement test, the scores of the Arizona’s Instrument to Measure Standards (AIMS), and scores of any school assessment programs;
2. Results of any audits conducted, including independent audits, Uniform System of Financial Records or Uniform System of Financial Records for Charter Schools compliance audits, or any audits conducted by the Auditor General’s Office;
3. Enrollment reports that include enrollment figures, funding sources, budget updates, and financial reporting of expenditures;
4. All complaints received;
5. Copies of Board of Education minutes where consideration and action was taken on all issues related to the charter school;
6. Any other reports, information, or materials pertinent to the charter school.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 3211, effective August 24, 1999 (Supp. 99-4).

ARTICLE 15. EMPOWERMENT SCHOLARSHIP ACCOUNTS**R7-2-1501. Definitions**

In this Article, unless the context otherwise specifies:

1. “Administratively complete” means an ESA application that contains all components required by statute or this Article.
2. “Board” means the State Board of Education.
3. “Curriculum” means a course of study for content areas or grade levels, including any supplemental materials required or recommended by the curriculum, approved by the Department.
4. “Department” means the Arizona Department of Education.
5. “Eligible postsecondary institution” means a community college as defined in A.R.S. § 15-1401, a university under the jurisdiction of the Arizona Board of Regents, or an accredited private postsecondary institution.
6. “Empowerment scholarship account” or “ESA” means an account administered by the Department and funded by the state to provide options for the education of qualified students pursuant to A.R.S. § 15-2401 et seq.
7. “Hearing Officer” means a non-partial representative with either at least three years of verified experience in the practice of law or at least one year of verified experience in conducting hearings, who oversees hearings pursuant to this Article.

8. “Informal Settlement Conference” means a meeting between the Department and the Parent in an attempt to settle the appeal prior to an appeal hearing. The Board and the Hearing Officer do not attend.
9. “Misuse of funds” means the use of ESA funds on goods or services not permitted by A.R.S. § 15-2402, this Article or the Department pursuant to R7-2-1507.
10. “Parent” means a resident of this state who is the parent, stepparent, legal guardian, or account holder of a qualified student.
11. “Program” means the Empowerment Scholarship Account Program.
12. “Qualified school” means a nongovernmental primary or secondary school or a preschool for pupils with disabilities that is located in this state or, for qualified students who reside within the boundaries of an Indian reservation in this state, and that is located in an adjacent state and that is within two miles of the border of the state in which the qualified student resides, and that does not discriminate on the basis of race, color or national origin.
13. “Qualified student” means a resident of this state who:
 - a. Is any of the following:
 - i. Identified as having a disability under section 504 of the rehabilitation act of 1973 (29 U.S.C. 794);
 - ii. Identified by a school district or by an independent third party pursuant to A.R.S. § 15-2403(J) as a child with a disability as defined in A.R.S. § 15-731 or § 15-761;
 - iii. A child with a disability who is eligible to receive services from a school district under A.R.S. § 15-763;
 - iv. Attending a school or school district that was assigned a letter grade of D or F pursuant to A.R.S. § 15-241 for the most recent year in which letter grades were assigned or is currently eligible to attend kindergarten and who resides within the attendance boundary of a school that was assigned a letter grade of D or F pursuant to A.R.S. § 15-241 for the most recent year in which letter grades were assigned. A child who meets the requirements of this item and who meets the income eligibility requirements for free and reduced-price lunches under the National School Lunch and Child Nutrition Acts (42 U.S.C. 1751 through 1793) is not subject to R7-2-1501(12)(b);
 - v. A previous recipient of a scholarship issued pursuant to A.R.S. § 15-891 or this Section, unless the qualified student’s parent has been removed from eligibility in the Program for failure to comply pursuant to A.R.S. § 15-2403(C);
 - vi. A child of a parent who is a member of the armed forces of the United States and who is on active duty or was killed in the line of duty. A child who meets the requirements of this subsection is not subject to R7-2-1501(12)(b);
 - vii. A child who is a ward of the juvenile court and who is residing with a prospective permanent placement pursuant to A.R.S. § 8-862 and the case plan is adoption or permanent guardianship;

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- viii. A child who was a ward of the juvenile court and who achieved permanency through adoption or permanent guardianship;
 - ix. A child who is the sibling of a current or previous ESA recipient or of an eligible qualified student who accepts the terms of and enrolls in an ESA;
 - x. A child who resides within the boundaries of an Indian reservation in this state as determined by the Department or a tribal government; or
 - xi. A child of a parent who is legally blind or deaf or hard of hearing as defined in A.R.S. § 36-1941.
- b. And, except as provided in R7-2-1501(12)(a)(iv) and R7-2-1501(12)(a)(vi), who meets any of the following requirements:
- i. Attended a governmental primary or secondary school as a full-time student as defined in A.R.S. § 15-901 for at least 45 days of the current or prior fiscal year and who transferred from a governmental primary or secondary school under a contract to participate in an ESA. Kindergarten students who are enrolled in Arizona online instruction must receive 100 hours of logged instruction to be eligible pursuant to this subsection. First, second and third grade students who are enrolled in Arizona online instruction must receive 200 hours of logged instruction to be eligible pursuant to this subsection. Fourth, fifth and sixth grade students who are enrolled in Arizona online instruction must receive 250 hours of logged instruction to be eligible pursuant to this subsection. Seventh and eighth grade students who are enrolled in Arizona online instruction must receive 275 hours of logged instruction to be eligible pursuant to this subsection. High school students who are enrolled in Arizona online instruction must receive 250 hours of logged instruction to be eligible pursuant to this subsection. For the purposes of this subsection, students may accumulate days of enrollment and hours of instruction in the current or prior fiscal year, or a combination thereof;
 - ii. Previously participated in an ESA;
 - iii. Received a scholarship under A.R.S. § 43-1505 and who continues to attend a qualified school if the student attended a governmental primary or secondary school as a full-time student as defined in A.R.S. § 15-901 for at least 90 days of the prior fiscal year or one full semester before attending a qualified school;
 - iv. Was eligible for an Arizona scholarship for pupils with disabilities and received monies from a school tuition organization pursuant to A.R.S. § 43-1505 or received an Arizona scholarship for pupils with disabilities but did not receive monies from a school tuition organization pursuant to A.R.S. § 43-1505 and who continues to attend a qualified school if the student attended a governmental primary or secondary school as a full-time student as defined in A.R.S. § 15-901 for at least 90 days of the prior fiscal year or one full semester prior to attending a qualified school;
 - v. Attended a nonpublic school for pupils with disabilities in the prior year if placement at the school was approved by the Department and contracted for by a public school district;
 - vi. Has not previously attended a governmental primary or secondary school but is currently eligible to enroll in a kindergarten program in a school district or charter school in this state or attended a program for preschool children with disabilities. For the purposes of this item, a child is eligible to enroll in a kindergarten program if the child is at least five years of age on January 1 of the current school year, is under seven years of age, and has not already completed a kindergarten program and is not enrolled in grade one of a private or governmental school in the current year; or
 - vii. Has not previously attended a governmental primary or secondary school but is currently eligible to enroll in a program for preschool children with disabilities in this state.
14. “Stay” means a Parent may have access to a terminated ESA account pending the resolution of their appeal.
 15. “Substantively complete” means an ESA application that meets all substantive criteria required by statute or this Article.
 16. “Supplemental materials” referenced in A.R.S. § 15-2401(2), means relevant materials directly related to the course of study for which they are being used that introduce content and instructional strategies or that enhance, complement, enrich, extend or support the curriculum.
 17. “Treasurer” means the Office of the State Treasurer.
 18. Unless otherwise specifically defined herein, all defined terms shall have the same meaning as those ascribed to them in the A.R.S., Title 41.
- Historical Note**
- New Section made by final exempt rulemaking at 26 A.A.R. 2900, effective November 1, 2020 (Supp. 20-4). Amended by final exempt rulemaking at 28 A.A.R. 187 (January 14, 2022), effective December 13, 2021 (Supp. 21-4). Amended by final exempt rulemaking at 29 A.A.R. 542 (February 10, 2023), effective January 23, 2023 (Supp. 23-1).
- R7-2-1501.01. Expanded Qualified Student Definition**
- Notwithstanding A.R.S. § 15-2401 and R7-2-1501, beginning in the 2022-2023 school year, unless the context otherwise requires, “Qualified Student” includes a resident of this state who both:
1. Is eligible to enroll in a public school in this state in any of the following:
 - a. A preschool program for children with disabilities,
 - b. A kindergarten program, or
 - c. Any of grades 1 through 12.
 2. Does not otherwise qualify for an Arizona Empowerment Scholarship Account pursuant to this Article.
- Historical Note**
- New Section made by final exempt rulemaking at 29 A.A.R. 542 (February 10, 2023), effective January 23, 2023 (Supp. 23-1).
- R7-2-1502. General Provisions**
- A. This Section is adopted pursuant to A.R.S. § 15-2403.

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- B. The Department and the Treasurer shall administer and provide general supervision and oversight of the Program pursuant to A.R.S. § 15-2401 et seq and this Article.
- C. The Department and the Board shall include intermediate Saturday, Sundays, and legal holidays when computing days under this Article. If the final day of a deadline established pursuant to this Article falls on a Saturday, Sunday or legal holiday, the next business day is the final day of the deadline.
- D. Unless otherwise specified, the Department shall serve a notice or decision that removes a parent from the Program, through personal delivery, first class mail, or certified mail to the parent's last address with the Department, and also by any other method or methods that are reasonably determined to give actual notice to the parent, including electronic mail, text message, phone call, or through an online portal. Each parent shall provide the Department with the parent's mailing address, home address, phone number and email and shall inform the Department of any change of mailing address, home address, phone number or email within 30 days of the change. For all other communications that do not contain notice of removal from the Program, the Board and the Department may communicate through any method or methods, including first class mail, certified mail, electronic mail, text message, phone call or through an online portal.
- E. A document is filed with the Board or the Department on the date it is received by the Board or the Department, as established by the Board's or the Department's date stamp on the face of the document. A notice or decision containing an appealable action issued by the Board or the Department pursuant to this Article is served on a party as follows:
 - 1. On the date it is personally served,
 - 2. Five days after it is mailed by first class mail, or
 - 3. On the date of the return receipt if it is mailed by certified mail.
- b. If the yearly handbook is adopted after July 1st, the newly adopted handbook would become effective immediately following adoption.
- 2. Establish a dedicated call center for exclusive use for the ESA Program that works in conjunction with the Exceptional Student Services division of the Department or its successor division. Subject to review and approval by the Board, the Department may contract with a third party to operate the call center;
- 3. Implement customer service performance management policies, procedures, and metrics;
- 4. Provide training to parents who use the private financial management firm contracted to assist with financial management of the program;
- 5. Provide a quarterly report to the Board on the ESA Program, including:
 - a. The number of students in the program disaggregated by eligibility, grade level and the school district or charter school associated with each student:
 - i. The total number of special needs students by grade level,
 - ii. The number of special needs students by disability category, and
 - b. The annual award amount associated with each student;
 - c. The number of ESA applications received, approved and denied in the preceding quarter, including the justification for the denied applications;
 - d. The number of applications processed within 30 days of receipt and the number of administratively incomplete applications. Provide the reasons the administratively incomplete applications were not approved;
 - e. A summary of any parent input or feedback collected pursuant to R7-2-1503(6) and how the Department is responding to concerns submitted as part of the process;
 - f. Information on the private financial management firm contracted to assist with financial management of the Program, including:
 - i. The number and eligibility type of accounts utilizing the firm,
 - ii. The number of providers and vendors on the firm's platform,
 - iii. Communications and training provided to parents,
 - iv. Concerns from parents submitted to the Department, the Treasurer and the private financial management firm and how the Department, Treasurer and private financial management firm are addressing the concerns, and
 - g. Information regarding appeals filed with the Board that were resolved prior to a hearing;
 - h. Information related to the audits completed, including:
 - i. Scope of the audit,
 - ii. Data and narratives on audit findings from the Quarter,
 - iii. Data and narratives of finding outcomes from the Quarter, and
 - i. Summary of all outages within the Department, private financial management firm, Department of Treasury, GAO, ADOA, etc. that cause a delay of the ESA program;

Historical Note

New Section made by final exempt rulemaking at 26 A.A.R. 2900, effective January 1, 2021 (Supp. 20-4). The word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 28 A.A.R. 187 (January 14, 2022), effective December 13, 2021 (Supp. 21-4).

R7-2-1503. Department Responsibilities

The Department shall:

- 1. On or before March 1 of each year, provide the Board with a handbook, developed in consultation with parents of children on the Program, that includes information relating to policies and processes of ESAs and complies with A.R.S. § 15-2401 et seq and this Article. The Board shall adopt the handbook on or before May 1 of each year. The Board shall limit substantive changes to the handbook to once every three years. The Board may approve changes to the handbook more frequently than every three years to conform and comply with changes to statute or this Article or at the Board's discretion. The handbook shall be posted on the Department's website and distributed to parents and shall clearly identify changes from the prior version, and include the date and time the new handbook was changed:
 - a. The yearly handbook, when adopted, shall become effective July 1st of each fiscal year.

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- j. Information related to MCC Codes, including:
 - i. Cumulative list of all MCC code expansions requested and specific reason for each denial,
 - ii. Cumulative list of all MCC code expansions and exceptions granted by the Department, and
- k. Data related reimbursement submissions, including:
 - i. The average number of days it takes a reimbursement submission to be assigned to a Department staffer,
 - ii. The average number of days it takes a reimbursement submission to be reviewed by a Department staffer,
 - iii. The average number of days it takes a reimbursement submission to be approved by a Department staffer, and
- l. Provide data related to Help Desk Tickets, including:
 - i. The quantity of help desk tickets not responded to within three business days,
 - ii. The quantity of help desk tickets prematurely closed and reopened, and
- m. Provide data related to the escalation of Help Desk Tickets, including:
 - i. The quantity of escalated help desk tickets by category type,
 - ii. The average number of days to resolution,
 - iii. A summary of resolutions, and
- n. Provide updates on the bidding process for all eligible Department contracts, including:
 - i. A.R.S. § 15-2403(A): The treasurer may contract with private financial management firms to manage Arizona empowerment scholarship accounts,
 - ii. A.R.S. § 15-2403(B): The Department shall conduct or contract for annual audits of Arizona empowerment scholarship accounts to ensure compliance with A.R.S. § 15-2402(B)(4),
 - iii. A.R.S. § 15-2403(B): The Department shall also conduct or contract for random, quarterly and annual audits of Arizona empowerment scholarship accounts as needed to ensure compliance with A.R.S. § 15-2402(B)(4),
 - iv. A.R.S. § 15-2403(J): The Department shall contract with an independent third party for the purposes of determining whether a qualified student is eligible to receive educational therapies or services pursuant to A.R.S. § 15-2402(B)(4)(c),
 - v. R7-2-1503(2): Subject to review and approval by the Board, the Department may contract with a third party to operate the call center,
 - vi. Any other eligible Department contracts, and
- o. The date of the most recent update to the online database of approved expenses and disallowed expenses. A summarization of the changes made.
- p. An approximation of the most common award amount. Provide the method or methods and Formula utilized to calculate award amounts.
- q. Any other information the Board requests.
- 6. Establish and provide to the Board a process to collect parent input and feedback regarding the Program.

Historical Note

New Section made by final exempt rulemaking at 26 A.A.R. 2900, effective January 1, 2021 (Supp. 20-4). Amended by final exempt rulemaking at 28 A.A.R. 187 (January 14, 2022), effective December 13, 2021 (Supp. 21-4). Amended by final exempt rulemaking at 29 A.A.R. 542 (February 10, 2023), effective January 23, 2023 (Supp. 23-1).

R7-2-1504. Application and Account Activation

- A. The Department shall accept applications to participate in the Program between July 1 and June 30 of each year.
- B. The Department shall provide information for prospective applicants on eligibility.
- C. The Department shall enroll and issue an award letter to eligible applicants within 30 days after receipt of a completed application and all required documentation. The award letter shall include information on how to activate the account and the amount of ESA funding the student will receive.
- D. Within 30 days of issuing the award letter, the Department shall issue the contract to eligible applicants.
- E. Prior to issuing a notice of a denied application, the Department shall provide notice describing the administrative or substantive incompleteness of the application and provide the applicant 30 days to provide the missing documentation or information. The Department shall include the justification for the denial and, if the application was substantively incomplete, the Department shall include the applicant's right to appeal.
- F. Pursuant to R7-2-1511, a person who has had an application denied due to being substantively incomplete may file a written request for a hearing within 30 days after being served the notice of denial. Administratively incomplete applications are not appealable.
- G. If the Board finds in favor of a parent who appealed a denied application, the Department shall expedite the contract and funding to the parent to the extent possible.

Historical Note

New Section made by final exempt rulemaking at 26 A.A.R. 2900, effective January 1, 2021 (Supp. 20-4). Amended by final exempt rulemaking at 28 A.A.R. 187 (January 14, 2022), effective December 13, 2021 (Supp. 21-4).

R7-2-1505. Contract Between Parent and Department

- A. To enroll a qualified student in an ESA, a parent of the qualified student shall sign a contract with the Department. The parent:
 - 1. Shall use a portion of the ESA monies allocated annually to provide an education for the qualified student in at least the subjects of reading, grammar, mathematics, social studies and science, unless the ESA is allocated monies according to a transfer schedule other than quarterly transfers pursuant to A.R.S. § 15-2403(F). This subsection does not require a parent to spend a portion of ESA monies on each subject every quarter;
 - 2. Shall not enroll the qualified student in a school district or charter school, and shall release the school district from all obligations to educate the qualified student. This subsection does not:
 - a. Relieve the school district or charter school that the qualified student previously attended from the obligation to conduct an evaluation pursuant to A.R.S. § 15-766, or
 - b. Require a qualified student to withdraw from a school district or charter school before enrolling for

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an ESA if the qualified student withdraws from the school district or charter school before receiving any monies in the qualified student's ESA.

- c. Prevent a qualified student from applying in advance for an ESA to be funded beginning the following school year.
 3. Shall not accept a scholarship from a school tuition organization pursuant to A.R.S., Title 43 concurrently with an ESA for the qualified student in the same year a parent signs the contract pursuant to this Section;
 4. Shall use the monies deposited in the qualified student's ESA only for the expenses listed in A.R.S. § 15-2402(B)(4);
 5. Shall not file an affidavit of intent to homeschool pursuant to A.R.S. § 15-802(B)(2) or (3);
 6. Shall not use monies deposited in the qualified student's account for any of the following:
 - a. Computer hardware or other technological devices, except as provided in R7-2-1505(B) and A.R.S. § 15-2402(B)(4)(p); or
 - b. Transportation of the pupil, except for transportation services described in A.R.S. § 15-2402(B)(4)(o).
 7. Shall submit expenses and documentation as required in R7-2-1508.
- B.** If a qualified student meets any of the criteria specified in A.R.S. § 15-2401(7)(a)(i), (ii), or (iii), as determined by a school district or by an independent third party under A.R.S. § 15-2403(J), the qualified student may use the following additional services:
1. Educational therapies from a licensed or accredited practitioner or provider including and up to any amount not covered by insurance if the expense is partially paid by a health insurance policy for the qualified students,
 2. A licensed or accredited paraprofessional or educational aide,
 3. Tuition for vocational and life skills education approved by the Department, and
 4. Associated goods and services that include, but are not limited to, educational and psychological evaluations, assistive technology rentals and braille translation goods and services approved by the Department. Associated goods as described in this subsection may include computer hardware or technological devices that assist in accessing educational materials or services and that are associated with the qualified student's needs. Parents that are seeking to use Program funds for an associated good or service pursuant to this subsection shall provide to the Department the special education course of study, service or educational need that the good or service is associated with or may provide the Department with the most current individualized education program, evaluation, or a letter from a qualified service provider. Parents are not advised to contact their districts seeking to update or change their students' individualized education programs or request special education reevaluations in order to make ESA purchases.
 5. Pursuant to A.R.S. § 15-2403(J)(2), the Department shall accept independent educational evaluations that are obtained by the parent of a student and performed by a qualified examiner. A "qualified examiner" is defined in A.R.S. § 15-2403(J)(2). A "parent" is defined in R7-2-1501. Such evaluations shall not be denied based solely on the age of the evaluation.

Historical Note

New Section made by final exempt rulemaking at 26 A.A.R. 2900, effective November 1, 2020 (Supp. 20-4). Amended by final exempt rulemaking at 28 A.A.R. 187 (January 14, 2022), effective December 13, 2021 (Supp. 21-4). Amended by final exempt rulemaking at 29 A.A.R. 542 (February 10, 2023), effective January 23, 2023 (Supp. 23-1).

R7-2-1506. Contract Renewal

- A.** A parent is eligible to renew an ESA if:
1. Pursuant to R7-2-1508, the parent submitted expenses and documentation or submitted quarterly attestations;
 2. If required, the Department approved expenses pursuant to R7-2-1508;
 3. The parent spent monies to provide an education in at least reading, grammar, mathematics, social studies, and science for the contract year pursuant to R7-2-1505(A)(1); and
 4. The parent does not owe the Department monies for disallowed expenses. A parent remains eligible to renew an ESA if the parent has an unresolved appeal regarding a disallowed expense.
- B.** A student with a disability as defined in A.R.S. § 15-2401(7)(a)(i), (ii), or (iii), as determined by a school district or by an independent third party under A.R.S. § 15-2403(J), may continue on the Program until the end of the school year in which the student reaches the age of 22, if the student or the parent provides documentation to the Department that demonstrates the student has not finished high school.
- C.** A parent shall renew ESAs on an annual basis as follows:
1. The Department shall provide renewal contracts on or before May 1 to each parent who meets R7-2-1506(A) of this Section;
 2. Each parent shall submit the renewal contract to the Department on or before June 30; and
 3. Within 30 days of receipt, the Department shall notify each parent of the renewal of the contract. The Department may provide notification through an online portal.
- D.** If a parent does not submit a renewal contract pursuant to R7-2-1506(C), the Department shall temporarily close the account and cease funding to the ESA until the parent submits the appropriate signed renewal contract. During the temporary closure, funding shall remain in the account until the parent signs the appropriate renewal contract in a format provided by the Department or the Department closes the ESA pursuant to R7-2-1506(E).
- E.** After an ESA has been temporarily closed for non-renewal pursuant to R7-2-1506(D), a parent may submit the appropriate signed renewal contract in a format provided by the Department to reactivate the ESA. If a parent does not submit a renewal contract for a period of three academic years, the Department shall provide notice through certified mail, email and telephone, if applicable, that the ESA will be closed. To renew the ESA, the parent shall submit a renewal contract within 60 days of receipt of the notification. If the parent does not submit a renewal contract within 60 days, the Department shall close the ESA and return any remaining monies in the ESA to the state general fund. Notwithstanding R7-2-1506(C)(1) and (2), a parent may submit the appropriate signed renewal contract between July 1 and June 30 for the purposes of this subsection.
- F.** Notwithstanding R7-2-1506(E), on the qualified student's graduation from a postsecondary institution or after any period of four consecutive years after high school graduation in

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which the student is not enrolled in an eligible postsecondary institution, but not before this time as long as the account holder continues using a portion of account monies for eligible expenses each year and is in good standing, the qualified student's Arizona empowerment scholarship account shall be closed and any remaining monies shall be returned to the state general fund.

- G. Pursuant to R7-2-1511, a parent whose contract was not renewed by the Department may file a written request for a hearing within 30 days after being served the notice of the non-renewal.
- H. At the written request of a parent, the Department shall extend the renewal contract timeframe for up to 30 days from the deadline prescribed in this Section if the parent demonstrates hardship, including an act of God or similar circumstance that prevented the parent from responding by the deadline.

Historical Note

New Section made by final exempt rulemaking at 26 A.A.R. 2900, effective January 1, 2021 (Supp. 20-4). Amended by final exempt rulemaking at 28 A.A.R. 187 (January 14, 2022), effective December 13, 2021 (Supp. 21-4). Amended by final exempt rulemaking at 29 A.A.R. 542 (February 10, 2023), effective January 23, 2023 (Supp. 23-1).

R7-2-1507. Use of Funds

- A. The Department shall establish and maintain a database of approved expenses and disallowed expenses for the current and upcoming fiscal years pursuant to A.R.S. § 15-2401 et seq, and this Article. The Department shall make the database available to parents online and disaggregate the approved expenses by eligibility category.
- B. The Department shall establish a process to review an expense before making an administrative decision to deny the expense. The Department shall provide a copy of the process to the Board and include the process in the handbook adopted pursuant to R7-2-1503.
- C. The Department shall not request repayment for an expense it has approved for a specific ESA. The Department shall treat similar expenditures by similarly situated account holders in the same manner. This Section does not create authorization for an account holder to expend funds in a manner not permitted by statute.
- D. The Department shall consider all account holder requests for MCC Code expansions. Any MCC code exceptions granted to one parent, shall be extended to all parents within five business days.
- E. Pursuant to R7-2-1511, a parent who has had an expense disallowed by the Department may file a written request for a hearing within 30 days after being served the notice of the disallowed expense.

Historical Note

New Section made by final exempt rulemaking at 26 A.A.R. 2900, effective January 1, 2021 (Supp. 20-4). Amended by final exempt rulemaking at 28 A.A.R. 187 (January 14, 2022), effective December 13, 2021 (Supp. 21-4). Amended by final exempt rulemaking at 29 A.A.R. 542 (February 10, 2023), effective January 23, 2023 (Supp. 23-1).

R7-2-1508. Review of Expenses

- A. The Department may conduct or contract for random or annual audits as needed to ensure monies are used only for expenses that were approved or allowed at the time the expense was

made. The Department shall use record retention requirements that were in place at the time the expense was made to determine compliance. The Department may only audit account activity from the last two fiscal years, including the current fiscal year.

- B. The Department shall provide annual notice to each parent of when and how the Department will conduct reviews of expenses and audits. The notice may be provided in the handbook adopted pursuant to R7-2-1503. Notwithstanding any other Section, the Department may review expenses less frequently using a risk-based approach, if the Department provides notice to parents and the Board pursuant to this Section.
- C. Parents shall submit expenses that shall include, but are not limited to, the following:
 1. Invoices for each vendor, individual or product;
 2. Invoices for private schools, which shall include the following:
 - a. The name of the qualified student,
 - b. The name of the private school,
 - c. The transaction date,
 - d. Tuition or fee amounts, and
 - e. Total charged to the card, and for reimbursements, proof of method of payment;
 3. Invoices for tutors, paraprofessionals, service type or therapists which shall include:
 - a. Name of the qualified student,
 - b. The name of one of the following: the vendor, facility, therapist or tutor,
 - c. A description of the services,
 - d. The transaction date,
 - e. The rate amounts,
 - f. Any processing fees, and
 - g. Total charged to the card, and for reimbursements, proof of method of payment.
- D. For debit card transactions, a parent shall submit all debit card transaction expense receipts to the Department as follows:
 1. On or before October 31 for quarter one,
 2. On or before January 31 for quarter two,
 3. On or before April 30 for quarter three, and
 4. On or before July 31 for quarter four.
- E. The Department shall review and approve expenses and make its next quarterly disbursement of funds within 30 days of the deadlines prescribed in R7-2-1508(D).
- F. On receipt and approval of debit card transaction expense receipts or reimbursements, the Department shall notify the parent through electronic mail or through an online portal. The Department shall not withhold funds for a subsequent quarter if it fails to review expenses, debit card transaction expense receipts or reimbursements within 30 days of the deadline. A parent may submit corrected debit card transaction expense receipts any time prior to the quarterly submission deadline.
- G. If a parent fails to submit debit card transaction expense receipts, if required, by the deadlines prescribed in R7-2-1508(D) or submits incomplete debit card transaction expense receipts or reimbursements, the Department shall:
 1. Serve notice to the parent of the deficiencies,
 2. Provide the parent 15 days from the date of receipt of the notice to submit complete debit card transaction expense receipts or reimbursements, and
 3. Review debit card transaction expense receipts or reimbursements submitted pursuant to this subsection within five days of receipt from the parent.
- H. Following the 15 day period provided in R7-2-1508(G)(2), the Department may remove a parent from the Program for failing

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to submit required debit card transaction expense receipts or failing to correct the deficiencies of a debit card transaction expense receipt.

- I. Pursuant to R7-2-1511, a parent that has been removed from the Program may file a written request for a hearing within 30 days after being served the notice of removal. Except in cases in which the Board has found misuse of funds or fraud pursuant to R7-2-1509, the Department shall not withhold funding to one qualified student's ESA due to deficiencies in the expense reporting of a sibling's account.
- J. At the written request of a parent, the Department shall extend the deadlines prescribed in R7-2-1508(D) for up to 30 days from the deadlines prescribed in this Section if the parent demonstrates hardship, including an act of God or similar circumstance that prevented the parent from responding by the deadline.
- K. If a parent does not make any expenses in a quarter, the parent shall submit attest to that fact in a format provided by the Department.

Historical Note

New Section made by final exempt rulemaking at 26 A.A.R. 2900, effective January 1, 2021 (Supp. 20-4). The word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 28 A.A.R. 187 (January 14, 2022), effective December 13, 2021 (Supp. 21-4). Amended by final exempt rulemaking at 29 A.A.R. 542 (February 10, 2023), effective January 23, 2023 (Supp. 23-1).

R7-2-1509. Misuse of Funds

- A. Based on a finding that a parent knowingly misuses funds, the Department shall temporarily suspend the account and provide notice to the parent. The notice shall:
 - 1. Include the reason for the temporary suspension and a detailed description of the disallowed expense; and
 - 2. Provide the parent 15 days, not including weekends, to either:
 - a. Present documentation that demonstrates the expense is allowable or that the parent was victim to identity theft or fraud; or
 - b. Agree to repay the amount.
- B. The Department shall review the documentation submitted pursuant to R7-2-1509(A)(2)(a) within five days of receipt to determine if the expense is allowable or if the parent was victim to identity theft or fraud. If the Department determines the expense is allowable or that the parent was victim to identity theft or fraud, the Department shall lift the temporary suspension, reinstate the account and make any disbursements that were withheld during the suspension.
- C. If the Department determines the documentation fails to demonstrate the expense is allowable or that the parent was victim to identity theft or fraud, the Department shall provide notification to the parent that the amount must be repaid. The Department shall withhold the disbursement of any additional ESA funds until repayment is made. The Department may agree to a gradual repayment plans at the request of the parent and shall reinstate additional ESA funding once repayment has begun. The Department may remove a parent from the Program that fails to repay an amount or agree to a repayment plan.
- D. Once a parent agrees to a gradual repayment plan or repays an amount pursuant to R7-2-1509(A)(2)(b) or R7-2-1509(C), the Department shall lift the temporary suspension, reinstate the

account and make any disbursements that were withheld during the suspension as follows:

- 1. Within one day, if the repayment is made by cashier's check or money order; or
- 2. Within seven days, if repayment is made by personal check.
- E. Except in cases which the Attorney General determines that a parent or account holder has committed fraud, any expenditure from an Arizona Empowerment Scholarship Account for a purchase that is deemed ineligible pursuant to A.R.S. § 15-2402 and that is subsequently repaid by the parent or account holder shall be credited back to the Arizona Empowerment Scholarship Account balance within 30 days after the receipt of payment.
- F. Pursuant to R7-2-1511, a parent who has been removed from the Program pursuant to this Section may file a written request for a hearing within 30 days after being served the notice of removal.
- G. The Department shall refer a case to the Board if a parent does not file an appeal pursuant to R7-2-1511 and either:
 - 1. Fails to repay the amount of a disallowed expense; or
 - 2. Fails to make a payment on a gradual repayment plan.
- H. On a finding of misuse of monies, the Board may refer the case to the Attorney General who may bring an action to recover the monies. Upon obtaining evidence of fraudulent use of an account, the Board may refer the case to the Attorney General for the purpose of a criminal investigation.
- I. A parent or qualified student is not eligible to enroll a qualified student in the ESA Program if that parent was an account holder on an account that was referred to the Attorney General for misuse of monies unless the parent's expense was subsequently found to be allowable or the parent was the victim of identity theft or fraud.
- J. If a parent commits fraud, the Department shall withhold funds from all accounts in the parent's name and close the accounts.

Historical Note

New Section made by final exempt rulemaking at 26 A.A.R. 2900, effective January 1, 2021 (Supp. 20-4). Amended by final exempt rulemaking at 28 A.A.R. 187 (January 14, 2022), effective December 13, 2021 (Supp. 21-4). Amended by final exempt rulemaking at 29 A.A.R. 542 (February 10, 2023), effective January 23, 2023 (Supp. 23-1).

R7-2-1510. Corrective Action

- A. Except for misuse of funds or failing to submit debit card transaction expense receipts pursuant to R7-2-1508, if the Department finds that a parent violated A.R.S. § 15-2401 et seq, this Article or the terms and conditions set forth by the Department in the contract signed by the parent, the Department shall:
 - 1. Temporarily suspend the account;
 - 2. Provide notice to the parent of the violation, including an explanation of the violation; and
 - 3. Provide the parent 15 days to correct the violation.
- B. The Department may remove a parent or qualified student from the Program for failing to correct a violation pursuant to this Section.
- C. Pursuant to R7-2-1511, a parent or qualified student who has been removed from the Program pursuant to this Section may file a written request for a hearing within 30 days after being served the notice of removal.

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Historical Note

New Section made by final exempt rulemaking at 26 A.A.R. 2900, effective January 1, 2021 (Supp. 20-4).
Amended by final exempt rulemaking at 28 A.A.R. 187 (January 14, 2022), effective December 13, 2021 (Supp. 21-4). Amended by final exempt rulemaking at 29 A.A.R. 542 (February 10, 2023), effective January 23, 2023 (Supp. 23-1).

R7-2-1511. Appeals

- A.** A parent may appeal to the Board any administrative decision the Department makes pursuant to A.R.S. Title 15, Chapter 19, Article 1, including determinations of allowable expenses, removal from the Program or enrollment eligibility.
- B. Stay**
1. Pending the resolution of an appeal during which an account is suspended, a parent may request a stay on the account suspension.
 - a. Included in the request for a hearing filed pursuant to R7-2-1511(F), a parent may file a request to the Board to stay an account suspension. Such request shall be in writing and shall address the matters stated in the Department's notice in R7-2-1511(E).
 - b. The Department may file a response to the parent's request to stay the suspension of the account. Such response shall be filed with the Board within five business days of receipt of the parent's request to stay the suspension. Such response shall be in writing and shall address the matters stated in the parent's request.
 - c. Within 10 business days after receipt of the Department's response, the executive director of the Board or the executive director's designee shall make a written determination to either:
 - i. Proceed with suspension of the account, or
 - ii. Stay all or part of the suspension of the account if there is a reasonable probability that the appeal will be upheld or that the stay is in the best interest of the State. If a stay is issued, the Department may not withhold funding or contract renewal for the account holder on account of the appealed administrative decision during the stay unless directed by the Board to do so.
 - d. The executive director or the executive director's designee shall provide the parent and the Department with a written copy of the stay determination including the basis for the determination.
- C.** Notwithstanding any other Section, the Department may, with the agreement of the account holder on the resolution, informally resolve a disputed administrative action at any time without a formal appeal pursuant to this Article.
- D.** The Department, on its website and in the parent handbook, shall provide information on the Board's appeals process.
- E.** The Department shall provide parents with written notice of an appealable action taken by the Department. Such written notice shall inform the parents of his/her right to request a hearing on the action and shall include the following:
1. The statute or rule that is alleged to have been violated or on which the action is based;
 2. Identify, with reasonable particularity, the nature of any alleged violation or action;
 3. Include a description of the parent's right to request a hearing on the appealable agency action; and
 4. Include a description of the parent's right to request an informal settlement conference.
- F.** Within 30 days after being served with notice of an appealable action, a parent may file a request for a hearing. The notice must be in writing and shall state the following:
1. The identity of the party requesting the hearing,
 2. The mailing address of the party requesting the hearing,
 3. The agency that rendered the decision related to the appealable action,
 4. Identification of the action being appealed,
 5. A concise statement of the reasons for the request for hearing,
 6. A copy of the administrative decision issued by the Department, and
 7. Any other information or documentation requested by the Board applicable to the appeal process.
- G.** If good cause is submitted, the Board may accept a request for a hearing that is not filed in a timely manner. Such request must be made in writing and state the basis for not filing the request on time.
- H.** If a parent requests a hearing pursuant to R7-2-1511(F) and includes all of the items listed in R7-2-1511(F)(1) through (7), the Board shall schedule a hearing.
- I.** The Board shall provide all parties with a written notice at least 20 days prior to the date set for the hearing. The notice shall include:
1. A statement of the time, place and nature of the hearing;
 2. A statement of the legal authority and jurisdiction under which the hearing is to be held;
 3. A reference to the particular sections of the statutes and rules involved; and
 4. A short and plain statement of the matters asserted. If a party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter upon application a more definite and detailed statement shall be furnished.
- J.** All notices shall be served via personal delivery or certified mail, return receipt requested or by any other method reasonably calculated to effect actual notice on the agency and all parties to the action at each party's last address of record.
- K.** A hearing on the appealable action shall be held after a complete appeal is filed and may be advanced or delayed on the agreement of the parties or on a showing of good cause.
- L. Informal Settlement Conference**
1. A parent may request an informal settlement conference be held with the Department. The request shall be in writing and shall be filed with the Department, and a copy provided to the Board, no later than 10 days after the Board provides notice that the appeal is complete. The Department shall hold an informal settlement conference within seven days after receiving the request. The Department shall notify the Board of the result of the informal settlement conference within five days of the conclusion of the informal settlement conference or prior to the hearing date, whichever is first. The request for an informal settlement conference does not alter the date the hearing is to be held.
 2. If an informal settlement conference is held, a person with the authority to act on behalf of the Department must represent the Department at the conference. The Department representative shall notify the parent in writing that statements, either written or oral, made at the conference, including a written document, created or expressed solely for the purpose of settlement negotiations are inadmissible in any subsequent administrative hearing.

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- M.** Informal disposition may be made by stipulation, agreed settlement, consent order or default.
- N. Hearing Process**
1. All hearings shall be conducted before a hearing officer pursuant to this Section.
 2. The parties to the appealable agency action have the right to be represented by legal counsel or to proceed without counsel, to submit evidence and to cross-examine witnesses.
 - a. Pursuant to A.R.S. § 15-2403(E), a parent may designate a representative, not necessarily an attorney, before any hearing held pursuant to this Section. Any designated representative who is not an attorney admitted to practice may not charge for any services rendered in connection with such a hearing.
 - b. The fact that a representative participated in the hearing or assisted the account holder is not grounds for reversing any administrative decision or order if the evidence supporting the decision or order is substantial, reliable and probative.
 3. The Board shall schedule a prehearing conference on request of any party. A prehearing conference may be held for the following purposes:
 - a. Clarify or limit procedural, legal or factual issues;
 - b. Consider amendments to any pleading;
 - c. Identify and exchange lists of witnesses and exhibits intended to be introduced at the hearing;
 - d. Obtain stipulations or rulings regarding testimony, exhibits, facts or law;
 - e. Schedule deadlines, hearing dates and locations if not previously set; or
 - f. Allow the parties opportunity to discuss settlement.
 4. The record in a contested case shall include:
 - a. All pleadings, motions and interlocutory rulings.
 - b. Evidence received or considered.
 - c. A statement of matters officially noticed.
 - d. Objections and offers of proof and rulings thereon.
 - e. Proposed findings of fact and conclusions of law and exceptions thereto.
 - f. Any decision, opinion, recommendation or report of the hearing officer.
 - g. All staff memoranda, other than privileged communications, or data submitted to the hearing officer in connection with its consideration of the case.
 5. Findings of fact shall be based exclusively on the evidence and on matters officially noticed.
 6. A participant of record shall not communicate, either directly or indirectly, with the Hearing Officer about any substantive issue in a pending matter unless:
 - a. All participants of record are present;
 - b. Communication is during a scheduled proceeding, where an absent participant of record fails to appeal after proper notice; or
 - c. Communication is by written motion with copies to all participants of record.
 7. The Hearing Officer may postpone, continue, or cancel a hearing for good cause upon the written request of either party. The participant of record must establish good cause for the written request.
 8. For good cause shown, the hearing officer may grant continuances and extensions of time for filing notices or other documents.
 9. The Hearing Officer may direct a party to submit additional memorandum or information within a reasonable period of time. The Hearing Officer shall grant the opposing party a reasonable period of time to respond to the additional memorandum or information.
 10. Upon written request, any party may request an opportunity to compare a document copy with the original. The Hearing Officer may grant the request if the record establishes good cause.
- O. Conduct of Hearing**
1. All hearings shall be recorded. The Board shall secure either a court reporter or an electronic means of producing a clear and accurate record of the proceeding.
 2. A hearing may be conducted in an informal manner and without adherence to the rules of evidence required in judicial proceedings. Neither the manner of conducting the hearing nor the failure to adhere to the rules of evidence required in judicial proceedings shall be grounds for reversing any administrative decision or order if the evidence supporting the decision or order is substantial, reliable and probative.
 3. The parties may submit proposed findings of fact and conclusions of law prior to the hearing. The hearing officer may require that the parties submit proposed findings of fact and conclusions of law prior to the hearing or at the close of evidence.
 4. All interested parties shall be ready and present with all witnesses and documents at the time and place specified in the notice of hearing and shall be prepared at such time to dispose of all issues and questions involved in the appeal. An interested party shall arrange for the presence of that party's witnesses at a hearing.
 5. If a party fails to appear at a hearing, the hearing body may proceed with the presentation of the evidence of the appearing party.
 6. The Hearing Officer conducting the hearing may close the hearing to other than interested parties to the extent necessary to protect the interests and rights of the interested parties, within the requirements of A.R.S. §§ 38-431.01, and 38-431.03.
 7. The Hearing Officer may conduct all or part of the hearing by telephone other electronic means, as long as each party has an opportunity to participate in the entire proceeding as it takes place.
 8. Conduct at any hearing that is disruptive or shows contempt for the proceeding shall be grounds for exclusion from further participation.
- P. Evidence**
1. All witnesses shall testify under oath or affirmation. The hearing officer shall administer oaths and affirmations.
 2. The hearing officer shall afford interested parties an opportunity either to present oral or documentary evidence, or both, and to conduct such cross-examination as may be required for a full and fair disclosure of the facts. The hearing officer may limit the time of oral argument.
 3. The hearing officer may choose to admit evidence, a witness' deposition, or a witness' affidavit and determine evidentiary weight of all submitted evidence. The party taking a witness' deposition or affidavit shall bear all deposition-related or affidavit-related costs. The hearing officer shall make rulings necessary to prevent argumentative, repetitive, or irrelevant questioning, to exclude evidence the hearing officer determines to be irrelevant, immaterial or unduly repetitious, and to expedite the examination to the extent consistent with the disclosure of all relevant testimony and information.

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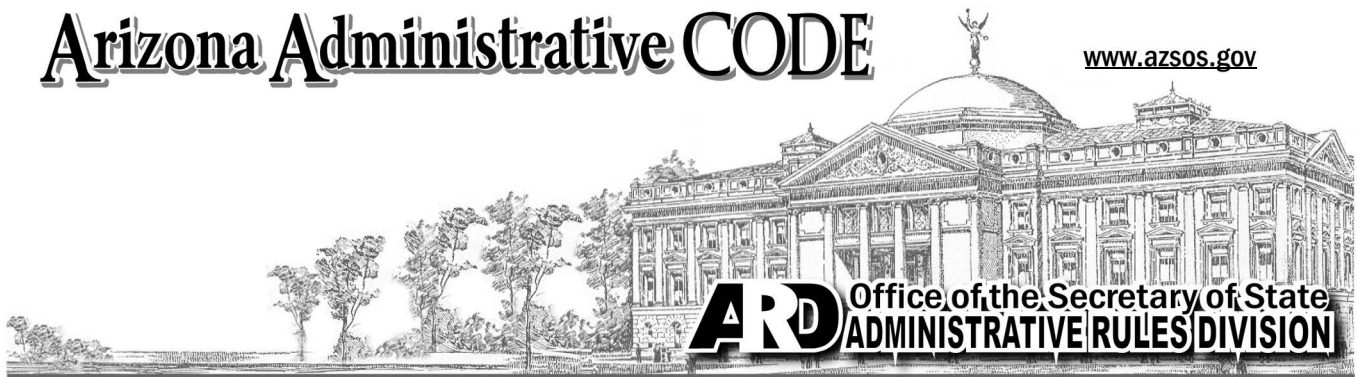
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- Q.** Stipulations. Parties to any contested case may stipulate, in writing, agreement upon any matter involved in the proceeding. If approved by the hearing officer, agreement on matters of procedure shall be binding upon the parties to the stipulation. No substantive matter agreed to by the parties shall be binding upon the Board unless incorporated into the decision of the Board.
- R.** Final Administrative Decision
1. The hearing officer shall issue a written recommendation within 20 days after the hearing is concluded. The written recommendation shall contain a concise explanation of the reasons supporting the recommendation, including the findings of fact and conclusions of law.
 2. The hearing officer shall serve a copy of the recommendation on the Board. On request of the Board, the hearing officer shall also transmit to the Board the record of the hearing as described in A.R.S. § 12-904.
 3. At one of the following two regularly scheduled meetings of the Board after the hearing officer sends a copy of the recommendation to the Board, the Board may review the recommendation and accept, reject or modify it.
 - a. If the Board declines to review the hearing officer's recommendation, the Board shall serve a copy of the recommendation on all parties.
 - b. If the Board rejects or modifies the recommendation, the Board shall serve on all parties, a copy of the hearing officer's recommendation with the rejection or modification and a written justification setting forth the reasons for the rejection or modification of each finding of fact or conclusion of law.
 4. The Board shall provide all parties with at least 20 days written notice of the date, time and location of the public meeting at which the Board will consider the hearing officer's recommendation.
- S.** Rehearing and Review of Decisions
1. A party may file a motion for rehearing or review within 10 days after service of the final administrative decision. The motion shall be in writing and state the basis upon which the rehearing or review is requested. The motion shall be filed with the Board and a copy provided to the opposing party. When a motion of rehearing is based on new evidence, the new evidence shall be served to the Board with the written motion.
 2. The opposing party may file a response to the motion for rehearing within 15 days after the date the motion for rehearing is filed. The response shall be in writing and address the basis upon which the rehearing or review is requested. The motion shall be filed with the Board and a copy provide to the moving party.
 3. A rehearing of a final administrative decision by the Board may be granted for any of the following causes materially affecting the moving party's rights:
 - a. Except as provided for in R7-2-1511(O)(2), irregularity in the administrative proceedings of the hearing, or abuse of discretion, whereby the moving party was deprived of a fair hearing;
 - b. Misconduct of the hearing officer; or
 - c. Newly discovered materials which could not with reasonable diligence have been discovered and produced at the hearing.
 4. The filed motion shall be considered at one of the following two regularly scheduled meetings of the Board.
 5. Service is complete on personal service or five days after the date the final administrative decision is mailed to the party's last known address.
 6. After a hearing has been held and a final administrative decision has been entered a party is not required to file a motion for rehearing or review of the decision in order to exhaust the party's administrative remedies.
- Historical Note**
- New Section made by final exempt rulemaking at 26 A.A.R. 2900, effective January 1, 2021 (Supp. 20-4). The word "rule" has been changed to "Section" to reflect current standards in Chapter style and format (Supp. 21-2). Amended by final exempt rulemaking at 28 A.A.R. 187 (January 14, 2022), effective January 1, 2022 (Supp. 21-4). Amended by final exempt rulemaking at 29 A.A.R. 542 (February 10, 2023), effective January 23, 2023 (Supp. 23-1).

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TITLE 9. HEALTH SERVICES

CHAPTER 16. DEPARTMENT OF HEALTH SERVICES - OCCUPATIONAL LICENSING

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of
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Questions about these rules? Contact:

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The release of this Chapter in Supp. 23-1 replaces Supp. 22-4, 1-55 pages.

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, www.azsos.gov under Services-> Legislative Filings.

EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

PERSONAL USE/COMMERCIAL USE

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Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.

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Administrative Rules Division

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TITLE 9. HEALTH SERVICES

CHAPTER 16. DEPARTMENT OF HEALTH SERVICES - OCCUPATIONAL LICENSING

Authority: A.R.S. §§ 36-132(A)(1) and 36-136(G)

Supp. 23-1

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Editor's Note: Historical references to repealed Table 1 and Exhibits A through E, moved to the end of the Article for codification scheme continuity (Supp. 22-2).

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Article 3, consisting of Sections R9-16-301 through R9-16-314, adopted effective June 25, 1993 (Supp. 93-1).

Article 3, consisting of Sections R9-16-301 through R9-16-305, repealed effective June 25, 1993 (Supp. 93-1).

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ARTICLE 1. LICENSING OF MIDWIFERY

R9-16-101. Definitions

In addition to the definitions in A.R.S. § 36-751, the following definitions apply in this Article unless otherwise specified:

1. "Amniotic" means the fluid surrounding a fetus while in the mother's uterus.
2. "Apgar score" means the number indicating a newborn's physical condition, attained by rating selected body functions.
3. "Breech" means a complete breech, a frank breech, or an incomplete breech.
4. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
5. "Certified nurse midwife" means an individual who meets the criteria in 4 A.A.C. 19, Article 5, and is certified by the Arizona State Board of Nursing.
6. "Cervix" means the narrow lower end of the uterus that protrudes into the cavity of the vagina.
7. "Client" means a pregnant woman accepted by a midwife for the provision of midwifery services from the midwife.
8. "Complete breech" means that, at the time of birth, the buttocks of a fetus are pointing downward with both legs folded at the knees and the feet near the buttocks.
9. "Consultation" means communication between a midwife and a physician or a midwife and a certified nurse midwife for the purpose of receiving a written or verbal recommendation and implementing prospective advice regarding the care of a pregnant woman or the woman's fetus or newborn.
10. "Dilation" means opening of the cervix during the mechanism of labor to allow for passage of the fetus.
11. "Effacement" means the gradual thinning of the cervix during the mechanism of labor and indicates progress in labor.
12. "Emergency care plan" means the arrangements established by a midwife for a client's transfer of care in a situation in which the health or safety of the client or newborn is determined to be at risk.
13. "Emergency medical services provider" has the same meaning as in A.R.S. § 36-2201.
14. "Episiotomy" means the cutting of the perineum, at the center, middle, or midline, in order to enlarge the vaginal opening for delivery.
15. "Fetus" means a child in utero from conception to birth.
16. "Frank breech" means that, at the time of birth, the buttocks of a fetus are pointing downward with both legs folded flat up against the head.
17. "Gestation" means the length of time from conception to birth, as calculated from the first day of the last normal menstrual period.
18. "Incomplete breech" means that, at the time of birth, the buttocks of a fetus are pointing downward with one leg folded at the knee with the foot near the buttocks.
19. "Informed consent" means a document signed by a client, as provided in R9-16-109, agreeing to the provision of midwifery services.
20. "Jurisprudence test" means an assessment of an individual's knowledge of the:
 - a. Laws of this state concerning the reporting of births, prenatal blood tests, and newborn screening; and
 - b. Rules pertaining to the practice of midwifery.
21. "Ketones" means certain harmful chemical elements that, when present in the body in excessive amounts, results in compromised bodily function.
22. "Meconium" means the first bowel movement of the newborn, which is greenish black in color and tarry in consistency.
23. "Midwifery services" means health care, provided by a midwife to a mother, related to pregnancy, labor, delivery, or postpartum care.
24. "Newborn" has the same meaning as in A.R.S. § 36-694.
25. "Perineum" means the muscular region in the female between the vaginal opening and the anus.
26. "Physician" means an allopathic, an osteopathic, or a naturopathic practitioner licensed according to A.R.S. Title 32, Chapter 13, 14, or 17.
27. "Postpartum" means the six-week period following delivery of a newborn and placenta.
28. "Prenatal" means the period from conception to the onset of labor and birth.
29. "Prenatal visit" means each clinical examination of a pregnant woman for the purpose of monitoring the course of gestation and the overall health of the woman.
30. "Quickening" means the first perceptible movement of the fetus in the uterus, occurring usually in the 16th to the 20th week of gestation.
31. "Rh" means a blood antigen.
32. "Transfer of care" means that a midwife refers the care of a client or newborn to an emergency medical services provider, a certified nurse midwife, a hospital, or a physician who then assumes responsibility for the direct care of the client or newborn.
33. "Working day" means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state holiday or a statewide furlough day.

Historical Note

Section repealed, new Section adopted effective March 14, 1994 (Supp. 94-1). Section amended by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-16-102. Application for an Initial License

- A.** An applicant for an initial license to practice midwifery shall submit:
1. An application in a format provided by the Department that contains:
 - a. The applicant's name, address, telephone number, and e-mail address;
 - b. The applicant's Social Security Number, as required under A.R.S. §§ 25-320 and 25-502;
 - c. Whether the applicant has ever been convicted of a felony or a misdemeanor in this or another state or jurisdiction;
 - d. If the applicant was convicted of a felony or misdemeanor:
 - i. The date of the conviction,
 - ii. The state or jurisdiction of the conviction,
 - iii. An explanation of the crime of which the applicant was convicted, and
 - iv. The disposition of the case;

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- e. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-16-107(C)(2);
- f. An attestation that information required as part of the application is true and accurate; and
- g. The applicant's signature and date of signature;
- 2. Documentation for the applicant that complies with A.R.S. § 41-1080;
- 3. Documentation that demonstrates the applicant is 21 years of age or older if the documentation submitted in subsection (A)(2) does not demonstrate that the applicant is 21 years of age or older;
- 4. Current documentation of completion of training in:
 - a. Adult basic cardiopulmonary resuscitation through a course recognized by the American Heart Association, and
 - b. Neonatal resuscitation through a course recognized by the American Academy of Pediatrics or American Heart Association;
- 5. Documentation of a high school diploma, a high school equivalency diploma, an associate degree, or a higher degree;
- 6. Documentation that the applicant is certified by the North American Registry of Midwives as a Certified Professional Midwife;
- 7. Except as provided in subsection (B), a non-refundable application fee of \$25; and
- 8. A non-refundable testing fee of \$100 for a jurisprudence test administered by the Department.
- B.** An applicant is not required to submit the fee in subsection (A)(7) or (E)(1) if the applicant, as part of the application in subsection (A), submits an attestation that the applicant meets the criteria for waiver of licensing fees in A.R.S. § 41-1080.01.
- C.** The Department shall review an application for an initial license to practice midwifery according to R9-16-107 and Table 1.1.
- D.** If an applicant receives notification of eligibility to take the jurisprudence test, the applicant:
 - 1. Shall take the jurisprudence test administered by the Department,
 - 2. Shall provide proof of identity by a government-issued photographic identification card upon the request of the individual administering the jurisprudence test,
 - 3. May take the jurisprudence test as many times as desired, within 180 calendar days after the date of the notification, without paying an additional testing fee, and
 - 4. Shall score 80% or higher correct answers on the jurisprudence test to be eligible to receive an initial license to practice midwifery.
- E.** If an applicant scores 80% or higher correct answers on the jurisprudence test, the Department shall provide written notice to the applicant, within five working days after the date of the jurisprudence test, to submit to the Department:
 - 1. Except as provided in subsection (B), a licensing fee of \$25; and
 - 2. The documentation required in subsection (A)(4) or (6), if the documentation of training required in subsection (A)(4) or certification required in subsection (A)(6) is not current.
- F.** The Department shall issue an initial license to practice midwifery within five working days after receiving the applicable documentation and licensing fee required in subsection (E).
- G.** The Department shall provide to an applicant a written notice of denial that complies with A.R.S. § 41-1092.03(A) and inform the applicant that the applicant may reapply under subsection (A) if the applicant does not:
 - 1. Score 80% or higher correct answers on the jurisprudence test within 180 calendar days after the date of the notification of eligibility to take the jurisprudence test, or
 - 2. Submit to the Department the applicable documentation and licensing fee required in subsection (D) within 120 calendar days after the date of the notification in subsection (D).

Historical Note

Section repealed, new Section adopted effective March 14, 1994 (Supp. 94-1). Amended by final rulemaking at 8 A.A.R. 2896, effective June 18, 2002 (Supp. 02-2). Section R9-16-102 repealed; new Section R9-16-102 renumbered from R9-16-103 and amended by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-16-103. License Renewal

- A.** At least 30 calendar days and no more than 60 calendar days before the expiration date of a midwifery license, a midwife shall submit to the Department:
 - 1. An application for renewal of a midwifery license, in a format provided by the Department, that contains:
 - a. The midwife's name, address, telephone number, and e-mail address;
 - b. The midwife's license number;
 - c. Whether the midwife has been convicted of a felony or a misdemeanor in this or another state or jurisdiction in the previous two years;
 - d. If the midwife was convicted of a felony or misdemeanor:
 - i. The date of the conviction,
 - ii. The state or jurisdiction of the conviction,
 - iii. An explanation of the crime of which the midwife was convicted, and
 - iv. The disposition of the case;
 - e. Whether the midwife agrees to allow the Department to submit supplemental requests for information under R9-16-107(C)(2);
 - f. An attestation that the midwife has completed the continuing education requirement in R9-16-105;
 - g. An attestation that the midwife is complying with the requirements in A.R.S. § 32-3211;
 - h. An attestation that information required as part of the application is true and accurate; and
 - i. The midwife's signature and date of signature;
 - 2. Either:
 - a. Documentation that the midwife is currently certified by the North American Registry of Midwives as a Certified Professional Midwife; or
 - b. For a midwife who has been continuously licensed as a midwife by the Department since 1999, a copy of both sides of documentation showing the completion of current training in:
 - i. Adult basic cardiopulmonary resuscitation that meets the requirements in R9-16-102(A)(4)(a), and
 - ii. Neonatal resuscitation that meets the requirements in R9-16-102(A)(4)(b); and

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3. A non-refundable renewal fee of \$25.

- B.** The Department shall review an application for renewal of a license to practice midwifery according to R9-16-107 and Table 1.1.

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1). Section R9-16-103 renumbered to R9-16-102; new Section R9-16-103 made by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022; citation to Table 1 under subsection (B) corrected to Table 1.1. (Supp. 22-2).

R9-16-104. Administration

- A.** A midwife may submit a written request for the Department to:
1. Add the midwife's name, address, and telephone number to a list of licensed midwives on the Department's website; or
 2. Remove the midwife's name, address, and telephone number from a list of licensed midwives on the Department's website.
- B.** A midwife shall:
1. Notify the Department in a format provided by the Department within five working days after:
 - a. A client has died while under the midwife's care,
 - b. A stillborn child has been delivered by the midwife, or
 - c. A newborn delivered by the midwife has died within the first six weeks after birth; and
 2. Provide a summary of the:
 - a. Circumstances leading up to the event, and
 - b. Actions taken by the midwife in response to the event.
- C.** A midwife shall:
1. Maintain documentation of:
 - a. Completion of current training in:
 - i. Adult basic cardiopulmonary resuscitation that meets the requirements in R9-16-102(A)(4)(a), and
 - ii. Neonatal resuscitation that meets the requirements in R9-16-102(A)(4)(b);
 - b. Except as provided in R9-16-103(A)(2)(b), current certification as a Certified Professional Midwife by the North American Registry of Midwives; and
 - c. The continuing education required in subsection R9-16-105 for at least the previous three years; and
 2. Provide a copy of documentation required in subsection (C)(1) to the Department within two working days after the Department's request.

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-16-105. Continuing Education

During the term of a midwifery license, the midwife shall obtain at least 20 hours of continuing education that:

1. Improve the midwife's ability to:

- a. Provide services within the midwife's scope of practice,
 - b. Recognize and respond to situations outside the midwife's scope of practice, or
 - c. Provide guidance to other services a client may need; and
2. Have been approved as applicable to the practice of midwifery by the:
 - a. American Nurses Association,
 - b. American Congress of Obstetrics and Gynecologists,
 - c. Midwives Alliance of North America,
 - d. Arizona Medical Association,
 - e. American College of Nurse Midwives,
 - f. Midwifery Education Accreditation Council, or
 - g. Another health professional organization.

Historical Note

Adopted effective March 14, 1994, except for subsections (B)(3) and (C) which are effective September 15, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-16-105.01. Repealed**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2896, effective June 18, 2002 (Supp. 02-2). Section repealed by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2).

R9-16-106. Name Change; Duplicate License

- A.** To request a name change on a midwifery license or a duplicate midwifery license, a midwife shall submit in writing to the Department:
1. The midwife's name on the current midwifery license;
 2. If applicable, the midwife's new name;
 3. The midwife's address, license number, and e-mail address;
 4. As applicable:
 - a. Documentation supporting the midwife's name change, or
 - b. A statement that the midwife is requesting a duplicate midwifery license; and
 5. A non-refundable fee of \$10.00.
- B.** Upon receipt of the written request required in subsection (A), the Department shall issue, as applicable:
1. An amended midwifery license that incorporates the name change but retains the expiration date of the midwifery license, or
 2. A duplicate midwifery license.

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1). Section R9-16-106 renumbered to R9-16-108; new Section R9-16-106 made by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2).

R9-16-107. Time-frames

- A.** The overall time-frame described in A.R.S. § 41-1072(2) for each type of license granted by the Department is specified in Table 1.1. The applicant or midwife and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame. The substantive review time-frame

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and the overall time-frame may not be extended by more than 25 percent of the overall time-frame.

B. The administrative completeness review time-frame described in A.R.S. § 41-1072(1) for each type of license granted by the Department is specified in Table 1.1.

1. The administrative completeness review time-frame begins:
 - a. For an applicant submitting an application for an initial license, when the Department receives the application packet required in R9-16-102(A); and
 - b. For a licensed midwife applying to renew a midwifery license, when the Department receives the application packet required in R9-16-103(A).
2. If an application is complete, the Department shall provide to the applicant or midwife, during the administrative completeness review time-frame:
 - a. A notice of administrative completeness, or
 - b. A notice of eligibility to take the jurisprudence test or a license.
3. If an application is not complete, the Department shall provide a notice of deficiencies to the applicant or midwife describing the missing documentation or incomplete information.
 - a. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice until the date the Department receives the documentation or information listed in the notice of deficiencies.
 - b. An applicant or midwife shall submit to the Department the documentation or information listed in the notice of deficiencies in subsection (B)(3) within the time specified in Table 1.1 for responding to a notice of deficiencies.
 - c. If the applicant or midwife submits the documentation or information listed in the notice of deficiencies within the time specified in Table 1.1, the Department shall provide a written notice of administrative completeness to the applicant or midwife.
 - d. If the applicant or midwife does not submit the documentation or information listed in the notice of deficiencies within the time specified in Table 1.1, the Department shall consider the application withdrawn.

C. The substantive review time-frame described in A.R.S. § 41-1072(3) is specified in Table 1.1 and begins on the date of the notice of administrative completeness.

1. If an application complies with the requirements in this Article and A.R.S. Title 36, Chapter 6, Article 7, the Department shall issue a notice of eligibility to take the jurisprudence test to an applicant or a license to a midwife.
2. If an application does not comply with the requirements in this Article or A.R.S. Title 36, Chapter 6, Article 7, the Department shall make one comprehensive written request for additional information, unless the applicant or midwife has agreed in writing to allow the Department to submit supplemental requests for information.
 - a. The substantive review time-frame and the overall time-frame are suspended from the date that the Department sends a comprehensive written request for additional information or a supplemental request for information until the date that the Department receives all of the information requested.
 - b. An applicant or midwife shall submit to the Department all of the information requested in a comprehensive written request for additional information or a supplemental request for information in subsection (C)(2) within the time specified in Table 1.1.
 - c. If the applicant or midwife does not submit the additional information within the time specified in Table 1.1 or the additional information submitted by the applicant or midwife does not demonstrate compliance with this Article and A.R.S. Title 36, Chapter 6, Article 7, the Department shall provide to the applicant a written notice of denial that complies with A.R.S. § 41-1092.03(A).
 - d. If the applicant or midwife submits the additional information within the time specified in Table 1.1 and the additional information submitted by the applicant or midwife demonstrates compliance with this Article and A.R.S. Title 36, Chapter 6, Article 7, the Department shall issue a notice of eligibility to take the jurisprudence test to an applicant or a license to a midwife.

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1). Section R9-16-107 renumbered to R9-16-115; new Section R9-16-107 made by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

Table 1.1. Time-frames (in calendar days)

Type of Approval	Statutory Authority	Overall Time-Frame	Administrative Completeness Review Time-Frame	Time to Respond to Notice of Deficiency	Substantive Review Time-Frame	Time to Respond to Comprehensive Written Request
Eligibility for Jurisprudence Test (R9-16-102)	A.R.S. §§ 36-753, 36-754, and 36-755	30	15	60	15	30
Midwifery License Renewal (R9-16-103)	A.R.S. § 36-754	30	15	30	15	15

Historical Note

Table 1.1 made by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2).

R9-16-108. Responsibilities of a Midwife; Scope of Practice

- A.** A midwife shall provide midwifery services only to a woman:

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1. Who does not have any of the conditions specified in R9-16-111(B) through (E) or another condition that may increase the risk of harm to the woman or the woman's fetus or newborn during pregnancy or labor, as determined through a physical assessment and review of the woman's medical history and past pregnancies; and
 2. Whose expected outcome of pregnancy is most likely to be the delivery of a newborn, with none of the conditions requiring transfer of care as specified in R9-16-111(J)(1), and an intact placenta.
- B.** Except as provided in R9-16-111(C) or (D), a midwife who is certified by the North American Registry of Midwives as a Certified Professional Midwife may accept a client for a vaginal delivery:
1. After prior Cesarean section, or
 2. Of a fetus in a complete breech or frank breech presentation.
- C.** Before providing services to a pregnant woman, a midwife shall:
1. Inform the pregnant woman, both orally and in writing, of:
 - a. The midwife's scope of practice, educational background, and credentials, as specified in R9-16-102(A)(4) and (6) as applicable;
 - b. If applicable to the pregnant woman's condition, the midwife's experience with:
 - i. Vaginal birth after prior Cesarean section delivery, or
 - ii. Delivery of a fetus in a complete breech or frank breech presentation;
 - c. The potential risks; adverse outcomes; neonatal or maternal complications, including death; and alternatives associated with an at-home delivery specific to the pregnant woman's condition, including the conditions described in subsection (C)(1)(b);
 - d. The requirement for tests specified in subsections (I) and (K)(3)(c), and the potential risks for declining a test, and, if a test is declined, the need for a written assertion of a pregnant woman's decision to decline testing;
 - e. The requirement for consultation for a condition specified in R9-16-112; and
 - f. The requirement for the transfer of care for a condition specified in R9-16-111; and
 2. Obtain a written informed consent for midwifery services according to R9-16-109.
- D.** A midwife shall:
1. Establish an emergency care plan for a client that includes:
 - a. The name of the client;
 - b. The name of the midwife;
 - c. The name, address, and phone number of:
 - i. The hospital closest to the birthing location that provides obstetrical services, and
 - ii. An emergency medical services provider that provides service between the birthing location and the hospital identified in subsection (D)(1)(c)(i);
 - d. The signature of the client and the date signed; and
 - e. The signature of the midwife and the date signed; and
 2. For a delivery identified in subsection (B), ensure that the hospital identified in subsection (D)(1)(c)(i) is within 25 miles of the birthing location.
- E.** A midwife shall ensure the client receives a copy of the emergency care plan required in subsection (D).
- F.** A midwife shall implement the emergency care plan by immediately calling the emergency medical services provider identified in subsection (D)(1)(c)(ii) for any condition that threatens the life of the client or the client's fetus or newborn.
- G.** A midwife shall maintain all instruments used for delivery in a germ-free manner and other birthing equipment and supplies in clean and good condition.
- H.** A midwife shall assess a client's physical condition in order to establish the client's continuing eligibility to receive midwifery services.
- I.** During the prenatal period, the midwife shall:
1. Except as provided in R9-16-110, ensure that the following tests are completed by the client within 28 weeks gestation:
 - a. Blood type, including ABO and Rh, with antibody screen;
 - b. Urinalysis;
 - c. HIV;
 - d. Hepatitis B;
 - e. Hepatitis C;
 - f. Syphilis as required in A.R.S. § 36-693;
 - g. Rubella titer;
 - h. Chlamydia; and
 - i. Gonorrhea;
 2. Except as provided in R9-16-110, ensure that the following tests are completed by the client:
 - a. A blood glucose screening test for diabetes completed between 24 and 28 weeks of gestation;
 - b. A hematocrit and hemoglobin or complete blood count test completed between 28 and 36 weeks of gestation;
 - c. A vaginal-rectal swab for Group B Strep Streptococcus culture completed between 35 and 37 weeks of gestation;
 - d. At least one ultrasound and recommended follow-up testing to determine placental location and risk for placenta previa and placenta accrete; and
 - e. An ultrasound at 36-37 weeks gestation to confirm fetal presentation and estimated fetal weight for a breech pregnancy;
 3. Conduct a prenatal visit at least once every four weeks until the beginning of 28 weeks of gestation, once every two weeks from the beginning of 28 weeks until the end of 36 weeks of gestation, and once a week after 36 weeks of gestation that includes:
 - a. Taking the client's weight; urinalysis for protein, nitrites, glucose, and ketones; blood pressure; and assessment of the lower extremities for swelling;
 - b. Measurement of the fundal height and listening for fetal heart tones and, later in the pregnancy, feeling the abdomen to determine the position of the fetus;
 - c. Documentation of fetal movement beginning at 28 weeks of gestation;
 - d. Documentation of:
 - i. The occurrence of bleeding or invasive uterine procedures, and
 - ii. Any medications taken during the pregnancy that are specific to the needs of an Rh negative client;
 - e. Referral of a client for lab tests or other assessments, if applicable, based upon examination or history; and

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- f. Either:
 - i. Recommendation of administration of Rh immunoglobulin to an unsensitized Rh negative client after 28 weeks, or any time bleeding or invasive uterine procedures are done; or
 - ii. Midwife administration of Rh immunoglobulin under a physician's written orders;
 - 4. Monitor fetal heart tones with a fetoscope;
 - 5. Document the client's report of first quickening;
 - 6. Conduct weekly visits until signs of first quickening have occurred if first quickening has not been reported by 20 weeks of gestation;
 - 7. Initiate a consultation if first quickening has not occurred by the end of 22 weeks of gestation;
 - 8. Conduct a prenatal visit of the birthing location before the end of 35 weeks of gestation to ensure that the birthing environment is appropriate for birth and that communication is available to the hospital and emergency medical services provider identified in subsection (D)(1)(c)(i) and (ii); and
 - 9. Review with the client the circumstances when a transfer of care is required, as specified in R9-16-111.
- J.** During the intrapartum period from the onset of labor until after the delivery of the placenta, a midwife shall:
- 1. Determine if the client is in labor and the appropriate course of action to be taken by:
 - a. Assessing the interval, duration, intensity, location, and pattern of the contractions;
 - b. Determining the condition of the membranes, including whether the membranes are intact or ruptured, and the amount and color of fluid;
 - c. Reviewing with the client the need for fluid intake related to subsection (J)(3)(d), relaxation, and activity; and
 - d. Deciding whether to go to the client's home or other birthing location, remain in telephone contact, or arrange for transfer of care or consultation;
 - 2. Contact the hospital identified in subsection (D)(1)(c)(i) according to the policies and procedures established by the hospital regarding communication with midwives when the client begins labor and ends labor;
 - 3. During labor:
 - a. Assess the condition of the client and fetus:
 - i. Upon initial contact;
 - ii. Every half hour during active labor until completely dilated; and
 - iii. Every 15 to 20 minutes during pushing, following rupture of the amniotic bag, or until the newborn is delivered;
 - b. Include in the assessments required in subsection (J)(3)(a):
 - i. A physical assessment and checking of the client's vital signs every two to four hours; and
 - ii. Assessing fetal heart tones every 30 minutes during active first stage labor, and every 15 minutes during second stage labor, following rupture of the amniotic bag, or with any significant change in labor patterns;
 - c. Periodically assess contractions, fetal presentation, dilation, effacement, and fetal position by vaginal examination;
 - d. Maintain proper fluid balance for the client throughout labor as determined by urinary output and monitoring urine for presence of ketones; and
 - e. Assist in support and comfort measures to the client and family;
 - 4. For deliveries described in subsection (B), during labor determine the progression of active labor:
 - a. For a pregnant woman giving birth to her first newborn, by monitoring whether dilation occurs at an average of one centimeter per hour until completely dilated, and a second stage does not exceed two hours;
 - b. For a pregnant woman who has previously given birth to one or more newborns, by monitoring whether dilation occurs at an average of 1.5 to two centimeters per hour until completely dilated, and a second stage does not exceed one hour; or
 - c. According to the Management Guidelines recommended by the American Congress of Obstetricians and Gynecologists;
 - 5. After delivery of the newborn:
 - a. Assess the newborn at one minute and five minutes to determine the Apgar scores;
 - b. Physically assess the newborn for any abnormalities;
 - c. Inspect the client's perineum, vagina, and cervix for lacerations;
 - d. Deliver the placenta within 1 hour and assess the client for signs of placental separation from the inner wall of the uterus, resulting in vaginal or internal bleeding; and
 - e. Examine the placenta for intactness and to determine the number of umbilical cord vessels; and
 - 6. Recognize and respond to any situation requiring immediate intervention, including measures to be taken during an emergency, as specified in R9-16-113.
- K.** During the postpartum period, the midwife shall:
- 1. During the two hours after delivery of the placenta, provide the following care to the client:
 - a. Every 15 to 20 minutes for the first hour and every 30 minutes for the second hour:
 - i. Take vital signs of the client,
 - ii. Perform external massage of the uterus, and
 - iii. Evaluate bleeding;
 - b. Assist the client to urinate within two hours following the birth;
 - c. Evaluate the perineum, vagina, and cervix for tears, bleeding, or blood clots;
 - d. Assist with maternal-newborn bonding to develop a relationship between the client and newborn;
 - e. Assist with initial breast feeding, instructing the client in the care of the breast, and reviewing potential danger signs, if appropriate;
 - f. Provide instruction to the family about:
 - i. Fluid and nutritional intake requirements to meet the needs of the mother and newborn;
 - ii. Rest and the types of exercise allowed;
 - iii. Normal and abnormal bleeding, bladder and bowel function;
 - iv. How to care for the newborn;
 - v. Signs and symptoms of postpartum depression; and
 - v. Any symptoms that may pose a threat to the health or life of the client or the client's newborn and appropriate emergency phone numbers;
 - g. Recommend, or administer under physician's written orders, Rh immunoglobulin to an unsensitized

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- Rh-negative client who delivers an Rh-positive newborn so that administration occurs within 72 hours after birth; and
- h. Document any medications taken by an unsensitized Rh-negative client who delivers an Rh-positive newborn in the client's record;
2. During the two hours after delivery of the placenta, provide the following care to the newborn:
 - a. Perform a newborn physical assessment to determine the newborn's gestational age and any abnormalities;
 - b. Comply with the requirements in A.A.C. R9-6-338;
 - c. Recommend, or administer under physician's written orders, Vitamin K to the newborn so that administration occurs within 72 hours after birth; and
 - d. Document the physical assessment and administration of any medications or vitamins to the newborn in the newborn's record according to the physician's written orders;
 3. Evaluate the client or newborn for any abnormal or emergency situation and seek consultation or intervention, if applicable, according to these rules; and
 4. Re-evaluate the condition of the client and newborn between 24 and 72 hours after delivery to determine whether the recovery is following a normal course, including:
 - a. Assessing baseline indicators such as the client's vital signs, bowel and bladder function, bleeding, breasts, feeding of the newborn, sleep/rest cycle, and activity, with any recommendations for change;
 - b. Assessing baseline indicators of well-being in the newborn such as vital signs, weight, cry, suck and feeding, fontanel, sleeping, and bowel and bladder function with documentation of meconium, and providing any recommendations for changes made to the family;
 - c. Submitting blood obtained from a heel stick to the newborn to the state laboratory for screening according to A.R.S. § 36-694(B) and 9 A.A.C. 13, Article 2, unless a written refusal is obtained from the client and documented in the client's record and the newborn's record; and
 - d. Recommending to the client that the client secure medical follow-up for her newborn.
- L.** A midwife shall request the registration of the birth of a newborn according to A.A.C. R9-19-203 within seven calendar days after the birth of the newborn.
- Historical Note**
- Adopted effective March 14, 1994 (Supp. 94-1). R9-16-108 renumbered to R9-16-111; new Section R9-16-108 renumbered from R9-16-106 and amended by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).
- R9-16-109. Informed Consent for Midwifery Services**
- A.** A midwife shall obtain a written informed consent for midwifery services in a format provided by the Department that contains:
1. The midwife's:
 - a. Name,
 - b. Telephone number,
 - c. License number, and
 - d. E-mail address;
 2. The client's:
 - a. Name;
 - b. Address;
 - c. Telephone number;
 - d. Date of birth; and
 - e. E-mail address, if applicable;
 3. An attestation that the client was:
 - a. Provided the information required in R9-16-108(C)(1);
 - b. Informed of the emergency care plan as required in R9-16-108(D); and
 - c. Given an opportunity to have questions answered, have an understanding of the information provided, and choose to continue with midwifery services; and
 4. The signatures of the client and midwife and date signed.
- B.** A midwife shall ensure that the written informed consent for midwifery services is placed in the client record.
- C.** A midwife shall ensure that a copy of the written informed consent for midwifery services is provided to the:
1. Client, and
 2. Department within five calendar days after a Department request.
- Historical Note**
- Adopted effective March 14, 1994 (Supp. 94-1). R9-16-109 renumbered to R9-16-112; new Section R9-16-109 made by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Manifest typographical errors corrected in subsections (A)(3)(a) and (b) to rule Section reference of incorrect Chapter number; request made by Department at file number R13-232 (Supp. 13-3). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).
- R9-16-110. Assertion to Decline Required Tests**
- A.** Except for R9-16-108(I)(1)(f), if the client declines a test required in R9-16-108(I)(1) or (2), a midwife shall obtain a written assertion of a client's decision to decline a required test in a format provided by the Department, that contains:
1. The midwife's:
 - a. Name,
 - b. Telephone number,
 - c. License number, and
 - d. E-mail address;
 2. The client's:
 - a. Name;
 - b. Address;
 - c. Telephone number;
 - d. Date of birth; and
 - e. E-mail address, if applicable;
 3. The required test being declined by the client;
 4. Additional information as required by the Department;
 5. An attestation that the client:
 - a. Was provided the information as required in R9-16-108(C)(1)(d), and
 - b. Is declining testing; and
 6. The signatures of the client and midwife and date signed.
- B.** A midwife shall ensure that the written assertion of the decision to decline a test is placed in the client record.
- C.** A midwife shall ensure that a copy of the written assertion of the decision to decline a test is provided to the:
1. Client, and

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2. Department within five calendar days after a Department request.

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1). R9-16-110 renumbered to R9-16-113; new Section R9-16-110 made by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Manifest typographical error corrected in subsection (A)(5)(a) to rule Section reference of incorrect Chapter number; request made by Department at file number R13-232 (Supp. 13-3). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-16-111. Prohibited Practice; Transfer of Care

- A. A midwife shall not provide midwifery services in a location that has the potential to cause harm to the client or the client's fetus or newborn.
- B. A midwife shall not accept as a client for midwifery services a pregnant woman who has any of the following:
 1. A previous surgery that involved:
 - a. An incision in the uterus, except as provided in R9-16-108(B)(1); or
 - b. A previous uterine surgery that enters the myometrium;
 2. A history of severe postpartum bleeding, of unknown cause, which required transfusion;
 3. Gestational age greater than 34 weeks with no prior prenatal assessments or clinical examinations;
 4. Multiple fetuses;
 5. A pelvis that will not safely allow a fetus to pass through during labor;
 6. Placenta previa or placenta accreta;
 7. Deep vein thrombosis or pulmonary embolism;
 8. Uncontrolled gestational diabetes;
 9. Insulin-dependent diabetes;
 10. Hypertension;
 11. Rh disease with positive titers;
 12. Active:
 - a. Tuberculosis,
 - b. Syphilis,
 - c. Hepatitis until treated and recovered, or
 - d. Gonorrhea until treated and recovered;
 13. A blood pressure of 140/90 or an increase of 30 millimeters of Mercury systolic or 15 millimeters of Mercury diastolic over the client's lowest baseline blood pressure for two consecutive readings taken at least six hours apart;
 14. A persistent hemoglobin level below 10 grams;
 15. A condition related to emotional or behavioral functioning, as a result of a mental disorder as defined in A.R.S. § 36-501, that:
 - a. Is severe and persistent, resulting in a long-term limitation of the client's capacity for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment, or recreation; and
 - b. Impairs or substantially interferes with the client's capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration; or
 16. Indications of the continued use of one of the following despite negative consequences, including six months prior to pregnancy, that is evident during an assessment of a client:
 - a. Alcohol,
 - b. Narcotics, or
 - c. Other drugs.
- C. A midwife shall not continue midwifery services for a client who is diagnosed with or develops any of the following:
 1. Any condition specified in subsections (B)(4) through (16);
 2. A hematocrit below 30 during the third trimester;
 3. Except as provided in R9-16-108(B)(2), a fetus that is not in a head-down position with the crown of the head being the leading body part;
 4. Labor beginning before the beginning of 36 weeks gestation;
 5. A progression of labor that does not meet the requirements of R9-16-108(J)(4), if applicable;
 6. A gestation beyond 42 weeks;
 7. Presence of ruptured membranes without onset of labor within 24 hours;
 8. Abnormal fetal heart rate consistently less than 120 beats per minute or more than 160 beats per minute;
 9. Presence of thick meconium, blood-stained amniotic fluid, or abnormal fetal heart tones;
 10. A postpartum hemorrhage of greater than 500 milliliters in the current pregnancy; or
 11. A non-bleeding placenta retained for more than 60 minutes.
- D. A midwife shall not perform a vaginal delivery after prior Cesarean section for a client who:
 1. Had:
 - a. More than one previous Cesarean section;
 - b. A previous Cesarean section:
 - i. With a classical, vertical, or unknown uterine incision;
 - ii. Within 18 months before the expected delivery;
 - iii. With complications, including uterine infection; or
 - iv. Due to failure to progress as a result of cephalopelvic insufficiency; or
 - c. Complications during a previous vaginal delivery after a Cesarean section; or
 2. Has a fetus:
 - a. With fetal anomalies, confirmed by an ultrasound; or
 - b. In a breech presentation.
- E. A midwife shall not perform a vaginal delivery of a fetus in a breech presentation for a client who:
 1. Had a previous:
 - a. Unsuccessful vaginal delivery or other demonstration of an inadequate maternal pelvis, or
 - b. Cesarean section; or
 2. Has a fetus:
 - a. With fetal anomalies, confirmed by an ultrasound;
 - b. With an estimated fetal weight less than 2500 grams or more than 3800 grams; or
 - c. In an incomplete breech presentation.
- F. If the client has any of the conditions in subsections (C) through (E), a midwife shall:
 1. Document the condition in the client record, and
 2. Initiate transfer of care.
- G. A midwife shall not perform any operative procedures except as provided in R9-16-113.
- H. A midwife shall not:
 1. Use any artificial, forcible, or mechanical means to assist birth; or

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2. Attempt to correct fetal presentations by external or internal movement of the fetus.
- I. A midwife shall not administer drugs or medications except as provided in R9-16-108(I)(3)(f), (K)(1)(g), or (K)(2)(c), or R9-16-113.
- J. Except as provided in R9-16-113, a midwife shall:
 1. Discontinue midwifery services and transfer care of a newborn in which any of the following conditions are present:
 - a. Birth weight less than 2000 grams;
 - b. Pale, blue, or gray color after 10 minutes;
 - c. Severe swelling, especially of the newborn's abdomen;
 - d. Major congenital anomalies; or
 - e. Respiratory distress; and
 2. Document the condition in subsection (J)(1) in the newborn record.

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1). R9-16-111 renumbered to R9-16-116; new Section R9-16-111 renumbered from R9-16-108 and amended by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-16-112. Required Consultation

- A. A midwife shall obtain a consultation at the time a client is determined to have any of the following during the current pregnancy:
 1. A positive culture for Group B Streptococcus;
 2. History of seizure disorder;
 3. History of stillbirth, premature labor, or having delivered more than five newborns;
 4. Age younger than 16 years;
 5. A first pregnancy in a client older than 40 years of age;
 6. Failure to auscultate fetal heart tones by the beginning of 22 weeks gestation;
 7. Failure to gain 12 pounds by the beginning of 30 weeks gestation or gaining more than eight pounds in any two-week period during pregnancy;
 8. Greater than 1+ sugar, ketones, or protein in the urine on two consecutive visits;
 9. Excessive vomiting or continued vomiting after the end of 20 weeks gestation;
 10. Symptoms of decreased fetal movement;
 11. A fever of 100.4° F or 38° C or greater measured twice at 24 hours apart;
 12. Tender uterine fundus;
 13. Effacement or dilation of the cervix, greater than a fingertip, accompanied by contractions, prior to the beginning of 36 weeks gestation;
 14. Measurements for fetal growth that are not within 2 centimeters of the gestational age;
 15. Second degree or greater lacerations of the birth canal;
 16. Except as provided in R9-16-111(C)(4), a progression of labor that does not follow the guidelines in R9-16-108(J)(4)(c);
 17. An unengaged head at seven centimeters dilation in active labor;
 18. Failure of the uterus to return to normal size in the current postpartum period;

19. Persistent shortness of breath requiring more than 24 breaths per minute, or breathing which is difficult or painful;
20. Gonorrhea;
21. Chlamydia;
22. Syphilis;
23. Heart disease;
24. Kidney disease;
25. Blood disease; or
26. A positive test result for:
 - a. HIV,
 - b. Hepatitis B, or
 - c. Hepatitis C.
- B. A midwife shall obtain a consultation at the time a newborn demonstrates any of the following conditions:
 1. Weight less than 2500 grams or five pounds, eight ounces;
 2. Congenital anomalies;
 3. An Apgar score less than 7 at five minutes;
 4. Persistent breathing at a rate of more than 60 breaths per minute;
 5. An irregular heartbeat;
 6. Persistent poor muscle tone;
 7. Less than 36 weeks gestation or greater than 42 weeks gestation by gestational exam;
 8. Yellowish-colored skin within 48 hours;
 9. Abnormal crying;
 10. Meconium staining of the skin;
 11. Lethargy;
 12. Irritability;
 13. Poor feeding;
 14. Excessively pink coloring over the entire body;
 15. Failure to urinate or pass meconium in the first 24 hours of life;
 16. A hip examination which results in a clicking or incorrect angle;
 17. Skin rashes not commonly seen in the newborn; or
 18. Temperature persistently above 99.0° or below 97.6° F.
- C. The midwife shall inform the client of the consultation required in subsections (A) or (B) and recommendations of the physician or certified nurse midwife.
- D. The midwife shall document the consultation required in subsections (A) or (B) and recommendations received in the client record or newborn record, as specified in R9-16-115(B)(14) or (C)(7) as applicable.

Historical Note

Adopted effective March 14, 1994 (Supp. 94-1). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5029, effective September 30, 2001 (Supp. 01-4). New Section R9-16-112 renumbered from R9-16-109 and amended by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-16-113. Emergency Measures

- A. In an emergency situation in which the health or safety of the client or newborn are determined to be at risk, a midwife:
 1. Shall ensure that an emergency medical services provider is called; and
 2. May perform the following procedures as necessary:
 - a. Cardiopulmonary resuscitation of the client or newborn with a bag and mask;

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- b. Administration of oxygen at no more than eight liters per minute via mask for the client and five liters per minute for the newborn via neonatal mask;
 - c. Episiotomy to expedite the delivery during fetal distress;
 - d. Suturing of episiotomy or tearing of the perineum to stop active bleeding, following administration of local anesthetic, contingent upon consultation with a physician or certified nurse midwife, or physician's written orders;
 - e. Release of shoulder dystocia, the wedging of the shoulders of the fetus in the client's pelvis in such a way that the fetus is unable to be born without emergency action, by utilizing:
 - i. Hyperflexion of the client's legs to the abdomen,
 - ii. Application of external pressure suprapubically,
 - iii. Rotation of the nonimpacted shoulder until the impacted shoulder is released,
 - iv. Delivery of the posterior shoulder,
 - v. Application of posterior pressure on the anterior shoulder, or
 - vi. Positioning of the client on all fours with the back arched;
 - f. Manual exploration of the uterus for control of severe bleeding; or
 - g. Manual removal of placenta.
- B.** A licensed midwife may administer a maximum dose of 20 units of pitocin intramuscularly, in 10-unit dosages each, 30 minutes apart, to a client for the control of postpartum hemorrhage, contingent upon physician or certified nurse midwife consultation and written orders by a physician, and arrangements for immediate transport of the client to a hospital.
- C.** A midwife shall document in the client's record any medications taken by a client for the control of postpartum hemorrhage.

Historical Note

New Section R9-16-113 renumbered from R9-16-110 and amended by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-16-114. Midwife Report after Termination of Midwifery Services

- A.** A midwife shall complete a midwife report for each client, in a format provided by the Department, that includes the following:
- 1. The midwife's:
 - a. First name,
 - b. Last name, and
 - c. License number;
 - 2. The client's:
 - a. Date of birth;
 - b. Client number;
 - c. Date of last menstrual period;
 - d. Estimated date of delivery;
 - e. Gravida, the number of times the client has been pregnant, including a current pregnancy, regardless of whether these pregnancies were carried to term;
 - f. Para, the number of times the client has given birth at greater than 20 weeks of gestation, including via-

- ble and non-viable births, where multiples are counted as one birth; and
 - g. If applicable, whether the client had a vaginal delivery after prior Cesarean section or vaginal delivery of a fetus in a complete breech or frank breech presentation;
- 3. A description of the maternal outcome, including any complications;
 - 4. If a vaginal delivery after prior Cesarean section or vaginal delivery of a fetus in a complete breech or frank breech presentation:
 - a. Rate of dilation, and
 - b. Duration of second stage labor;
 - 5. If applicable, the newborn's:
 - a. Date of birth;
 - b. Gender;
 - c. Weight;
 - d. Length;
 - e. Head circumference;
 - f. Designation of average, small, or large for gestational age;
 - g. Apgar score at one minute;
 - h. Apgar score at five minutes;
 - i. Existence of complications;
 - j. Description of complications, if applicable;
 - k. Birth certificate filing date; and
 - l. Birth certificate number, if available;
 - 6. Whether the client required transfer of care and, if applicable:
 - a. Method of transport,
 - b. Type of facility or individual to which the midwife transferred care of the client,
 - c. Name of destination,
 - d. Time arrived at destination,
 - e. Confirmation the emergency care plan was utilized, and
 - f. Medical reason for transfer of care;
 - 7. The date midwifery services were terminated;
 - 8. Reason for the termination of midwifery services;
 - 9. If termination of midwifery services was due to a medical condition, the specific medical condition;
 - 10. Whether information was provided on newborn screening; and
 - 11. Whether newborn screening tests were ordered as required in A.R.S. § 36-694.

- B.** The midwife shall submit a midwife report for a client to the Department within 30 calendar days after the termination of midwifery services to the client.

Historical Note

Section made by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-16-115. Client and Newborn Records

- A.** A midwife shall ensure that a record is established and maintained according to A.R.S. §§ 12-2291 and 12-2297 for each:
- 1. Client, and
 - 2. Newborn delivered by the midwife from a client.
- B.** A midwife shall ensure that a record for each client includes the following:
- 1. The client's full name, date of birth, address, and client number;

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2. Names, addresses, and telephone numbers of the client's spouse or other individuals designated by the client to be contacted in an emergency;
 3. Written informed consent for midwifery services, as required in R9-16-108(C)(2);
 4. If applicable, assertion to decline required tests, as required in R9-16-110(A);
 5. A copy of the emergency care plan, as required in R9-16-108(D);
 6. The date the midwife began providing midwifery services to the client;
 7. The date the client is expected to deliver the newborn;
 8. The date the newborn was delivered, if applicable;
 9. An initial assessment of the client to:
 - a. Determine whether the client has a history of a condition or circumstance that would preclude care of the client by the midwife, as specified in R9-16-111; and
 - b. Determine the:
 - i. Number and outcome of previous pregnancies, and
 - ii. Number of previous medical or midwife visits the client has had during the current pregnancy;
 10. Progress notes documenting the midwifery services provided to the client;
 11. For a delivery identified in R9-16-108(B):
 - a. Rate of dilation, and
 - b. Duration of second stage labor;
 12. Laboratory and diagnostic reports, required in R9-16-108(I);
 13. Documentation of consultations as required in R9-16-112, including:
 - a. Reason for the consultation,
 - b. Name of physician or certified nurse midwife contacted,
 - c. Date of consultation,
 - d. Time of consultation,
 - e. Recommendation made by the physician or certified nurse midwife, and
 - f. Actions taken as a result of the consultation;
 14. Any written reports received from consultations required in R9-16-112;
 15. A description of any conditions or circumstances arising during the pregnancy that required the transfer of care;
 16. The name of the physician, certified nurse midwife, or hospital to which the care of the client was transferred, if applicable;
 17. Documentation of medications or vitamins taken by the client;
 18. Documentation of medications or vitamins administered to the client and the physician's written orders for the medications or vitamins;
 19. The outcome of the pregnancy;
 20. The date the midwife stopped providing midwifery services to the client; and
 21. Instructions provided to the client before the midwife stopped providing midwifery services to the client.
- C. A midwife shall ensure that a record for each newborn includes the following:
1. The full name, date of birth, and address of the newborn's mother;
 2. The newborn's:
 - a. Date of birth,
 - b. Gender,
 - c. Weight at birth,
 - d. Length at birth, and
 - e. Apgar scores at one minute and five minutes after birth;
 3. The newborn's estimated gestational age at birth;
 4. Progress notes documenting the midwifery services provided to the newborn;
 5. Laboratory and diagnostic reports, as required in R9-16-108(I);
 6. Documentation of consultations as required in R9-16-112, including:
 - a. Reason for the consultation,
 - b. Name of physician or certified nurse midwife contacted,
 - c. Date of consultation,
 - d. Time of consultation,
 - e. Recommendation made by the physician or certified nurse midwife, and
 - f. Actions taken as a result of the consultation;
 7. Any written reports received from consultations required in R9-16-112;
 8. A description of any conditions or circumstances arising during or after the newborn's birth that required the transfer of care;
 9. The name of the physician, certified nurse midwife, or hospital to which the care of the newborn was transferred, if applicable;
 10. Documentation of medications or vitamins taken by the newborn;
 11. Documentation of medications or vitamins administered to the newborn and the physician's written orders for the medications or vitamins;
 12. Documentation of newborn screening, including when the specimen collection kit, as defined in A.A.C. R9-13-201, was submitted and results received, as required in R9-16-108(K)(4)(c);
 13. The date the midwife stopped providing midwifery services to the newborn; and
 14. Instructions provided to the client about the newborn before the midwife stopped providing midwifery services to the newborn.

Historical Note

New Section R9-16-115 renumbered from R9-16-107 and amended by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-16-116. Denial, Suspension, or Revocation of License; Civil Penalties; Procedures

In addition to the grounds specified in A.R.S. §§ 13-904(E) and 36-756, the Department may deny, suspend, or revoke a license permanently or for a definite period of time, and may assess a civil penalty for each violation, for any of the following causes:

1. Practicing under a false name or alias so as to interfere with or obstruct the investigative or regulatory process,
2. Practicing under the influence of drugs or alcohol,
3. Falsification of records,
4. Obtaining any fee for midwifery services by fraud or misrepresentation,
5. Permitting another to use the midwife's license, or
6. Knowingly providing false information to the Department.

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Historical Note

New Section R9-16-116 renumbered from R9-16-111 and amended by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-16-117. Expired**Historical Note**

New Section made by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 1044, effective August 26, 2017 (Supp. 17-3).

Table 1. Repealed**Historical Note**

Table 1 made by final rulemaking at 8 A.A.R. 2896, effective June 18, 2002 (Supp. 02-2). Table 1 repealed by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2).

Exhibit A. Repealed**Historical Note**

Section repealed, new Section adopted effective March 14, 1994 (Supp. 94-1). Exhibit A repealed by final rulemaking at 8 A.A.R. 2896, effective June 18, 2002 (Supp. 02-2).

Exhibit B. Repealed**Historical Note**

Adopted effective March 14, 1994 (Supp. 94-1). Exhibit B repealed by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2).

Exhibit C. Repealed**Historical Note**

Adopted effective March 14, 1994 (Supp. 94-1). Exhibit C repealed by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2).

Exhibit D. Repealed**Historical Note**

Adopted effective March 14, 1994 (Supp. 94-1). Exhibit D repealed by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2).

Exhibit E. Repealed**Historical Note**

Adopted effective March 14, 1994 (Supp. 94-1). Amended to correct printing errors (Supp. 99-4). Exhibit E repealed by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2).

ARTICLE 2. LICENSING AUDIOLOGISTS AND SPEECH-LANGUAGE PATHOLOGISTS

R9-16-201. Definitions

1. "Accredited" means approved by the:
 - a. New England Commission of Higher Education,
 - b. Middle States Commission on Higher Education,
 - c. Higher Learning Commission,
 - d. Northwest Commission on Colleges and Universities,
 - e. Southern Association of Colleges and Schools Commission on Colleges, or
 - f. WASC Senior College and University Commission.
2. "Applicant" means an individual who submits an application and required documentation for approval to practice as an audiologist or a speech-language pathologist.
3. "ASHA" means the American Speech-Language-Hearing Association, a national professional, scientific, and credentialing association for audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.
4. "Calendar day" means each day, not including the day of the act, event, or default, from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
5. "CCC" means Certificate of Clinical Competence, an award issued by ASHA to an individual who:
 - a. Completes a degree in audiology or speech-language pathology from an accredited college or university that includes a clinical practicum,
 - b. Passes the ETSNEA or ETSNESLP, and
 - c. Completes a clinical fellowship.
6. "Clinical fellow" means an individual engaged in a clinical fellowship.
7. "Clinical fellowship" means an individual's postgraduate professional experience assessing, diagnosing, screening, treating, writing reports, and counseling individuals exhibiting speech, language, hearing, or communication disorders, obtained:
 - a. After completion of graduate level academic course work and a clinical practicum;
 - b. Under the supervision of a clinical fellowship supervisor; and
 - c. While employed on a full-time or part-time equivalent basis.
8. "Clinical fellowship agreement" means the document submitted to the Department by a clinical fellow to register the initiation of a clinical fellowship.
9. "Clinical fellowship report" means a document completed by a clinical fellowship supervisor containing:
 - a. A summary of the diagnostic and therapeutic procedures performed by the clinical fellow,
 - b. A verification by the clinical fellowship supervisor of the clinical fellow's performance of diagnostic and therapeutic procedures, and
 - c. An evaluation of the clinical fellow's ability to perform the diagnostic and therapeutic procedures.
10. "Clinical fellowship supervisor" means a licensed speech-language pathologist who:
 - a. Is or has been a sponsor of a temporary licensee,
 - b. Had a CCC while supervising a clinical fellow before October 28, 1999, or
 - c. Has a CCC while supervising a clinical fellow in another state.
11. "Clinical practicum" means the experience acquired by an individual who is completing course work in audiology or speech-language pathology, while supervised by a licensed audiologist, a licensed speech-language pathologist,

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gist, or an individual holding a CCC, by assessing, diagnosing, evaluating, screening, treating, and counseling individuals exhibiting speech, language, cognitive, hearing, or communication disorders.

12. "Continuing education" means a course that provides instruction and training that is designed to develop or improve a licensee's professional competence in disciplines directly related to the licensee's scope of practice.
13. "Course" means a workshop, seminar, lecture, conference, or class.
14. "Diagnostic and therapeutic procedures" means the principles and methods used by an audiologist in the practice of audiology or a speech-language pathologist in the practice of speech-language pathology.
15. "Disciplinary action" means a proceeding that is brought against a licensee by the Department under A.R.S. § 36-1934 or a state licensing entity.
16. "ETSNEA" means Educational Testing Service National Examination in Audiology, the specialty area test of the Praxis Series given by the Education Testing Service, Princeton, N.J.
17. "ETSNESLP" means Educational Testing Service National Examination in Speech-Language Pathology, the specialty area test of the Praxis Series given by the Education Testing Service, Princeton, N.J.
18. "Full-time" means 30 clock hours or more per week.
19. "Hearing aid dispenser examination" means the International Licensing Examination for Hearing Healthcare Professionals approved by the Department as complying with A.R.S. § 36-1924.
20. "Local education agency" means a governing board established by A.R.S. § 15-101 or A.R.S. Title 15, Chapter 3, Article 3.
21. "Monitoring" means being responsible for and providing direction to a clinical fellow without directly observing diagnostic and therapeutic procedures.
22. "On-site observations" means the presence of a clinical fellowship supervisor who is watching a clinical fellow perform diagnostic and therapeutic procedures.
23. "Part-time equivalent" means:
 - a. 25-29 clock hours per week for 48 weeks,
 - b. 20-24 clock hours per week for 60 weeks, or
 - c. 15-19 clock hours per week for 72 weeks.
24. "Semester credit hour" means one earned academic unit of study based on completing, at an accredited college or university, a 50 to 60 minute class session per calendar week for 15 to 18 weeks.
25. "Semester credit hour equivalent" means one quarter credit, which is equal in value to 2/3 of a semester credit hour.
26. "State-supported institution" means a school, a charter school, a private school, or an accommodation school as defined in A.R.S. § 15-101.
27. "Student" means a child attending a school, a charter school, a private school, or an accommodation school as defined in A.R.S. § 15-101.
28. "Supervision" means being responsible for and providing direction to:
 - a. A clinical fellow during on-site observations or monitoring of the clinical fellow's performance of diagnostic and therapeutic procedures; or
 - b. An individual completing a clinical practicum.
29. "Supervisory activities" means evaluating and assessing a clinical fellow's performance of diagnostic and therapeutic

tic procedures in assessing, diagnosing, evaluating, screening, treating, and counseling individuals exhibiting speech, language, cognitive, hearing, or communication disorders.

Historical Note

Former Section R9-16-201 repealed, new Section R9-16-201 adopted effective January 23, 1978 (Supp. 78-1).

Repealed effective March 14, 1994 (Supp. 94-1).

Adopted by final rulemaking at 5 A.A.R. 4359, effective October 28, 1999 (Supp. 99-4). Amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-202. Application

A. An applicant for licensure shall submit to the Department:

1. An application in a Department-provided format that contains:
 - a. The applicant's name, home address, telephone number, and e-mail address;
 - b. The applicant's Social Security number, as required under A.R.S. §§ 25-320 and 25-502;
 - c. If applicable, the applicant's business addresses and telephone number;
 - d. The applicant's current employment, if applicable, including:
 - i. The employer's name,
 - ii. The licensee's position,
 - iii. Dates of employment,
 - iv. The address of the employer,
 - v. The supervisor's name,
 - vi. The supervisor's email address, and
 - vii. The supervisor's telephone number;
 - e. If applicable, whether the applicant is requesting an audiology license to fit and dispense;
 - f. Whether the applicant has ever been convicted of a felony or a misdemeanor in this or another state;
 - g. If the applicant has been convicted of a felony or a misdemeanor:
 - i. The date of the conviction,
 - ii. The state or jurisdiction of the conviction,
 - iii. An explanation of the crime of which the applicant was convicted, and
 - iv. The disposition of the case;
 - h. Whether the applicant is or has been licensed as an audiologist, an audiologist to fit and dispense hearing aids, or a speech-language pathologist in another state or country;
 - i. Whether the applicant has had a license revoked or suspended by any state;
 - j. Whether the applicant is currently ineligible for licensing in any state because of a license revocation or suspension;
 - k. Whether any disciplinary action has been imposed by any state, territory or district in this country for an act related to the applicant's practice of audiology or a speech-language pathologist license;
 - l. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-16-214(C);
 - m. An attestation that the information submitted as part of the application is true and accurate; and
 - n. The applicant's signature and date of signature;

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2. If a license for the applicant has been revoked or suspended by any state documentation that includes:
 - a. The date of the revocation or suspension,
 - b. The state or jurisdiction of the revocation or suspension, and
 - c. An explanation of the revocation or suspension;
 3. If the applicant is currently ineligible for licensing in any state because of a license revocation or suspension, documentation that includes:
 - a. The date of the ineligibility for licensing,
 - b. The state or jurisdiction of the ineligibility for licensing, and
 - c. An explanation of the ineligibility for licensing;
 4. If the applicant has been disciplined by any state, territory, or district of this country for an act related to the applicant's license to practice audiology or a speech-language pathologist license that is consistent with A.R.S. Title 36, Chapter 17, documentation that includes:
 - a. The date of the disciplinary action,
 - b. The state or jurisdiction of the disciplinary action,
 - c. An explanation of the disciplinary action, and
 - d. Any other applicable documents, including a legal order or settlement agreement;
 5. Documentation of the applicant's citizenship or alien status that complies with A.R.S. § 41-1080; and
 6. A fee specified in R9-16-216.
- B.** In addition to complying with subsection (A), an applicant that may be eligible for licensure under A.R.S. § 36-1922 shall submit documentation to the Department that includes:
1. The name of each state that issued the applicant a current license, including:
 - a. The license number of each current license, and
 - b. The date each current license was issued;
 2. Documentation of the professional license or certification issued to the applicant by each state in which the applicant holds a professional license or certification;
 3. For each state named in subsection (B)(1), a statement, signed and dated by the applicant, attesting that the applicant:
 - a. Has been licensed or certified in another state for at least one year, with a scope of practice consistent with the scope of practice for which licensure is being requested;
 - b. Has met minimum education requirements according to A.R.S. §§ 36-1940 or 36-1940.01;
 - c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
 - d. Does not have a complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct.
- C.** The Department shall review the application and required documentation for a license according to R9-16-214 and Table 2.1.

Historical Note

Former Section R9-16-202 repealed, new Section R9-16-202 adopted effective January 23, 1978 (Supp. 78-1). Repealed effective March 14, 1994 (Supp. 94-1). Adopted by final rulemaking at 5 A.A.R. 4359, effective October 28, 1999 (Supp. 99-4). Section R9-16-202 repealed; new Section R9-16-202 renumbered from R9-16-203 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section R9-16-

202 repealed; new Section made by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-203. Initial Application for an Audiologist

- A.** In addition to complying with R9-16-202, an applicant for initial licensure as an audiologist shall submit to the Department the following:
1. A transcript or equivalent documentation issued to the applicant from an accredited college or university after the applicant's completion of a doctoral degree consistent with the standards of this state's universities, as required in A.R.S. § 36-1940(A)(2) or documentation of the applicant's current CCC.
 2. Documentation of a passing grade on a ETSNEA or current CCC dated within three years before the date of application required in A.R.S. §§ 36-1902(E) and 36-1940(A)(3) or current license from other state.
 3. Documentation of completing supervised clinical rotation consistent with the standards of this state's universities required in A.R.S. § 36-1940(B)(2) or current CCC.
 4. Whether the applicant is applying to fit and dispense hearing aids.
 5. If applicable, a list of all states and countries in which the applicant is or has been licensed as an audiologist or an audiologist to fit and dispense hearing aids.
- B.** In addition to complying with R9-16-202, an applicant for initial licensure as an audiologist licensed to fit and dispense hearing aids who was awarded a master's degree before December 31, 2007 shall submit to the Department the following:
1. A transcript or equivalent documentation issued to the applicant from an accredited college or university demonstrating the applicant's completion of a master's degree in audiology before December 31, 2007 or documentation of the applicant's current CCC;
 2. Documentation of a passing grade on an ETSNEA or current CCC dated within three years before the date of application; and
 3. Documentation of a passing grade obtained by the applicant on a written hearing aid dispenser examination as required in A.R.S. § 36-1940(C)(4).

Historical Note

Former Section R9-16-203 repealed, new Section R9-16-203 adopted effective January 23, 1978 (Supp. 78-1). Repealed effective March 14, 1994 (Supp. 94-1). Adopted by final rulemaking at 5 A.A.R. 4359, effective October 28, 1999 (Supp. 99-4). Amended by final rulemaking at 10 A.A.R. 2063, effective July 3, 2004 (Supp. 04-2). Section R9-16-203 renumbered to R9-16-202; new Section R9-16-203 made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section R9-16-203 repealed; new Section made by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-204. Initial Application for a Speech-language Pathologist

In addition to complying with R9-16-202(A), an applicant for initial licensure as a speech-language pathologist shall submit to the Department the following:

1. A transcript or equivalent documentation issued to the applicant by an accredited college or university after the applicant's completion of a master's degree consistent with the standards of this state's universities, as required

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- in A.R.S. § 36-1940.01(A)(2)(a) or documentation of current CCC;
2. Completion of a clinical practicum, as required in A.R.S. § 36-1940.01(A)(2)(b) or documentation of current CCC;
3. Documentation of the applicant's completion of the ETS-NESLP as required in A.R.S. § 36-1940.01(A)(3) or documentation of current CCC; and
4. Documentation of the completion of clinical fellowship or documentation of current CCC.

Historical Note

Former Section R9-16-204 repealed, new Section R9-16-204 adopted effective January 23, 1978 (Supp. 78-1).

Repealed effective March 14, 1994 (Supp. 94-1).

Adopted by final rulemaking at 5 A.A.R. 4359, effective October 28, 1999 (Supp. 99-4). Amended by final rulemaking at 10 A.A.R. 2063, effective July 3, 2004 (Supp. 04-2). Section R9-16-204 renumbered to R9-16-209; new Section R9-16-204 made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section R9-16-204 repealed; new Section made by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-205. Initial Application for a Temporary Speech-language Pathologist

- A. In addition to complying with R9-16-202(A), an applicant for initial licensure as a temporary speech-language pathologist shall submit to the Department the following:
 1. A transcript or equivalent documentation issued to the applicant by an accredited college or university after the applicant's completion of a master's degree consistent with the standards of this state's universities, as required in A.R.S. § 36-1940.01(A)(2)(a).
 2. Completion of a clinical practicum, as required in A.R.S. § 36-1940.01(A)(2)(b).
 3. Documentation of the applicant's completion of the ETS-NESLP as required in A.R.S. § 36-1940.01(A)(3).
 4. Documentation of the applicant's clinical fellowship agreement that includes:
 - a. The applicant's name, home address, and telephone number;
 - b. The clinical fellowship supervisor's name, business address, telephone number, and speech-language pathology license number;
 - c. The name and address where the clinical fellowship will take place;
 - d. A statement by the clinical fellowship supervisor agreeing to comply with R9-16-209; and
 - e. The signatures of the applicant and the clinical fellowship supervisor.
- B. A temporary license issued is effective for 12 months from the date of issuance.
- C. A temporary license may be renewed only once.
- D. An applicant issued a temporary speech-language pathologist license shall:
 1. Practice under the supervision of a licensed speech-language pathologist, and
 2. Not practice under the supervision of an individual who has a temporary speech-language pathologist license.

Historical Note

Former Section R9-16-205 repealed, new Section R9-16-205 adopted effective January 23, 1978 (Supp. 78-1).

Repealed effective March 14, 1994 (Supp. 94-1).

Adopted by final rulemaking at 5 A.A.R. 4359, effective

October 28, 1999 (Supp. 99-4). Section R9-16-205 renumbered to R9-16-210; new Section R9-16-205 renumbered from R9-16-206 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section R9-16-205 repealed; new Section made by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-206. Requirements for a Speech-language Pathologist - Limited

In addition to complying with R9-16-202(A), an applicant for initial licensure as a speech-language pathologist - limited as specified in A.R.S. § 36-1940.01(B) shall submit to the Department the following:

1. A certificate in speech and language therapy awarded by the Department of Education.
2. A document representing an employee or contractor relationship with a local education agency or a state supported institution.

Historical Note

Former Section R9-16-206 repealed, new Section R9-16-206 adopted effective January 23, 1978 (Supp. 78-1).

Repealed effective March 14, 1994 (Supp. 94-1).

Adopted by final rulemaking at 5 A.A.R. 4359, effective October 28, 1999 (Supp. 99-4). Amended by final rulemaking at 10 A.A.R. 2063, effective July 3, 2004 (Supp. 04-2). Section R9-16-206 renumbered to R9-16-205; new Section R9-16-206 made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section R9-16-206 repealed; new Section made by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-207. License Renewal

- A. Before the expiration date of a license, a licensee shall submit to the Department:
 1. A renewal application in a Department-provided format that contains:
 - a. The licensee's name, home address, telephone number, and e-mail address;
 - b. If applicable, the licensee's business address and telephone number;
 - c. The licensee's current employment, if applicable, including:
 - i. The employer's name,
 - ii. The licensee's position,
 - iii. Dates of employment,
 - iv. The address of the employer,
 - v. The supervisor's name,
 - vi. The supervisor's email address, and
 - vii. The supervisor's telephone number;
 - d. The licensee's license number and date of expiration;
 - e. Since the previous license application, whether the licensee has been convicted of a felony or a misdemeanor in this or another state;
 - f. If the licensee was convicted of a felony or a misdemeanor:
 - i. The date of the conviction,
 - ii. The state or jurisdiction of the conviction,
 - iii. An explanation of the crime of which the licensee was convicted, and
 - iv. The disposition of the case;

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- g. Whether the licensee has had, within two years before the renewal application date, an audiology or speech-language pathology license suspended or revoked by any state;
- h. If the applicant has been disciplined by any state, territory, or district of this country for an act related to the applicant's license to practice audiology or a speech-language pathologist license that is consistent with A.R.S. Title 36, Chapter 17, documentation that includes:
 - i. The date of the disciplinary action,
 - ii. The state or jurisdiction of the disciplinary action,
 - iii. An explanation of the disciplinary action, and
 - iv. Any other applicable documents, including a legal order or settlement agreement;
- i. An attestation that the licensee completed continuing education required under A.R.S. § 36-1904 and documentation of completion is available upon request;
- j. The licensee agrees to allow the Department to submit supplemental requests for information under R9-16-214(C);
- k. An attestation that the information submitted as part of the application is true and accurate; and
 - l. The licensee's signature and date of signature; and
- 2. A renewal fee specified in R9-16-216.
- B.** A licensee licensed as a speech-language pathologist, whose practice is limited to providing services to students under the authority of a local education agency or state-supported institution, shall provide documentation required in A.R.S. § 36-1940.01(B);
- C.** If a licensee is renewing a temporary speech-language pathology license:
 - 1. A statement signed and dated by the licensee's clinical fellowship supervisor agreeing to comply with R9-16-209; and
 - 2. The name, business address, telephone number, and license number of the speech language pathologist providing supervision to the licensee.
- D.** In addition to subsection (A), a licensee who submits a renewal application within 30 calendar days after the license expiration date shall submit a late fee specified in R9-16-216.
- E.** A licensee who does not submit the documentation and the fee in subsection (A) and, if applicable, (B) within 30 calendar days after the license expiration date shall apply for a new license in R9-16-202.
- F.** If a licensee applies for a license according to R9-16-202 more than 30 calendar days but less than one year after the expiration date of the applicant's previous license, the applicant:
 - 1. Is not required to submit ETSNEA or ETSNESLP documentation, and
 - 2. Shall submit an attestation of continuing education according to R9-16-208, completed within the twenty-four months before the date of application.
- G.** The Department shall review the application for a renewal license according R9-16-214 and Table 2.1.

Historical Note

Former Section R9-16-207 repealed, new Section R9-16-207 adopted effective January 23, 1978 (Supp. 78-1).

Repealed effective March 14, 1994 (Supp. 94-1).

Adopted by final rulemaking at 5 A.A.R. 4359, effective October 28, 1999 (Supp. 99-4). Section R9-16-207 renumbered to R9-16-208; new Section R9-16-207 made

by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section R9-16-207 repealed; new Section made by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-208. Continuing Education

- A.** Twenty-four months prior to submitting a renewal application, a licensee shall complete continuing education.
 - 1. Except as provided in (A)(2), a licensed audiologist shall complete at least 20 continuing education hours related to audiology;
 - 2. A licensed audiologist who fits and dispenses hearing aids shall complete:
 - a. At least 20 continuing education hours related to audiology and hearing aid dispensing, and
 - b. No more than eight continuing education hours required in subsection (A)(2)(a) provided by a single manufacturer of hearing aids; and
 - 3. A licensed speech-language pathologist shall complete at least 20 continuing education hours in speech-language pathology related courses.
- B.** Continuing education shall:
 - 1. Directly relate to the practice of audiology, speech-language pathology, or fitting and dispensing hearing aids;
 - 2. Have educational objectives that exceed an introductory level of knowledge of audiology, speech-language pathology, or fitting and dispensing hearing aids; and
 - 3. Consist of courses that include advances within the last five years in:
 - a. Practice of audiology,
 - b. Practice of speech-language pathology,
 - c. Procedures in the selection and fitting of hearing aids,
 - d. Pre- and post-fitting management of clients,
 - e. Instrument circuitry and acoustic performance data,
 - f. Ear mold design and modification contributing to improved client performance,
 - g. Audiometric equipment or testing techniques that demonstrate an improved ability to identify and evaluate hearing loss,
 - h. Auditory rehabilitation,
 - i. Ethics,
 - j. Federal and state statutes or rules, or
 - k. Assistive listening devices.
- C.** A continuing education course developed, endorsed, or sponsored by one of the following meets the requirements in subsection (B):
 - 1. Hearing Healthcare Providers of Arizona,
 - 2. Arizona Speech-Language-Hearing Association,
 - 3. American Speech-Language-Hearing Association,
 - 4. International Hearing Society,
 - 5. International Institute for Hearing Instruments Studies,
 - 6. American Auditory Society,
 - 7. American Academy of Audiology,
 - 8. Academy of Doctors of Audiology,
 - 9. Arizona Society of Otolaryngology, Head and Neck Surgery,
 - 10. American Academy of Otolaryngology-Head and Neck Surgery, or
 - 11. An organization determined by the Department to be consistent with an organization in subsection (C)(1) through (10).

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Historical Note

Adopted by final rulemaking at 5 A.A.R. 4359, effective October 28, 1999 (Supp. 99-4). Section R9-16-208 renumbered to R9-16-214; new Section R9-16-208 renumbered from R9-16-207 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-209. Clinical Fellowship Supervisors

In addition to complying with the requirements in A.R.S. § 36-1905, a clinical fellowship supervisor shall complete a minimum of 36 supervisory activities throughout an individual's clinical fellowship that include:

1. A minimum of 18 on-site observations,
2. No more than six on-site observations in a 24-hour period, and
3. A minimum of 18 monitoring activities.

Historical Note

Adopted by final rulemaking at 5 A.A.R. 4359, effective October 28, 1999 (Supp. 99-4). Section R9-16-209 renumbered to R9-16-212; new Section R9-16-209 renumbered from R9-16-204 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section R9-16-209 repealed; new Section made by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-210. Requirements for Supervising a Speech-language Pathologist Assistant

A licensed speech-language pathologist who provides direct supervision or indirect supervision to a speech-language pathologist assistant shall comply with A.R.S. § 36-1940.04(F) and (G):

1. Establish a record for each speech-language pathologist assistant who receives direct supervision and indirect supervision from the speech-language pathologist that includes:
 - a. The speech-language pathologist assistant's license number, name, home address, telephone number, and e-mail;
 - b. A plan indicating the types of skills and the number of hours allocated to the development of each skill that the speech-language pathologist assistant is expected to complete;
 - c. A document listing each occurrence of direct supervision or indirect supervision provided to the speech-language pathologist assistant that includes:
 - i. Business name and address where supervision occurred,
 - ii. The date and times when the supervision started and ended,
 - iii. The types of clinical interactions provided, and
 - iv. Notation of speech-language pathologist assistant's progress;
 - d. Documentation of evaluations provided to the speech-language pathologist assistant during the time supervision was provided; and
 - e. Documentation of when supervision was terminated; and
2. Maintain a speech-language pathologist assistant record:
 - a. Throughout the period that the speech-language pathologist assistant receives direct supervision and

indirect supervision clinical interactions from the supervisor; and

- b. For at least two years after the last date the speech-language pathologist assistant received clinical interactions from the supervisor.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2063, effective July 3, 2004 (Supp. 04-2). Section R9-16-210 renumbered to R9-16-215; new Section R9-16-210 renumbered from R9-16-205 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section R9-16-210 repealed; new Section made by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-211. Equipment; Records

- A. A licensee shall maintain equipment used by the licensee in the practice of audiology or the practice of speech-language pathology according to the manufacturer's specifications.
- B. If a licensee uses equipment that requires calibration, the licensee shall ensure that:
 1. The equipment is calibrated a minimum of every 12 months and according to the American National Standard - Specifications for Audiometers S3.6-2018, incorporated by reference and on file with the Department, with no future additions or amendments and available from the Standards Secretariat, c/o Acoustical Society of America, 1305 Walt Whitman Road, Suite 300, Melville, New York, 11747-4300, September 20, 2018; and
 2. A written record of the calibration is maintained in the same location as the calibrated equipment for at least 36 months after the date of the calibration.
- C. A licensee shall maintain the following records according to A.R.S. § 32-3211 for each client for at least 36 months after the date the licensee provided a service or dispensed a product while engaged in the practice of audiology, practice of speech-language pathology, or practice of fitting and dispensing hearing aids:
 1. The client's name, address, and telephone number;
 2. The name or description and the results of each test and procedure used in evaluating speech, language, and hearing disorders or determining the need for dispensing a product or service; and
 3. If a product such as a hearing aid, augmentative communication device, or laryngeal device is dispensed, a record of the following:
 - a. The name of the product dispensed;
 - b. The product's serial number, if any;
 - c. The product's warranty or guarantee, if any;
 - d. The refund policy for the product, if any;
 - e. A statement of whether the product is new or used;
 - f. The total amount charged for the product;
 - g. The name of the licensee; and
 - h. The name of the intended user of the product.

Historical Note

Adopted as an emergency effective July 12, 1982, pursuant to A.R.S. § 41-1003, valid for 90 days (Supp. 82-4). Emergency expired. Permanent rule R9-16-211 adopted effective January 14, 1983 (Supp. 83-1). Repealed effective March 14, 1994 (Supp. 94-1). New Section R9-16-211 made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section R9-16-211 repealed; new Section made by final expedited rulemak-

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ing at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-212. Bill of Sale Requirements

An audiologist who dispenses hearing aids shall provide a bill of sale to a client at the time the audiologist provides a hearing aid to the client or at a time requested by the client that complies with the requirements in R9-16-311(A)(7).

Historical Note

Adopted as an emergency effective July 12, 1982, pursuant to A.R.S. § 41-1003, valid for 90 days (Supp. 82-4). Emergency expired. Permanent rule R9-16-212 adopted effective January 14, 1983 (Supp. 83-1). Repealed effective March 14, 1994 (Supp. 94-1). New Section R9-16-212 renumbered from R9-16-209 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section R9-16-212 repealed; new Section made by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-213. Enforcement

- A. The Department may, as applicable:
 - 1. Deny, revoke, or suspend an audiology or speech-language pathology's license under A.R.S. § 36-1934;
 - 2. Request an injunction under A.R.S. § 36-1937; or
 - 3. Assess a civil money penalty under A.R.S. § 36-1939.
- B. In determining which disciplinary action specified in subsection (A) is appropriate, the Department shall consider:
 - 1. The type of violation,
 - 2. The severity of the violation,
 - 3. The danger to the public health and safety,
 - 4. The number of violations,
 - 5. The number of clients affected by the violations,
 - 6. The degree of harm to the consumer,
 - 7. A pattern of noncompliance, and
 - 8. Any mitigating or aggravating circumstances.
- C. A licensee may appeal a disciplinary action taken by the Department according to A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

Adopted as an emergency effective July 12, 1982, pursuant to A.R.S. § 41-1003, valid for 90 days (Supp. 82-4). Emergency expired. Permanent rule R9-16-213 adopted effective January 14, 1983 (Supp. 83-1). Repealed effective March 14, 1994 (Supp. 94-1). New Section R9-16-213 made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section R9-16-213 repealed; new Section made by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-214. Time-frames

- A. For each type of license issued by the Department under this Article, Table 2.1 specifies the overall time-frame described in A.R.S. § 41-1072(2).
 - 1. An applicant and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame.
 - 2. The extension of the substantive review time-frame and the overall time-frame may not exceed 25% of the overall time-frame.

- B. For each type of license issued by the Department under this Article, Table 2.1 specifies the administrative completeness review time-frame described in A.R.S. § 41-1072(1).
 - 1. The administrative completeness review time-frame begins the date the Department receives an application required in this Article.
 - 2. Except as provided in subsection (B)(3), the Department shall provide a written notice of administrative completeness or a notice of deficiencies to an applicant within the administrative completeness review time-frame.
 - a. If a license application is not complete, the notice of deficiencies listing each deficiency and the information or documentation needed to complete the application.
 - b. A notice of deficiencies suspends the administrative completeness review time-frame and the overall time-frame from the date of the notice until the date the Department receives the missing information or documentation.
 - c. If the applicant does not submit to the Department all the information or documentation listed in the notice of deficiencies within 30 calendar days after the date of the notice of deficiencies, the Department shall consider the application withdrawn.
 - 3. If the Department issues a license during the administrative completeness review time-frame, the Department shall not issue a separate written notice of administrative completeness.
- C. For each type of license issued by the Department under this Article, Table 2.1 specifies the substantive review time-frame described in A.R.S. § 41-1072(3), which begins on the date the Department sends a written notice of administrative completeness.
 - 1. Within the substantive review time-frame, the Department shall provide a written notice to the applicant that the Department approved or denied.
 - 2. During the substantive review time-frame:
 - a. The Department may make one comprehensive written request for additional information or documentation; and
 - b. If the Department and the applicant agree in writing, the Department may make supplemental requests for additional information or documentation.
 - 3. A comprehensive written request or a supplemental request for additional information or documentation suspends the substantive review time-frame and the overall time-frame from the date of the request until the date the Department receives all the information or documentation requested.
 - 4. If the applicant does not submit to the Department all the information or documentation listed in a comprehensive written request or supplemental request for additional information or documentation within 30 calendar days after the date of the request, the Department shall deny the license or approval.
- D. The Department shall issue a regular license or a temporary license:
 - 1. Within five calendar days after receiving the license fee, and
 - 2. From the date of issue, the license is valid for:
 - a. Two years, if a regular license, and
 - b. Twelve months, if a temporary license.
- E. An applicant who is denied a license may appeal the denial according to A.R.S. Title 41, Chapter 6, Article 10.

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Historical Note

Adopted as an emergency effective July 12, 1982, pursuant to A.R.S. § 41-1003, valid for 90 days (Supp. 82-4). Emergency expired. Permanent rule R9-16-214 adopted effective January 14, 1983 (Supp. 83-1). Repealed effective March 14, 1994 (Supp. 94-1). New Section R9-16-214 renumbered from R9-16-208 and amended by

exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section R9-16-214 repealed; new Section made by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

Table 2.1 Time-frames (in calendar days)

Type of Approval	Statutory Authority	Overall Time-Frame	Administrative Completeness Review Time-Frame	Time to Respond to Notice of Deficiency	Substantive Review Time-Frame	Time to Respond to Comprehensive Written Request
Application for an Initial or Temporary License (R9-16-202)	A.R.S. §§ 36-1904 and 36-1940	60	30	30	30	30
License Renewal (R9-16-207)	A.R.S. § 36-1904	60	30	30	30	30

Historical Note

Table 2.1 made by exempt rulemaking under R9-16-209 at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Table 2.1 repealed; new Table 2.1 made and recodified under new Section R9-16-214, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-215. Changes Affecting a License or a Licensee; Request for a Duplicate License

A. A licensee shall submit to the Department a notice in a Department-provided format within 30 calendar days after the effective date of a change in:

1. The licensee's home address or e-mail address, including the new home address or e-mail address;
2. The licensee's name, including a copy of one of the following with the licensee's new name:
 - a. Marriage certificate,
 - b. Divorce decree, or
 - c. Other legal document establishing the licensee's new name; and
3. The place or places, including address or addresses, where the licensee engages in the practice of audiology or speech-language pathology.

B. A licensee may obtain a duplicate license by submitting to the Department a written request for a duplicate license in a format provided by the Department that includes:

1. The licensee's name and address,
2. The licensee's license number and expiration date,
3. The licensee's signature and date of signature, and
4. A duplicate license fee specified in R9-16-216.

Historical Note

New Section R9-16-215 renumbered from R9-16-210 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-216. Fees

A. An applicant shall submit to the Department the following nonrefundable fee for:

1. An initial application as an audiologist, \$100;
2. An initial application as a speech-language pathologist, \$100; and
3. An initial application as a temporary speech-language pathologist, \$100.

B. An applicant shall submit to the Department the following fee for:

1. An initial license as an audiologist, \$200;

2. An initial license as a speech-language pathologist, \$200; and
3. A temporary license as a speech-language pathologist, \$100.

C. A licensee shall submit to the Department the following fee for:

1. A renewal license as an audiologist, \$200;
2. A renewal license as a speech-language pathologist, \$200; and
3. A temporary renewal license as a speech-language pathologist, \$100.

D. If a licensed audiologist or speech-language pathologist submits a renewal license application specified in subsection (C) within 30 calendar days after the license expiration date, the licensee shall submit with the renewal license application a \$25 late fee.

E. The fee for a duplicate license is \$25.

F. An applicant for initial licensure is not required to submit the applicable fee in subsection (A) and (B) if the applicant, as part of the applicable application in R9-16-202, submits an attestation that the applicant meets the criteria for waiver of licensing fees in A.R.S. § 41-1080.01.

Historical Note

New Section made by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

ARTICLE 3. LICENSING HEARING AID DISPENSERS**R9-16-301. Definitions**

In addition to the definitions in A.R.S. § 36-1901, the following definitions apply in this Article unless otherwise specified:

1. "Applicant" means an individual or a business organization that submits an application and required documentation for approval to practice as a hearing aid dispenser.
2. "Business organization" means an entity identified in A.R.S. § 36-1910.
3. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough

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day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.

4. "Continuing education" means a course that provides instruction and training that directly relates to the practice of fitting and dispensing hearing aids specified in A.R.S. § 36-1904.
5. "Designated agent" means an individual who:
 - a. Is authorized by an applicant or hearing aid dispenser [a person] to receive communications from the Department, including legal service of process;
 - b. May file or sign documents on behalf of the applicant or hearing aid dispenser;
 - c. Is a U.S. citizen or legal resident;
 - d. Has an Arizona address; and
 - e. Is a controlling person of the business organization, if applicable.
6. "Disciplinary action" means a proceeding that is brought against a licensee by the Department under A.R.S. § 36-1934 or a state specified in R9-16-308(A)(2).
7. "GED" means a general education development test.
8. "Hearing aid dispenser examination" means one of the following that has been identified by the Department as complying with the requirements in A.R.S. § 36-1924:
 - a. The International Licensing Examination for Hearing Health Professionals, administered by the International Hearing Society; or
 - b. A test provided by the Department or other organization.
9. "Practical examination" means a test:
 - a. Designated by the Department that demonstrates an applicant's proficiency in the practice of fitting and dispensing of hearing aids, and
 - b. Compliant with A.R.S. § 36-1924(A)(4).
10. "State licensing entity" means a state agency or board that approves licensure and takes disciplinary action of individuals or businesses that practice as a hearing aid dispenser.
11. "Temporary hearing aid dispenser" means a person who is licensed under A.R.S. Title 36, Chapter 17 and this Article for a specified period of time under the sponsorship of a hearing aid dispenser also licensed under A.R.S. Title 36, Chapter 17 and this Article.

Historical Note

Section repealed, new Section adopted effective June 25, 1993 (Supp. 93-2). Section amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-302. Examination Requirements

- A. Within two years after the date an applicant receives the approval notification in R9-16-306(B), or a temporary hearing aid dispenser receives the approval in R9-16-305(B), the applicant or temporary hearing aid dispenser shall take and obtain a passing score on the Department-designated:
 1. Written hearing aid dispenser examination required in subsection (B), and
 2. Practical examination required in subsection (B).
- B. An applicant approved to take the Department-designated practical examination or a temporary hearing aid dispenser approved to take the Department-designated practical examination shall:
 1. Arrive on the scheduled date and time of the examination,
 2. Provide proof of identity by a government-issued photographic identification card that is provided by the applicant or temporary hearing aid dispenser upon the request of the individual administering the examination, and
 3. Exhibit ethical conduct during the examination process.

- C. After the Department receives an applicant's Department-designated written hearing aid dispenser examination results, the Department shall notify the applicant of:
 1. A passing score and approval to take the practical examination; or
 2. A failing score that includes, as applicable, approval to retake the written hearing aid dispenser examination.
- D. An applicant or temporary hearing aid dispenser who does not comply with subsection (B)(1) or (B)(2) is ineligible to take the examination on the scheduled date and time.
- E. An applicant or temporary hearing aid dispenser taking the examination will receive a passing score on the examination if the applicant or temporary hearing aid dispenser demonstrates the proficiencies in A.R.S. § 36-1924, as determined by the Department.
- F. After the Department receives an applicant's practical examination results, the Department shall notify the applicant whether the applicant received:
 1. A passing score; or
 2. A failing score and, as applicable, approval to retake the Department-designated practical examination for the examination sections that the applicant failed.
- G. The Department shall notify an applicant or temporary hearing aid dispenser that the applicant or temporary hearing aid dispenser may apply for an initial hearing aid dispenser license when the applicant or temporary hearing aid dispenser has received a passing score on both of the examinations in subsection (A).

Historical Note

Amended effective March 22, 1976 (Supp. 76-2). Section repealed, new Section adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-303. Application

- A. An applicant for licensure shall submit to the Department:
 1. An application in a Department-provided format that contains:
 - a. The applicant's name, home address, telephone number, and e-mail address;
 - b. The applicant's Social Security number, as required under A.R.S. §§ 25-320 and 25-502;
 - c. The applicant's current employment, if applicable, including:
 - i. The employer's name,
 - ii. The licensee's position,
 - iii. Dates of employment,
 - iv. The address of the employer,
 - v. The supervisor's name,
 - vi. The supervisor's email address, and
 - vii. The supervisor's telephone number;
 - d. Whether the applicant has ever been convicted of a felony or a misdemeanor in this or another state or jurisdiction;

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- e. If the applicant was convicted of a felony or misdemeanor:
 - i. The date of the conviction,
 - ii. The state or jurisdiction of the conviction,
 - iii. An explanation of the crime of which the applicant was convicted, and
 - iv. The disposition of the case;
- f. Whether a hearing aid dispenser license issued to the applicant has been suspended or revoked;
- g. Whether the applicant is currently ineligible to apply for a hearing aid dispenser license due to a prior revocation or suspension of the applicant's hearing aid dispenser license;
- h. Whether the applicant has been disciplined by any state, territory or district in this country for an act upon the applicant's hearing aid dispenser license;
- i. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-16-314;
- j. An attestation that the information submitted as part of the application is true and accurate; and
- k. The applicant's signature and date of signature;
- 2. Documentation of the applicant's citizenship or alien status that complies with A.R.S. § 41-1080;
- 3. Documentation that the applicant received a high school diploma, a high school equivalency diploma, an associate degree, or a higher degree;
- 4. Whether a professional license or certificate has been revoked or suspended by another state or jurisdiction;
- 5. If a license for an applicant has been revoked or suspended by any state, documentation that includes:
 - a. The date of the revocation or suspension,
 - b. The state or jurisdiction of the revocation or suspension, and
 - c. An explanation of the revocation or suspension;
- 6. If an applicant is currently ineligible for licensing in any state because of a license revocation or suspension, documentation that includes:
 - a. The date of the ineligibility for licensing,
 - b. The state or jurisdiction of the ineligibility for licensing, and
 - c. An explanation of the ineligibility for licensing;
- 7. If an applicant has been disciplined by any state, territory or district, in this country for an act upon the applicant's hearing aid dispenser license, documentation that includes:
 - a. The date of the disciplinary action,
 - b. The state or jurisdiction of the disciplinary action,
 - c. An explanation of the disciplinary action, and
 - d. Any other applicable documents, including a legal order or settlement agreement; and
- 8. A nonrefundable application fee specified in R9-16-316.
- B.** The Department shall review an application and documentation for approval according to R9-16-314 and Table 3.1.

Historical Note

The Department of Health Services advises that this rule is preempted by Section 521(a) of the federal Food, Drug and Cosmetic Act (21 U.S.C. 360K). See 21 CFR 808.53, effective November 10, 1980 (Supp. 80-6). Section repealed, new Section adopted effective June 25, 1993 (Supp. 93-2). Amended by final rulemaking at 10 A.A.R. 2063, effective July 3, 2004 (Supp. 04-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section

repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-304. Requirements for an Initial Hearing Aid Dispenser License

- A.** An applicant for initial licensure shall submit an application to the Department that includes:
 - 1. The information and documents required in R9-16-303;
 - 2. Documentation of passing the:
 - a. Written hearing aid dispenser examination, and
 - b. Practical examination; and
 - 3. The fees specified in R9-16-316.
- B.** In addition to complying with subsections (A)(1) and (A)(3), an applicant that may be eligible for licensure under A.R.S. § 36-1922 shall submit documentation to the Department that includes:
 - 1. The name of each state that issued the applicant a current hearing aid dispenser license, including:
 - a. The license number of each current hearing aid dispenser license, and
 - b. The date each current hearing aid dispenser license was issued;
 - 2. Documentation of the professional license or certification issued to the applicant by each state in which the applicant holds a professional license or certification;
 - 3. For each state named in subsection (B)(1), a statement, signed and dated by the applicant, attesting that the applicant:
 - a. Has been licensed or certified in another state for at least one year, with a scope of practice consistent with the scope of practice for which licensure is being requested;
 - b. Has met minimum education requirements according to A.R.S. § 36-1923(A);
 - c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
 - d. Does not have a complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct.
- C.** An initial hearing aid dispenser license is valid for two years from the date of issue for licensure by examination or licensure by reciprocity.
- D.** If the Department does not issue an initial hearing aid dispenser license to an applicant, the Department shall return the license fee to the applicant.

Historical Note

Amended effective March 22, 1976 (Supp. 76-2). The Department of Health Services advises that this rule is preempted by Section 521(a) of the federal Food, Drug and Cosmetic Act (21 U.S.C. 360K). See 21 CFR 808.53, effective November 10, 1980 (Supp. 80-6). Section repealed, new Section adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-305. Requirements for an Initial Temporary Hearing Aid Dispenser License

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- A. In addition to complying with R9-16-303, an applicant for a temporary hearing aid dispenser license shall submit to the Department:
1. The sponsor's:
 - a. Name,
 - b. Business address,
 - c. Business telephone number, and
 - d. Arizona hearing aid dispenser license number.
 2. A statement signed by the sponsor that the sponsor is a licensed hearing aid dispenser who agrees to train, supervise, and be responsible for the applicant's hearing aid dispenser practice according to A.R.S. § 36-1905.
- B. If the Department issues a temporary license to the applicant, the Department shall notify the applicant of approval to take the hearing aid dispenser examination as specified in R9-16-302.
- C. A temporary hearing aid dispenser may renew a temporary license according to A.R.S. § 36-1926.
- D. A temporary license is no longer valid on the date the Department receives notice from the sponsor that the sponsor is terminating sponsorship.
- E. A hearing aid dispenser whose temporary license is terminated according to subsection (D):
1. Shall not practice until issued a new license,
 2. May apply for an initial or temporary license as a hearing aid dispenser according to this Article; and
 3. May choose to:
 - a. Complete the two-year test period issued to the applicant with a previous temporary license, or
 - b. Restart the two-year test period on the date the Department approves the hearing aid dispenser's temporary license in subsection (E)(2); and
 4. If the applicant chooses to restart the two-year test period in subsection (3)(b), the previous test result obtained will not apply.
- F. An initial hearing aid dispenser license is valid for 12 months from the date of issue for a temporary license or in compliance with A.R.S. § 36-1926(D).

Historical Note

Section repealed, new Section adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-306. Application for Examination

- A. In addition to complying with R9-16-303, an applicant for initial licensure by examination shall submit an application to the Department that includes:
1. Information and documentation required in R9-16-303, and
 2. The fee in R9-16-316.
- B. If the Department approves the application, the Department shall notify the applicant of approval to take the written hearing aid dispenser examination as specified in R9-16-302.
- C. If the Department approves an application, the applicant shall not practice fitting and dispensing hearing aids without a license issued by the Department.

Historical Note

Adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section

repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-307. Initial Application for a Business Hearing Aid Dispenser License

- A. An applicant for a business hearing aid dispenser license shall submit to the Department:
1. An application in a Department-provided format that contains:
 - a. The name of the business organization;
 - b. The business organization's Arizona business name, address, e-mail address, and telephone number;
 - c. If the business organization has more than one location, provide the name, address, e-mail address, and telephone number for each location;
 - d. The name, address, telephone number, and e-mail address of the individual authorized by the business organization to be the designated agent;
 - e. The name, business telephone number, and Arizona hearing aid dispenser license number of each hearing aid dispenser employed by the business organization in Arizona;
 - f. Whether the business organization or a hearing aid dispenser working for the business organization has had a hearing aid dispenser license suspended or revoked by any state;
 - g. Whether the business organization or a hearing aid dispenser working for the business organization is currently ineligible for licensing in any state due to a suspension or revocation;
 - h. An attestation that the:
 - i. Business organization allows the Department to make supplemental requests for additional information; and
 - ii. Information required as part of the application has been submitted and is true and accurate; and
 - i. The signature and date of signature from the designated agent; and
 2. An application and license fee specified in R9-16-316.
- B. A business organization with more than one location shall submit a duplicate license fee for each additional location according to R9-16-315 and R9-16-316.
- C. The Department shall review an application for an initial business hearing aid dispenser license according to R9-16-314 and Table 3.1.
- D. A business organization licensed according to this Article shall comply with A.R.S. § 36-1910.
- E. An initial license issued to a business organization according to this Section is valid for two years from the date of issue.

Historical Note

Adopted effective June 25, 1993 (Supp. 93-2). Amended by final rulemaking at 10 A.A.R. 2063, effective July 3, 2004 (Supp. 04-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-308. License Renewal

- A. A licensee, except for a temporary hearing aid dispenser, shall submit a renewal application in a Department-provided format that contains:

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1. For an individual licensed as a hearing aid dispenser:
 - a. The licensee's name, home address, telephone number, and e-mail address;
 - b. The licensee's current employment, if applicable, including:
 - i. The employer's name,
 - ii. The licensee's position,
 - iii. Dates of employment,
 - iv. The address of the employer,
 - v. The supervisor's name,
 - vi. The supervisor's email address, and
 - vii. The supervisor's telephone number;
 - c. The licensee's license number and expiration date;
 - d. Since the hearing aid dispenser's previous license application, whether the licensee has been convicted of a felony or a misdemeanor in this or another state or jurisdiction;
 - e. If the licensee was convicted of a felony or misdemeanor:
 - i. The date of the conviction,
 - ii. The state or jurisdiction of the conviction,
 - iii. An explanation of the crime of which the licensee was convicted, and
 - iv. The disposition of the case;
 - f. Whether the licensee has had a license revoked or suspended by any state within the previous two years;
 - g. Whether the licensee is currently ineligible for licensure in any state because of a prior license revocation or suspension;
 - h. Whether the licensee agrees to allow the Department to submit supplemental requests for information under R9-16-314;
 - i. An attestation that the licensee completed continuing education required under A.R.S. § 36-1904 and that documentation of completion is available upon request;
 - j. An attestation that the information required as part of the application has been submitted and is true and accurate; and
 - k. The licensee's signature and date of signature;
 2. Whether the licensee has, within the two years before the date of the application, had:
 - a. A license issued under this Article suspended or revoked; or
 - b. A professional license or certificate revoked by another state or jurisdiction; and
 3. A license renewal fee specified in R9-16-316; or
 4. For a business organization licensed as a hearing aid dispenser:
 - a. The information in subsection R9-16-307(A)(1), and
 - b. A license renewal fee specified in R9-16-316.
- B.** A licensee, except for a temporary hearing aid dispenser, who renews a license within 30 calendar days after the expiration date of the license, shall submit to the Department:
1. The information and renewal fee required in subsection (A), and
 2. A late fee specified in R9-16-316.
- C.** A renewal license issued to a licensee, except for temporary hearing aid dispenser, is valid for two years after the expiration date of the previous license issued by the Department.
- D.** If a licensee does not comply with subsections (A) or (B), the license is nonrenewable and:
1. The hearing aid dispenser may apply for a new license according to subsection (E), or
 2. The business organization may apply for a new license according to R9-16-307.
- E.** A licensee whose license is nonrenewable, according to subsection (D)(1), and is within one year after the expiration date of the hearing aid dispenser's license, the licensee shall submit:
1. The information in R9-16-303(A);
 2. An attestation of continuing education, according to R9-16-309, completed with twenty-four months before the date of the date of application; and
 3. A nonrefundable application fee and a license fee specified in R9-16-316.
- F.** If allowed in R9-16-303, a temporary hearing aid dispenser shall submit at least 30 calendar days before the expiration date on the license, a renewal application to the Department in a Department-provided format that contains:
1. The information in R9-16-303(A);
 2. The applicant's sponsor's:
 - a. Name,
 - b. Business address,
 - c. Business telephone number, and
 - d. Arizona hearing aid dispenser license number;
 3. A statement signed by the sponsor that the sponsor is a licensed hearing aid dispenser who agrees to train, supervise, and be responsible for the applicant's hearing aid dispenser practice according to A.R.S. § 36-1905; and
 4. A license renewal fee specified in R9-16-316.
- G.** A renewal license issued to a licensee according to subsection (F) is valid for one year after the expiration date of the previous license issued by the Department.
- H.** The Department shall review a renewal application according to R9-16-314 and Table 3.1.

Historical Note

Adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-309. Continuing Education

- A.** Twenty-four months prior to submitting a renewal application, a licensee shall complete 24 continuing education hours that includes no more than eight continuing education hours provided by a single manufacturer of hearing aids.
- B.** Continuing education shall:
1. Directly relate to the practice of fitting and dispensing hearing aids;
 2. Have educational objectives that exceed an introductory level of knowledge of fitting and dispensing hearing aids; and
 3. Consist of courses that include advances within the last five years in:
 - a. Procedures in the selection and fitting of hearing aids,
 - b. Pre- and post-fitting management of clients,
 - c. Instrument circuitry and acoustic performance data,
 - d. Ear mold design and modification contributing to improved client performance,
 - e. Audiometric equipment or testing techniques that demonstrate an improved ability to identify and evaluate hearing loss,

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- f. Auditory rehabilitation,
 - g. Ethics,
 - h. Federal and state statutes or rules, or
 - i. Assistive listening devices.
- C. A continuing education course developed, endorsed, or sponsored by one of the following meets the requirements in subsection (B):
1. Hearing Healthcare Providers of Arizona,
 2. Arizona Speech-Language-Hearing Association,
 3. American Speech-Language-Hearing Association,
 4. International Hearing Society,
 5. International Institute for Hearing Instruments Studies,
 6. American Auditory Society,
 7. American Academy of Audiology,
 8. Academy of Doctors of Audiology,
 9. Arizona Society of Otolaryngology, Head and Neck Surgery,
 10. American Academy of Otolaryngology-Head and Neck Surgery, or
 11. An organization determined by the Department to be consistent with an organization in subsection (B)(1) through (10).

Historical Note

Adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-310. Sponsors

- A. A sponsor shall:
1. Provide to a temporary hearing aid dispenser for on-site training and supervision that:
 - a. Consists of coordinating, directing, watching, inspecting, and evaluating the fitting and dispensing activities of the temporary hearing aid dispenser; and
 - b. Directly relates to the type of training and education needed to pass the licensing examination required in A.R.S. § 36-1924;
 2. Maintain a training record that:
 - a. Is signed by the temporary hearing aid dispenser;
 - b. Has the date, time, and content of the training and supervision provided to the temporary hearing aid dispenser, as required in subsection (A)(1); and
 - c. Is available for inspection by the Department for at least 12 months after the end of the sponsorship agreement; and
 3. Not provide sponsorship to more than two temporary hearing aid dispenser licensees at one time.
- B. When a sponsor terminates a sponsorship agreement with a temporary hearing aid dispenser, the sponsor shall:
1. Provide to the temporary hearing aid dispenser a:
 - a. Written notice indicating termination of the sponsorship agreement, and
 - b. Copy of the hearing aid dispenser's records in subsection (A)(2); and
 2. Provide to the Department documentation of the notice required in subsection (B)(1)(a).

Historical Note

Adopted effective June 25, 1993 (Supp. 93-2). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5029, effective September 30, 2001 (Supp. 01-4). New Section

made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-311. Responsibilities of a Hearing Aid Dispenser

- A. A hearing aid dispenser licensed shall:
1. Upon licensure, notify the Department in writing of the address where the hearing aid dispenser practices the fitting and dispensing of hearing aids;
 2. Conspicuously post the license received in the hearing aid dispenser's office or place of business;
 3. Except as specified in subsections (A)(4) or (A)(5), conduct audiometric tests before selecting a hearing aid for a client that provides detailed information about the client's hearing loss, including:
 - a. Type, degree, and configuration of hearing loss;
 - b. Ability, as measured by the percentage of words the client is able to repeat correctly, to discriminate speech; and
 - c. The client's most comfortable and uncomfortable loudness levels in decibels;
 4. Have the option to conduct audiometric testing required in subsection (A)(3) before selling a client a hearing aid if the client provides to the dispenser the information required in subsection (A)(3) from a licensed professional and the information was:
 - a. Obtained within the previous 12 months for an adult, or
 - b. Within the previous six months for an individual under the age of 18;
 5. Have the option to conduct audiometric testing required in subsection (A)(3) if the tests cannot be performed on the client due to:
 - a. The client's young age, or
 - b. A physical or mental disability;
 6. Evaluate the performance characteristics of the hearing aid as it functions on the client's ear for the purpose of assessing the degree of audibility provided by the device and benefit to the client;
 7. Provide a bill of sale to a client according to A.R.S. § 36-1909(A) that contains:
 - a. Information required in A.R.S. § 36-1909;
 - b. A complete description of:
 - i. Warranty information, and
 - ii. The conditions of any offer of a trial period with a money back guarantee or partial refund; and
 - c. The client's signature and date of signature; and
 8. Not:
 - a. Practice without a license according to A.R.S. § 36-1907,
 - b. Commit unlawful acts according to A.R.S. § 36-1936, or
 - c. Commit actions described in A.R.S. § 36-1934(A).
- B. The trial period described in subsection (A)(7)(b)(ii) shall not include any time that the hearing aid is in the possession of the hearing aid dispenser or the manufacturer of the hearing aid.

Historical Note

Adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of

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April 8, 2020 (Supp. 20-2).

R9-16-312. Equipment and Records

- A. A licensee shall maintain an audiometer and other hearing devices according to the manufacturer's specifications.
- B. If a licensee uses equipment that requires calibration, the licensee shall ensure that:
 - 1. The equipment is calibrated at least every 12 months and according to the American National Standard Institution/Acoustical Society incorporated by reference and on file with the Department, with no future additions or amendments, and available from the American National Standards Institution at <http://webstore.ansi.org>; and
 - 2. A written record of the calibration is maintained in the same location as the calibrated equipment for at least 36 months after the date of the calibration.
- C. A licensee shall maintain a record according to A.R.S. § 32-3211 for each client with the following documents for at least 36 months after the date the licensee provided a service or dispensed a product while engaged in the practice of fitting and dispensing hearing aids:
 - 1. The name, address, and telephone number of the individual to whom services are provided;
 - 2. A written statement from a licensed physician that the client has medical clearance to use hearing aids or a medical waiver signed by the client who is 18 years of age or older;
 - 3. For each audiometric test conducted for the client, the:
 - a. Audiometric test results by date and procedure used in evaluating hearing disorders or determining the need for dispensing a product or service,
 - b. Name of the individual who performed the audiometric tests, and
 - c. Signature of the individual who performed the audiometric tests;
 - 4. A copy of the bill of sale required in R9-16-311(A)(7);
 - 5. Documented verification of the effectiveness of the hearing aid required in R9-16-311(A)(6); and
 - 6. The contracts, agreements, warranties, trial periods, or other documents involving the client.

Historical Note

Adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-313. Enforcement

- A. The Department may, as applicable:
 - 1. Deny, revoke, or suspend a license under A.R.S. § 36-1934,
 - 2. Request an injunction under A.R.S. § 36-1937, or
 - 3. Assess a civil money penalty under A.R.S. § 36-1939.
- B. In determining which disciplinary action specified in subsection (A), the Department shall consider:
 - 1. The type of violation,
 - 2. The severity of the violation,
 - 3. The danger to the public health and safety,
 - 4. The number of violations,
 - 5. The number of clients affected by the violations,
 - 6. The degree of harm to the consumer,
 - 7. A pattern of noncompliance, and
 - 8. Any mitigating or aggravating circumstances.

- C. A licensee may appeal a disciplinary action taken by the Department according to A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

Adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-314. Time-frames

- A. For each type of license issued by the Department under this Article, Table 6.1 specifies the overall time-frame described in A.R.S. § 41-1072(2).
 - 1. An applicant or licensee and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame.
 - 2. The extension of the substantive review time-frame and overall time-frame may not exceed 25% of the overall time-frame.
- B. For each type of license issued by the Department under this Article, Table 6.1 specifies the administrative completeness review time-frame described in A.R.S. § 41-1072(1).
 - 1. The administrative completeness review time-frame begins on the date the Department receives an application required in this Article.
 - 2. Except as provided in subsection (B)(3), the Department shall provide written notice of administrative completeness or a notice of deficiencies to an applicant within the administrative completeness review time-frame.
 - a. If an application and required documentation is not complete, the notice of deficiencies shall list each deficiency and the information or documentation needed to complete the application.
 - b. A notice of deficiencies suspends the administrative completeness review time-frame and the overall time-frame from the date of the notice until the date the Department receives the missing information or documentation.
 - c. If the applicant does not submit to the Department all the information or documentation listed in the notice of deficiencies within 30 calendar days after the date of the notice of deficiencies, the Department shall consider the application withdrawn.
 - 3. If the Department issues a license during the administrative completeness review time-frame, the Department shall not issue a separate written notice of administrative completeness.
- C. For each type of license issued by the Department under this Article, Table 6.1 specifies the substantive review time-frame described in A.R.S. § 41-1072(3), which begins on the date the Department sends a written notice of administrative completeness.
 - 1. Within the substantive review time-frame, the Department shall provide written notice to the applicant that the Department approved or denied the application.
 - 2. During the substantive review time-frame:
 - a. The Department may make one comprehensive written request for additional information or documentation; and
 - b. If the Department and the applicant agree in writing, the Department may make supplemental requests for additional information or documentation.

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3. A comprehensive written request or a supplemental request for additional information or documentation suspends the substantive review time-frame and the overall time-frame from the date of the request until the date the Department receives all the information or documentation requested.
4. If the applicant does not submit to the Department all the information or documentation listed in a comprehensive written request or supplemental request for additional information or documentation within 30 calendar days

after the date of the request, the Department shall deny the license.

- D. An applicant who is denied a license may appeal the denial according to A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

Adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

Table 3.1. Time-frames (in calendar days)

Type of Approval	Statutory Authority	Overall Time-frame	Administrative Completeness Review Time-frame	Time to Respond to Notice of Deficiency	Substantive Review Time-frame	Time to Respond to Comprehensive Written Request
Initial Application for a Hearing Aid Dispenser	A.R.S. §§ 36-1904, 36-1923	60	30	30	30	30
Initial Application for a Business Organization	A.R.S. § 36-1910	60	30	30	30	30
License Renewal	A.R.S. § 36-1904	60	30	30	30	30

Historical Note

Table 3.1 renumbered from Table 1 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Table 3.1 repealed; new Table 3.1 made and recodified under R9-16-314 by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-315. Change Affecting a License or a Licensee; Request for Duplicate License

- A. A hearing aid dispenser licensee or temporary hearing aid dispenser licensee shall submit a written notice to the Department in writing within 30 calendar days after the effective date of a change in:
 1. The licensee's home address or e-mail address, including the new home address or e-mail address;
 2. The licensee's name, including a copy of one of the following with the licensee's new name:
 - a. Marriage certificate,
 - b. Divorce decree, or
 - c. Other legal document establishing the licensee's new name; or
 3. The place or places where the licensee engages in the practice of hearing aid dispensing, including the address or addresses of the place or places where the licensee engages in the practice of hearing aid dispensing.
- B. A licensee may obtain a duplicate license by submitting to the Department a request for a duplicate license in a Department-provided format that includes:
 1. The licensee's name and address,
 2. The licensee's license number and expiration date,
 3. The licensee's signature and date of signature, and
 4. A duplicate license fee specified in R9-16-316.
- C. A business hearing aid dispenser licensee shall submit a written notice to the Department within 30 calendar days after the licensee:
 1. Has a change in the information provided in R9-16-307(A)(1)(b).
 2. Closes a location specified in R9-16-307(A)(1)(b) and (c), including the location address.
 3. Begins operating at new location, not specified in R9-16-307(A)(1)(c), including the new location address.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2688, effective June 7, 2002 (Supp. 02-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

Table 1. Renumbered**Historical Note**

Table 1 made by final rulemaking at 8 A.A.R. 2688, effective June 7, 2002 (Supp. 02-2). Table 1 renumbered to Table 3.1 by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2).

R9-16-316. Fees

- A. An applicant shall submit to the Department the following fee for:
 1. A nonrefundable initial application, \$100;
 2. An initial license for a regular or business hearing aid dispenser, \$200;
 3. A renewal application for temporary hearing aid dispenser license, \$100.
 4. A regular or business hearing aid dispenser licensee for a renewal license, \$200.
- B. If a renewal application is submitted within 30 calendar days after the license expiration date, a licensee shall submit with the renewal application a \$25 late fee.
- C. The fee for a duplicate license is \$25.
- D. An applicant, who is not a business organization, for initial licensure is not required to submit the applicable fee in subsection (A) if the applicant, as part of the applicable application in R9-16-303 or R9-16-306, submits an attestation that the appli-

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cant meets the criteria for waiver of licensing fees in A.R.S. § 41-1080.01.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2063, effective July 3, 2004 (Supp. 04-2). Historical note corrected to reflect the rulemaking action on file and effective with the 04-2 supplement (Supp. 05-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-317. Repealed**Historical Note**

New Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

ARTICLE 4. REGISTRATION OF ENVIRONMENTAL HEALTH SANITARIANS**R9-16-401. Definitions**

The following definitions apply in this Article, unless otherwise specified:

1. "Accredited" means that an educational institution is recognized by the U.S. Department of Education as providing standards necessary to meet acceptable levels of quality for its graduates to gain admission to other reputable institutions of higher learning or to achieve credentials for professional practice.
2. "Administrative completeness review time-frame" has the same meaning as in A.R.S. § 41-1072.
3. "Applicant" means an individual who submits an application packet or renewal application packet for registration as an environmental health sanitarian.
4. "Application packet" means the information, documents, and fees required by the Department to:
 - a. Determine eligibility to take a sanitarian examination, and
 - b. Be registered as an environmental health sanitarian.
5. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run and including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
6. "Continuing education" means a course that provides instruction and training that is designed to develop or improve a registered environmental health sanitarian's professional competence in disciplines directly related to the practice of a registered environmental health sanitarian.
7. "Continuing education hour" means 50 to 60 minutes of continuous course work.
8. "Course" means a workshop, seminar, lecture, conference, or other learning program activities as approved by the Department.
9. "Department" means the Arizona Department of Health Services established in A.R.S. § 36-104 and the Sanitarians Council established in A.R.S. § 36-136.01.
10. "Environmental health" means the science and practice of preventing human injury and illness and promoting well-being by identifying sources that produce potential hazardous physical, chemical, and biological agents in air, water, soil, food, and other conditions; and eliminating or minimizing exposure to the sources that adversely affect or may adversely affect human health.
11. "Environmental health sanitarian aide" means an individual who performs and assists with environmental health services as described and under the supervision of an individual in R9-16-403.
12. "Hazardous environmental agent" means a material, whether liquid, solid, gas, or sludge, that contains properties that make the material potentially harmful to public health or the environment.
13. "Immediate family member" means an individual related by birth, marriage, or adoption.
14. "License or licensed" means a permit, certificate, or similar form of approval issued by a state agency according to state law that an individual may practice in the profession indicated by the approval.
15. "Natural science" means a branch of science that deals with the physical world, including life, physical, and health sciences.
16. "Overall time-frame" has the same meaning as in A.R.S. § 41-1072.
17. "Practice of a registered environmental health sanitarian" means acting under the authority of R9-16-402.
18. "Registered environmental health sanitarian" means the same as a "registered sanitarian" in A.R.S. § 36-136.01.
19. "Renewal application packet" means the information, documents, and fees required by the Department to apply for a renewal registration as an environmental health sanitarian.
20. "Sanitarian examination" means a test that consists of questions related to environmental health including natural sciences, facility and system inspections, investigations, compliance, responding to emergencies, and promoting environmental public health awareness.
21. "Semester credit" means one earned academic unit of study or equivalent, with a grade of "C" or better, at an accredited college or university by:
 - a. Attending a 50 to 60 minute class session each calendar week for at least 16 weeks, or
 - b. Completing practical work for a class as determined by the accredited college or university.
22. "Substantive review time-frame" has the same meaning as in A.R.S. § 41-1072.
23. "Supervision" means being responsible for and providing direction to an individual who:
 - a. Performs and assists a registered environmental health sanitarian with environmental health services as described in R9-16-403, and
 - b. Is employed as an environmental health sanitarian aide in a position directly related to environmental health.
24. "Testing center" means a facility, approved by the Department that provides a proctored computer-based sanitarian examination.

Historical Note

Adopted effective September 29, 1976 (Supp. 76-4). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective September 30, 2001 (Supp. 01-4). New Section made by final rulemaking at 8 A.A.R. 2444, effective

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May 16, 2002 (Supp. 02-2). Amended by final rulemaking at 10 A.A.R. 3004, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 23 A.A.R. 3038, effective October 5, 2017 (Supp. 17-4). Amended by final rulemaking at 26 A.A.R. 1875, with an immediate effective date of September 2, 2020 (Supp. 20-3).

R9-16-402. Eligibility and Responsibilities for a Registered Environmental Health Sanitarian

- A.** An individual is eligible to be a registered environmental health sanitarian, if the individual meets at least one of the following:
1. Has completed at least 30 semester credits at an accredited college or university in the natural sciences or the equivalent credits from a college or university from outside the United States or its territories verified by a Department-approved third party evaluation service;
 2. Has completed at least five years of employment as a sanitarian aide in a position directly related to environmental health;
 3. Has completed at least five years of active military service in the field of environmental health;
 4. Is currently licensed as a sanitarian in another jurisdiction, has passed a sanitarian examination that is equivalent to this state's examination as specified in A.R.S. § 36-136.01, and has completed at least one of the requirements identified in subsections (A)(1), (2), or (3); or
 5. Has received a copy of official sanitarian examination test results from a testing center that contains the sanitarian examination test results with a score of 70% or more and has completed at least one of the requirements identified in subsections (A)(1), (2), or (3).
- B.** An individual who is eligible to be a registered environmental health sanitarian according to subsection (A)(1) through (3) shall pass a sanitarian examination administered by a testing center.
- C.** The practice of a registered environmental health sanitarian may include:
1. Investigate, sample, measure, and assess hazardous environmental agents;
 2. Recommend and apply protective interventions that control hazards to health;
 3. Develop, promote, and enforce guidelines, policies, rules, statutes, and regulations;
 4. Perform system analysis;
 5. Interpret research utilizing science and evidence to understand the relationship between health and environment; or
 6. Interpret data and prepare technical summaries and reports.
- D.** A registered environmental health sanitarian shall:
1. Comply with A.R.S. § 41-1009;
 2. Comply with A.A.C. Title 9, Chapter 8; and
 3. Review and, as applicable, sign reports prepared by a sanitarian aide.

Historical Note

Adopted effective September 29, 1976 (Supp. 76-4). Amended effective April 12, 1985 (Supp. 85-2). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2). Amended by final rulemaking at 10 A.A.R. 3004, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 23 A.A.R. 3038, effective October 5, 2017 (Supp. 17-4). Amended by final rulemaking at 26 A.A.R. 1875, with an immediate effective date of September 2,

2020 (Supp. 20-3).

R9-16-403. Requirements for an Environmental Health Sanitarian Aide

- A.** An environmental health sanitarian aide may perform and assist in any of the following environmental health services:
1. Inspections related to food establishments, food processing, food distribution, sewage and refuse disposal, water supplies, hotels, motels, campground, swimming pools, and other related public facilities regulated under A.A.C. Title 9, Chapter 8;
 2. Investigations of complaints to ensure compliance with environmental regulations;
 3. Routine samplings of water, sewage, food, and other samples for analysis; or
 4. Application of ordinances, codes, rules, and regulations governing public health.
- B.** An environmental health sanitarian aide shall:
1. Have reports reviewed by a registered environmental health sanitarian;
 2. Not approve or disapprove the operation of an establishment under A.A.C. Title 9, Chapter 8; and
 3. Not sign on behalf of a registered environmental health sanitarian.
- C.** A sanitarian aide, who has completed at least five years of employment as an environmental health sanitarian aide in a position directly related to environmental health, may apply for registration as an environmental health sanitarian according to R9-16-405.
- D.** An individual who provides supervision to an environmental health sanitarian aide shall:
1. Ensure that the number of hours and type of supervision in providing environmental health services is consistent with:
 - a. The sanitarian aide's skills and experience,
 - b. The setting where the environmental health services are provided, and
 - c. The tasks assigned;
 2. Establish a record for the environmental health sanitarian aide who receives supervision that includes:
 - a. The sanitarian aide's name, address, e-mail address, and telephone number;
 - b. A plan indicating the types of skills and the number of hours allocated to the development of each skill that the environmental health sanitarian aide is expected to complete;
 - c. Documentation of evaluations provided to the environmental health sanitarian aide during the time supervision was provided; and
 - d. Documentation of when supervision began and ended; and
 3. Maintain a sanitarian aide's record throughout the period that the environmental health sanitarian aide received supervision.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2). Former R9-16-403 renumbered to R9-16-404; new R9-16-403 made by final rulemaking at 10 A.A.R. 3004, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 23 A.A.R. 3038, effective October 5, 2017 (Supp. 17-4).

R9-16-404. Continuing Education Requirements; Continuing Education Deferral; and Renewal Extension

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- A.** A registered environmental health sanitarian shall complete 12 continuing education hours during the 12 months prior to December 31 of each calendar year, unless the registered environmental health sanitarian:
1. Has been a registered environmental health sanitarian for less than 12 months as indicated on the renewal application;
 2. Was prevented from completing continuing education according to subsection (A) due to a personal or immediate family member's illness during at least six continuous months of the preceding 12 months; or
 3. Was called to active military service.
- B.** Except for a registered environmental health sanitarian in subsection (A)(1) and (3), by November 1 of each calendar year, a registered environmental health sanitarian may request to defer continuing education by submitting:
1. A request in a Department-provided format that contains:
 - a. The registered environmental health sanitarian's name, address, e-mail address, and telephone number;
 - b. The registered environmental health sanitarian's registration number;
 - c. A statement regarding the registered environmental health sanitarian's personal or immediate family member's illness;
 - d. Indicate the number of continuing education hours requesting to defer;
 - e. An attestation that the Department is authorized to verify all information provided in the continuing education deferral request; and
 - f. The registered environmental health sanitarian's signature, including date of signature;
 2. Documentation that verifies the duration of the registered environmental health sanitarian's personal or immediate family member's illness from the physician treating or who treated the registered environmental health sanitarian's personal or immediate family member's illness; and
 3. If a registered environmental health sanitarian has completed any continuing education hours, report the completed continuing education hours according to R9-16-406(D)(1)(h).
- C.** A registered environmental health sanitarian that deferred continuing education in subsection (B) shall obtain:
1. The deferred continuing education by the end of the subsequent renewal year, and
 2. The continuing education required in subsection (A) for the current renewal year.
- D.** A registered environmental health sanitarian called to active military service:
1. Shall submit:
 - a. Written notice for renewal extension to the Department that includes:
 - i. The registered environmental health sanitarian's name, address, e-mail address, and telephone number;
 - ii. The registered environmental health sanitarian's registration number;
 - iii. A statement stating the reason for the notice of renewal extension; and
 - iv. The registered environmental health sanitarian's signature, including date of signature; and
 - b. A copy of the registered environmental health sanitarian's deployment documentation;
 2. Retains registration as an environmental health sanitarian for the term of service or deployment plus 180 calendar days;
 3. Defers the requirement for completing the continuing education for the term of service or deployment plus 180 calendar days; and
 4. Shall submit a renewal application packet according to R9-16-406 after the term of service or deployment plus 180 calendar days.
- E.** The Department shall review the request to defer continuing education submitted in subsection (B) for approval according to R9-16-407 and Table 4.1.
- F.** If the Department denies a registered environmental health sanitarian's request to defer continuing education, the registered environmental health sanitarian shall submit the required continuing education hours in subsection (A) according to R9-16-406(D)(1)(h).

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2). Former R9-16-404 renumbered to R9-16-406; new R9-16-404 renumbered from R9-16-403 and amended by final rulemaking at 10 A.A.R. 3004, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 23 A.A.R. 3038, effective October 5, 2017 (Supp. 17-4).

R9-16-405. Application for Sanitarian Examination and Registration

- A.** An individual may apply to take the sanitarian examination for registration as a sanitarian if the individual meets one of the eligibility requirements in R9-16-402(A)(1) through (A)(3).
- B.** At least seven calendar days before a Sanitarians Council meeting, an applicant for environmental health sanitarian registration shall submit an application packet to the Department containing:
1. The following information in a Department-provided format:
 - a. The applicant's name, address, e-mail address, and telephone number;
 - b. If applicable, applicant's former names;
 - c. The applicant's social security number, required under A.R.S. §§ 25-320 and 25-502;
 - d. If applicable, the applicant's current employment information:
 - i. The employer's name, address, e-mail address, and telephone number;
 - ii. The applicant's position title; and
 - iii. The applicant's employment start date;
 - e. If an applicant meets the eligibility requirement in R9-16-402(A)(1), the following for each college or university where the applicant completed semester credits or the equivalent credits from a college or university:
 - i. The college or university's name, address, e-mail address, and telephone number;
 - ii. The number of natural science semester credits completed; and
 - iii. If applicable, the degree obtained;
 - f. If an applicant meets the eligibility requirement in R9-16-402(A)(2), the following for each employer during the five years the applicant was employed as a sanitarian aide:
 - i. The employer's name, address, e-mail address, and telephone number;

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- ii. The name, title, e-mail address, and telephone number of a contact individual for the employer;
- iii. The applicant's position and description of responsibilities; and
- iv. The months and years of employment;
- g. If an applicant meets the eligibility requirement in R9-16-402(A)(3), the following for each active military service assignment during the five years the applicant held a military job position in the field of environmental health:
 - i. The military branch name, address, e-mail address, and telephone number;
 - ii. The name, title, e-mail address, and telephone number of a contact individual from the military branch;
 - iii. The applicant's military job position and description of responsibilities; and
 - iv. The months and years of active military service assignments;
- h. If an applicant meets the eligibility requirement in R9-16-402(A)(4), the following for a sanitarian licensed in another state or jurisdiction:
 - i. The state, county, and city that issued the applicant's current license as a sanitarian;
 - ii. The testing organization that administered the sanitarian examination;
 - iii. The name of the sanitarian examination;
 - iv. The sanitarian examination administration date;
 - v. The number of sanitarian examination questions;
 - vi. The sanitarian examination score;
 - vii. The other eligibility requirement in R9-16-402(A)(1) through (A)(3) met by the applicant; and
 - viii. As applicable, the information required in subsection (B)(1)(e), (f), or (g);
- i. If an applicant meets the eligibility requirement in R9-16-402(A)(5), an applicant shall provide the following information:
 - i. The name of the testing center;
 - ii. The date the sanitarian examination was completed;
 - iii. The sanitarian examination score; and
 - iv. As applicable, the information required in subsection (B)(1)(e), (f), or (g);
- j. Whether the applicant is or has been licensed as a sanitarian in another state or jurisdiction;
- k. Whether the applicant has had an application for licensure as a sanitarian denied in a state or jurisdiction;
- l. If the applicant has had an application for licensure as a sanitarian denied, the:
 - i. Reason for denial;
 - ii. Date of the denial; and
 - iii. Name, address, and telephone number of the licensing agency that denied the applicant's application;
- m. Whether the applicant has had a license as a sanitarian suspended or revoked by a state or jurisdiction or entered into a consent agreement with a state or jurisdiction;
- n. If the applicant has had a license as a sanitarian suspended or revoked or entered into a consent agreement, the:
 - i. Reason for the suspension, revocation, or consent agreement;
 - ii. Date of the suspension, revocation, or consent agreement; and
 - iii. Name, address, and telephone number of the licensing agency that suspended, revoked, or entered into a consent agreement with the applicant;
- o. Whether the applicant has been convicted of a felony or a misdemeanor related to the functions of the applicant's employment or occupation as a sanitarian in this state or another state;
- p. If the applicant has been convicted of a felony or a misdemeanor in subsection (B)(1)(o):
 - i. The date of the conviction,
 - ii. The state or jurisdiction of the conviction,
 - iii. An explanation of the crime of which the applicant was convicted, and
 - iv. The disposition of the case;
- q. Whether the applicant agrees to allow the Department to submit supplemental requests for additional information or documentation in R9-16-407;
- r. An attestation that:
 - i. The applicant authorizes the Department to verify all information provided in the application packet, and
 - ii. The information submitted as part of the application packet is true and accurate; and
- s. The applicant's signature and date of signature;
- 2. In addition to the application in subsection (B)(1), the following:
 - a. A copy of applicant's Social Security card;
 - b. Proof of U.S. citizenship or alien status according to A.R.S. § 41-1080;
 - c. If applicable, a copy of an applicant's sanitarian license issued by another state or jurisdiction;
 - d. If an official transcript is issued by a college or university from outside of the United States or its territories, documentation from a third party evaluation service verifying equivalent credits identified in subsection (B)(1)(e);
 - e. If applicable, a letter verifying an applicant's start and end dates of employment for each employer identified in subsection (B)(1)(f);
 - f. If applicable, a letter verifying an applicant's start and end dates of the military job position for each active military service assignment identified in subsection (B)(1)(g);
 - g. If applicable, documentation of the completed sanitarian examination, including the sanitarian examination test results, from the testing center or jurisdiction that administered the sanitarian examination required by another state or jurisdiction in subsection (B)(1)(h); and
 - h. If applicable, a copy of the official notice from a testing center in subsection (B)(1)(i); and
- 3. The nonrefundable \$25 application fee.
- C. If an official transcript documents natural science semester credit hours identified in subsection (B)(1)(e), an applicant shall instruct the college or university to send the official transcript to the Department.

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- D.** The Department shall review an application packet for an applicant to take a sanitarian examination according to R9-16-407 and Table 4.1.
- E.** The Department shall review a sanitarian examination for an applicant licensed by another state or jurisdiction for approval for the applicant to practice as a registered environmental health sanitarian according to R9-16-407 and Table 4.1.
- F.** An applicant approved to take a sanitarian examination shall:
1. Select a testing center,
 2. Take a scheduled sanitarian examination administered by the testing center,
 3. Pass the sanitarian examination with a score of 70% or more and submit a copy of the applicant's official sanitarian examination test results to the Department.
- G.** The Department shall review an application packet for approval for an applicant to practice as a registered environmental health sanitarian according to R9-16-407 and Table 4.1.
- H.** An applicant, who does not submit a copy of official sanitarian examination test results to the Department in subsection (F) within six months after the date that the applicant received the notice of approval to take the sanitarian examination, shall submit a new application packet according to R9-16-405(B).
- I.** An applicant, who submits a copy of official sanitarian examination test results to the Department in subsection (F) within six months after the date that the applicant received the notice of approval to take the sanitarian examination and does not score 70% or more, shall:
1. Have 12 months from the date of the approval letter the applicant received from the Department to provide a copy of official sanitarian examination test results in subsection (F); and
 2. Comply with subsection (F)(1) through (F)(3) to retake the sanitarian examination.
- Historical Note**
- Adopted effective September 29, 1976 (Supp. 76-4). Amended effective April 12, 1985 (Supp. 85-2). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective September 30, 2001 (Supp. 01-4). New Section made by final rulemaking at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2). Former R9-16-405 renumbered to R9-16-407; new R9-16-405 made by final rulemaking at 10 A.A.R. 3004, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 23 A.A.R. 3038, effective October 5, 2017 (Supp. 17-4). Amended by final rulemaking at 26 A.A.R. 1875, with an immediate effective date of September 2, 2020 (Supp. 20-3).
- R9-16-406. Application for Renewal Registration**
- A.** Except as provided in R9-16-404(D), a registered environmental health sanitarian shall submit an application packet for registration renewal on or before December 31 of each calendar year.
- B.** A registered environmental health sanitarian who does not submit a renewal application packet by December 31 has a grace period until February 15 to submit a renewal application packet.
- C.** A registered environmental health sanitarian, who does not submit a renewal application packet by February 15, shall not practice as a registered environmental health sanitarian.
- D.** By December 31 of each calendar year, an applicant shall submit to the Department a renewal application packet containing:
1. The following information in a Department-provided format:
 - a. The applicant's name, address, e-mail address, and telephone number;
 - b. The applicant's environmental health sanitarian registration number;
 - c. Whether the applicant, since the applicant last submitted an application packet or renewal application packet, has had a license as a sanitarian suspended or revoked by a state or jurisdiction or entered into a consent agreement with another jurisdiction;
 - d. If the applicant has had a license as a sanitarian suspended or revoked or entered into a consent agreement with another jurisdiction, the:
 - i. Reason for the suspension, revocation, or consent agreement;
 - ii. Date of the suspension, revocation, or consent agreement; and
 - iii. Name, address, and telephone number of the licensing agency that suspended, revoked, or entered into a consent agreement;
 - e. Whether the applicant, since the applicant last submitted a renewal application packet, has been convicted of a felony or a misdemeanor related to the applicant's employment or occupation as a sanitarian in this state or another jurisdiction;
 - f. If the applicant has been convicted of a felony or a misdemeanor as stated according to subsection (D)(1)(e):
 - i. The date of the conviction,
 - ii. The state or jurisdiction of the conviction,
 - iii. An explanation of the crime of which the applicant was convicted, and
 - iv. The disposition of the case;
 - g. Whether the applicant requested to defer continuing education due to a personal or immediate family member's illness according to R9-16-404(B);
 - h. Except for a registered environmental health sanitarian in R9-16-404(A), for each continuing education course completed during the previous 12 months, the following:
 - i. The course title,
 - ii. A course description,
 - iii. The name of the individual providing the continuing education course,
 - iv. The date the continuing education course was completed, and
 - v. The total number of continuing education hours attended;
 - i. Whether the applicant has been a registered environmental health sanitarian for less than 12 months according to R9-16-404(A)(1);
 - j. An attestation that:
 - i. The applicant affirms that the continuing education courses specified according to subsection (h) are applicable and consistent with the Department's approved continuing education courses or with the practice of a registered environmental sanitarian described in R9-16-402(C);
 - ii. The applicant authorizes the Department to verify all information provided in the renewal application packet; and

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- iii. The information submitted as part of the renewal application packet is true and accurate; and
 - k. The applicant's signature and date of signature;
 - 2. If applicable, a copy of the approved request to defer continuing education, and
 - 3. The \$10 renewal application fee.
- E. If a registered environmental health sanitarian does not submit a renewal application packet in subsection (D) by February 15:
 - 1. The registered environmental health sanitarian's registration expires on February 16; and
 - 2. Before practicing as a registered environmental health sanitarian, a registered environmental health sanitarian whose environmental health sanitarian registration expired shall submit a new application packet according to R9-16-405.
- F. The Department shall review the renewal application packet for approval of registration as an environmental health sanitarian according to R9-16-407 and Table 4.1.

Historical Note

Adopted effective September 29, 1976 (Supp. 76-4). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2). Former R9-16-406 renumbered to R9-16-408; new R9-16-406 renumbered from R9-16-404 by final rulemaking at 10 A.A.R. 3004, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 23 A.A.R. 3038, effective October 5, 2017 (Supp. 17-4).

R9-16-407. Time-frames

- A. The overall time-frame begins, for:
 - 1. A sanitarian examination approval, on the date the Department receives an application packet in R9-16-405;
 - 2. An environmental health sanitarian registration approval, on the date the Department receives the applicant's sanitarian examination test results administered by:
 - a. A testing center described in R9-16-405(B)(1)(i) or (F), or
 - b. A testing organization or jurisdiction that administered the sanitarian examination required by another state or jurisdiction described in R9-16-405(B)(1)(h);
 - 3. A continuing education deferral approval, on the date the Department receives the continuing education deferral request in R9-16-404; and
 - 4. A renewal registration approval, on the date the Department receives a renewal application packet in R9-16-406.
- B. The applicant and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame. The substantive review time-frame and the overall time-frame may not be extended by more than 25% of the overall time-frame.
- C. Within the administrative completeness review time-frame in Table 4.1, the Department shall:
 - 1. Provide a notice of administrative completeness to an applicant; or
 - 2. Provide a notice of deficiencies to an applicant, including a list of the missing information or documents.
- D. If the Department provides a notice of deficiencies to an applicant:
 - 1. The administrative completeness review time-frame and the overall time-frame are suspended after the date of the notice of deficiencies until the date the Department receives the missing information or documents from the applicant;
- 2. If the applicant submits the missing information or documents to the Department within the time-frame in Table 4.1, the substantive review time-frame resumes on the date the Department receives the missing information or documents; and
- 3. If the applicant does not submit the missing information or documents to the Department within the time-frame in Table 4.1, the Department shall consider the application or the request withdrawn.
- E. If the Department issues a registration or notice of an approval during the administrative completeness review time-frame, the Department may not issue a separate written notice of administrative completeness.
- F. Within the substantive review time-frame specified in Table 4.1, the Department:
 - 1. Shall approve an:
 - a. Applicant's request for registration as an environmental health sanitarian or
 - b. Applicant, who did not score 70% or more on the sanitarian examination, to resubmit a sanitarian examination according to R9-16-405(I);
 - 2. Shall deny an applicant's request for registration as an environmental health sanitarian;
 - 3. May make a written comprehensive request for additional information or documentation; and
 - 4. May make supplemental requests for additional information and documentation if agreed to by the applicant.
- G. If the Department provides a written comprehensive request for additional information or documentation or a supplemental request to the applicant:
 - 1. The substantive review time-frame and overall time-frame are suspended from the date of the written comprehensive request or supplemental request until the date the Department receives the information and documents requested; and
 - 2. The applicant shall submit to the Department the information and documents listed in the written comprehensive request within 15 calendar days after the date of the written comprehensive request or supplemental request.
- H. The Department shall issue:
 - 1. An approval to an applicant who submits:
 - a. An application packet to take a sanitarian examination that complies with the requirements in R9-16-405;
 - b. An application packet and a sanitarian examination with a score of 70% or more from a testing center that complies with the requirements in R9-16-405;
 - c. An application packet and a sanitarian examination test results from the testing organization or jurisdiction that administered the sanitarian examination that complies with the requirements in R9-16-405;
 - d. A continuing education deferral request that complies with the requirements in R9-16-404; and
 - e. An application for renewal registration that complies with the requirements R9-16-406; or
 - 2. A denial to an applicant, including the reason for the denial and the appeal process in A.R.S. Title 41, Chapter 6, Article 10, if:
 - a. The applicant does not submit all of the information and documentation listed in a written comprehensive request or supplemental request for additional information or documentation; or

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- b. The applicant does not comply with A.R.S. § 36-136.01 and this Article.

Historical Note

Adopted effective September 29, 1976 (Supp. 76-4). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2). Former R9-16-407 renumbered to R9-16-409; new R9-16-

407 renumbered from R9-16-405 and amended by final rulemaking at 10 A.A.R. 3004, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 23 A.A.R. 3038, effective October 5, 2017 (Supp. 17-4). Amended by final rulemaking at 26 A.A.R. 1875, with an immediate effective date of September 2, 2020 (Supp. 20-3).

Table 4.1. Time-frames (in calendar days)

Type of Approval	Statutory Authority	Overall Time-frame	Administrative Completeness Review Time-frame	Time to Respond to Deficiency Notice	Substantive Review Time-frame	Time to Respond to Written Comprehensive Request
Sanitarian Examination (R9-16-405)	A.R.S. § 36-136.01(B)	150	30	30	120	15
Initial Registration (R9-16-405)	A.R.S. § 36-136.01(B)	40	10	15	30	15
Registration by Reciprocity (R9-16-405)	A.R.S. § 36-136.01(C)	150	30	30	120	15
Deferred Continuing Education (R9-16-404)	A.R.S. § 36-136.01(E)	45	30	15	15	15
Renewal Registration (R9-16-406)	A.R.S. § 36-136.01(D)	75	60	15	15	15

Historical Note

Table 4.1 Time-frames made by final rulemaking at 23 A.A.R. 3038, effective October 5, 2017 (Supp. 17-4). Amended by final rulemaking at 26 A.A.R. 1875, with an immediate effective date of September 2, 2020 (Supp. 20-3).

R9-16-408. Requesting a Change

Within 30 calendar days after the effective date of a change, a registered environmental health sanitarian requesting a change to personal information shall submit in a Department-provided format:

1. A written notice stating the information to be changed and indicating the new information; and
2. If the change is to the registered environmental health sanitarian's legal name, a copy of one of the following with the registered environmental health sanitarian's new name:
 - a. Marriage certificate,
 - b. Divorce decree,
 - c. Professional license, or
 - d. Other legal document establishing the registered environmental health sanitarian's legal name.

Historical Note

Adopted effective September 29, 1976 (Supp. 76-4). Section repealed by final rulemaking at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2). Section R9-16-408 renumbered from R9-16-406 by final rulemaking at 10 A.A.R. 3004, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 23 A.A.R. 3038, effective October 5, 2017 (Supp. 17-4).

R9-16-409. Denial, Suspension, or Revocation

- A.** The Department may deny an application packet for approval for registration or renewal of registration if the Department determines that an applicant:
1. Intentionally provided false information or documents in an application packet or renewal application packet;
 2. Had an application for a license related to the practice of a registered environmental health sanitarian denied by a state or jurisdiction;

3. Had a license related to the practice of a registered environmental health sanitarian suspended or revoked by a state or jurisdiction or entered into a consent agreement with a state or jurisdiction; or
 4. Was convicted of or entered into a plea of no contest to a misdemeanor resulting from employment as a registered environmental health sanitarian or a felony.
- B.** The Department may suspend or revoke a registered environmental health sanitarian's registration if the Department determines that a registered environmental health sanitarian:
1. Assisted an individual who is not a registered environmental health sanitarian to circumvent the requirements in this Article;
 2. Allowed an individual who is not a registered environmental health sanitarian to use the registered environmental health sanitarian's registration;
 3. Falsified records to interfere with or obstruct an investigation or regulatory process of the Department or a political subdivision; or
 4. Failed to comply with any of the requirements in A.R.S. § 36-136.01 or this Article.
- C.** In determining whether to suspend or revoke a registered environmental health sanitarian's registration, the Department shall consider the threat to public health based on:
1. Whether there is repeated non-compliance with statutes or rules,
 2. Type of non-compliance,
 3. Severity of non-compliance, and
 4. Number of non-compliance actions.
- D.** The Department's notice of suspension or revocation to the applicant or registered environmental health sanitarian shall comply with A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

Adopted effective September 29, 1976 (Supp. 76-4).

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Amended effective April 12, 1985 (Supp. 85-2). Section repealed by final rulemaking at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2). Section R9-16-409 renumbered from R9-16-407 and amended by final rulemaking at 10 A.A.R. 3004, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 23 A.A.R. 3038, effective October 5, 2017 (Supp. 17-4).

R9-16-410. Repealed**Historical Note**

Adopted effective September 29, 1976 (Supp. 76-4). Former Section R9-16-410 repealed, new Section R9-16-410 adopted effective April 12, 1985 (Supp. 85-2). Section repealed by final rulemaking at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2).

R9-16-411. Repealed**Historical Note**

Adopted effective September 29, 1976 (Supp. 76-4). Former Section R9-16-411 renumbered as Section R9-16-414, new Section R9-16-411 adopted effective April 12, 1985 (Supp. 85-2). Section repealed by final rulemaking at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2).

R9-16-412. Repealed**Historical Note**

Adopted effective April 12, 1985 (Supp. 85-2). Section repealed by final rulemaking at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2).

R9-16-413. Repealed**Historical Note**

Adopted effective April 12, 1985 (Supp. 85-2). Section repealed by final rulemaking at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2).

R9-16-414. Expired**Historical Note**

Former Section R9-16-411 renumbered as Section R9-16-414 effective April 12, 1985 (Supp. 85-2). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective September 30, 2001 (Supp. 01-4).

Table 1. Repealed**Historical Note**

Table 1. Time-frames made by final rulemaking under new Section R9-16-405 at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2). Table 1. Time-frames following Section R9-16-405 renumbered below Section R9-16-407 and amended by final rulemaking at 10 A.A.R. 3004, effective September 11, 2004 (Supp. 04-3). Table 1. Time-frames repealed by final rulemaking at 23 A.A.R. 3038, effective October 5, 2017 (Supp. 17-4).

ARTICLE 5. LICENSING SPEECH-LANGUAGE PATHOLOGIST ASSISTANTS**R9-16-501. Definitions**

In addition to the definitions in A.R.S. § 36-1901, the following definitions apply in this Article unless otherwise specified:

1. "Accredited" means approved by the:
 - a. New England Commission of Higher Education,
 - b. Middle States Commission on Higher Education,
 - c. Higher Learning Commission,

- d. Northwest Commission on Colleges and Universities,
 - e. Southern Association of Colleges and Schools Commission on Colleges, or
 - f. WASC Senior College and University Commission.
2. "Applicant" means an individual who submits a license application and required documentation for approval to practice as a speech-language pathologist assistant.
 3. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
 4. "Continuing education" means a course that provides instruction and training that is designed to develop or improve a licensee's professional competence in disciplines that directly relate to the licensee's scope of practice.
 5. "Course" means a workshop, seminar, lecture, conference, or class.
 6. "Documentation" means information in written, photographic, electronic, or other permanent form.
 7. "General education" means instruction that includes:
 - a. Oral communication,
 - b. Written communication,
 - c. Mathematics,
 - d. Computer instruction,
 - e. Social sciences, and
 - f. Natural sciences.
 8. "Observation" means to witness:
 - a. The provision of speech-language pathology services to a client, or
 - b. A demonstration of how to provide speech-language pathology services to a client.
 9. "Semester credit hour" means one earned academic unit of study completed, at an accredited college or university, by:
 - a. Attending a 50 to 60 minute class session each calendar week for at least 16 weeks, or
 - b. Completing practical work for a course as determined by the accredited college or university.
 10. "Speech-language pathologist" means an individual who is licensed under A.R.S. § 36-1940.01.
 11. "Speech-language pathology technical course work" means a curriculum that provides knowledge to develop core skills and assume job responsibilities, including:
 - a. Language acquisition,
 - b. Speech development,
 - c. Communication disorders,
 - d. Articulation and phonology, and
 - e. Intervention techniques for speech and language disorders.
 12. "Supervision" means instruction and monitoring provided by a licensed speech-language pathologist as required in A.R.S. § 36-1940.04(E) and (F) to an individual training to become a speech-language pathologist assistant.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 2132, effective January 30, 2010 (Supp. 09-4). Amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Amended by final expedited

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rulemaking at 26 A.A.R. 852, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-502. Initial Application

A. An applicant for licensure shall submit to the Department:

1. An application in a Department-provided format that contains:
 - a. The applicant's name, home address, telephone number, and e-mail address;
 - b. The applicant's Social Security number, as required under A.R.S. §§ 25-320 and 25-502;
 - c. If applicable, the name of the applicant's employer and the employer's business address and telephone number;
 - d. Whether the applicant has ever been convicted of a felony or of a misdemeanor in this state or another state;
 - e. If the applicant has been convicted of a felony or a misdemeanor:
 - i. The date of the conviction,
 - ii. The state or jurisdiction of the conviction,
 - iii. An explanation of the crime of which the applicant was convicted, and
 - iv. The disposition of the case;
 - f. Whether the applicant has had a license revoked or suspended by any state;
 - g. Whether the applicant is currently ineligible for licensure in any state because of a prior license revocation or suspension;
 - h. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-16-506;
 - i. An attestation that the information submitted is true and accurate; and
 - j. The applicant's signature and date of signature;
2. If applicable, a list of all states and countries in which the applicant is or has been licensed as a speech-language pathologist assistant;
3. If a license for an applicant has been revoked or suspended by any state, documentation that includes:
 - a. The date of the revocation or suspension,
 - b. The state or jurisdiction of the revocation or suspension, and
 - c. An explanation of the revocation or suspension;
4. If the applicant is currently ineligible for licensure in any state because of a prior license revocation or suspension, documentation that includes:
 - a. The date of the ineligibility for licensure,
 - b. The state or jurisdiction of the ineligibility for licensure, and
 - c. An explanation of the ineligibility for licensure;
5. Documentation of the applicant's citizenship or alien status that complies with A.R.S. § 41-1080.
6. A transcript or equivalent documentation issued to the applicant from an accredited college or university, showing completion of at least 60 semester credit hours of general education and speech-language pathology technical course work specified in A.R.S. § 36.1940.04(A) that requires:
 - a. No less than 20 semester credit hours of general education, and
 - b. No less than 20 semester credit hours of speech-language pathology technical course work;
7. Documentation, signed by a licensed speech-language pathologist as required in A.R.S. § 36-1940.04 who pro-

vided supervision to the applicant, confirming the applicant's completion of at least 100 hours of clinical interaction that did not include observation; and

8. The application and licensing fees specified in R9-16-508.

B. In addition to complying with subsection (A)(1) through (5), an applicant that may be eligible for licensure under A.R.S. § 36-1922 shall submit documentation to the Department that includes:

1. The name of each state that issued the applicant a current speech-language pathologist assistant, including:
 - a. The license number of each current speech-language pathologist assistant license, and
 - b. The date each current speech-language pathologist assistant license was issued;
2. Documentation of the professional license or certification issued to the applicant by each state in which the applicant holds a professional license or certification;
3. For each state named in subsection (B)(1), a statement, signed and dated by the applicant, attesting that the applicant:
 - a. Has been licensed or certified in another state for at least one year, with a scope of practice consistent with the scope of practice for which licensure is being requested;
 - b. Has met minimum education requirements according to A.R.S. § 36-1940.04;
 - c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
 - d. Does not have a complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct.
- C. A regular license is valid for two years from the date of issue.
- D. The Department shall review the application and required documentation for an initial license to practice as a speech-language pathologist assistant according to R9-16-506 and Table 5.1.
- E. If the Department does not issue an initial license to an applicant, the Department shall refund the license fee to the applicant.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 2132, effective January 30, 2010 (Supp. 09-4). Section R9-16-502 repealed; new Section R9-16-502 renumbered from R9-16-503 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 852, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-503. License Renewal

A. Before the expiration date of a speech-language pathologist assistant license, a licensee shall submit to the Department:

1. An application in a Department-provided format for renewal of a speech-language pathologist assistant license that contains:
 - a. The licensee's name, home address, telephone number, and e-mail address;
 - b. The licensee's current employment, if applicable, including:
 - i. The employer's name,
 - ii. The licensee's position,

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- iii. Dates of employment,
 - iv. The address of the employer,
 - v. The supervisor's name,
 - vi. The supervisor's e-mail address, and
 - vii. The supervisor's telephone number;
 - c. If applicable, the name of the licensee's supervising speech-language pathologist;
 - d. The licensee's license number and date of expiration;
 - e. Since the previous license application, whether the licensee has been convicted of a felony or a misdemeanor involving moral turpitude in this or another state;
 - f. If the licensee has been convicted of a felony or a misdemeanor:
 - i. The date of the conviction,
 - ii. The state or jurisdiction of the conviction,
 - iii. An explanation of the crime of which the licensee was convicted, and
 - iv. The disposition of the case;
 - g. Whether the licensee has had a license revoked or suspended by any state within the previous two years;
 - h. Whether the licensee is currently ineligible for licensure in any state because of a prior license revocation or suspension;
 - i. Whether the licensee agrees to allow the Department to submit supplemental requests for information under R9-16-506;
 - j. An attestation that the licensee has completed continuing education required under A.R.S. 36-1904 and this Article and documentation of completion is available upon request;
 - k. An attestation that the information required as part of the renewal application is true and accurate; and
 - l. The licensee's signature and date of signature;
 - 2. If a license for a licensee has been revoked or suspended by any state within the previous two years, documentation that includes:
 - a. The date of the revocation or suspension,
 - b. The state or jurisdiction of the revocation or suspension, and
 - c. An explanation of the revocation or suspension;
 - 3. If the licensee is currently ineligible for licensure in any state because of a prior license revocation or suspension, documentation that includes:
 - a. The date of the ineligibility for licensure,
 - b. The state or jurisdiction of the ineligibility for licensure, and
 - c. An explanation of the ineligibility for licensure;
 - 4. A renewal fee specified in R9-16-508.
- B.** According to A.R.S. § 36-1904, the Department shall allow a speech-language pathologist assistant to renew a license within 30 calendar days after the expiration date of the license by submitting to the Department:
- 1. The renewal application, including documentation required in subsection (A), and
 - 2. Fees specified in R9-16-508.
- C.** An individual who does not submit a renewal application, documentation; and fees required in subsection (A) or (B), shall reapply for an initial license according to R9-16-502.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 2132, effective January 30, 2010 (Supp. 09-4). Section

R9-16-503 renumbered to R9-16-502; new Section R9-16-503 renumbered from R9-16-504 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 852, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-504. Continuing Education

- A.** Twenty-four months prior to submitting a renewal application, a licensee shall complete continuing education.
- B.** Continuing education shall:
- 1. Directly relate to the practice of speech-language pathology;
 - 2. Have educational objectives that exceed an introductory level of knowledge of speech-language pathology; and
 - 3. Consist of courses that include advances within the last five years in:
 - a. Practice of speech-language pathology,
 - b. Auditory rehabilitation,
 - c. Ethics, or
 - d. Federal and state statutes or rules.
- C.** A continuing education course developed, endorsed, or sponsored by one of the following meets the requirements in subsection (B):
- 1. Hearing Healthcare Providers of Arizona,
 - 2. Arizona Speech-Language-Hearing Association,
 - 3. American Speech-Language-Hearing Association,
 - 4. International Hearing Society,
 - 5. International Institute for Hearing Instrument Studies,
 - 6. American Auditory Society,
 - 7. American Academy of Audiology,
 - 8. Academy of Doctors of Audiology,
 - 9. Arizona Medical Association,
 - 10. American Academy of Otolaryngology-Head and Neck Surgery, or
 - 11. An organization determined by the Department to be consistent with an organization in subsection (C)(1) through (10).
- D.** A speech-language pathologist assistant shall comply with the requirements in A.R.S. § 36-1904.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 2132, effective January 30, 2010 (Supp. 09-4). Section R9-16-504 renumbered to R9-16-503; new Section R9-16-504 renumbered from R9-16-506 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 852, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-505. Enforcement

- A.** The Department may, as applicable:
- 1. Deny, revoke, or suspend a speech-language pathologist assistant license under A.R.S. § 36-1934;
 - 2. Request an injunction under A.R.S. § 36-1937; or
 - 3. Assess a civil money penalty under A.R.S. § 36-1939.
- B.** In determining which disciplinary action specified in subsection (A) is appropriate, the Department shall consider:
- 1. The type of violation,
 - 2. The severity of the violation,
 - 3. The danger to public health and safety,
 - 4. The number of violations,
 - 5. The number of clients affected by the violations,
 - 6. The degree of harm to a client,
 - 7. A pattern of noncompliance, and

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8. Any mitigating or aggravating circumstances.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 2132, effective January 30, 2010 (Supp. 09-4). Amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 852, with an immediate effective date of April 8, 2020 (Supp. 20-2).

Table 1. Renumbered**Historical Note**

New Table 1 made by final rulemaking at 15 A.A.R. 2132, effective January 30, 2010 (Supp. 09-4). Table 1 renumbered to Table 5.1 by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2).

R9-16-506. Time-frames

- A.** For each type of license issued by the Department under this Article, Table 5.1 specifies the overall time-frame described in A.R.S. § 41-1072(2).
1. An applicant or licensee and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame.
 2. The extension of the substantive review time-frame and the overall time-frame may not exceed 25% of the overall time-frame.
- B.** For each type of license issued by the Department under this Article, Table 5.1 specifies the administrative completeness review time-frame described in A.R.S. § 41-1072(1).
1. The administrative completeness review time-frame begins on the date the Department receives an application and required documentation required in this Article.
 2. Except as provided in subsection (B)(3), the Department shall provide a written notice of administrative completeness or a notice of deficiencies to an applicant within the administrative completeness review time-frame.
 - a. If an application or required documentation is not complete, the notice of deficiencies shall list each deficiency and the information or documentation needed to complete the application.
 - b. A notice of deficiencies suspends the administrative completeness review time-frame and the overall time-frame from the date of the notice until the date the Department receives the missing documents or information.

- c. If the applicant does not submit to the Department all or documentation listed in the notice of deficiencies within 30 calendar days after the date of the notice of deficiencies, the Department shall consider the application withdrawn.

3. If the Department issues a license during the administrative completeness review time-frame, the Department shall not issue a separate written notice of administrative completeness.

- C.** For each type of license issued by the Department under this Article, Table 5.1 specifies the substantive review time-frame described in A.R.S. § 41-1072(3), which begins on the date of the notice of administrative completeness.
1. Within the substantive review time-frame, the Department shall provide a written notice to the applicant that the Department issued or denied the license.
 2. During the substantive review time-frame:
 - a. The Department may make one comprehensive written request for additional information or documentation; and
 - b. If the Department and the applicant agree in writing, the Department may make supplemental requests for additional information or documentation.
 3. A comprehensive written request or a supplemental request for additional information or documentation suspends the substantive review time-frame and the overall time-frame from the date of the request until the date the Department receives all the documents and information requested.
 4. If the applicant does not submit to the Department all the information or documentation listed in a comprehensive written request or supplemental request for additional information or documentation within 30 calendar days after the date of the request, the Department shall deny the license.
- D.** An applicant who is denied a license may appeal the denial according to A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 2132, effective January 30, 2010 (Supp. 09-4). Section R9-16-506 renumbered to R9-16-504; new Section R9-16-506 renumbered from R9-16-507 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 852, with an immediate effective date of April 8, 2020 (Supp. 20-2).

Table 5.1. Time-frames (in calendar days)

Type of Approval	Statutory Authority	Overall Time-Frame	Administrative Completeness Review Time-Frame	Time to Respond to Notice of Deficiency	Substantive Review Time-Frame	Time to Respond to Comprehensive Written Request
Initial License (R9-16-502)	A.R.S. §§ 36-1904 and 36-1940.04	60	30	30	30	30
Renewal License (R9-16-503)	A.R.S. § 36-1904	60	30	30	30	30

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Table 5.1 renumbered from Table 1 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2).
Table 5.1 repealed; new Table 5.1 made and recodified under Section R9-16-506 by final expedited rulemaking at 26 A.A.R. 852, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-507. Changes Affecting a License or a Licensee; Request for a Duplicate License

- A.** A licensee shall submit a notice to the Department in writing within 30 calendar days after the effective date of a change in:
1. The licensee's home address or e-mail address, including the new home address or e-mail address;
 2. The licensee's name, including one of the following with the licensee's new name:
 - a. Marriage certificate,
 - b. Divorce decree, or
 - c. Other legal document establishing the licensee's new name; or
 3. The place or places, including address or addresses, where the licensee engages in the practice of speech-language pathology.
- B.** A licensee may obtain a duplicate license by submitting to the Department a written request for a duplicate license in a Department-provided format that contains:
1. The licensee's name and address,
 2. The licensee's license number and expiration date,
 3. The licensee's signature and date of signature, and
 4. A duplicate license fee specified in R9-16-508.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 2132, effective January 30, 2010 (Supp. 09-4). Section R9-16-507 renumbered to R9-16-506; new Section R9-16-507 renumbered from R9-16-508 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 26 A.A.R. 852, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-508. Fees

- A.** An applicant shall submit to the Department the following fees:
1. An initial nonrefundable application fee, \$100; and
 2. An initial license fee, \$200.
- B.** An applicant shall submit to the Department a \$200 license fee for renewal.
- C.** If an applicant submits a renewal license application specified in subsection (B) within 30 calendar days after the license expiration date, the applicant shall submit with the renewal license application a \$25 late fee.
- D.** An applicant for initial licensure is not required to submit the applicable fee in subsection (A), if the applicant submits an attestation that the applicant meets the criteria for waiver of licensing fees in A.R.S. § 41-1080.01.
- E.** The fee for a duplicate license is \$25.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 2132, effective January 30, 2010 (Supp. 09-4). R9-16-508 renumbered to R9-16-507 by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). New Section made by final expedited rulemaking at 26 A.A.R. 852, with an immediate effective date of April 8, 2020 (Supp. 20-2).

ARTICLE 6. RADIATION TECHNOLOGISTS**R9-16-601. Definitions**

In addition to the definitions in A.R.S. § 32-2801, the following definitions apply in this Article unless otherwise specified:

1. "Applicant" means:
 - a. An individual who submits an application packet, or
 - b. A person who submits a request for approval of a radiation technologist training program.
2. "Application packet" means the information, documents, and fees required by the Department for a certificate or permit.
3. "ARRT" means the American Registry of Radiologic Technologists.
4. "Authorized user" means the same as in A.A.C. R9-7-102.
5. "Calendar day" means each day, not including the day of the act, event, or default, from which a designated period of time beings to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
6. "CBRPA" means the Certification Board for Radiology Practitioner Assistants.
7. "Certification" means the issuing of a certificate.
8. "Chest radiography" means radiography performed to visualize the heart and lungs only.
9. "Continuing education" means a course or learning activity that provides instruction and training designed to develop or improve the professional competence of a certificate holder related to the certificate holder's scope of practice.
10. "Contrast media" means material intentionally administered to a human body to define a part or parts of the human body that are not normally radiographically visible.
11. "Department-approved educational program" means a curriculum of courses and learning activities that is accredited by a nationally recognized accreditation body or granted approval through the Department.
12. "Department-approved examination" means a test administered through ARRT, NMTCB, ISCD, or CBRPA.
13. "Extremity" means the same as in A.A.C. R9-7-102.
14. "Fluoroscopy" means the use of radiography to directly visualize internal structures of the human body, the motion of internal structures, and fluids in real time, or near real-time, to aid in the treatment or diagnosis of disease or the performance of other medical procedures.
15. "ISCD" means the International Society for Clinical Densitometry.
16. "Nationally recognized accreditation body" means ARRT, NMTCB, ISCD, or CBRPA.
17. "NMTCB" means the Nuclear Medicine Technology Certification Board.
18. "Radiograph" means the record of an image, representing anatomical details of a part of a human body examined through the use of ionizing radiation, formed by the differential absorption of ionizing radiation within the part of the human body.
19. "Radiography" means the use of ionizing radiation in making radiographs.

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20. "Radiopharmaceutical agent" means a radionuclide or radionuclide compound designed and prepared for administration to human beings.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-602. Training Programs

- A. The Department shall maintain a list of Department-approved educational programs according to A.R.S. § 32-2804 on the Department's website at <https://www.azdhs.gov/licensing/special/index.php#mrt-approved-schools>.
- B. An applicant may request Department approval of a curriculum of courses and learning activities as a training program by submitting an application packet that contains:
1. An application, in a Department-provided format, that includes:
 - a. The name and address of the school providing the training program;
 - b. The name, title, telephone number, and e-mail address of the administrator or designee of the school; and
 - c. A list of each training program for which approval is being requested, including the number of hours of instruction provided for each;
 2. A copy of the curriculum that includes course titles and course descriptions; and
 3. A list of instructors providing the instruction and the credentials of each.
- C. The Department shall:
1. Review each application packet according to R9-16-621; and
 2. If approved, add the applicant's school to the list of Department-approved educational programs in subsection (A).
- D. If an applicant for certification or permit did not complete a Department-approved educational program, the applicant may submit to the Department a copy of the curriculum for the training program completed by the applicant with the applicant's application packet in R9-16-606(B), R9-16-607(A), or R9-16-609(A).

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 28 A.A.R. 3572 (November 18, 2022), with an immediate effective date of November 2, 2022 (Supp. 22-4).

R9-16-603. Practical Technologist in Radiology - Eligibility and Scope of Practice

- A. An individual is eligible for certification as a practical technologist in radiology if the individual:
1. Is at least 18 years of age; and
 2. Either:
 - a. Has completed a training program in radiologic technology through a Department-approved educational program and achieved a score of at least 67% on a Department-approved examination; or
 - b. Meets the criteria in A.R.S. § 32-4302(A).
- B. An individual certified as a practical technologist in radiology shall:
1. Follow the standards specified in the 2019 American Society of Radiologic Technologists Limited X-Ray Machine Operator Practice Standards available at https://www.asrt.org/docs/default-source/practice-standards-published/ps_lxmo.pdf?sfvrsn=29e176d0_16, incorporated by reference, on file with the Department, and including no future editions or amendments;

www.asrt.org/docs/default-source/practice-standards-published/ps_lxmo.pdf?sfvrsn=29e176d0_16, incorporated by reference, on file with the Department, and including no future editions or amendments;

2. Perform only:
 - a. Chest radiography; and
 - b. Radiography of the extremities; and
3. Not use fluoroscopy or contrast media.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 28 A.A.R. 3572 (November 18, 2022), with an immediate effective date of November 2, 2022 (Supp. 22-4).

R9-16-604. Practical Technologist in Podiatry - Eligibility and Scope of Practice

- A. An individual is eligible for certification as a practical technologist in podiatry if the individual:
1. Is at least 18 years of age; and
 2. Either:
 - a. Has:
 - i. Completed a training program in podiatry radiology through a Department-approved educational program;
 - ii. Received a signed and dated attestation from a podiatrist licensed according to A.R.S. Title 32, Chapter 7, verifying that the applicant:
 - (1) Completed training under the direction of the licensed podiatrist; and
 - (2) Is proficient in independently taking radiographs; and
 - iii. Achieved a score of at least 70% on a Department-approved examination; or
 - b. Meets the criteria in A.R.S. § 32-4302(A).
- B. An individual certified as a practical technologist in podiatry shall:
1. Follow the standards specified in the 2019 American Society of Radiologic Technologists Limited X-Ray Machine Operator Practice Standards, available at https://www.asrt.org/docs/default-source/practice-standards-published/ps_lxmo.pdf?sfvrsn=29e176d0_16, incorporated by reference, on file with the Department, and including no future editions or amendments; and
 2. Only perform radiographic examinations of the lower leg, ankle, and foot, without the use of fluoroscopy or contrast media.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 28 A.A.R. 3572 (November 18, 2022), with an immediate effective date of November 2, 2022 (Supp. 22-4).

R9-16-605. Practical Technologist in Bone Densitometry - Eligibility and Scope of Practice

- A. An individual is eligible for certification as a practical technologist in bone densitometry if the individual:
1. Is at least 18 years of age; and
 2. Either:
 - a. Has completed a training program in bone densitometry through a Department-approved educational program and achieved a score of at least 70% on a Department-approved examination; or

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- b. Meets the criteria in A.R.S. § 32-4302(A).
- B.** An individual certified as a practical technologist in bone densitometry shall:
1. Follow the standards specified in the 2019 American Society of Radiologic Technologists Bone Densitometry Practice Standards, available at https://www.asrt.org/docs/default-source/practice-standards-published/ps_bd.pdf?sfvrsn=11e176d0_22, incorporated by reference, on file with the Department, and including no future editions or amendments; and
 2. Apply ionizing radiation only to a person's hips, spine, and extremities through the use of a bone density machine without the use of fluoroscopy or contrast media.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).
Amended by final expedited rulemaking at 28 A.A.R. 3572 (November 18, 2022), with an immediate effective date of November 2, 2022 (Supp. 22-4).

R9-16-606. Application for Examination

- A.** An individual may apply for examination if the individual meets eligibility criteria for a:
1. Practical technologist in radiology listed in R9-16-603(A);
 2. Practical technologist in podiatry listed in R9-16-604(A); or
 3. Practical technologist in bone densitometry listed in R9-16-605(A).
- B.** An applicant for examination shall submit an application packet to the Department that includes:
1. The information and documents required in R9-16-619;
 2. Except as provided in R9-16-602(D), documentation of completion of a Department-approved educational program; and
 3. For an applicant for examination as a practical technologist in podiatry, the attestation specified in R9-16-604(A)(2)(a)(ii).
- C.** The Department shall approve or deny an individual's application for examination according to R9-16-621.
- D.** If the Department determines that the application packet submitted under subsection (B) is complete and in compliance, the Department shall notify the applicant that the applicant is approved to test.
- E.** Upon notification by the Department according to subsection (D), and applicant:
1. Shall arrange testing through ARRT, and
 2. Has six months to complete testing before the applicant is required to re-apply for examination.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).
Amended by final expedited rulemaking at 28 A.A.R. 3572 (November 18, 2022), with an immediate effective date of November 2, 2022 (Supp. 22-4).

R9-16-607. Application for Initial Certification as a Practical Technologist in Radiology, Practical Technologist in Podiatry, or Practical Technologist in Bone Densitometry

- A.** Except as provided in subsection (B), an applicant for initial certification as a practical technologist in radiology, practical technologist in podiatry, or practical technologist in bone densitometry shall submit an application packet to the Department that includes:

that includes:

1. The information and documents required in R9-16-619;
2. Except as provided in R9-16-602(D), documentation of completion of a Department-approved educational program;
3. Documentation of achieving the applicable minimum score on a Department-approved examination;
4. For an application for a practical technologist in podiatry, the signed attestation in R9-16-604(A)(2)(a)(ii) containing:
 - a. The name and date of birth of the applicant,
 - b. The name and license number of the licensed podiatrist,
 - c. A statement by the licensed podiatrist verifying completion of the applicant's clinical training and approval of radiographic images taken by the applicant, and
 - d. The licensed podiatrist's signature and date; and
5. The applicable fee in R9-16-623.

- B.** If an applicant for initial certification as a practical technologist in radiology, practical technologist in podiatry, or practical technologist in bone densitometry may be eligible for certification under A.R.S. § 32-4302(A), the applicant shall submit an application packet to the Department that includes:

1. The information and documentation required in R9-16-619;
2. Documentation of the professional license or certification issued to the applicant by each state in which the applicant holds a professional license or certification;
3. A statement, signed and dated by the applicant, attesting that the applicant:
 - a. Has been licensed or certified in another state for at least one year, with a scope of practice consistent with the scope of practice for which certification is being requested;
 - b. Has met minimum education requirements and, if applicable, work experience and clinical supervision requirements, according to A.R.S. § 32-4302(A)(3);
 - c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
 - d. Does not have a complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct; and
4. The applicable fee in R9-16-623.

- C.** The Department shall approve or deny an individual's application for initial certification according to R9-16-621.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-608. Radiologic Technologist, Nuclear Medicine Technologist, and Radiation Therapy Technologist - Eligibility and Scope of Practice

- A.** An individual is eligible to apply for initial certification as a radiologic technologist, nuclear medicine technologist, or radiation therapy technologist if the individual:

1. Is at least 18 years of age; and
2. Satisfies one of the following:
 - a. Holds current applicable ARRT or NMTCB certification,

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- b. Has completed a Department-approved educational program in radiation technology and has a passing score on a Department-approved examination, or
 - c. Meets the criteria in A.R.S. § 32-4302(A).
- B.** An individual certified as a radiologic technologist shall follow the standards specified in the 2019 American Society of Radiologic Technologists Radiography Practice Standards, available at https://www.asrt.org/docs/default-source/practice-standards-published/ps_rad.pdf?sfvrsn=13e176d0_18, incorporated by reference, on file with the Department, and including no future editions or amendments.
- C.** An individual certified as a nuclear medicine technologist shall:
 - 1. Follow the standards specified in the 2019 American Society of Radiologic Technologists Nuclear Medicine Practice Standards, available at https://www.asrt.org/docs/default-source/practice-standards-published/ps_nm.pdf?sfvrsn=1ee176d0_14, incorporated by reference, on file with the Department, and including no future editions or amendments; and
 - 2. Use radiopharmaceutical agents on humans for diagnostic or therapeutic purposes only.
- D.** An individual certified as a radiation therapy technologist shall follow the standards specified in the 2019 American Society of Radiologic Technologists Radiation Therapy Practice Standards, available at https://www.asrt.org/docs/default-source/practice-standards-published/ps_rt.pdf?sfvrsn=18e076d0_16, incorporated by reference, on file with the Department, and including no future editions or amendments.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).
 Amended by final expedited rulemaking at 28 A.A.R. 3572 (November 18, 2022), with an immediate effective date of November 2, 2022 (Supp. 22-4).

R9-16-609. Application for Initial Certification as a Radiation Technologist, Nuclear Medicine Technologist, or Radiation Therapy Technologist

- A.** Except as provided in subsection (B), an applicant for initial certification as a radiation technologist, nuclear medicine technologist, or radiation therapy technologist shall submit an application packet to the Department that includes:
 - 1. The information and documents required in R9-16-619;
 - 2. Either:
 - a. A copy of the applicant's current ARRT or NMTCB certification; or
 - b. Documentation of:
 - i. Completing a Department-approved educational program, except as provided in R9-16-602(D); and
 - ii. Having a passing score on a Department-approved examination; and
 - 3. The applicable fee in R9-16-623.
- B.** If an applicant for initial certification as a radiation technologist, nuclear medicine technologist, or radiation therapy technologist may be eligible for certification under A.R.S. § 32-4302(A), the applicant shall submit an application packet to the Department that includes:
 - 1. The information and documentation required in R9-16-619;
 - 2. Documentation of the professional license or certification issued to the applicant by each state in which the applicant holds a professional license or certification;

- 3. A statement, signed and dated by the applicant, attesting that the applicant:
 - a. Has been licensed or certified in another state for at least one year, with a scope of practice consistent with the scope of practice for which certification is being requested;
 - b. Has met minimum education requirements and, if applicable, work experience and clinical supervision requirements, according to A.R.S. § 32-4302(A)(3);
 - c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
 - d. Does not have an complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct; and
- 4. The applicable fee in R9-16-623.
- C.** The Department shall approve or deny an individual's application for initial certification according to R9-16-621.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-610. Mammographic Technologist - Eligibility and Scope of Practice

- A.** An individual is eligible to apply for initial certification as a mammographic technologist if the individual:
 - 1. Is at least 18 years of age;
 - 2. Possesses a current Department-issued certification in radiologic technology; and
 - 3. Satisfies one of the following:
 - a. Holds a current ARRT certification in mammography;
 - b. Meets the initial training and education requirements in 21 CFR 900.12 and has a passing score on a Department-approved examination in mammography, or
 - c. Meets the criteria in A.R.S. § 32-4302(A).
- B.** An individual certified as a mammographic technologist:
 - 1. Shall follow the standards specified in the 2019 American Society of Radiologic Technologists Mammography Practice Standards, available at https://www.asrt.org/docs/default-source/practice-standards-published/ps_mamm.pdf?sfvrsn=10e076d0_16, incorporated by reference, on file with the Department, and including no future editions or amendments; and
 - 2. May perform diagnostic mammography or screening mammography, as defined in A.R.S. § 30-651.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).
 Amended by final expedited rulemaking at 28 A.A.R. 3572 (November 18, 2022), with an immediate effective date of November 2, 2022 (Supp. 22-4).

R9-16-611. Student Mammography Permits

- A.** Before beginning the initial training in 21 CFR 900.12 under R9-16-610(A)(3)(b), an individual shall obtain a student mammography permit from the Department.
- B.** An applicant for a student mammography permit shall submit an application packet to the Department that includes:
 - 1. The information and documents required under R9-16-619; and

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2. A Department-provided agreement form that includes the following:
 - a. The name and date of birth of the applicant;
 - b. The name, license number, e-mail address, and telephone number of a radiologist, licensed under A.R.S. Title 32, Chapter 13 or 17 and certified in radiology by the American Board of Radiology;
 - c. A statement that the licensed radiologist is accepting responsibility for the applicant's supervision and training; and
 - d. The licensed radiologist's signature and date of signing.
- C. The Department shall approve or deny an individual's application for a student mammography permit according to R9-16-621.
- D. A student mammography permit is valid for one year from the date issued and may not be renewed.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-612. Application for Initial Certification as a Mammographic Technologist

- A. Except as provided in subsection (B), an applicant for initial certification as a mammographic technologist shall submit an application packet to the Department that includes:
 1. The information and documents required in R9-16-619;
 2. The applicant's current radiology technologist certificate number;
 3. The applicant's current student mammography permit number, if applicable;
 4. Either:
 - a. A copy of current ARRT certification in mammography; or
 - b. Documentation of:
 - i. Completing of initial education and training that meets the requirements specified in 21 CFR 900.12, and
 - ii. Having a passing score on a Department-approved examination in mammography; and
 5. The applicable fee in R9-16-623.
- B. If an applicant for initial certification as a mammographic technologist may be eligible for certification under A.R.S. § 32-4302(A), the applicant shall submit an application packet to the Department that includes:
 1. The information and documentation required in R9-16-619;
 2. Documentation of the license or certification as a mammographic technologist issued to the applicant by each state in which the applicant holds the license or certification;
 3. A statement, signed and dated by the applicant, attesting that the applicant:
 - a. Has been licensed or certified as a mammographic technologist in another state for at least one year;
 - b. Has met minimum education requirements and, if applicable, work experience and clinical supervision requirements, according to A.R.S. § 32-4302(A)(3);
 - c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
 - d. Does not have an complaint, allegation, or investigation pending before another regulatory entity in

another state or country related to unprofessional conduct; and

4. The applicable fee in R9-16-623.

- C. The Department shall approve or deny an individual's application for initial certification as a mammographic technologist according to R9-16-621.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-613. Computed Tomography Technologist - Eligibility and Scope of Practice

- A. An individual is eligible to apply for initial certification as a computed tomography technologist if the individual:
 1. Is at least 18 years of age;
 2. Possesses a current Department-issued certification as a radiologic technologist or nuclear medicine technologist; and
 3. Satisfies one of the following:
 - a. Holds a current ARRT or NMTCB certification in computed tomography,
 - b. Has completed two years of training in computed tomography and twelve hours of computed tomography-specific education, or
 - c. Meets the criteria in A.R.S. § 32-4302(A).
- B. An individual certified as a computed tomography technologist:
 1. Shall follow the standards specified in the 2019 American Society of Radiologic Technologists Computed Tomography Practice Standards, available at https://www.asrt.org/docs/default-source/practice-standards-published/ps_ct.pdf?sfvrsn=9e076d0_16, incorporated by reference, on file with the Department, and including no future editions or amendments; and
 2. May apply ionizing radiation to a human using a computed tomography machine for diagnostic purposes.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3). Amended by final expedited rulemaking at 28 A.A.R. 3572 (November 18, 2022), with an immediate effective date of November 2, 2022 (Supp. 22-4).

R9-16-614. Application for Computed Tomography Technologist Preceptorship and Temporary Certification

- A. Before beginning training under R9-16-613(A)(3)(b), an individual shall obtain a computed tomography preceptorship certificate from the Department.
- B. An applicant for a computed tomography preceptorship certificate shall submit an application packet to the Department that includes:
 1. The information and documents required under R9-16-619;
 2. A Department-provided agreement form from a radiologist, licensed under A.R.S. Title 32, Chapter 13 or 17 and certified in radiology by the American Board of Radiology, that includes the following:
 - a. The name and date of birth of the applicant;
 - b. The name, license number, e-mail address, and telephone number of the licensed radiologist;
 - c. A statement that the licensed radiologist is accepting responsibility for the applicant's supervision and training; and

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- d. The licensed radiologist's signature and date of signing; and
- 3. The applicable fee in R9-16-623.
- C. The Department shall approve or deny an individual's application for a computed tomography preceptorship certificate according to R9-16-621.
- D. A computed tomography preceptorship certificate is valid for one year from the date issued and may not be renewed.
- E. At least 30 days before the expiration of an individual's computed tomography preceptorship certificate, the individual may apply for a computed tomography temporary certificate by submitting an application packet to the Department that includes:
 - 1. The information and documents required under R9-16-619;
 - 2. A Department-provided agreement form from a radiologist, licensed under A.R.S. Title 32, Chapter 13 or 17 and certified in radiology by the American Board of Radiology, that includes the following:
 - a. The name and date of birth of the applicant;
 - b. The name, license number, e-mail address, and telephone number of the licensed radiologist;
 - c. A statement that the licensed radiologist is accepting responsibility for the applicant's supervision and training; and
 - d. The licensed radiologist's signature and date of signing; and
 - 3. The applicable fee in R9-16-623.
- F. The Department shall approve or deny an individual's application for a computed tomography temporary certificate according to R9-16-621.
- G. A computed tomography temporary certificate is valid for one year and may not be renewed.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).
 Section heading corrected to heading made in the table of contents at 25 A.A.R. 2409; Section amended by final rulemaking at 26 A.A.R. 350, effective April 5, 2020 (Supp. 20-1).

R9-16-615. Application for Initial Certification for a Computed Tomography Technologist

- A. Except as provided in subsection (B), an applicant for initial certification as a computed tomography technologist shall submit an application packet to the Department that includes:
 - 1. The information and documents required in R9-16-619;
 - 2. The applicant's current radiation technologist or nuclear medicine technologist certificate number;
 - 3. The applicant's computed tomography preceptorship number or temporary certificate number, if applicable;
 - 4. Either:
 - a. A copy of the applicant's current ARRT or NMTCB certification in computed tomography; or
 - b. Documentation of completion of:
 - i. Two years of training in computed tomography, and
 - ii. Twelve hours of computed tomography-specific education; and
 - 5. The applicable fee in R9-16-623.
- B. If an applicant for initial certification as a computed tomography technologist may be eligible for certification under A.R.S. § 32-4302(A), the applicant shall submit an application packet to the Department that includes:

- 1. The information and documentation required in R9-16-619;
- 2. Documentation of the license or certification as a computed tomography technologist issued to the applicant by each state in which the applicant holds the license or certification;
- 3. A statement, signed and dated by the applicant, attesting that the applicant:
 - a. Has been licensed or certified as a computed tomography technologist in another state for at least one year;
 - b. Has met minimum education requirements and, if applicable, work experience and clinical supervision requirements, according to A.R.S. § 32-4302(A)(3);
 - c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
 - d. Does not have a complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct; and
- 4. The applicable fee in R9-16-623.
- C. The Department shall approve or deny an individual's application for initial certification as a computed tomography technologist according to R9-16-621.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-616. Radiologist Assistant - Eligibility and Scope of Practice

- A. An individual is eligible to apply for initial certification as a radiologist assistant if the individual:
 - 1. Is at least 18 years of age; and
 - 2. Satisfies one of the following:
 - a. Holds a current ARRT or CBRPA certification as a radiologist assistant;
 - b. Has:
 - i. Completed a baccalaureate degree or post-baccalaureate certificate from an accredited educational institution that encompasses a radiologist assistant curriculum that includes a radiologist-directed clinical preceptorship, and
 - ii. Achieved a passing score on an ARRT or a CBRPA examination for radiologist assistants; or
 - c. Meets the criteria in A.R.S. § 32-4302(A).
- B. An individual certified as a radiologist assistant:
 - 1. Shall follow the standards specified the 2019 American Society of Radiologic Technologists Radiologist Assistant Practice Standards, available at https://www.asrt.org/docs/default-source/practice-standards-published/ps_raa.pdf?sfvrsn=1ae076d0_16, incorporated by reference on file with the Department, and including no future editions or amendments; and
 - 2. May perform the following procedures under the direction of a radiologist, licensed under A.R.S. Title 32, Chapter 13 or 17 and certified in radiology by the American Board of Radiology:
 - a. Fluoroscopy;
 - b. Assessment and evaluation of the physiological and psychological responsiveness of individuals undergoing radiologic procedures;

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- c. Evaluation of image quality, making initial image observations and communicating observations to the supervising radiologist; and
 - d. Administration of contrast media or other medications prescribed by the supervising radiologist.
- C. A radiologist assistant shall not interpret images, make diagnoses, or prescribe medications or therapies.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).
Amended by final expedited rulemaking at 28 A.A.R. 3572 (November 18, 2022), with an immediate effective date of November 2, 2022 (Supp. 22-4).

R9-16-617. Application for Initial Certification as a Radiologist Assistant

- A. Except as provided in subsection (B), an applicant for initial certification as a radiologist assistant shall submit an application packet to the Department that includes:
1. The information and documents required in R9-16-619;
 2. Either:
 - a. The applicant's current ARRT or CBRPA certification as a radiologist assistant; or
 - b. Documentation of:
 - i. Completing a baccalaureate degree or post-baccalaureate certificate from an accredited educational institution that encompasses a radiologist assistant curriculum that includes a radiologist-directed clinical preceptorship, and
 - ii. Having a passing score on an ARRT or a CBRPA examination for radiologist assistants; and
 3. The applicable fee in R9-16-623.
- B. If an applicant for initial certification as a radiologist assistant may be eligible for certification under A.R.S. § 32-4302(A), the applicant shall submit an application packet to the Department that includes:
1. The information and documentation required in R9-16-619;
 2. Documentation of the license or certification as a radiologist assistant issued to the applicant by each state in which the applicant holds the license or certification;
 3. A statement, signed and dated by the applicant, attesting that the applicant:
 - a. Has been licensed or certified as a radiologist assistant in another state for at least one year;
 - b. Has met minimum education requirements and, if applicable, work experience and clinical supervision requirements, according to A.R.S. § 32-4302(A)(3);
 - c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
 - d. Does not have a complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct; and
 4. The applicable fee in R9-16-623.
- C. The Department shall approve or deny an individual's application for initial certification as a radiologist assistant according to R9-16-621.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-618. Special Permits

- A. An applicant for a special permit under A.R.S. § 32-2814(B) shall submit an application packet to the Department containing:
1. The information and documents required in R9-16-619;
 2. An attestation, in a Department-provided format, from the health care institution in which the applicant proposes to practice:
 - a. Stating that the requesting health care institution is located in an Arizona medically underserved area, as defined in A.A.C. R9-15-101(4), or a health professional shortage area, as defined in A.A.C. R9-15-101(25);
 - b. Verifying that the health care institution developed and is implementing a program of continuing education for the applicant to protect the health and safety of individuals undergoing radiologic procedures; and
 - c. Signed and dated by the health care institution's administrator or designee; and
 3. A letter signed by the health care institution's administrator or designee that provides justification for the issuance of a special permit.
- B. The Department shall approve or deny an application for a special permit according to R9-16-621.
- C. A special permit is valid for no more than one year, but may be renewed as provided in subsection (A) if the circumstances justifying the issuance of a special permit have not changed.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-619. Application Information

An applicant for certification shall submit to the Department:

1. The following information in a Department-provided format:
 - a. The applicant's name;
 - b. The applicant's residential address and, if different, mailing address;
 - c. The applicant's telephone number;
 - d. The applicant's e-mail address;
 - e. The applicant's Social Security number, as required under A.R.S. §§ 25-320 and 25-502;
 - f. The applicant's date of birth;
 - g. The applicant's current employment in the radiation technology field, if applicable, including:
 - i. The employer's name,
 - ii. The applicant's position,
 - iii. Dates of employment,
 - iv. The address of the employer,
 - v. The supervisor's name,
 - vi. The supervisor's email address, and
 - vii. The supervisor's telephone number;
 - h. The applicant's educational history related to radiation technology, including:
 - i. The name and address of each educational institution,
 - ii. The degree or certification received, and
 - iii. The applicant's date of graduation;
 - i. The type of certificate being applied for;
 - j. Whether the applicant has ever been convicted of a felony or a misdemeanor in this or another state;
 - k. If the applicant has been convicted of a felony or a misdemeanor:
 - i. The date of the conviction,

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- ii. The state or jurisdiction of the conviction,
- iii. An explanation of the crime of which the applicant was convicted, and
- iv. The disposition of the case;
- l. Whether the applicant holds other professional licenses or certifications and, if so:
 - i. The professional license or certification, and
 - ii. The state in which the professional license or certification was issued;
- m. Whether the applicant has had a professional license or certificate suspended, revoked, or had disciplinary action taken against the professional license or certificate;
- n. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-16-621;
- o. An attestation that the information submitted as part of an application packet is true and accurate; and
- p. The applicant's signature and date of signing;
- 2. If the applicant has had a professional license or certificate suspended, revoked, or had disciplinary action taken against the professional license or certificate within the previous five years, documentation that includes:
 - a. The date of the disciplinary action, revocation, or suspension;
 - b. The state or nationally accredited certifying body that issued the disciplinary action, revocation, or suspension; and
 - c. An explanation of the disciplinary action, revocation, or suspension;
- 3. If the applicant is currently ineligible for licensing or certification in any state because of a license revocation or suspension, documentation that includes:
 - a. The date of the ineligibility for licensing or certification,
 - b. The state or jurisdiction of the ineligibility for licensing or certification, and
 - c. An explanation of the ineligibility for licensing or certification; and
- 4. Documentation for the applicant that complies with A.R.S. § 41-1080.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-620. Renewal of Certification

- A. Certifications issued under R9-16-607, R9-16-609, R9-16-612, R9-16-615, and R9-16-617 are valid for two years after issuance, unless revoked.
- B. A certificate holder may apply to renew a certification:
 - 1. Within 90 days before the expiration date of the certificate holder's current certification;
 - 2. Within the 30-day period after the expiration date of the certificate holder's certification, if the certificate holder pays the late renewal penalty fee in R9-16-623; or
 - 3. Within the extension time period granted under A.R.S. § 32-4301.
- C. An applicant for renewal of a certification shall submit to the Department an application packet, including:
 - 1. The following in a Department-provided format:
 - a. The applicant's name, address, telephone number, email address, date of birth, and Social Security number;

- b. The applicant's current certification number and type;
- c. The applicant's current employment in the radiation technology field, if applicable, including:
 - i. The employer's name,
 - ii. The applicant's position,
 - iii. Dates of employment,
 - iv. The address of the employer,
 - v. The supervisor's name,
 - vi. The supervisor's email address, and
 - vii. The supervisor's telephone number;
- d. Whether the applicant has, within the two years before the date of the application, had:
 - i. A certificate issued under this Article suspended or revoked; or
 - ii. A professional license or certificate revoked by another state, jurisdiction, or nationally recognized accreditation body;
- e. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-16-621;
- f. Attestation that all the information submitted as part of the application packet is true and accurate; and
- g. The applicant's signature and date of signature;
- 2. As applicable:
 - a. For renewal of certification as a mammographic technologist, documentation that meets the requirements in A.R.S. § 32-2841(E); or
 - b. For renewal of all other certifications issued under this Article, either:
 - i. An attestation that the applicant completed continuing education required under A.R.S. § 32-2815(D) and that documentation of completion is available upon request, signed and dated by the applicant; or
 - ii. A copy of the applicant's current certification from a nationally recognized accreditation body; and
- 3. The applicable renewal fee and, if applicable, the late renewal penalty fee required in R9-16-623.
- D. The Department shall approve or deny an application for recertification according to R9-16-621.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).
Amended by final expedited rulemaking at 28 A.A.R. 3572 (November 18, 2022), with an immediate effective date of November 2, 2022 (Supp. 22-4).

R9-16-621. Review Time-frames

- A. For each type of certificate or permit issued by the Department under this Article, Table 6.1 specifies the overall time-frame described in A.R.S. § 41-1072(2).
 - 1. An applicant and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame.
 - 2. The extension of the substantive review time-frame and overall time-frame may not exceed 25% of the overall time-frame.
- B. For each type of certificate or permit issued by the Department under this Article, Table 6.1 specifies the administrative completeness review time-frame described in A.R.S. § 41-1072(1).

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1. The administrative completeness review time-frame begins on the date the Department receives an application packet required in this Article.
 2. Except as provided in subsection (B)(3), the Department shall provide written notice of administrative completeness or a notice of deficiencies to an applicant within the administrative completeness review time-frame.
 - a. If an application packet is not complete, the notice of deficiencies shall list each deficiency and the information or documentation needed to complete the application packet.
 - b. A notice of deficiencies suspends the administrative completeness review time-frame and the overall time-frame from the date of the notice until the date the Department receives the missing information or documentation.
 - c. If the applicant does not submit to the Department all the information or documentation listed in the notice of deficiencies within 30 calendar days after the date of the notice of deficiencies, the Department shall consider the application packet withdrawn.
 3. If the Department issues a certificate during the administrative completeness review time-frame, the Department shall not issue a separate written notice of administrative completeness.
- C.** For each type of certificate or permit issued by the Department under this Article, Table 6.1 specifies the substantive review time-frame described in A.R.S. § 41-1072(3), which begins on
- the date the Department sends a written notice of administrative completeness.
1. Within the substantive review time-frame, the Department shall provide written notice to the applicant that the Department approved or denied the application.
 2. During the substantive review time-frame:
 - a. The Department may make one comprehensive written request for additional information or documentation; and
 - b. If the Department and the applicant agree in writing, the Department may make supplemental requests for additional information or documentation.
 3. A comprehensive written request or a supplemental request for additional information or documentation suspends the substantive review time-frame and the overall time-frame from the date of the request until the date the Department receives all the information or documentation requested.
 4. If the applicant does not submit to the Department all the information or documentation listed in a comprehensive written request or supplemental request for additional information or documentation within 30 calendar days after the date of the request, the Department shall deny the certificate or permit.
- D.** An applicant who is denied a certificate or permit may appeal the denial according to A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

Table 6.1. Time-frames

Type of Application	Administrative Completeness Review Time-frame (in Calendar Days)	Substantive Review Time-frame (in Calendar Days)	Overall Time-frame (in Calendar Days)
Application for Examination	30	30	60
Initial Certificate	30	30	60
Renewal Certificate	30	30	60
Student Mammography Permit	30	30	60
Computed Tomography Preceptorship Certificate or Computed Tomography Temporary Certificate	30	30	60
Special Permit	30	30	60
School Approval	60	60	120

Historical Note

New Table 6.1 made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-622. Changes Affecting a Certificate or Certificate Holder; Request for a Duplicate Certificate

- A.** A certificate holder shall notify the Department in writing, within 30 calendar days after the effective date of a change in:
1. The certificate holder's residential address, mailing address, or e-mail address, including the new residential address, mailing address, or e-mail address;
 2. The certificate holder's name, including a copy of the legal document establishing the certificate holder's new name; or
 3. The certificate holder's employer, including the name and address of the new employer.
- B.** A certificate holder may obtain a duplicate certificate by submitting to the Department:
1. A written request for a duplicate certificate, in a Department-provided format, that includes:
 - a. The certificate holder's name and address,
 - b. The certificate holder's certificate number and expiration date, and
 - c. The certificate holder's signature and date of signature; and
 2. The duplicate certificate fee in R9-16-623.
- C.** A certificate holder may submit to the Department, either as a separate written document or as part of the renewal application, a signed and dated request to transfer to inactive status or retirement status under A.R.S. § 32-2816(F).

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-623. Fees

- A.** Except as provided in subsection (C) or (D), an applicant shall submit to the Department the following nonrefundable fees for:

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1. An initial application or renewal application for certification as a practical technologist in radiology, practical technologist in podiatry, or practical technologist in bone densitometry, \$100;
2. An initial application or renewal application for certification as a radiation technologist, nuclear medicine technologist, or radiation therapy technologist, \$100;
3. An initial application or renewal application for certification as a mammographic technologist, \$20;
4. A computed tomography preceptorship certificate or computed tomography temporary certificate, \$10;
5. An initial application or renewal application for certification as a computed tomography technologist, \$20;
6. An initial application or renewal application for certification as a radiologist assistant, \$100; and
7. A late renewal penalty fee according to A.R.S. § 32-2816(C), \$50.

B. The fee for a duplicate certificate is \$10.

C. An applicant for initial certification is not required to submit the applicable fee in subsection (A) if the applicant, as part of the applicable application packet in R9-16-607, R9-16-609, R9-16-612, R9-16-615, or R9-16-617, submits an attestation that the applicant meets the criteria for waiver of licensing fees in A.R.S. § 41-1080.01.

D. As allowed under A.R.S. § 32-2816(F), a certificate holder is not required to submit a fee for renewal of certification if the certificate holder submits to the Department an affidavit stating that the certificate holder:

1. Is retired from the practice of radiologic technology, or
2. Requests to be placed on inactive status.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).
Section amended by final rulemaking at 26 A.A.R. 350, effective April 5, 2020 (Supp. 20-1).

R9-16-624. Enforcement

A. The Department may, as applicable:

1. Deny, revoke, or suspend a certificate or permit under A.R.S. § 36-2821;
2. Request an injunction under A.R.S. § 36-2825; or
3. Assess a civil money penalty under A.R.S. § 36-2821.

B. In determining which disciplinary action specified in subsection (A) is appropriate, the Department shall consider:

1. The type of violation,
2. The severity of the violation,
3. The danger to public health and safety,
4. The number of violations,
5. The number of individuals affected by the violations,
6. The degree of harm to an individual,
7. A pattern of noncompliance, and
8. Any mitigating or aggravating circumstances.

C. A certificate holder or permittee may appeal a disciplinary action taken by the Department according to A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

ARTICLE 7. RESERVED**ARTICLE 8. COMMUNITY HEALTH WORKERS****R9-16-801. Definitions**

In addition to the definitions in A.R.S. § 36-765, the following definitions apply in this Article, unless otherwise specified:

1. "Accredited" means approved by the:
 - a. New England Commission of Higher Education,
 - b. Middle States Commission on Higher Education,
 - c. Higher Learning Commission,
 - d. Northwest Commission on Colleges and Universities,
 - e. Southern Association of Colleges and Schools Commission on Colleges, or
 - f. WASC Senior College and University Commission.
2. "Administrative completeness review time-frame" has the same meaning as in A.R.S. § 41-1072.
3. "Applicant" means an individual who submits an application and required documentation for approval to practice as a certified CHW.
4. "Behavioral health services" means information and care provided by certified or licensed behavioral health professionals consistent with practices specified in A.R.S. § 32-3251(8).
5. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run and including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
6. "Certification" means an approval granted to individuals who meet the qualifications, including education and training requirements, in this Article for certified CHWs.
7. "Certified CHW" means the same as a "certified community health worker" in A.R.S. § 36-765.
8. "CHW" means the same as a "community health worker" in A.R.S. § 36-765.
9. "CHW trainer" means an individual who meets the requirements in R9-16-803 and provides training and supervision to individuals who seek certification as a certified CHW.
10. "CHW training program" means approved community health education and instruction required for individuals seeking a CHW certification issued by the Department.
11. "Client" means an individual receiving community health services provided by a certified CHW.
12. "Community Health Representative" or "CHR" means an individual who has completed an Indian Health Services National Training Program for:
 - a. Basic training through completing general health education to promote health and social services and assist in the prevention of disease and disabilities in tribal communities; or
 - b. Advanced training through increased health and knowledge for a variety of public health topics designed to improve outreach capacity to advance tribal health systems.
13. "Community health services" means non-medical support, care, and assistance:
 - a. Specified in the scope of practice and core competencies in this Article;
 - b. Provided by a certified CHW to a client on behalf of a service provider, whether physical health services or behavioral health services; and
 - c. Improves the quality of delivery and coordination of care resulting in better medical and behavioral health outcomes.

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14. "Continuing education" means a course that provides training and instruction that is designed to develop or improve a certified CHW's or certified CHW trainer's professional competence in areas directly related to the practice of a CHW.
15. "Contractor" means the same as in A.R.S. § 36-2901.
16. "Core competencies" means curriculum that provides knowledge to develop core skills and assume job responsibilities, including:
 - a. Communication skills,
 - b. Interpersonal and relationship-building,
 - c. Service coordination and navigation,
 - d. Capacity-building,
 - e. Advocacy,
 - f. Education and facilitation,
 - g. Individual and community assessment,
 - h. Outreach,
 - i. Professional skills and conduct,
 - j. Evaluation and research skills, and
 - k. Knowledge base.
17. "Course" means a workshop, seminar, lecture, conference, or class.
18. "Direct services" means personal interaction to assist or deliver care provided by a certified CHW, including:
 - a. Transportation assistance,
 - b. Fall risk assessments,
 - c. Welfare checks,
 - d. Employment assistance, and
 - e. Other similar health and social services not provided by a licensed health or behavioral health professional.
19. "Documentation" means information in written, photographic, electronic or other permanent form.
20. "Licensed health care facility" means the same as "health care institution" specified in A.R.S. § 36-401.
21. "National Training Program" means a health education and skills management curriculum approved by Indian Health Services for individuals wishing to obtain a CHR certification to provide community health services in a tribal and Native community.
22. "Observation" means to witness:
 - a. The provision of community health services to a client, or
 - b. A demonstration of how to provide community health services to a client.
23. "Organization" means a person specified in A.R.S. § 1-215, and includes a tribal government.
24. "Overall time-frame" has the same meaning as in A.R.S. § 41-1072.
25. "Person" means the same as in A.R.S. § 1-215 and includes a governmental agency.
26. "Physical health services" means information and care provided by licensed health professionals consistent with practices specified in A.R.S. § 32-3201.
27. "Service provider" means a person, who engages in practice of health professionals specified in A.R.S. § 32-320, and behavioral health professionals specified in A.R.S. § 32-3251(8) who provide services to clients according to a contract or service agreement.
28. "Supervision" means training and monitoring provided by a certified CHW trainer specified in A.R.S. § 36-765.02(A)(5) to prepare individuals wishing to obtain a CHW certification.
29. "Training and instruction" means educational activities that develop and improve an individual's professional competence in areas related to the practice as a certified CHW specified in A.R.S. § 36-765 and specific to the delivery of services identified in CHW's scope of practice and core competencies specified in this Article.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 2552 (September 30, 2022), effective November 7, 2022 (Supp. 22-3).

R9-16-802. Community Health Workers Eligibility and Scope of Practice

- A. An individual may provide community health services in Arizona without obtaining certification as a certified CHW specified in this Article.
- B. An individual is eligible to practice as a certified CHW, if the individual:
 1. Is 18 years of age or older;
 2. Has at least a high school diploma or high school equivalency diploma;
 3. Has documentation of:
 - a. Nine hundred and sixty hours of paid or volunteer experience providing CHR or CHW services in the core competencies specified in this Article and completed during the previous three-year time-period:
 - i. In a licensed health care facility;
 - ii. In the service of a licensed health care provider specified in A.R.S. § 32-3201(2), including licensed behavioral health care providers specified in A.R.S. § 32-3251(8); or
 - iii. In the service of a contractor providing CHR or CHW services under A.R.S. Title 36, Chapter 29, Article 1 specified in A.R.S. § 36-765.02(C);
 - b. Completing a CHW certificate program, including core competencies, provided by an accredited college, and 480 hours of paid or volunteer CHR or CHW experience completed during the previous three years;
 - c. Completing a CHW training program provided by an organization or certified CHW trainer, including core competencies and 480 hours of paid or volunteer CHR or CHW experience completed during the previous three years; or
 - d. Completing a CHR National Training Program for:
 - i. Basic training certification and 480 hours of paid or volunteer CHR or CHW experience completed during the previous three years; or
 - ii. Advanced training certification and 380 hours of paid or volunteer CHR or CHW experience completed during the previous three years; and
 4. Completes an initial CHW application.
- C. A certified CHW's scope of practice includes:
 1. Providing cultural mediation among individuals, communities, and health and social systems;
 2. Providing culturally appropriate health education and information;
 3. Providing care coordination, case coordination and system navigation;
 4. Providing coaching and social support;
 5. Advocating for individuals and communities;
 6. Building individual and community capacity;
 7. Providing direct services;

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8. Implementing individual and community assessments;
 9. Conducting outreach; and
 10. Participating in evaluation and research.
- D.** In addition to core competencies specified in R9-16-801(16), a CHW's roles and activities may include:
1. Diabetes education;
 2. Disease intervention;
 3. Nutrition, specifically food preparation and purchasing;
 4. Parenting education;
 5. Community wellness partner;
 6. Connect clients to health education and community resources;
 7. Blood pressure education;
 8. Delivery of medical supplies and equipment to assist client's needs;
 9. Outreach to clients who are out of care;
 10. Hearing and vision screenings; and
 11. Other similar health and social services provided on behalf of a health and behavioral health service providers.
- E.** A certified CHW shall not provide physical health services or behavioral health services to a client.

Historical Note

New Section made by final rulemaking at 28 A.A.R.
2552 (September 30, 2022), effective November 7, 2022
(Supp. 22-3).

R9-16-803. Community Health Workers Trainer Qualifications

- A.** A certified CHW, who wishes to provide training and supervision to individuals who wish to obtain a CHW certification, shall:
1. Be 21 years of age or older;
 2. Have at least:
 - a. A high school diploma or high school equivalency diploma and 250 hours providing training and instruction related to practices specified in R9-16-802(C) and (D) to individuals who wish to obtain a CHW certification;
 - b. A diploma in public health or other medical disciplines, including behavioral health, from an accredited college or university for which the individual received a degree, and 150 hours of providing training and instruction related to practices specified in R9-16-802(C) and (D) to individuals who wish to obtain a CHW certification; or
 - c. A diploma in public health or other medical disciplines, including behavioral health, from an accredited college or university for which the individual received a degree and provided training and instruction related to practices specified in R9-16-802(C) and (D) to individuals who wish to obtain a CHW certification including:
 - i. An associate's degree and 200 hours providing training and instruction;
 - ii. A bachelor's degree and 150 hours providing training and instruction;
 - iii. A master's degree and 100 hours providing training and instruction; or
 - iv. A doctorate's degree and 50 hours providing training and instruction;
 3. Maintain documentation that demonstrates completion of the requirements in subsection (A)(2); and
 4. Provide copy of documentation specified in subsection (A)(3) to individuals who wish to obtain a CHW certification for individuals to provide to the Department when completing an initial CHW application.

- B.** A certified CHW trainer who provides training and supervision to an individual seeking certification as a certified CHW shall:
1. Establish a record for each individual who receives training and supervision that includes:
 - a. The individual's name, home address, telephone number, and e-mail address;
 - b. A plan indicating the types of skills and number of hours allocated to the development of each skill that is expected to be completed;
 - c. A document listing each occurrence of training and supervision provided to an individual that includes:
 - i. Business name and address where training or supervision occurred,
 - ii. The date and time when a training or supervision started and ended,
 - iii. The types of knowledge and skills provided, and
 - iv. Notation explaining the individual's progress;
 - d. Documentation of evaluations provided to the individual during the time training or supervision was provided; and
 - e. Documentation of when training and supervision was terminated.
 2. Maintain an individual's CHW records for at least two years after the last date the individual received training and supervision from the certified CHW trainer.
 3. Provide individuals, who have completed training and supervision, a certificate that specifies:
 - a. The individual's first and last name;
 - b. The title of the training;
 - c. A description of the knowledge or types of skills provided;
 - d. The core competencies covered;
 - e. The number of classroom training hours attended;
 - f. The number of supervision hours provided, if applicable;
 - g. The individual's training score, whether pass or not pass;
 - h. The date the training was held or completed;
 - i. The name of the organization providing training and location; and
 - j. The CHW trainer's written name, signature, and date signed.

Historical Note

New Section made by final rulemaking at 28 A.A.R.
2552 (September 30, 2022), effective November 7, 2022
(Supp. 22-3).

R9-16-804. Initial Community Health Workers Application

- A.** An applicant for a CHW certification shall submit to the Department:
1. An application provided in a Department-provided format that contains:
 - a. The applicant's name, home address, telephone number, and e-mail address;
 - b. The applicant's Social Security number, as required under A.R.S. §§ 25-320 and 25-502;
 - c. Whether the applicant has completed high school or a high school equivalency program;
 - d. Whether the applicant is or has been certified as a CHW in another state or country;

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- e. Whether the applicant has ever been convicted of a felony or a misdemeanor involving moral turpitude in this or another state;
- f. If the applicant has been convicted of a felony or a misdemeanor involving moral turpitude:
 - i. The date of the conviction,
 - ii. The state or jurisdiction of the conviction,
 - iii. An explanation of the crime of which the applicant was convicted, and
 - iv. The disposition of the case;
- g. Whether the applicant has had a certification or license revoked or suspended by any state within the previous two years;
- h. Whether the applicant is currently ineligible for certification or licensure in any state because of a revocation or suspension;
- i. Whether any disciplinary action has been imposed by any state, territory or district in this country for an act related to the applicant's practice as a CHW;
- j. Whether the applicant agrees to allow the Department to submit supplemental requests for information under A.R.S. § 41-1075;
- k. An attestation that the information submitted is true and accurate; and
 - l. The applicant's signature and date of signature;
- 2. If applicable, a list of all states and countries in which the applicant is or has been certified or licensed as a CHW;
- 3. Documentation of an applicant's conviction of a felony or a misdemeanor involving moral turpitude in this or another state that includes:
 - a. The date of the conviction,
 - b. The state or jurisdiction of the conviction,
 - c. A description of the crime of which the applicant was convicted, and
 - d. The disposition of the case;
- 4. If a certificate or license for the applicant has been revoked or suspended by any state within the previous two years, documentation that includes:
 - a. The date of the revocation or suspension,
 - b. The state or jurisdiction of the revocation or suspension, and
 - c. An explanation of the revocation or suspension;
- 5. If the applicant is currently ineligible for certificate or license in any state because of a revocation or suspension, documentation that includes:
 - a. The date of the ineligibility for certification or license,
 - b. The state or jurisdiction of the ineligibility for certification or license, and
 - c. An explanation of the ineligibility for certification or license;
- 6. If the applicant has been disciplined by any state, territory, or district of this country for an act related to the applicant's practice as a CHW, documentation that includes:
 - a. The date of the disciplinary action,
 - b. The state or jurisdiction of the disciplinary action,
 - c. An explanation of the disciplinary action, and
 - d. Any other applicable documents, including a legal order or settlement agreement;
- 7. Documentation of the applicant's citizenship or alien status that complies with A.R.S. § 41-1080;
- 8. As applicable, documentation that demonstrates:
 - a. Nine hundred and sixty hour of paid or volunteer CHW experience in core competencies specified in R9-16-802(B)(3)(a):
 - i. The applicant's name;
 - ii. As applicable, the name of each health care facility, licensed health care provider, or contractor for whom core competencies were completed;
 - iii. Name of the applicant's supervisor and supervisor's title;
 - iv. The types of core competencies completed for each health care facility, licensed health care provider, or contractor listed in subsection (A)(8)(a)(ii);
 - v. The dates or range of dates when the core competencies in subsection (A)(8)(a)(iv) were completed;
 - vi. The number of hours completed for the core competencies listed in subsection (A)(8)(a)(v); and
 - vii. The supervisor's signature and date of signature;
 - b. Completion of a CHW certificate program provided by an accredited college and 480 hours of paid or volunteer CHW experience specified in R9-16-802(B)(3)(b);
 - c. Completion of a CHW training program provided by an organization or certified CHW trainer and 480 hours of paid or volunteer CHW experience specified in R9-16-802(B)(3)(c), including:
 - i. The applicant's name;
 - ii. The name of the CHW training program attended;
 - iii. The name of the organization providing the CHW training program;
 - iv. The types of core competencies completed;
 - v. The dates or range of dates when the core competencies in subsection (A)(8)(c)(iii) were completed;
 - vi. The number of hours completed for each core competency completed in subsection (A)(8)(c)(iv); and
 - vii. The signature of the individual overseeing the instruction of the CHW training program and the date of signature;
 - d. Completion of a CHR National Training Program specific in R9-16-802(B)(3)(d):
 - i. Basic training certification and 480 hours of paid or volunteer CHR or CHW experience; or
 - ii. Advanced training certification and 380 hours of paid or volunteer CHR or CHW experience; and
 - e. Completion of high school or high school equivalency or higher degree; and
- 9. A fee specified in R9-16-810.
- B.** In lieu of the documentation required in (A)(8), an applicant may submit documentation to the Department that includes:
 - 1. The name of each state that issued the applicant a current certification, including:
 - a. The certification number of each current certification, and
 - b. The date each current certification was issued;

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2. Documentation of the professional certificate or license issued to the applicant by each state in which the applicant holds a professional certificate or license;
3. A statement, signed and dated by the applicant, attesting that the applicant:
 - a. Has been certified or licensed in another state for at least one year, with a scope of practice consistent with the scope of practice for which certification is being requested;
 - b. Has met minimum education requirements specified in this Article;
 - c. Has not voluntarily surrendered a certification or license in any other state or country while under investigation for unprofessional conduct; and
 - d. Does not have a complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct.
- C. The Department shall review the application and required documentation for certification as a CHW according to R9-16-808 and Table 8.1.

Historical Note

New Section made by final rulemaking at 28 A.A.R.
2552 (September 30, 2022), effective November 7, 2022
(Supp. 22-3).

R9-16-805. Certification Renewal

- A. From the date of issuance, a CHW certification is valid for two years.
- B. At least 30 calendar days before the expiration date of a certification, an applicant shall submit to the Department:
 1. A renewal application in a Department-provided format that contains:
 - a. The applicant's name, home address, telephone number, and e-mail address;
 - b. The applicant's certification number and date of expiration;
 - c. Since the previous certification application, whether the applicant has been convicted of a felony or a misdemeanor involving moral turpitude in this or another state;
 - d. If the applicant was convicted of a felony or a misdemeanor involving moral turpitude:
 - i. The date of the conviction,
 - ii. The state or jurisdiction of the conviction,
 - iii. An explanation of the crime of which the applicant was convicted, and
 - iv. The disposition of the case;
 - e. Whether the applicant has had, within two years before the renewal application date, a certificate suspended or revoked by any state;
 - f. An attestation that:
 - i. The applicant has completed 24 hours of continuing education required in R9-16-806 and documentation of the completed continuing education is available upon the Department's request;
 - ii. The applicant authorizes the Department to verify all information provided in the renewal application packet;
 - iii. The information submitted as part of the renewal application packet is true and accurate; and
 - iv. The applicant's signature and date of signature.

2. A fee specified in R9-16-810.
- C. Documentation of an applicant's conviction of a felony or a misdemeanor involving moral turpitude in this or another state that includes the information specified in subsection (A)(1)(d) issued by the prosecuting state or jurisdiction.
- D. An applicant who does not submit the documentation and the fee in subsection (B) shall apply for a new certificate in R9-16-804.
- E. The Department shall review the application and required documentation for renewal certification as a CHW according to R9-16-808 and Table 8.1.

Historical Note

New Section made by final rulemaking at 28 A.A.R.
2552 (September 30, 2022), effective November 7, 2022
(Supp. 22-3).

R9-16-806. Continuing Education

- A. A certified CHW shall complete 24 hours of continuing education hours within the two years prior to renewing certification specified in A.R.S. § 36-765.02.
- B. Continuing education shall:
 1. Directly relate to CHW core competencies including services, skills, and knowledge that:
 - a. Facilitates access to quality of care delivery and health outcomes for clients receiving services; and
 - b. Expands health and wellness in diverse communities to reduce health disparities;
 2. Have educational objectives that exceed an introductory level of knowledge related to health and community services; and
 3. Consist of courses related to core competencies, such as:
 - a. Health and social service systems;
 - b. Disease prevention to help manage health conditions;
 - c. Health promotion education;
 - d. Health literacy and cross-cultural communication;
 - e. Referrals and providing follow-up;
 - f. Individual support and coaching;
 - g. Outreach methods and strategies;
 - h. Client and community assessment;
 - i. Health education for behavior change;
 - j. Provide direct services;
 - k. Home visits to provide education, assessment, and social support; and
 - l. Support, advocacy, and health system navigation for clients.
- C. A continuing education course developed, endorsed, or sponsored by one of the following that meets the requirements in subsection (B):
 1. National Community Health Worker Training Center;
 2. Arizona Community Health Workers Association;
 3. Centers for Disease Control and Prevention: Training and Continuing Education;
 4. Arizona Alliance for Community Health Centers;
 5. National Commission for Health Education Credentialing;
 6. American Diabetes Association;
 7. Western Region Public Health Training Center;
 8. Indian Health Service; and
 9. Other certified CHW training programs approved by the Department.

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Historical Note

New Section made by final rulemaking at 28 A.A.R.
2552 (September 30, 2022), effective November 7, 2022
(Supp. 22-3).

R9-16-807. Enforcement

- A.** The Department may deny, suspend, or revoke a certificate holder's certification, permanently or for a fixed period of time specified in A.R.S. § 36-765.03 and this Article.
- B.** In determining which disciplinary action specified in subsection (A) is appropriate, the Department shall consider:
1. The type of violation,
 2. The severity of the violation,
 3. The danger to the public health and safety,
 4. The number of violations,
 5. The number of clients affected by the violations,
 6. The degree of harm to the consumer,
 7. A pattern of noncompliance, and
 8. Any mitigating or aggravating circumstances.
- C.** A certificate holder may appeal an enforcement action taken by the Department according to A.R.S. Title 41, Chapter 6, Article 10.
- D.** If a certified CHW is employed by a tribe and appears to have violated this Article according to A.R.S. § 36-765.03(D), the tribal government having jurisdiction and following Tribal ordinances and policies shall:
1. Review and determine whether the certified CHW has violated this Article; and
 2. Provide the Department with a written determination whether denied, suspended, or revoked, including specific penalties from disciplinary actions taken by the tribal government.

Historical Note

New Section made by final rulemaking at 28 A.A.R.
2552 (September 30, 2022), effective November 7, 2022
(Supp. 22-3).

R9-16-808. Time-frames

- A.** For a certificate or approval issued by the Department under this Article, Table 8.1 specifies the overall time-frame.
1. An applicant and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame.
 2. The extension of the substantive review time-frame and the overall time-frame may not exceed 25% of the overall time-frame.
- B.** For a certificate or approval issued by the Department under this Article, Table 8.1 specifies the administrative completeness review time-frame.
1. The administrative completeness review time-frame begins the date the Department receives an application required in this Article.
 2. Except as provided in subsection (B)(3), the Department shall provide a written notice of administrative completeness

ness or a notice of deficiencies to an applicant within the administrative completeness review time-frame.

- a. If a certificate application is not complete, the notice of deficiencies listing each deficiency and the information or documentation needed to complete the application.
 - b. A notice of deficiencies suspends the administrative completeness review time-frame and the overall time-frame from the date of the notice until the date the Department receives the missing information or documentation.
 - c. If the applicant does not submit to the Department all the information or documentation listed in the notice of deficiencies within 30 calendar days after the date of the notice of deficiencies, the Department shall consider the application withdrawn.
3. If the Department issues a certificate during the administrative completeness review time-frame, the Department shall not issue a separate written notice of administrative completeness.
- C.** For a certificate or approval issued by the Department under this Article, Table 8.1 specifies the substantive review time-frame, which begins on the date the Department sends a written notice of administrative completeness.
1. Within the substantive review time-frame, the Department shall provide a written notice to the applicant that the Department approved or denied the application.
 2. During the substantive review time-frame:
 - a. The Department may make one comprehensive written request for additional information or documentation; and
 - b. If the Department and the applicant agree in writing, the Department may make supplemental requests for additional information or documentation.
 3. A comprehensive written request or a supplemental request for additional information or documentation suspends the substantive review time-frame and the overall time-frame from the date of the request until the date the Department receives all the information or documentation requested.
 4. If the applicant does not submit to the Department all the information or documentation listed in a comprehensive written request or supplemental request for additional information or documentation within 30 calendar days after the date of the request, the Department shall deny the certificate or approval.
- D.** An applicant who is denied a certification may appeal the denial according to A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

New Section made by final rulemaking at 28 A.A.R.
2552 (September 30, 2022), effective November 7, 2022
(Supp. 22-3).

Table 8.1. Time-frames (in calendar days)

Type of Approval	Statutory Authority	Overall Time-frame	Administrative Completeness Review Time-frame	Time to Respond to Deficiency Notice	Substantive Review Time-frame
Initial Application	A.R.S. § 36-765.01	60	30	30	30
Certification Renewal	A.R.S. § 36-765.01	60	30	30	30

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Table 8.1, Time-Frames (in calendar days) made by final rulemaking at 28 A.A.R. 2552 (September 30, 2022), effective November 7, 2022 (Supp. 22-3).

R9-16-809. Changes Affecting a Certificate; Request for a Duplicate Certificate

- A.** A certified CHW shall submit to the Department a notice in a Department-provided format within 30 calendar days after the effective date of a change in:
1. The certified CHW's home address, telephone number, or e-mail address, including the new home address, telephone number, or e-mail address; and
 2. The certified CHW's name, including a copy of one of the following with the certified CHW's new name:
 - a. Marriage certificate,
 - b. Divorce decree, or
 - c. Other legal document establishing the certified CHW's new name.
- B.** A certificate holder may obtain a duplicate certificate by submitting to the Department a written request for a duplicate certificate in a Department-provided format that includes:
1. The certified CHW's name and address,
 2. The certified CHW's certification number and expiration date,
 3. The certified CHW's signature and date of signature, and
 4. A duplicate certificate fee specified in R9-16-810.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 2552 (September 30, 2022), effective November 7, 2022 (Supp. 22-3).

R9-16-810. Fees

- A.** An applicant shall submit to the Department for a CHW certification, a \$100 nonrefundable initial application fee.
- B.** An applicant shall submit to the Department for a CHW certification, a \$200 initial certification fee.
- C.** A certified CHW shall submit to the Department for a renewal certification, a \$200 nonrefundable renewal fee.
- D.** The fee for a duplicate certificate is \$25.
- E.** An applicant for initial certification is not required to submit the applicable fee in subsections (A) and (B) if the applicant, as part of the applicable application in R9-16-804, submits an attestation that the applicant meets the criteria for waiver of licensing fees in A.R.S. § 41-1080.01.
- F.** Subject to the availability of Department funding, an applicant may receive a discounted fee for an initial application, initial certification, or renewal certification.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 2552 (September 30, 2022), effective November 7, 2022 (Supp. 22-3).

ARTICLE 9. DOULA CERTIFICATION**R9-16-901. Definitions**

In addition to the definitions in A.R.S. § 36-766, the following definitions apply in this Article unless otherwise specified:

1. "Administrative completeness review time-frame" has the same meaning as in A.R.S. § 41-1072.
2. "Applicant" means an individual who submits an application and required documentation for approval to practice as a certified doula.
3. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run and including the last day of the

period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.

4. "Certification" means an approval granted to individuals who meet the qualifications, including education and training requirements, in this Article for certified doulas.
5. "Certified doula" means the same as "state-certified doula" in A.R.S. § 36-766.
6. "Client" means an individual receiving doula services provided by a certified doula.
7. "Code of ethics agreement" means the document submitted to the Department by an applicant that agrees to the general ethics and compliance of the standards of practice, and doula scope of practice of a certified doula.
8. "Continuing education" means a course that provides training and instruction that is designed to develop or improve a certified doula's professional competence in areas directly related to the practice of a doula.
9. "Core competencies" means a curriculum that provides knowledge to develop core skills and assume job responsibilities, including:
 - a. Entrepreneurship,
 - b. Standards of practice and ethics,
 - c. The childbirth processes,
 - d. Parental engagement,
 - e. Postpartum care,
 - f. Grief,
 - g. Trauma-informed care,
 - h. Cultural doula practices,
 - i. Anatomy and physiology, and
 - j. HIPAA.
10. "Course" means a workshop, seminar, lecture, conference, or class.
11. "Department" means the same as in A.R.S. § 36-101.
12. "Doula scope of practice" includes:
 - a. Providing care coordination, coaching, and social support;
 - b. Providing emotional support of the individuals parenting choices;
 - c. Providing encouragement and positive affirmations;
 - d. Advocating for parents;
 - e. Assessing the needs of the family;
 - f. Providing newborn care hands-on education and care including:
 - i. Normal newborn behavior,
 - ii. Newborn appearance,
 - iii. Sleep habits,
 - iv. Feeding,
 - v. Bathing, and
 - vi. Dressing the baby;
 - g. Infant feeding support;
 - h. Cord and circumcision care;
 - i. Establishing a routine;
 - j. Organizing the nursery and home; and
 - k. Sibling education and transition.
13. "Documentation" means information in written, photographic, electronic or other permanent form.
14. "Evaluation" means the assessment of the client in order to provide doula services.

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15. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, according to U.S. Public Law 104-191.
 16. "Licensed midwife" has the same meaning as "midwife" in A.R.S. § 36-751 and is licensed by the Department to provide midwifery services.
 17. "Medical provider" means an individual licensed in the state of Arizona as a:
 - a. "Physician" as defined in A.R.S. §§ 32-1401, 32-1501, or 32-1800;
 - b. "Certified nurse midwife" as defined in A.R.S. § 32-1601; or
 - c. "Clinical nurse specialist" as defined in A.R.S. § 32-1601.
 18. "Observing" means to witness:
 - a. The provision of doula services to a client, or
 - b. A demonstration of how to provide doula services to a client.
 19. "Organization" means a person specified in A.R.S. § 1-215, and includes a tribal government.
 20. "Overall time-frame" has the same meaning as in A.R.S. § 41-1072.
 21. "Physical health services" means information and care provided by licensed health professionals consistent with practices specified in A.R.S. § 32-3201.
 22. "Postpartum" means the six-week period following delivery of a newborn and placenta.
 23. "Training and instruction" means educational activities that develop and improve an individual's professional competence in areas related to the practice as a certified doula specified in A.R.S. § 36-766.03 and specific to the delivery of services identified in the doula scope of practice and core competencies specified in this Article.
- a. Observing at least one birth after training is completed by the medical provider or licensed midwife who assisted the laboring mother;
 - b. Attending a minimum of three births while serving as the primary doula, including evaluations from the laboring mother and from the medical provider or licensed midwife who assisted the laboring mother;
 - c. Completing first aid and adult basic cardiopulmonary resuscitation through a course recognized by the American Heart Association;
 - d. Completing neonatal resuscitation through a course recognized by the American Academy of Pediatrics or American Heart Association;
 - e. A code of ethics agreement as prescribed by the Department, and
 - f. A valid fingerprint clearance card issued according to A.R.S. Title 41, Chapter 12, Article 3.1;
5. Meets the requirements of core competencies as specified in R9-16-901(9) and certified doula scope of practice as specified in R9-16-901(12); and
 6. Submits an initial doula application in a Department-provided format to the Department.
- C.** An individual who does not meet the requirements in subsections (B)(3) and (4), but who has been practicing as a doula in this state for at least five years before the effective date of A.R.S. 36-766.03, may be eligible to be a certified doula if the individual submits to the Department the following:
1. Proof of current certification from a nationally recognized doula organization; and
 2. Three letters of recommendation from medical providers or licensed midwives who have worked with the applicant within the preceding two years and can attest to the applicant's competency in providing doula services.
- D.** A certified doula shall not provide physical health services or behavioral health services to a client.

Historical Note

New Section made by exempt rulemaking at 29 A.A.R. 803 (March 31, 2023), effective August 1, 2023 (Supp. 23-1).

R9-16-902. Doula Eligibility and Doula Scope of Practice

- A.** An individual may provide doula services in Arizona without obtaining certification as a certified doula specified in this Article.
- B.** An individual is eligible to practice as a certified doula, if the individual:
1. Is 18 years of age or older;
 2. Has at least a high school diploma or high school equivalency diploma;
 3. Has training or educational documentation for:
 - a. Completing at least 30 hours of in-person instruction or a combination of in-person and online in core competency specified in this Article; or
 - b. If an individual from a community trained in non-western doula practices, as determined by the Department, documentation confirming that core competencies have been met through culturally specific training or education subject to Department review; or
 - c. If an individual provides documentation of other related individualized; or experiential training or education that is subject to review by the Director; or
 - d. Proof of current certification from a nationally recognized doula organization;
 4. Has written documentation of:

Historical Note

New Section made by exempt rulemaking at 29 A.A.R. 803 (March 31, 2023), effective August 1, 2023 (Supp. 23-1).

R9-16-903. Certification Initial Application

- A.** An applicant for a doula certification shall submit to the Department:
1. An application provided in a Department-provided format that contains:
 - a. The applicant's name, home address, telephone number, and email address;
 - b. The applicant's Social Security number, as required under A.R.S. §§ 25-320 and 25-502;
 - c. Whether the applicant has completed high school or a high school equivalency program;
 - d. Whether the applicant is or has been certified as a doula in another state or country;
 - e. Whether the applicant has had a certification or license revoked or suspended by any state within the previous two years;
 - f. Whether the applicant is currently ineligible for certification or licensure in any state because of a revocation or suspension;
 - g. Whether any disciplinary action has been imposed by any state, territory or district in this country for an act related to the applicant's practice as a doula;

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- h. Whether the applicant agrees to allow the Department to submit supplemental requests for information under A.R.S. § 41-1075;
- i. An attestation that the information submitted is true and accurate; and
- j. The applicant's signature and date of signature;
- 2. If applicable, a list of all states and countries in which the applicant is or has been certified as a doula;
- 3. If a certificate or license for the applicant has been revoked or suspended by any state within the previous two years, documentation that includes:
 - a. The date of the revocation or suspension,
 - b. The state or jurisdiction of the revocation or suspension, and
 - c. An explanation of the revocation or suspension;
- 4. If the applicant is currently ineligible for any occupational certificate or license in any state because of a revocation or suspension, documentation that includes:
 - a. The date of the ineligibility for certification or license,
 - b. The state or jurisdiction of the ineligibility for certification or license, and
 - c. An explanation of the ineligibility for certification or license;
- 5. If the applicant has been disciplined by any state, territory, or district of this country for an act related to the applicant's practice as a doula, documentation that includes:
 - a. The date of the disciplinary action,
 - b. The state or jurisdiction of the disciplinary action,
 - c. An explanation of the disciplinary action, and
 - d. Any other applicable documents, including a legal order or settlement agreement;
- 6. Documentation of the applicant's citizenship or alien status that complies with A.R.S. § 41-1080;
- 7. As applicable, documentation that demonstrates:
 - a. At least 30 hours of in-person instruction or a combination of in-person and online in core competencies; or
 - b. Specific cultural training or education received related to community training in non-western doula practices confirming completion of required core competencies; or
 - c. Individualized or experiential training or education that is consistent with core competencies; or
 - d. Practicing as a doula in this state for at least five years, before the effective date of A.R.S. § 36-766.03, and includes:
 - i. Proof of current certification from a nationally recognized doula organization; and
 - ii. Three letters of recommendation from a medical provider or licensed midwife who has worked with the applicant within the preceding two years and attest to the applicant's competency; and
 - e. Observing at least one birth after training is completed;
 - f. Attending at least three births while serving as the primary doula, including evaluations from the laboring mother and medical provider or licensed midwife who assisted the laboring mother;
 - g. Completion of training in:
 - i. First aid and cardiopulmonary resuscitation, and
 - ii. Neonatal resuscitation; and
 - h. A valid code of ethics agreement; and
 - i. A valid fingerprint clearance card issued according to A.R.S. Title 41, Chapter 12, Article 3.1; and
- 8. A fee specified in R9-16-909.
- B.** In lieu of the documentation required in subsection (A)(7), an applicant may submit documentation to the Department that includes:
 - 1. The name of each state that issued the applicant a current certification, including:
 - a. The certification number of each current certification, and
 - b. The date each current certification was issued;
 - 2. Documentation of the professional certificate or license issued to the applicant by each state in which the applicant holds a professional certificate or license;
 - 3. A statement, signed and dated by the applicant, attesting that the applicant:
 - a. Has been certified or licensed in another state for at least one year, with a scope of practice consistent with the scope of practice for which certification is being requested;
 - b. Has met minimum education requirements specified in this Article;
 - c. Has not voluntarily surrendered a certification or license in any other state or country while under investigation for unprofessional conduct; and
 - d. Does not have a complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct.
- C.** The Department may waive the minimum training and education requirements for doula state-certification in subsections (A)(7) and (B) for applicants who shall provide documentation of current certification with a nationally recognized doula organization.
- D.** The Department shall review the application and required documentation for certification as a certified doula according to R9-16-907 and Table 9.1.

Historical Note

New Section made by exempt rulemaking at 29 A.A.R. 803 (March 31, 2023), effective August 1, 2023 (Supp. 23-1).

R9-16-904. Certification Renewal

- A.** From the date of issuance, a doula certification is valid for three years.
- B.** At least 30 calendar days and not more than 90 calendar days before the expiration date of a certification, an applicant shall submit to the Department:
 - 1. A renewal application in a Department-provided format that contains:
 - a. The applicant's name, home address, telephone number, and email address;
 - b. The applicant's certification number and date of expiration;
 - c. Whether the applicant has had, within two years before the renewal application date, a certificate suspended or revoked by any state;
 - d. An attestation that the applicant has completed 15 hours of continuing education required in R9-16-905 and documentation of the completed continuing education is available upon the Department's request;

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- e. Whether the applicant agrees to allow the Department to submit supplemental request for information under R9-16-907(C);
 - f. An attestation that the information submitted as part of the renewal application packet is true and accurate; and
 - g. The applicant's signature and date of signature.
2. A fee specified in R9-16-909.
- C. An applicant who does not submit the documentation and the fee in subsection (B) shall apply for a new certificate in R9-16-903.
- D. The Department shall review the application and required documentation for renewal certification as a doula according to R9-16-904 and Table 9.1.

Historical Note

New Section made by exempt rulemaking at 29 A.A.R. 803 (March 31, 2023), effective August 1, 2023 (Supp. 23-1).

R9-16-905. Continuing Education

- A. A certified doula shall complete 15 hours of continuing education hours within the three years prior to renewing certification specified in A.R.S. § 36-766.01.
- B. Continuing education shall:
- 1. Directly relate to doula core competencies as specified in R9-16-901(9) including services, skills, and knowledge that:
 - a. Facilitates access to quality of care delivery and health outcomes for clients receiving services; and
 - b. Expands health and wellness in diverse communities to reduce health disparities;
 - 2. Have educational objectives that exceed an introductory level of knowledge related to doula core competencies and scope of practices; and
 - 3. Consist of courses related to core competencies, such as:
 - a. Health and social service systems, including disease prevention to help manage health conditions;
 - b. Health promotion education;
 - i. Health literacy and cross-cultural communication;
 - ii. Referrals and providing follow-up;
 - iii. Individual support and coaching; and
 - iv. Outreach methods and strategies;
 - c. Client and community assessment;
 - d. Health education for behavior change;
 - e. Provide direct services;
 - f. Home visits to provide education, assessment, and social support; and
 - g. Support, advocacy, and health system navigation for clients.
- C. A continuing education course developed, endorsed, or sponsored by the Department according to A.R.S. § 36-766.09(B) is available at www.azdhs.gov.

Historical Note

New Section made by exempt rulemaking at 29 A.A.R. 803 (March 31, 2023), effective August 1, 2023 (Supp. 23-1).

R9-16-906. Enforcement

- A. The Department may deny, suspend, or revoke a certificate holder's certification, permanently or for a fixed period of time specified in A.R.S. § 36-766.04 and this Article.
- B. In determining which disciplinary action specified in subsection (A) is appropriate, the Department shall consider:

- 1. The type of violation,
 - 2. The severity of the violation,
 - 3. The danger to public health and safety,
 - 4. The number of violations,
 - 5. The number of clients affected by the violations,
 - 6. The degree of harm to the consumer,
 - 7. A pattern of noncompliance, and
 - 8. Any mitigating or aggravating circumstances.
- C. A certificate holder may appeal an enforcement action taken by the Department according to A.R.S. Title 41, Chapter 6, Article 10.
- D. If a certified doula is employed by a tribe and appears to have violated this Article according to A.R.S. § 36-766.04(C), the tribal government having jurisdiction and following tribal ordinances and policies shall:
- 1. Review and determine whether the certified doula has violated this Article; and
 - 2. Provide the Department with a written determination of whether denied, suspended, or revoked, including specific penalties from disciplinary actions taken by the tribal government.

Historical Note

New Section made by exempt rulemaking at 29 A.A.R. 803 (March 31, 2023), effective August 1, 2023 (Supp. 23-1).

R9-16-907. Time-frames

- A. For a certificate or approval issued by the Department under this Article, Table 9.1 specifies the overall time-frame.
- 1. An applicant and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame.
 - 2. The extension of the substantive review time-frame and the overall time-frame may not exceed 25% of the overall time-frame.
- B. For a certificate or approval issued by the Department under this Article, Table 9.1 specifies the administrative completeness review time-frame.
- 1. The administrative completeness review time-frame begins the date the Department receives an application required in this Article.
 - 2. Except as provided in subsection (B)(3), the Department shall provide a written notice of administrative completeness or a notice of deficiencies to an applicant within the administrative completeness review time-frame.
 - a. If a certificate application is not complete, the notice of deficiencies listing each deficiency and the information or documentation needed to complete the application.
 - b. A notice of deficiencies suspends the administrative completeness review time-frame and the overall time-frame from the date of the notice until the date the Department receives the missing information or documentation.
 - c. If the applicant does not submit to the Department all the information or documentation listed in the notice of deficiencies within 30 calendar days after the date of the notice of deficiencies, the Department shall consider the application withdrawn.
 - 3. If the Department issues a certificate during the administrative completeness review time-frame, the Department shall not issue a separate written notice of administrative completeness.

TITLE 9. HEALTH SERVICES

CHAPTER 16. DEPARTMENT OF HEALTH SERVICES - OCCUPATIONAL LICENSING

- C. For a certificate or approval issued by the Department under this Article, Table 9.1 specifies the substantive review time-frame, which begins on the date the Department sends a written notice of administrative completeness.
1. Within the substantive review time-frame, the Department shall provide a written notice to the applicant that the Department approved or denied the application.
 2. During the substantive review time-frame:
 - a. The Department may make one comprehensive written request for additional information or documentation; and
 - b. If the Department and the applicant agree in writing, the Department may make supplemental requests for additional information or documentation.
 3. A comprehensive written request or a supplemental request for additional information or documentation suspends the substantive review time-frame and the overall time-frame from the date of the request until the date the Department receives all the information or documentation requested.
 4. If the applicant does not submit to the Department all the information or documentation listed in a comprehensive written request or supplemental request for additional information or documentation within 30 calendar days after the date of the request, the Department shall deny the certificate or approval.
- D. An applicant who is denied certification may appeal the denial according to A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

New Section made by exempt rulemaking at 29 A.A.R. 803 (March 31, 2023), effective August 1, 2023 (Supp. 23-1).

Table 9.1. Time-frames (in calendar days)

Type of Approval	Statutory Authority	Overall Time-frame	Administrative Completeness Review Time-frame	Time to Respond to Deficiency Notice	Substantive Review Time-frame	Time to Respond to a Comprehensive Written Request
Initial Application	A.R.S. § 36-766.02	60	30	30	30	30
Certification Renewal	A.R.S. § 36-766.02	60	30	30	30	30

Historical Note

New Table 9.1, Time-Frames (in calendar days) made by exempt rulemaking at 29 A.A.R. 803 (March 31, 2023), effective August 1, 2023 (Supp. 23-1).

R9-16-908. Changes Affecting a Certificate; Request for a Duplicate Certificate

- A. A certified doula shall submit to the Department a notice in a Department-provided format within 30 calendar days after the effective date of a change in:
1. The certified doula's home address, telephone number, or email address, including the new home address, telephone number, or email address; and
 2. The certified doula's name, including a copy of one of the following with the certified doula's new name:
 - a. Marriage certificate,
 - b. Divorce decree, or
 - c. Other legal documents establishing the certified doula's new name.
- B. A certificate holder may obtain a duplicate certificate by submitting to the Department a written request for a duplicate certificate in a Department-provided format that includes:
1. The certified doula's name and address,
 2. The certified doula's certification number and expiration date,
 3. The certified doula's signature and date of signature, and
 4. A duplicate certificate fee specified in R9-16-909.

Historical Note

New Section made by exempt rulemaking at 29 A.A.R. 803 (March 31, 2023), effective August 1, 2023 (Supp. 23-1).

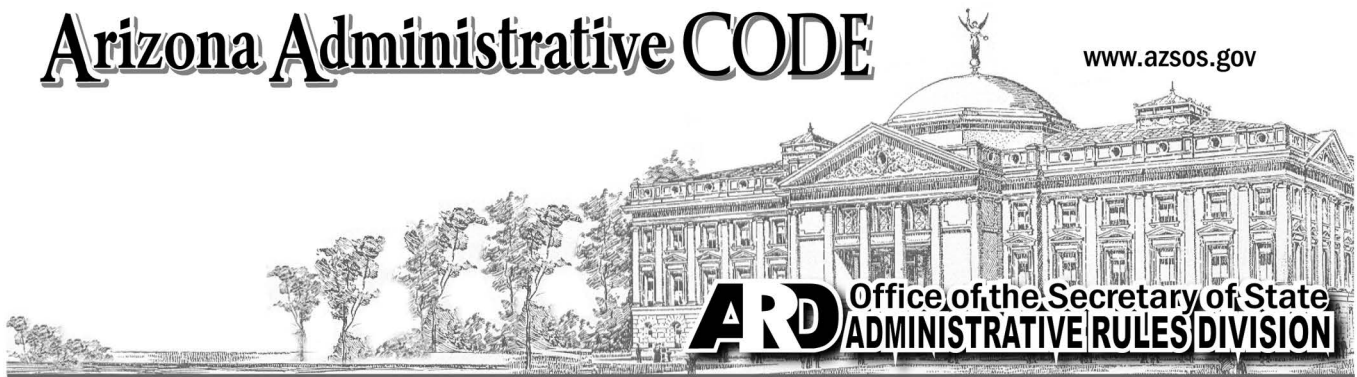
R9-16-909. Fees

- A. An applicant shall submit to the Department for a doula certification, a \$100 nonrefundable initial application fee.
- B. An applicant shall submit to the Department for a doula certification, a \$200 initial certification fee.
- C. A certified doula shall submit to the Department for a renewal certification, a \$200 nonrefundable renewal fee.
- D. The fee for a duplicate certificate is \$25.
- E. An applicant for initial certification is not required to submit the applicable fee in subsections (A) and (B) if the applicant, as part of the applicable application in R9-16-903, submits an attestation that the applicant meets the criteria for waiver of licensing fees in A.R.S. § 41-1080.01.
- F. Subject to the availability of Department funding, an applicant may receive a discounted fee for an initial application, initial certification, or renewal certification.

Historical Note

New Section made by exempt rulemaking at 29 A.A.R. 803 (March 31, 2023), effective August 1, 2023 (Supp. 23-1).

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9 A.A.C. 21

Supp. 21-3

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of
January 1, 2023 through March 31, 2023

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Questions about these rules? Contact:

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The release of this Chapter in Supp. 21-3 replaces Supp. 22-4, 1-63 pages.

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, www.azsos.gov under Services-> Legislative Filings.

EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

PERSONAL USE/COMMERCIAL USE

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Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.

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Administrative Rules Division

The Arizona Secretary of State electronically publishes each A.A.C. Chapter with a digital certificate. The certificate-based signature displays the date and time the document was signed and can be validated in Adobe Acrobat Reader.

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Authority: A.R.S. § 36-520

Supp. 21-3

Editor's Note: Laws 2015, Ch. 195 provided for the statutory transfer of behavioral health responsibilities from the Arizona Department of Health Services to the Arizona Health Care Cost Containment System (AHCCCS). Therefore the Chapter name has been amended from Department of Health Services to the Arizona Health Care Cost Containment System at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

Editor's Note: The Office of the Secretary of State publishes all Chapters on white paper (Supp. 01-3).

Editor's Note: Title 9, Chapter 21 was adopted and amended by the Department of Health Services under the provisions of Laws 1992, Ch. 301, § 61, which provided for an exemption from the rulemaking process as specified in the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, § 41-1001 et seq.). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department was not required to hold public hearings on these rules; and the Attorney General has not certified these rules. Because this Chapter contains rules which are exempt from the provisions of the Arizona Administrative Procedure Act, the Chapter is printed on blue paper.

Former Title 9, Chapter 21 renumbered to Title 18, Chapter 11.

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ARTICLE 1. GENERAL PROVISIONS

R9-21-101. Definitions and Location of Definitions

- A. Location of definitions. Unless the context otherwise requires, terms used in this Chapter that are defined in A.R.S. § 36-501 shall have the same meaning as in A.R.S. § 36-501. In addition, the following definitions applicable to this Chapter are found in the following Section or Citation:

"Abuse"	R9-21-101
"ADHS"	R9-22-101
"Administration"	A.R.S. § 36-2901
"Court"	A.R.S. § 36-501
"Danger to others"	A.R.S. § 36-501
"Department"	R9-21-101, A.R.S. § 36-501
"Director"	A.R.S. § 36-501
"Evaluation"	A.R.S. § 36-501
"Family member"	A.R.S. § 36-501
"Informed consent"	A.R.S. § 36-501
"Licensed physician"	A.R.S. § 36-501
"Mental disorder"	A.R.S. § 36-501
"Mental health provider"	A.R.S. § 36-501
"Outpatient treatment"	A.R.S. § 36-501
"Persistent or acute disability"	A.R.S. § 36-501
"Professional"	A.R.S. § 36-501
"Proposed patient"	A.R.S. § 36-501
"Psychiatrist"	A.R.S. § 36-501
"Psychologist"	A.R.S. § 36-501
"Records"	A.R.S. § 36-501
"Regional Behavioral Health Authority (RBHA)"	A.R.S. § 36-3401
"Seriously Mentally Ill (SMI)"	A.R.S. § 36-550
"Social worker"	A.R.S. § 36-501

- B. In this Chapter, unless the context otherwise requires:

"Abuse" means, with respect to a client, the infliction of, or allowing another person to inflict or cause, physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior. Such abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a client receiving behavioral health services or community services under this Chapter. Abuse shall also include sexual misconduct, assault, molestation, incest, or prostitution of, or with, a client under the care of personnel of a mental health agency.

"Administration" means the Arizona Health Care Cost Containment System.

"Agency director" means the person primarily responsible for the management of an outpatient or inpatient mental health agency, service provider, health plan or the Administration, or their designees.

"AHCCCS" means the Arizona Health Care Cost Containment System.

"Applicant" means an individual who:

Submits to a health plan an application for behavioral health services under this Chapter or on whose behalf an application has been submitted; or

Is referred to a health plan for a determination of eligibility for behavioral health services according to this Chapter.

"ASH" means the Arizona State Hospital.

"Authorization" means written permission for a mental health agency to release or disclose a client's record or information, containing:

The name of the mental health agency releasing or disclosing the client's record or information;

The purpose of the release or disclosure;

The individual, mental health agency, or entity requesting or receiving the client's record or information;

A description of the client's record or information to be released or disclosed;

A statement:

Of permission for the mental health agency to release or disclose the client's record or information; and

That permission may be revoked at any time;

The date when or conditions under which the permission expires;

The date the document is signed; and

The signature of the client or, if applicable, the client's guardian.

"Behavioral health issue" means an individual's condition related to a mental disorder, personality disorder, substance abuse, or a significant psychological or behavioral response to an identifiable stressor or stressors.

"Behavioral health service" means the assessment, diagnosis, or treatment of an individual's behavioral health issue.

"Burden of proof" means the necessity or obligation of affirmatively proving the fact or facts in dispute.

"Case manager" means the person responsible for locating, accessing and monitoring the provision of services to clients in conjunction with a clinical team.

"Client" means an individual who has a qualifying serious mental illness and is being evaluated or treated for a mental disorder by or through a health plan.

"Client record" means the written compilation of information that describes and documents the evaluation, diagnosis or treatment of a client.

"Client who needs special assistance" means a client who has been:

Deemed by a qualified clinician, case manager, clinical team, or health plan to need special assistance in participating in the ISP or ITDP process, which may include, but is not limited to:

A client who requires 24-hour supervision;

A client who is, in fact, incapable of making or communicating needs but is without a court-appointed fiduciary; or

A client with physical disabilities or language difficulties impacting the client's ability to make or communicate decisions or to prepare or participate in meetings; or

Otherwise deemed by a program director, the Administration, or an Administrative Law Judge to

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

need special assistance to effectively file a written grievance, to understand the grievance and investigation procedure, or to otherwise effectively participate in the grievance process under this Chapter.

“Clinical team” refers to the interdisciplinary team of persons who are responsible for providing continuous treatment and support to a client and for locating, accessing and monitoring the provision of behavioral health services or community services. A clinical team consists of a psychiatrist, case manager, vocational specialist, psychiatric nurse, and other professionals or paraprofessionals, such as a psychologist, social worker, consumer case management aide, or rehabilitation specialist, as needed, based on the client’s needs. The team shall also include a team leader who is a certified behavioral health supervisor.

“Community services” means services such as clinical case management, outreach, housing and residential services, crisis intervention and resolution services, mobile crisis teams, day treatment, vocational training and opportunities, rehabilitation services, peer support, social support, recreation services, advocacy, family support services, outpatient counseling and treatment, transportation, and medication evaluation and maintenance.

“Condition requiring investigation” means, within the context of the grievance and investigation procedure set forth in Article 4 of this Chapter, an incident or condition which appears to be dangerous, illegal, or inhumane, including a client death.

“Court-ordered treatment” means treatment ordered by the court under A.R.S. Title 36, Chapter 5.

“Court-ordered evaluation” means evaluation ordered by the court under A.R.S. Title 36, Chapter 5.

“Crisis services” or “emergency services” means immediate and intensive, time-limited, crisis intervention and resolution services which are available on a 24-hour basis and may include information and referral, evaluation and counseling to stabilize the situation, triage to an inpatient setting, clinical crisis intervention services, mobile crisis services, emergency crisis shelter services, and follow-up counseling for clients who are experiencing a psychiatric emergency.

“Dangerous” as used in Article 4 of this Chapter means a condition that poses or posed a danger or the potential of danger to the health or safety of any client.

“Department” means the Arizona Department of Health Services.

“Designated representative” means a parent, guardian, relative, advocate, friend, or other person, designated in writing by a client or guardian who, upon the request of the client or guardian, assists the client in protecting the client’s rights and voicing the client’s service needs.

“Determining Entity” means either the AHCCCS designee authorized to make SMI determinations or a Tribal Regional Behavioral Health Authority (for each TRBHA, tribal members only) authorized to make the final determination of SMI eligibility.

“Discharge plan” means a hospital or community treatment and discharge plan prepared according to Article 3 of this Chapter.

“Drug used as a restraint” means a pharmacological restraint as used in A.R.S. § 36-513 that is not standard treatment for a client’s medical condition or behavioral health issue and is administered to:

Manage the client’s behavior in a way that reduces the safety risk to the client or others,

Temporarily restrict the client’s freedom of movement.

“DSM” means the latest edition of the “Diagnostic and Statistical Manual of Mental Disorders,” edited by the American Psychiatric Association.

“Emergency safety situation” means unanticipated client behavior that creates a substantial and imminent risk that the client may inflict injury, and has the ability to inflict injury, upon:

The client, as evidenced by threats or attempts to commit suicide or to inflict injury on the client; or

Another individual, as evidenced by threats or attempts to inflict injury on another individual or individuals, previous behavior that has caused injury to another individual or individuals, or behavior that places another individual or individuals in reasonable fear of sustaining injury.

“Exploitation” means the illegal or improper use of a client or a client’s resources for another’s profit or advantage.

“Frivolous” as used in this Chapter, means a grievance that is devoid of merit. Grievances are presumed not to be frivolous unless the grievance:

Involves conduct that is not within the scope of this Chapter,

Is impossible on its face, or

Is substantially similar to conduct alleged in two previous grievances within the past year that have been determined to be unsubstantiated as provided in this Chapter.

“Generic services” means services other than behavioral health or other services for which clients may have a need and include, but are not limited to, health, dental, vision care, housing arrangements, social organizations, recreational facilities, jobs, and educational institutions.

“Grievance” means a complaint regarding an act, omission or condition, as provided in this Chapter.

“Guardian” means an individual appointed by court order according to A.R.S. Title 14, Chapter 5, or similar proceedings in another state or jurisdiction where said guardianship has been properly domesticated under Arizona law.

“Health Plan” means a Regional Behavioral Health Authority (RBHA), health plan, or Arizona Long Term Care Plan under contract with the Administration to coordinate the delivery of behavioral health services members in a geographically specific service area of the state for eligible persons.

“Hearing officer” refers to an impartial person designated by the Office of Administrative Hearing to hear a dispute and render a written decision.

“Human rights advocate” means the human rights advocates appointed by the Administration under R9-21-105.

“Independent Oversight committee” means the committee established under A.R.S. § 41-3803.

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CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

“Illegal” means, within the context of the grievance and investigation procedure set forth in Article 4 of this Chapter, an incident or occurrence which is or was likely to constitute a violation of a state or federal statute, regulation, court decision or other law, including the provisions of these Articles.

“Individual service plan” or “ISP” means the written plan for services to a client, prepared in accordance with Article 3 of this Chapter.

“Inhumane” as used in Article 4 of this Chapter means an incident, condition or occurrence that is demeaning to a client, or which is inconsistent with the proper regard for the right of the client to humane treatment.

“Inpatient facility” means the Arizona State Hospital, the County Annex, or any other inpatient treatment facility registered with or funded by or through the Administration to provide behavioral health services, including psychiatric health facilities, psychiatric hospitals, and psychiatric units in general hospitals.

“Inpatient treatment and discharge plan” or “ITDP” means the written plan for services to a client prepared and implemented by an inpatient facility in accordance with Article 3 of this Chapter.

“Long-term view” means a planning statement that identifies, from the client’s perspective, what the client would like to be doing for work, education, and leisure and where the client would like to be living for up to a three-year period. The long-term view is based on the client’s unique interests, strengths, and personal desires. It includes predicted times for achievement.

“Mechanical restraint” means any, device, article, or garment attached or adjacent to a client’s body that the client cannot easily remove and that restricts the client’s freedom of movement or normal access to the client’s body, but does not include a device, article, or garment:

- Used for orthopedic or surgical reasons, or
- Necessary to allow a client to heal from a medical condition or to participate in a treatment program for a medical condition.

“Medical practitioner” means a

- Physician,
- Physician assistant, or
- Nurse practitioner.

“Meeting” means an encounter or assembly of individuals which may be conducted in person or by telephone or by video-conferencing.

“Mental health agency” includes a health plan, service provider, inpatient facility, or an entity that conducts screening and evaluation under Article 5.

“MIHS Behavioral Health Annex” means the Maricopa County Psychiatric Annex of the Maricopa Medical Center.

“Nurse” means an individual licensed as a registered nurse or a practical nurse according to A.R.S. Title 32, Chapter 15.

“Party” or “parties” as used in Articles 3 and 4 of these rules means the person filing a grievance under this Chapter, the agency director who issued any final resolution or decision of such a grievance, the person whose conduct is complained of

in the grievance, any client or applicant who is the subject of the request or grievance, the legal guardian of client or applicant, and, in selected cases, the appropriate Independent Oversight committee.

“Personal restraint” means the application of physical force without the use of any device, for the purpose of restricting the free movement of a client’s body.

“PRN order” or “Pro re nata medication” means medication given as needed.

“Program director” means the person with the day-to-day responsibility for the operation of a programmatic component of a service provider, such as a specific residential, vocational, or case management program.

“Qualified clinician” means a behavioral health professional who is licensed or certified under A.R.S. Title 32, or a behavioral health technician who is supervised by a licensed or certified behavioral health professional.

“Region” means the geographical region designated by the Administration in its contract with the health plan.

“Restraint” means personal restraint, mechanical restraint, or drug used as a restraint.

“Seclusion” means restricting a client to a room or area through the use of locked doors or any other device or method which precludes a client from freely exiting the room or area or which a client reasonably believes precludes his unrestricted exit. In the case of an inpatient facility, confining a client to the facility, the grounds of the facility, or a ward of the facility does not constitute seclusion. In the case of a community residence, restricting a client to the residential site, according to specific provisions of an individual service plan or court order, does not constitute seclusion.

“Seriously mentally ill” means a person 18 years of age or older as defined in A.R.S. § 36-550.

“Service provider” means an agency, inpatient facility or other mental health provider funded by or through, under contract or subcontract with, certified by, approved by, registered with, or supervised by the Administration or receiving funds under Title XIX, to provide behavioral health services or community services.

“State Protection and Advocacy System” means the agency designated as the Protection and Advocacy System for individuals with mental illness, according to 42 U.S.C. 10801-10851.

“Title XIX” means Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq.

“Treatment team” means the multidisciplinary team of persons who are responsible for providing continuous treatment and support to a client who is in an inpatient facility

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 7 A.A.R. 3469, effective July 17, 2001 (Supp. 01-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final

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rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-102. Applicability

With regard to the provision of behavioral health services or community services to clients under A.R.S. Title 36 Chapter 5, this Chapter shall apply to the Administration and to all mental health agencies. This Chapter shall not apply to the Arizona Department of Corrections.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

R9-21-103. Computation of Time

For any period of time prescribed or allowed by this Chapter, the time shall be calculated as follows:

1. The period of time shall not include the day of the act, event or default from which the designated period of time begins to run;
2. If the period of time prescribed or allowed is less than 11 days, the period of time shall not include intermediate Saturdays, Sundays and legal holidays;
3. If the period of time is 11 days or more, the period of time shall include intermediate Saturdays, Sundays and legal holidays;
4. If the last day of the period of time is a Saturday, Sunday, or legal holiday, the period of time shall extend until the end of the next day that is not a Saturday, Sunday or legal holiday.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Section repealed; new Section R9-21-103 renumbered from R9-21-104 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

R9-21-104. Office of Human Rights; Human Rights Advocates

- A. An Office of Human Rights shall be established within the Administration. The office shall have its own chief officer who shall be responsible for the management and control of the office, as well as the hiring, training, supervision, and coordination of human rights advocates.
- B. The chief officer shall appoint at least one human rights advocate for each 2,500 clients in each region. Each region shall have at least one human rights advocate. The chief officer shall appoint at least one human rights advocate for ASH. All clients shall have the right of access to The Office of Human Rights in order to understand, exercise, and protect their rights. The human rights advocate shall advocate on behalf of clients and shall assist clients in understanding and protecting their rights and obtaining needed services. The human rights advocate shall also assist clients in resolving appeals and grievances under Article 4 of this Chapter and shall coordinate

and assist the Independent Oversight committees in performing their duties.

- C. The human rights advocates shall be given access to all:
 1. Clients; and
 2. Client records from a service provider, health plan, or the Administration, except as prohibited by federal or state law.
- D. Staff of inpatient facilities, health plans, and service providers shall cooperate with the advocate by providing relevant information, reports, investigations, and access to meetings, staff persons, and facilities except as prohibited by federal or state law and the client's right to privacy.
- E. An agency director shall notify the health plan and the Office of Human Rights of each client who needs special assistance.
- F. The Office of Human Rights shall:
 1. Assign a designated representative to each Special Assistance member;
 - a. The Office of Human Rights shall assign a natural support if one exists and is willing to act as a designated representative, (e.g. a family member or friend), or
 - b. If a natural support does not exist or is unwilling, an Advocate from the Office of Human Rights.
 2. Maintain a list that contains the names of each client who needs special assistance and, if applicable, the name and address of the residential program providing behavioral services to the client; and
 3. Provide each Independent Oversight committee with a list of all clients who need special assistance who reside in the respective jurisdiction of the Independent Oversight committee.
- G. The Administration shall ensure appropriate Independent Oversight committees have access to copies of all reports received according to this Chapter (e.g., reports regarding clients who need special assistance, allegations of mistreatment, denial of rights, restraint, and seclusion).

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-104 renumbered to R9-21-103; new Section R9-21-104 renumbered from R9-21-105 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-105. Independent Oversight Committees

- A. According to A.R.S. §§ 41-3803 and 41-3804, the Department of Administration shall establish Independent Oversight committees to provide independent oversight to ensure that the rights of clients are protected. The Administration shall establish at least one human rights committee for each region and the Arizona State Hospital. Upon the establishment of a human rights committee, if more than 2,500 clients reside within a region, the Administration shall establish additional human rights committees until there is one human rights committee for each 2,500 clients in a region.
- B. Each human rights committee shall be composed of at least seven and not more than 15 members. At least two members of the committee shall be clients or former clients, at least two members shall be relatives of clients, two members shall be

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parents of enrolled children and at least three members shall have expertise in one of the following areas: psychology, law, medicine, education, special education, social work, or behavioral health services.

- C. The Department of Administration shall appoint the initial members to each regional committee and the Independent Oversight committee for the Arizona State Hospital. Members shall be appointed to fill vacancies on an Independent Oversight committee, subject to the approval of the committee.
- D. Each committee shall meet at least four times each year. Within three months of its formation, each committee shall establish written guidelines governing the committee's operations. These guidelines shall be consistent with A.R.S. §§ 41-3803 and 41-3804. The adoption and amendment of the committee's guidelines shall be by a majority vote of the committee and shall be submitted to the Administration for approval.
- E. No employee or individual under contract with the Administration, regional authority, or service provider may be a voting member of a committee.
- F. If a member of an Independent Oversight committee or the Independent Oversight committee determines that a member has a conflict of interest regarding an agenda item, the member shall refrain from:
 1. Participating in a discussion regarding the agenda item, and
 2. Voting on the agenda item.
- G. Each committee shall, within its respective jurisdiction, provide independent oversight and review of:
 1. Allegations of illegal, dangerous, or inhumane treatment of clients;
 2. Reports filed with the committee under R9-21-203 and R9-21-204 concerning the use of seclusion, restraint, abuse, neglect, exploitation, mistreatment, accidents, or injuries;
 3. The provision of services to clients identified under R9-21-301 in need of special assistance;
 4. Violations of rights of clients and conditions requiring investigation under Article 4 of this Chapter;
 5. Research in the field of mental health according to A.R.S. § 41-3804(E); and
 6. Any other issue affecting the human rights of clients.
- H. Within its jurisdiction, each Independent Oversight committee shall, for a client who needs special assistance, and may, for other clients:
 1. Make regular site visits to residential environments;
 2. Meet with the client, including a client who needs special assistance, in residential environments to determine satisfaction of the clients with the residential environments; and
 3. Inspect client records, upon written request to the Administration, including client records for clients who need special assistance, except as prohibited by federal or state law and a client's right to privacy.
- I. A committee may request the services of a consultant or staff person to advise the committee on specific issues. The cost of the consultant or staff person shall be assumed by the Administration or health plan subject to the availability of funds specifically allocated for that purpose. A consultant or staff person may, in the sole discretion of the committee, be a member of another committee or an employee of the Administration, health plan, or service provider. No committee consultant or staff person shall vote or otherwise direct the committee's decisions.

- J. Committee members and committee consultants and staff persons shall have access to client records according to A.R.S. §§ 36-509(A)(11) and 41-3804(I). If an Independent Oversight committee's request for information or records is denied, the committee may request a review of the decision to deny the request according to A.R.S. § 41-3804(J). Nothing in this Section shall be construed to require the disclosure of records or information to the extent that such information is protected by A.R.S. § 36-445 et seq.
- K. On the first day of the months of January, April, July, and October of each year, each committee shall issue a quarterly report summarizing its activities for the prior quarter, including any written objections to the Department of Administration according to A.R.S. § 41-3804, and make any recommendations for changes it believes the Administration or health plans should implement. In addition, the committee may, as it deems appropriate, issue reports on specific problems or violations of client's rights. The report of a regional committee shall be delivered to the Administration.
- L. The Department of Administration shall provide training and support to Independent Oversight committees.
- M. An Independent Oversight committee may request:
 1. An investigation for a client according to this Chapter, or
 2. A health plan or the Arizona State Hospital, as applicable, to conduct an investigation for an enrolled child.
- N. The health plan or the Arizona State Hospital, as applicable, when requested by an Independent Oversight committee, shall conduct an investigation concerning a client as provided in Article 4 of this Chapter.
- O. An Independent Oversight committee shall submit an annual report of the Independent Oversight committee's activities and recommendations to the Director at the end of each calendar year according to A.R.S. § 41-3804(G).

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Former Section R9-21-105 renumbered to R9-21-104; new Section R9-21-105 renumbered from R9-21-106 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-106. State Protection and Advocacy System

Staff of mental health agencies shall cooperate with the State Protection and Advocacy System in its investigations and advocacy for clients and shall provide the System access to clients, records and facilities to the extent permitted and required by federal law, 42 U.S.C. 10801-10851. Nothing in this Section shall be construed to create an independent cause of action that does not already exist for the State Protection and Advocacy System either in state court or any administrative proceeding provided by this Chapter.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to

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Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 7 A.A.R. 3469, effective July 17, 2001 (Supp. 01-3). Former Section R9-21-106 renumbered to R9-21-105; new Section R9-21-106 renumbered from R9-21-107 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

R9-21-107. Renumbered**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Renumbered to R9-21-106 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

ARTICLE 2. RIGHTS OF PERSONS WITH SERIOUS MENTAL ILLNESS**R9-21-201. Civil and Other Legal Rights**

A. Clients shall have all rights accorded by applicable law, including but not limited to those prescribed in A.R.S. §§ 36-504 through 36-517.02. Any individual or agency providing behavioral health services or community services as defined in R9-21-101 shall not abridge these rights, including the following:

1. Those civil rights set forth in A.R.S. § 36-506;
2. The right to acquire and dispose of property, to execute instruments, to enter into contractual relationships, to hold professional or occupational or vehicle operator's licenses, unless the client has been adjudicated incompetent or there has been a judicial order or finding that such client is unable to exercise the specific right or category of rights. In the case of a client adjudicated incompetent, these rights may be exercised by the client's guardian, in accordance with applicable law;
3. The right to be free from unlawful discrimination by the Administration or by any mental health agency on the basis of race, creed, religion, sex, sexual preference, age, physical or mental handicap or degree of handicap; provided, however, classifications based on age, sex, category or degree of handicap shall not be considered discriminatory, if based on written criteria of client selection developed by a mental health agency and approved by the Administration as necessary to the safe operation of the mental health agency and in the best interests of the clients involved;
4. The right to equal access to all existing behavioral health services, community services, and generic services provided by or through the state of Arizona;
5. The right to religious freedom and practice, without compulsion and according to the preference of the client;
6. The right to vote, unless under guardianship, including reasonable assistance when desired in registering and voting in a nonpartisan and noncoercive manner;
7. The right to communicate including:
 - a. The right to have reasonable access to a telephone and reasonable opportunities to make and receive confidential calls and to have assistance when desired and necessary to implement this right;
 - b. The unrestricted right to send and receive uncensored and unopened mail, to be provided with stationery and postage in reasonable amounts, and to

receive assistance when desired and necessary to implement this right;

8. The right to be visited and visit with others, provided that reasonable restrictions may be placed on the time and place of the visit but only to protect the privacy of other clients or to avoid serious disruptions in the normal functioning of the mental health agency;
 9. The right to associate with anyone of the client's choosing, to form associations, and to discuss as a group, with those responsible for the program, matters of general interest to the client, provided that these do not result in serious disruptions in the normal functioning of the mental health agency. Clients shall receive cooperation from the mental health agency if they desire to publicize and hold meetings and clients shall be entitled to invite visitors to attend and participate in such meetings, provided that they do not result in serious disruptions in the normal functioning of the mental health agency;
 10. The right to privacy, including the right not to be fingerprinted and photographed without authorization, except as provided by A.R.S. § 36-507(2);
 11. The right to be informed, in appropriate language and terms, of client rights;
 12. The right to assert grievances with respect to infringement of these rights, including the right to have such grievances considered in a fair, timely, and impartial procedure, as set forth in Article 4 of this Chapter, and the right not to be retaliated against for filing a grievance;
 13. The right of access to the Office of Human Rights to request assistance in order to understand, exercise, and protect a client's rights;
 14. The right to be assisted by an attorney or designated representative of the client's own choice, including the right to meet in a private area at the program or facility with an attorney or designated representative. Nothing in this Chapter shall be construed to require the Administration or any mental health agency to pay for the services of an attorney who consults with or represents a client;
 15. The right to exercise all other rights, entitlements, privileges, immunities provided by law, and specifically those rights of consumers of behavioral health services or community services set forth in A.R.S. §§ 36-504 through 36-517.02;
 16. The same civil rights as all other citizens of Arizona, including the right to marry and to obtain a divorce, to have a family, and to live in the community of their choice without constraints upon their independence, except those constraints to which all citizens are subject.
- B. Nothing in this Article shall be interpreted to:
1. Give the power, right, or authority to any person or mental health agency to authorize sterilization, abortion, or psychosurgery with respect to any client, except as may otherwise be provided by law; or
 2. Restrict the right of physicians, nurses, and emergency medical technicians to render emergency care or treatment in accordance with A.R.S. § 36-512; or
 3. Construe this rule to confer constitutional or statutory rights not already present.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to

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Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-202. Right to Support and Treatment

A. A client has the following rights with respect to the client's support and treatment:

1. The right to behavioral health services or community services:
 - a. Under conditions that support the client's personal liberty and restrict personal liberty only as provided by law or in this Chapter;
 - b. From a flexible service system that responds to the client's needs by increasing, decreasing and changing services as needs change;
 - c. Provided in a way that:
 - i. Preserves the client's human dignity;
 - ii. Respects the client's individuality, abilities, needs, and aspirations without regard to the client's psychiatric condition;
 - iii. Encourages the client's self-determination, freedom of choice, and participation in treatment to the client's fullest capacity;
 - iv. Ensures the client's freedom from the discomfort, distress and deprivation that arise from an unresponsive and inhumane environment;
 - v. Protects and promotes the client's privacy, including an opportunity whenever possible to be provided clearly defined private living, sleeping and personal care spaces; and
 - vi. Maximizes integration of the client into the client's community through services which are located in residential neighborhoods, rely as much as possible on generic support services to provide training and assistance in ordinary community experiences, and utilize specialized mental health programs that are situated in or near generic community services;
 - vii. Offers the client humane and adequate support and treatment that is responsive to the client's needs, recognizes that the client's needs may vary, and is capable of adjusting to the client's changing needs; and
 - d. That provide the client with an opportunity to:
 - i. Receive services that are adequate, appropriate, consistent with the client's individual needs, and least restrictive of the client's freedom;
 - ii. Receive treatment and services that are culturally sensitive in structure, process and content;
 - iii. Receive services on a voluntary basis to the maximum extent possible and entirely if possible;
 - iv. Live in the client's own home;
 - v. Undergo normal experiences, even though the experiences may entail an element of risk, unless the client's safety or well-being or that of others is unreasonably jeopardized; and
 - vi. Engage in activities and styles of living, consistent with the client's interests, which encourage and maintain the integration of the client into the community.
2. The right to ongoing participation in the planning of services as well as participation in the development and periodic revision of the individual service plan;
3. The right to be provided with a reasonable explanation of all aspects of one's condition and treatment;
4. The right to give informed consent to all behavioral health services and the right to refuse behavioral health services in accordance with A.R.S. §§ 36-512 and 36-513, except as provided for in A.R.S. §§ 36-520 through 36-544 and 13-3994;
5. The right not to participate in experimental treatment without voluntary, written informed consent; the right to appropriate protection associated with such participation; and the right and opportunity to revoke such consent;
6. The right to a humane treatment environment that affords protection from harm, appropriate privacy, and freedom from verbal or physical abuse;
7. The right to enjoy basic goods and services without threat of denial or delay. For residential service providers, these basic goods and services include at least the following:
 - a. A nutritionally sound diet of wholesome and tasteful food available at appropriate times and in as normal a manner as possible;
 - b. Arrangements for or provision of an adequate allowance of neat, clean, appropriate, and seasonable clothing that is individually chosen and owned;
 - c. Assistance in securing prompt and adequate medical care, including family planning services, through community medical facilities;
 - d. Opportunities for social contact in the client's home, work or schooling environments;
 - e. Opportunities for daily activities, recreation and physical exercise;
 - f. The opportunity to keep and use personal possessions; and
 - g. Access to individual storage space for personal possessions;
8. The right to be informed, in advance, of charges;
9. The right to a continuum of care in a unified and cohesive system of community services that is well integrated, facilitates the movement of clients among programs, and ensures continuity of care;
10. The right to a continuum of care that consists of, but is not limited to, clinical case management, outreach, supportive housing and residential services, crisis intervention and resolution services, mobile crisis teams, vocational training and opportunities, day treatment, rehabilitation services, peer support, social support, recreation services, advocacy, family support services, outpatient counseling and treatment, transportation, and medication evaluation and maintenance;
11. The right to a continuum of care with programs that offer different levels of intensity of services in order to meet the individual needs of each client;
12. The right to appropriate mental health treatment, based on each client's individual and unique needs, and to those community services from which the client would reasonably benefit;
13. The right to community services provided in the most normal and least restrictive setting, according to the least restrictive means appropriate to the client's needs;
14. The right to clinical case management services and a case manager. The clinical team negotiates and oversees the

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provision of services and ensures the client's smooth transition with service providers and among agencies;

15. The right to participate in treatment decisions and in the development and implementation of the client's ISP, and the right to participate in choosing the type and location of services, consistent with the ISP;
16. The right to prompt consideration of discharge from an inpatient facility and the identification of the steps necessary to secure a client's discharge as part of an ISP;
17. The rights prescribed in Articles 3 and 4 of this Chapter, including the right to:
 - a. A written individual service plan;
 - b. Assert grievances; and
 - c. Be represented by a qualified advocate or other designated representative of the client's choosing in the development of the ISP and the inpatient treatment and discharge plan and in the grievance process, in order to understand, exercise and protect the client's rights.

- B.** Subsection (A) shall not be construed to confer constitutional or statutory rights not already present.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-203. Protection from Abuse, Neglect, Exploitation, and Mistreatment

- A.** No mental health agency shall mistreat a client or permit the mistreatment of a client by staff subject to its direction. Mistreatment includes any intentional, reckless or negligent action or omission which exposes a client to a serious risk of physical or emotional harm. Mistreatment includes but is not limited to:
1. Abuse, neglect, or exploitation;
 2. Corporal punishment;
 3. Any other unreasonable use or degree of force or threat of force not necessary to protect the client or another person from bodily harm;
 4. Infliction of mental or verbal abuse, such as screaming, ridicule, or name calling;
 5. Incitement or encouragement of clients or others to mistreat a client;
 6. Transfer or the threat of transfer of a client for punitive reasons;
 7. Restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
 8. Any act in retaliation against a client for reporting any violation of the provisions of this Chapter to the Administration; or
 9. Commercial exploitation.
- B.** The following special sanctions shall be available to the Department and/or the Administration, in addition to those set forth in 9 A.A.C. 10, Article 10 of the Department's rules, to protect the interests of the client involved as well as other current and former clients of the mental health agency.
1. Mistreatment of a client by staff or persons subject to the direction of a mental health agency may be grounds for suspension or revocation of the license of the mental health agency or the provision of financial assistance,

and, with respect to employees of the mental health agency, grounds for disciplinary action, which may include dismissal.

2. Failure of an employee of the Administration to report any instance of mistreatment within any mental health agency subject to this Chapter shall be grounds for disciplinary action, which may include dismissal.
 3. Failure of a mental health agency to report client deaths and allegations of sexual and physical abuse to the Administration and to comply with the procedures described in Article 4 of this Chapter for the processing and investigation of grievances and reports shall be grounds for revocation of provider participation agreement of the mental health agency or the provision of financial assistance, and, with respect to a service provider directly operated by the Department, grounds for disciplinary action, which may include dismissal.
 4. A mental health agency shall report all allegations of mistreatment and denial of rights to the Office of Human Rights and the health plan for review and monitoring in accordance with R9-21-105.
- C.** A mental health agency shall report all incidents of abuse, neglect, or exploitation to the appropriate authorities as required by A.R.S. § 46-454 and shall document all such reports in the mental health agency's records.
- D.** If a mental health agency has reasonable cause to believe that a felony relevant to the functioning of the program has been committed by staff persons subject to the agency's direction, a report shall be filed with the county attorney.
- E.** The identity of persons making reports of abuse, neglect, exploitation, or mistreatment shall not be disclosed by the mental health agency or by the Administration, except as necessary to investigate the subject matter of the report.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-204. Restraint and Seclusion

- A.** A mental health agency shall only use restraint or seclusion to the extent permitted by and in compliance with this Chapter, and other applicable federal or state law.
- B.** A mental health agency shall only use restraint or seclusion:
1. To ensure the safety of the client or another individual in an emergency safety situation;
 2. After other available less restrictive methods to control the client's behavior have been tried and were unsuccessful;
 3. Until the emergency safety situation ceases and the client's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired; and
 4. In a manner that:
 - a. Prevents physical injury to the client,
 - b. Minimizes the client's physical discomfort and mental distress, and

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- c. Complies with the mental health agency's policies and procedures required in subsection (E) and with this Section.
- C. A mental health agency shall not use restraint or seclusion as a means of coercion, discipline, convenience, or retaliation.
- D. A service provider shall at all times have staff qualified on duty to provide:
 - 1. Restraint and seclusion according to this Section, and
 - 2. The behavioral health services the mental health agency is authorized to provide.
- E. A mental health agency shall develop and implement written policies and procedures for the use of restraint and seclusion that are consistent with this Section and other applicable federal or state law and include:
 - 1. Methods of controlling behavior that may prevent the need for restraint or seclusion,
 - 2. Appropriate techniques for placing a client in each type of restraint or seclusion; used at the mental health agency, and
 - 3. Immediate release of a client during an emergency.
- F. A mental health agency shall develop and implement a training program on the policies and procedures in subsection (E).
- G. A mental health agency shall only use restraint or seclusion according to:
 - 1. A written order given:
 - a. By a physician providing treatment to a client; or
 - b. If a physician providing treatment to a client is not present on the premises or on-call:
 - i. If the agency is licensed as a level 1 psychiatric acute hospital, by a physician or a nurse practitioner; or
 - ii. If the agency is licensed as a level 1 subacute agency or a level 1 RTC, by a medical practitioner.
 - 2. An oral order given to a nurse by:
 - a. A physician providing treatment to a client, or
 - b. If a physician providing treatment to a client is not present on the premises or on-call:
 - i. If the agency is licensed as a level 1 psychiatric acute hospital, by a physician or a nurse practitioner; or
 - ii. If the agency is licensed as a level 1 sub-acute agency or a level 1 RTC, by a medical practitioner.
- H. If a restraint or seclusion is used according to subsection (G)(2), the individual giving the order shall, at the time of the oral order in consultation with the nurse, determine whether, based upon the client's current and past medical, physical and psychiatric condition, it is clinically necessary for:
 - 1. If the agency is licensed as a level 1 psychiatric acute hospital, a physician to examine the client as soon as possible and, if applicable, the physician shall examine the client as soon as possible; or
 - 2. If the agency is licensed as a level 1 sub-acute agency or a level 1 RTC, a medical practitioner to examine the client as soon as possible and, if applicable, the medical practitioner shall examine the client as soon as possible.
- I. An individual who gives an order for restraint or seclusion shall:
 - 1. Order the least restrictive restraint or seclusion that may resolve the client's behavior that is creating the emergency safety situation, based upon consultation with a staff member at the agency;
 - 2. Be available to the agency for consultation, at least by telephone, throughout the period of the restraint or seclusion;
 - 3. Include the following information on the order:
 - a. The name of the individual ordering the restraint or seclusion,
 - b. The date and time that the restraint or seclusion was ordered,
 - c. The restraint or seclusion ordered,
 - d. The criteria for release from restraint or seclusion without an additional order, and
 - e. The maximum duration for the restraint or seclusion;
 - 4. If the order is for mechanical restraint or seclusion, limit the order to a period of time not to exceed three hours.
 - 5. If the order is for a drug used as a restraint, limit the:
 - a. Dosage to that necessary to achieve the desired effect, and
 - b. Drug ordered to a drug other than a time-released drug designed to be effective for more than three hours; and
 - 6. If the individual ordering the use of restraint or seclusion is not a physician providing treatment to the client:
 - a. After ordering the restraint or seclusion, consult with the physician providing treatment as soon as possible, and
 - b. Inform the physician providing treatment of the client's behavior that created the emergency safety situation and required the client to be restrained or placed in seclusion.
- J. PRN orders shall not be used for any form of restraint or seclusion.
- K. If an individual has not examined the client according to subsection (H), the following individual shall conduct a face-to-face assessment of a client's physical and psychological well-being within one hour after the initiation of restraint or seclusion:
 - 1. For a behavioral health agency licensed as a level 1 psychiatric acute hospital, a physician or nurse practitioner who is either on-site or on-call at the time the mental health agency initiates the restraint or seclusion; or
 - 2. For a behavioral health agency licensed as a level 1 RTC or a level 1 sub-acute agency a medical practitioner or a registered nurse with at least one year of full time behavioral health work experience, who is either on-site or on-call at the time the mental health agency initiates the restraint or seclusion.
- L. A face-to-face assessment of a client according to subsection (K) shall include a determination of:
 - 1. The client's physical and psychological status,
 - 2. The client's behavior,
 - 3. The appropriateness of the restraint or seclusion used,
 - 4. Whether the emergency safety situation has passed, and
 - 5. Any complication resulting from the restraint or seclusion used.
- M. For each restraint or seclusion of a client, a mental health agency shall include in the client's record the order and any renewal order for the restraint or seclusion, and shall document in the client's record:
 - 1. The nature of the restraint or seclusion;
 - 2. The reason for the restraint or seclusion, including the facts and behaviors justifying it;
 - 3. The types of less restrictive alternatives that were attempted and the reasons for the failure of the less restrictive alternatives;

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4. The name of each individual authorizing the use of restraint or seclusion and each individual restraining or secluding a client or monitoring a client who is in restraint or seclusion;
 5. The evaluation and assessment of the need for seclusion or restraint conducted by the individual who ordered the restraint or seclusion;
 6. The determination and the reasons for the determination made according to subsection (H);
 7. The specific and measurable criteria for client release from mechanical restraint or seclusion with documentation to support that the client was notified of the release criteria and the client's response;
 8. The date and times the restraint or seclusion actually began and ended;
 9. The time and results of the face-to-face assessment required in subsection (L);
 10. For the monitoring of a client in restraint or seclusion required by subsection (P):
 - a. The time of the monitoring,
 - b. The name of the staff member who conducted the monitoring, and
 - c. The observations made by the staff member during the monitoring; and
 11. The outcome of the restraint or seclusion.
- N.** If, at any time during a seclusion or restraint, a medical practitioner or registered nurse determines that the emergency which justified the seclusion or restraint has subsided, or if the required documentation reflects that the criteria for release have been met, the client shall be released and the order terminated. The client shall be released no later than the end of the period of time ordered for the restraint or seclusion, unless a the order for restraint or seclusion is renewed according to subsection (Q).
- O.** For any client in restraint, the individual ordering the restraint shall determine whether one-to-one supervision is clinically necessary and shall document the determination and the reasons for the determination in the client's record.
- P.** A mental health agency shall monitor a client in restraint or seclusion as follows:
1. The client shall be personally examined at least every 15 minutes for the purpose of ensuring the client's general comfort and safety and determining the client's need for food, fluid, bathing, and access to the toilet. Personal examinations shall be conducted by staff members with documented training in the appropriate use of restraint and seclusion and who are working under the supervision of a licensed physician, nurse practitioner or registered nurse.
 2. A registered nurse shall personally examine the client every hour to assess the status of the client's mental and physical condition and to ensure the client's continued well-being.
 3. If the client has any medical condition that may be adversely affected by the restraint or seclusion, the client shall be monitored every five minutes, until the medical condition resolves, if applicable.
 4. If other clients have access to a client being restrained or secluded or, if the individual ordering the restraint or seclusion determines that one-to-one supervision is clinically necessary according to subsection (O), a staff member shall continuously supervise the client on a one-to-one basis.
 5. If a mental health agency maintains a client in a mechanical restraint, a staff member shall loosen the mechanical restraints every 15 minutes.
 6. Nutritious meals shall not be withheld from a client who is restrained or secluded, if mealtimes fall during the period of restraint. Staff shall supervise all meals provided to the client while in restraint or seclusion.
 7. At least once every two hours, a client who is restrained or secluded shall be given the opportunity to use a toilet.
- Q.** An order for restraint or seclusion may be renewed as follows:
1. For the first renewal order, the order shall meet the requirements of subsection (G)(1) or (G)(2); and
 2. For a renewal order subsequent to the first renewal order:
 - a. The individual in (G)(1) or (G)(2) shall personally examine the client before giving the renewal order, and
 - b. The order shall not permit the continuation of the restraint or seclusion for more than 12 consecutive hours unless the requirements of subsection (P) are met.
- R.** No restraint or seclusion shall continue for more than 12 consecutive hours without the review and approval by the medical director or designee of the mental health agency in consultation with the client and relevant staff to discuss and evaluate the needs of the client. The review and approval, if any, and the reasons justifying any continued restraint or seclusion shall be documented in the client's record.
- S.** If a client requires the repeated or continuous use of restraint or seclusion during a 24-hour period, a review process shall be initiated immediately and shall include the client and all relevant staff persons and clinical consultants who are available to evaluate the need for an alternative treatment setting and the needs of the client. The review and its findings and recommendations shall be documented in the client's record.
- T.** Whenever a client is subjected to extended or repeated orders for restraint or seclusion during a 30-day period, the medical director shall require a special meeting of the client's clinical team according to R9-21-314 to determine whether other treatment interventions would be useful and whether modifications of the ISP or ITDP are required.
- U.** As part of a mental health agency's quality assurance program, an audit will be conducted and a report filed with the agency's medical director within 24 hours, or the first working day, for every episode of the use of restraint or seclusion to ensure that the agency's use of seclusion or restraint is in full compliance with the rules set forth in this Article.
- V.** Not later than the tenth day of every month, the program director shall prepare and file with the Administration and the Office of Human Rights a written report describing the use of any form of restraint or seclusion during the preceding month in the mental health agency or by any employees of the agency. In the case of an inpatient facility, the report shall also be filed with any patient or human rights committee for that facility.
- W.** The Office of Human Rights, and any applicable human rights committee shall review such reports to determine if there has been any inappropriate or unlawful use of restraint or seclusion and to determine if restraint or seclusion may be used in a more effective or appropriate fashion.
- X.** If any human rights committee or the Office of Human Rights determines that restraint or seclusion has been used in violation of any applicable law or rule, the committee or Office may take whatever action is appropriate, including investigat-

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ing the matter itself or referring the matter to the Administration for remedial action.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

R9-21-205. Labor

- A. No client shall be required to perform labor which involves the essential operation and maintenance of the service provider or the regular care, treatment or supervision of other clients, provided however, that:
 - 1. Only a residential service provider may require clients to perform activities related to maintaining their bedrooms, other personal areas, and their clothing and personal possessions in a neat and clean manner.
 - 2. Clients may perform labor in accordance with a planned and supervised program of vocational and rehabilitation training as set forth in an ISP or ITDP developed according to Article 3 of this Chapter.
- B. Any client may voluntarily perform any labor available.
- C. The requirements of federal and state laws relating to wages, hours of work, workers' compensation and other labor standards shall be met with respect to all labor.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-206. Competency and Consent

- A. A client shall not be deemed incompetent to manage the client's affairs, to contract, to hold professional, occupational or vehicle operator's licenses, to make wills, to vote or to exercise any other civil or legal right solely by reason of admission to a mental health agency.
- B. An applicant or client is presumed to be legally competent to conduct the client's personal and financial affairs, unless otherwise determined by a court in a guardianship or conservatorship proceeding.
- C. Only an applicant or client who is competent may provide informed consent, authorization, or permission as required in this Chapter. A mental health agency shall use the following criteria to determine if an applicant or client is competent and the appropriateness of establishing or removing a guardianship, temporary guardianship, conservatorship, or guardianship ad litem for the client:
 - 1. An applicant or client shall be determined to be in need of guardianship or conservatorship only if the applicant's or client's ability to make important decisions concerning the applicant or client or the applicant's or client's property is so limited that the absence of a person with legal authority to make such decisions for the applicant or client creates a serious risk to the applicant's or client's health, welfare or safety.

- 2. Although the capability of the applicant or client to make important decisions is the central factor in determining the need for guardianship, the capabilities of the applicant's or client's family, the applicant's or client's living circumstances, the probability that available treatment will improve the applicant's or client's ability to make decisions on the applicant's or client's behalf, and the availability and utility of nonjudicial alternatives to guardianships such as trusts, representative payees, citizen advocacy programs, or community support services should also be considered.
- 3. If the applicant or client has been determined to be incapable of making important decisions with regard to the applicant's or client's personal or financial affairs, and if nonjudicial, less restrictive alternatives such as trusts, representative payees, cosignatory bank accounts, and citizen advocates are inadequate to protect the applicant or client from a substantial and unreasonable risk to the applicant's or client's health, safety, welfare, or property, the applicant's or client's nearest living relatives shall be notified with an accompanying recommendation that a guardian or conservator be appointed.
- 4. If the applicant or client is capable of making important decisions concerning the applicant's or client's health, welfare, and property, either independently or through other less restrictive alternatives such as trusts, representative payees, cosignatory bank accounts, and citizen advocates, the applicant's or client's nearest living relative shall be notified with an accompanying recommendation that any existing guardian or conservator be removed.
- 5. If the client has been determined to require or no longer require assistance in the management of financial or personal affairs, and the nearest living relative cannot be found or is incapable of or not interested in caring for the client's interest, the mental health agency shall assist in the recruitment or removal of a trustee, representative payee, advocate, conservator, or guardian. Nothing in this Chapter shall be construed to require the Administration or any health plan or service provider to pay for the recruitment, appointment or removal of a trustee, representative payee, advocate, conservator, or guardian.
- 6. The assessment or periodic review shall identify the specific area or areas of the client's functioning that forms the basis of the recommendation for the appointment or removal of a guardian or conservator, such as an inability to respond appropriately to health problems or consent to medical care, or an inability to manage savings or routine expenses.
- D. Mental health agencies shall devise and implement procedures to ensure that suspected improprieties of a guardian, conservator, trustee, representative payee, or other fiduciary are reported to the court or other appropriate authorities.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

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Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-206.01. Informed Consent

- A.** Except in an emergency according to A.R.S. §§ 36-512 or 36-513 or R9-21-204, or a court order according to A.R.S. Title 36, Chapter 5, Articles 4 and 5, a mental health agency shall obtain written informed consent in at least the following circumstances:
- Before providing a client a treatment with known risks or side effects, including:
 - Psychotropic medication,
 - Electro-convulsive therapy, or
 - Telemedicine;
 - Before a client participates in research activities; and
 - Before admitting a client to any medical detoxification, inpatient facility, or residential program operated by a mental health agency.
- B.** The informed consent in subsection (A) shall be voluntary and shall be obtained from:
- The client, if the client is determined to be competent according to R9-21-206; or
 - The client's guardian, if a court of competent jurisdiction has adjudicated the client incompetent.
- C.** If informed consent is required according to subsection (A), a medical practitioner or a registered nurse with at least one year of behavioral health experience shall, before obtaining the informed consent, provide a client or, if applicable, the client's guardian with the following information:
- The client's diagnosis;
 - The nature of and procedures involved with the proposed treatment, the client's participation in a research activity, or the client's admission to a program operated by a mental health agency;
 - The intended outcome of the proposed treatment, the client's participation in a research activity, or the client's admission to a program operated by a mental health agency;
 - The risks, including any side effects, of the proposed treatment, the client's participation in a research activity, or the client's admission to a program operated by a mental health agency;
 - The risks of not proceeding with the proposed treatment, the client's participation in a research activity, or the client's admission to a program operated by a mental health agency;
 - The alternatives to the proposed treatment, the client's participation in a research activity, or the client's admission to a program operated by a mental health agency, particularly alternatives offering less risk or other adverse effects;
 - That any informed consent given may be withheld or revoked orally or in writing at any time, with no punitive action taken against the client;
 - The potential consequences of revoking the informed consent; and
 - A description of any clinical indications that might require suspension or termination of the proposed treatment, research activity, or program operated by a mental health agency.
- D.** A client or, if applicable, the client's guardian who gives informed consent for a treatment, participation in a research activity, or admission in a program operated by a mental health agency, shall give the informed consent by:

- Signing and dating an acknowledgment that the client or, if applicable, the client's guardian has received the information in subsection (C) and gives informed consent to the proposed treatment, participation in a research activity, or admission of the client to the program operated by a mental health agency; or
 - If the informed consent is for use of psychotropic medication or telemedicine and the client or, if applicable the client's guardian, refuses to sign an acknowledgement according to subsection (D)(1), giving verbal informed consent.
- E.** If a client or, if applicable, a client's guardian gives verbal informed consent according to subsection (D)(2), a medical practitioner shall document in the client's record that:
- The information in subsection (C) was given to the client or, if applicable, the client's guardian;
 - The client or, if applicable, the client's guardian refused to sign an acknowledgement according to subsection (D)(1); and
 - The client or, if applicable, the client's guardian gives informed consent to the use of the psychotropic medication or telemedicine.
- F.** A client or, if applicable, the client's guardian may revoke informed consent at any time orally or by submitting a written statement revoking the informed consent.
- G.** If informed consent is revoked according to subsection (F):
- The treatment, the client's participation in a research activity, or the applicant's or client's admission to a program operated by a mental health agency shall be immediately discontinued, or
 - If abrupt discontinuation of a treatment poses an imminent risk to a client, the treatment shall be phased out to avoid any harmful effects.
- H.** If a client or, if applicable, the client's guardian needs assistance with revoking informed consent according to subsection (F), the client or, if applicable, the client's guardian shall receive the assistance.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

R9-21-207. Medication

- A.** Medication shall only be administered with the informed consent of the client or Title 36 guardian. Information relating to common risks and side effects of the medication, the procedures to be taken to minimize such risks, and a description of any clinical indications that might require suspension or termination of the drug therapy shall be available to the client, guardian, if any, and the staff in every mental health agency. Such information shall be available to family members in accordance with A.R.S. §§ 36-504, 36-509, and 36-517.01.
- B.** All clients have a right to be free from unnecessary or excessive medication.
- C.** Medication shall not be used as punishment, for the convenience of the staff, or as a substitute for other behavioral health services and shall be given in the least amount medically necessary with particular emphasis placed on minimizing side effects which otherwise would interfere with aspects of treatment.
- D.** Medication administered by a mental health agency shall be prescribed by a licensed physician, certified physician assistant, or a licensed nurse practitioner.

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1. Psychotropic medication shall be prescribed by:
 - a. A psychiatrist who is a licensed physician; or
 - b. A licensed nurse practitioner, certified physician assistant, or physician trained or experienced in the use of psychotropic medication, who has seen the client and is familiar with the client's medical history or, in an emergency, is at least familiar with the client's medical history.
 2. Each client receiving psychotropic medication shall be seen monthly or as indicated in the client's ISP by a licensed nurse practitioner, certified physician's assistant or physician prescribing the medication, who shall note in the client's record:
 - a. The appropriateness of the current dosage,
 - b. All medication being taken by the client and the appropriateness of the mixture of medications,
 - c. Any signs of tardive dyskinesia or other side effects,
 - d. The reason for the use of the medication, and
 - e. The effectiveness of the medication.
 3. When a client on psychotropic medication receives a yearly physical examination, the results of the examination shall be reviewed by the physician prescribing the medication. The physician shall note any adverse effects of the continued use of the prescribed psychotropic medication in the client's record.
 4. Whenever a prescription for medication is written or changed, a notation of the medication, dosage, frequency of administration, and the reason why the medication was ordered or changed shall be entered in the client's record.
 - E. Self-administration of medication by clients shall be permitted unless otherwise restricted by the responsible physician or licensed nurse practitioner. Such clients shall be trained in self-administration of medication and, if necessary, shall be monitored by trained staff.
 - F. Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security.
 - G. PRN orders for medication shall not be given for a drug used as a restraint.
- Historical Note**
- Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).
- R9-21-208. Property and Possessions**
- A. No mental health agency shall interfere with a client's right to acquire, retain and dispose of personal property, including the right to maintain an individual bank account, except where:
 1. The client is under guardianship, conservatorship, or has a representative payee;
 2. Otherwise ordered by court; or
 3. A particular object, other than money or personal funds, poses an imminent threat of serious physical harm to the client or others. Any restriction on the client's control of property deemed to pose an imminent threat of serious physical harm shall be recorded in the client's record together with the reasons the particular object poses an imminent threat of serious physical harm to the client or others.
 - B. If a mental health agency, which offers assistance to its clients in managing their funds, takes possession or control of a client's funds at the request of the client, guardian, or by court order, the mental health agency shall issue a receipt to the client or guardian for each transaction involving such funds. If deposited funds in excess of \$250 are held by the mental health agency, where the likelihood of the client's stay will exceed 30 days, an individual bank account or an amalgamated client trust account shall be maintained for the benefit of the client. All interest shall become the property of the client or the fair allocation of the interest in the case of an amalgamated client trust account. The mental health agency shall provide a bond to cover client funds held.
 1. Unless a guardian, conservator, or representative payee has been appointed, the client shall have an unrestricted right to manage and spend deposited funds.
 2. The mental health agency shall obtain prior written permission from the client, the guardian or conservator for any arrangement involving shared or delegated management responsibilities. The permission shall set forth the terms and conditions of the arrangement.
 3. Where the mental health agency has shared or delegated management responsibilities, the mental health agency shall meet the following requirements:
 - a. Client funds shall not be applied to goods or services which the mental health agency is obligated by law or funded by contract to provide, except as permitted by a client fee schedule authorized by the Administration;
 - b. The mental health agency and its staff shall have no direct or indirect ownership or survivorship interest in the funds;
 - c. Such arrangements shall be accompanied by a training program, documented in the ISP, to eliminate the need for such assistance;
 - d. Staff shall not participate in arrangements for shared or delegated management of the client's funds except as representatives of the mental health agency;
 - e. Any arrangements made to transfer a client from one mental health agency to another shall include provisions for transferring shared or delegated management responsibilities to the receiving mental health agency;
 - f. The client shall be informed of all proposed expenditures and any expression of preference within reason shall be honored; and
 - g. Expenditures shall be made only for purposes which directly benefit the client in accordance with the client's interests and desires.
 4. A record shall be kept of every transaction involving deposited funds, including the date and amount received or disbursed, and the name of the person to or from whom the funds are received or disbursed. The client, guardian, conservator, mental health agency or regional human rights advocate or other representative may demand an accounting at any reasonable time, including at the time of the client's transfer, discharge or death.
 5. Any funds so deposited shall be treated for the purpose of collecting charges for care the same as any other property held by or on behalf of the client. The client or guardian shall be informed of any possible charges before the onset of services.

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Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

R9-21-209. Records

- A. Records of a client who is currently receiving or has received services from a mental health agency are private and shall be disclosed only to those individuals authorized according to federal and state law.
- B. Inspection by the client, the client's guardian, attorney, paralegal working under the supervision of an attorney, or any other designated representative shall be permitted as follows:
 1. Except as prohibited by federal and state law, the client and, if applicable, the client's guardian shall be permitted to inspect and copy the client's record as soon as possible after a request, and no later than 10 working days after a request. If any portion of the client record is withheld under federal or state law, the mental health agency shall provide written notice to the client or, if applicable, the client's guardian including:
 - a. The reason the mental health agency is withholding a portion of the client's record,
 - b. An explanation of the client's right to a review of the decision to withhold a portion of the client's record, and
 - c. An explanation of the client's right to file a grievance according to Article 4 of this Chapter.
 2. An attorney, paralegal working under the supervision of an attorney, or other designated representative of the client shall be permitted to inspect and copy the record, if such attorney or representative furnishes written authorization from the client or guardian.
 3. When necessary for the understanding of the client or guardian and, if the client or the client's guardian provides authorization, when necessary for the understanding of an attorney, paralegal working under the supervision of an attorney, or designated representative, staff of the mental health agency possessing the records shall read or interpret the record for the client, guardian, attorney, paralegal working under the supervision of an attorney, or designated representative.
- C. Inspection by specially authorized persons or entities shall be permitted as follows unless otherwise prohibited by federal or state law:
 1. Records of a client may be available to those individuals and agencies listed in A.R.S. § 36-509.
 2. Records of a client shall be open to inspection upon proper judicial order, whether or not such order is made in connection with pending judicial proceedings.
 3. Records of a client shall be made available to a physician who requests such records in the treatment of a medical emergency, provided that the client is given notice of such access as soon as possible.
 4. Records of a client shall be made available to staff authorized by the Administration to monitor the quality of services being provided by the mental health agency to the client.
 5. Records of a client shall be made available to guardians and family members actively participating in the client's care, treatment or supervision as provided by A.R.S. §§

36-504, 36-509(A)(8) and (B). Except when inspection of a client's record is required under a proper judicial order or by a physician in a medical emergency, a client, guardian or family member may challenge the decision to allow or deny inspection of the record by filing a request for administrative and judicial review in accordance with the provisions of A.R.S. § 36-517.01 or other applicable federal or state law. Once a request is filed, no further disclosure of records shall be made until the review has been completed.

- D. Unless otherwise permitted by federal or state law, records shall be open to inspection by other third parties only upon the authorization of the client or guardian. Before authorization is given, the client or guardian shall be offered an opportunity to examine the information to be disclosed and be provided with the name of the recipient and uses to be made of the information.
- E. The fee for copying records obtained under this Section shall be no more than the actual expense of reproducing the record or the requested parts and may be limited further by A.R.S. § 12-2295.
- F. A client or guardian shall be informed of a court order or subpoena commanding production of a client's record as soon as possible and in any event prior to the date for production and of the client's or guardian's right to request the court to quash or modify the order or subpoena.
- G. The records maintained by the mental health agency shall contain accurate, complete, timely, pertinent, and relevant information.
 1. If a client or guardian believes that the record contains inaccurate or misleading information, the client or guardian may prepare, with assistance if requested, a statement of disagreement which shall be entered in the record.
 2. If a client or guardian objects to the collection of the information in the record, the client or guardian may file a grievance according to Article 4 of this Chapter.
- H. A list shall be kept of every person or organization who inspects the client's records, other than the client's clinical team, the uses to be made of that information, and the person authorizing access. A list of such access shall be placed in the client's record and shall be made available to the client or other designated representative.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

R9-21-210. Policies and Procedures of Service Providers

- A. A mental health agency may establish policies and procedures for the provision of behavioral health services or community services that are consistent with Articles 1 through 5 of these rules and with all other requirements of Arizona law. No policy or procedure may restrict any right protected by these rules.
- B. The mental health agency shall inform all prospective clients of its policies and procedures prior to the client or, if applicable, the client's guardian giving informed consent to the cli-

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ent's admission to the program according to R9-21-206.01(A)(3).

- C. If a client acts in a manner that is seriously in disregard of a reasonable policy, the agency director shall make all reasonable efforts to respond to the situation, including making reasonable accommodation to the program's policy if the client's failure to conform to a reasonable policy is due to the client's disability.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-211. Notice of Rights

- A. Every mental health agency shall provide written notice of the civil and legal rights of its clients by posting a copy of AHCCCS Form MH-211, "Notice of Client's Rights," set forth in Exhibit A, in one or more areas of the agency so that it is readily visible to clients and visitors.
- B. In addition to posting as required by subsection (A), a copy of ADHS Form MH-211, set forth in Exhibit B, shall be given to each client, or guardian if any, at the time of admission to the agency for evaluation or treatment. The person receiving the notice shall be required to acknowledge in writing receipt of the notice and the acknowledgment shall be retained in the client's record.
- C. Every mental health agency shall provide written notice of the terms of A.R.S. § 36-506 to each client upon discharge by giving the client a copy of ADHS Form MH-209, "Discrimination Prohibited".
- D. All notices required under this Section shall be provided and posted in both English and Spanish.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

Exhibit A. Notice of Legal Rights for Persons with Serious Mental Illness

If you have a serious or chronic mental illness, you have legal rights under federal and state law. Some of these rights include:

- The right to appropriate mental health services based on your individual needs;
- The right to participate in all phases of your mental health treatment, including individual service plan (ISP) meetings;
- The right to a discharge plan upon discharge from a hospital;
- The right to consent to or refuse treatment (except in an emergency or by court order);
- The right to treatment in the least restrictive setting;
- The right to freedom from unnecessary seclusion or restraint;
- The right not to be physically, sexually, or verbally abused;
- The right to privacy (mail, visits, telephone conversations);

- The right to file an appeal or grievance when you disagree with the services you receive or your rights are violated;
- The right to choose a designated representative(s) to assist you in ISP meetings and in filing grievances;
- The right to a case manager to work with you in obtaining the services you need;
- The right to a written ISP that sets forth the services you will receive;
- The right to associate with others;
- The right to confidentiality of your psychiatric records;
- The right to obtain copies of your own psychiatric records (unless it would not be in your best interests to have them);
- The right to appeal a court-ordered involuntary commitment and to consult with an attorney and to request judicial review of court-ordered commitment every 60 days;
- The right not to be discriminated against in employment or housing.

If you would like information about your rights, you may request a copy of the "Your Rights in Arizona as an Individual with Serious Mental Illness" brochure or you may also call Administration, Office of Human Rights at 1-800-421-2124.

ADHS/BHS Form MH-211 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 21, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

Exhibit B. Notice of Legal Rights for Persons with Serious Mental Illness**NOTICE****Discrimination Prohibited**

Pursuant to A.R.S. § 36-506 and R9-21-101(B)

- A. Persons undergoing evaluation or treatment pursuant to this Chapter shall not be denied any civil right, including, but not limited to, the right to dispose of property, sue and be sued, enter into contractual relationships and vote. Court-ordered treatment or evaluation pursuant to this Chapter is not a determination of legal incompetency, except to the extent provided in A.R.S. § 36-512.
- B. A person who is or has been evaluated or treated in an agency for a mental disorder shall not be discriminated against in any manner, including but not limited to:
1. Seeking employment.
 2. Resuming or continuing professional practice or previous occupation.
 3. Obtaining or retaining housing.
 4. Obtaining or retaining licenses or permits, including but not limited to, motor vehicle licenses, motor vehicle operator's and chauffeur's licenses and professional or occupational licenses.
- C. "Discrimination" for purposes of this Section means any denial of civil rights on the grounds of hospitalization or outpatient care and treatment unrelated to a person's present capacity to meet the standards applicable to all persons. Applications for positions, licenses and housing shall contain no requests for information which encourage such discrimination.

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- D. Upon discharge from any treatment or evaluation agency, the patient shall be given written notice of the provisions of this Section.

AVISO**Discriminacion Prohibida**

Conforme a A.R.S. § 36-506 y R9-21-101(B)

- A. A las personas que estan bajo evaluacion o tratamiento conforme a este capitulo, no se les negara ningun derecho civil, incluyendo pero no limitado a, el derecho a disponer de propiedad, a demandar y ser demandado, a tomar parte en relaciones contractuales y a votar. El tratamiento o evaluacion ordenado por la corte conforme a este capitulo no es una determinacion de incompetencia legal, excepto hasta el punto proveido en la seccion 36-512.
- B. No se haran discriminaciones de ninguna clase, en contra de una persona que ha sido o esta siendo evaluada o tratada en una agencia debido a un desorden mental, incluyendo pero no limitado a:
1. Buscar trabajo.
 2. Reasumir o continuar una practica profesional u ocupacion previa.
 3. Obtener o retener vivienda.
 4. Obtener o retener licencias o permisos, incluyendo pero no limitado a, licencias para vehiculo de motor, licencias de operador de vehiculo de motor y de chofer, y licencias ocupacionales o profesionales.
- C. "Discriminacion" para propositos de esta seccion quiere decir cualquier denegacion de derechos civiles por motivos de hospitalizacion o tratamiento externo no relacionado a la capacidad actual de la persona para cumplir con las normas aplicables a toda persona. Las solicitudes para posiciones, licencias y vivienda no contendran peticion de informacion que pueda fomentar tal discriminacion.
- D. Al ser dado de alta de cualquier agencia de tratamiento o evaluacion, se dara al paciente notificacion por escrito sobre las provisiones de esta seccion.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

ARTICLE 3. INDIVIDUAL SERVICE PLANNING FOR BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS**R9-21-301. General Provisions**

- A. Responsibilities of the regional authority, clinical team, and case manager.
1. The regional authority is responsible for providing, purchasing, or arranging for all services identified in ISPs.
 - a. The regional authority shall perform all intake and case management for its region. The regional authority may contract with a mental health agency to perform intake or case management but only with the written approval of the Administration, which may be given in its sole discretion.
 - b. Other services may be provided directly by programs operated by the Administration or by the regional authority through contracts with service providers, or through arrangements with other agencies or generic providers.
 2. The regional authority and the clinical team shall work diligently to ensure equal access to generic services for its

clients in order to integrate the client into the mainstream of society.

3. The initial clinical team shall work to meet the individual's needs from the date of application or referral for services until such time as eligibility is established and an ISP is developed.
4. The assigned clinical team shall be primarily responsible for providing continuous treatment, outreach and support to a client, for identifying appropriate behavioral health services or community services, and for developing, implementing and monitoring ISPs for clients.
5. The case manager, in conjunction with the clinical team, shall:
 - a. Locate services identified in the ISP;
 - b. Confirm the selection of service providers and include the names of such providers in the ISP;
 - c. Obtain a written client service agreement from each provider;
 - d. Be responsible for ensuring that services are actually delivered in accordance with the ISP; and
 - e. Monitor the delivery of services rendered to clients. Monitoring shall consider, at a minimum, the consistency of the services with the goals and objectives of the ISP.
6. The case manager shall also be responsible to:
 - a. Initiate and maintain close contact with clients and service providers;
 - b. Provide support and assistance to a client, with the client's permission and consistent with the client's individual needs;
 - c. Ensure that each service provider participates in the development of the ISP for each client of the service provider;
 - d. Ensure that each inpatient facility, according to R9-21-312, develops an ITDP that is integrated in and consistent with the ISP;
 - e. Assess progress toward, and identify impediments to, the achievement of the client's goals and objectives identified in the ISP;
 - f. Promote client involvement in the development, review, and implementation of the ISP;
 - g. Attempt to resolve problems and disagreements with respect to any component of the ISP;
 - h. Assist in resolving emergencies concerning the implementation of the ISP;
 - i. Attend all periodic reviews of the ISP and ITDP meetings;
 - j. Assist in the exploration of less restrictive alternatives to hospitalization or involuntary commitment; and
 - k. Otherwise coordinate services provided to the client.
7. If a case manager is assigned to a client who, at any time, is admitted to an inpatient facility, the case manager shall ensure the development, modification or revision of a client's ISP and the integration of the ITDP according to this Article.
 - a. The inpatient facility clinician responsible for coordinating the ITDP shall immediately notify the client's case manager of the time of the admission and ensure that all treatment and discharge planning includes the case manager.
 - b. The case manager shall be provided notice of all treatment and discharge meetings, shall participate as a full member of the inpatient facility treatment

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team in such meetings, shall receive periodic and other reports concerning the client's treatment, and shall be responsible for identifying and securing appropriate community services to facilitate the client's discharge.

- c. If no case manager has been assigned, the inpatient facility clinician primarily responsible for the client's inpatient care shall, within three days of admission, make a referral to the appropriate regional authority for the appointment of a case manager.
- d. Delays in the assignment of a case manager or in the development or modification of an ISP or ITDP shall not be construed to prevent the clinically appropriate discharge of a client from an inpatient facility.
- e. Inpatient facilities shall establish a mechanism for the credentialing of case managers and other members of the clinical team in order that they may participate in ITDP meetings.

B. Client participation in service planning.

- 1. It is the responsibility of the regional authority and its service providers to engage in service planning, including the provision of assessments, case management, ISPs, ITDPs, and service referrals, according to the provisions of these rules for the benefit of clients requesting, receiving or referred for behavioral health services or community services. Clients and the clients' guardians may refuse to participate in or to receive any service planning. In the event of such refusal, service planning shall not be provided unless:
 - a. There is an emergency in which a qualified clinician determines that immediate intervention is necessary to prevent serious harm to the client or others; or
 - b. The client is subject to court-ordered evaluation or treatment.
- 2. A client's refusal to accept a particular service, including case management services, or a particular mode or course of treatment, shall not be grounds for refusing a client's access to other services that the client accepts.
- 3. A physical examination shall not be conducted over a client's refusal unless the examination is consented to by the client's guardian, or the examination is otherwise required by court order.
- 4. A decision to provide services, including assessment, service planning, and case management services, to a client who is refusing such services, or a decision not to provide such services to such an individual, may be appealed according to the provisions of R9-21-401. This subsection does not limit the rights of a client to accept, reject, or appeal particular results of the service planning process as identified in other applicable provisions of these rules.

C. Clients with special needs.

- 1. Whenever, according to an assessment or in the development or review of any plan prepared under this Article, it is determined that a client is a client who needs special assistance or a client who needs counsel or advice in making treatment decisions or in enforcing the client's rights, the case manager shall:
 - a. Notify the regional authority, the Office of Human Rights, and the appropriate human rights committee of the client's need so that the client can be provided special assistance from the human rights advocate or special review by the human rights committee; and

- b. If the client does not have a guardian, identify a friend, relative, or other person who is willing to serve as a designated representative of the client.

- 2. The clinical team shall make arrangements to have qualified interpreters or other reasonable accommodations, including qualified interpreters for the deaf, present at any assessment, meeting, service delivery, notice, review, or grievance for clients who cannot converse adequately in spoken English.
- 3. Clients who are incarcerated in jails shall receive ISPs in accordance with R9-21-307. If legitimate security requirements of any jail in which a client is incarcerated require a reasonable modification of a specific procedure set forth in this rule, the clinical team may modify the method for preparing the ISP only to the extent necessary to accommodate the legitimate security concerns.
 - a. No modification may unreasonably restrict the client's right to participate in the ISP process;
 - b. No modification may alter the standards for developing an ISP, the client's right to obtain services identified in the ISP, as provided in this Article, or the client's right to appeal any aspect of treatment planning according to R9-21-401, including the decision to modify the process for security reasons.

D. Notices to the individual.

- 1. Any individual or mental health agency required to give notice to an individual of any documents, including eligibility determinations, assessment reports, ISPs, and ITDPs according to this rule shall do so by:
 - a. Providing a copy of the document to the individual;
 - b. Providing copies to any designated representative and guardian;
 - c. Personally explaining to the individual and designated representative and/or guardian any right to accept, reject, or appeal the contents of the document and the procedures for doing so under this Article.
- 2. Individuals requesting or receiving behavioral health services or community services shall be informed:
 - a. Of the right to request an assessment;
 - b. Of the right to have a designated representative assist the client at any stage of the service planning process;
 - c. Of the right to participate in the development of any plan prepared under this Article, including the right to attend all planning meetings;
 - d. Of the right to appeal any portion of any assessment, plan, or modification to an assessment or plan, according to R9-21-401;
 - e. Of the Administration's authority to require necessary and relevant information about the individual's needs, income, and resources;
 - f. Of the availability of assistance from the regional authority in obtaining information necessary to determine the need for behavioral health services or community services;
 - g. Of the Administration's or mental health agency's authority to charge for services and assessments;
 - h. That if the individual declines the services of a case manager or an ISP, the individual has the right to apply for services at a subsequent time; and
 - i. That if the individual declines any particular service or treatment modality, it will not jeopardize other accepted services.

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- E. Extensions of time.
1. The time to initiate or complete eligibility determinations, assessments, ISPs, and other actions according to this Chapter may be extended if:
 - a. There is substantial difficulty in scheduling a meeting at which all necessary participants can attend;
 - b. The client fails to keep an appointment for assessment, evaluation, or any other necessary meeting;
 - c. The client is capable of but temporarily refuses to cooperate in the preparation of the plan or completion of an assessment or evaluation;
 - d. The client or the client's guardian and/or designated representative requests an extension of time or
 - e. Additional documentation has been requested but has not yet been received.
 2. An extension under this rule shall not exceed the number of days incurred by the delay and in no event may exceed 20 days, unless the whereabouts of the client are unknown.
 3. For an SMI eligibility determination, an extension of time shall only apply if an applicant agrees to the extension.
- F. Meeting attendance through telecommunications link. Attendance by any person at any meeting that is required or recommended according to this Article may be accomplished through a telecommunications link that is contemporaneous with the meeting.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

R9-21-302. Identification, Application, and Referral for Services of Persons with Serious Mental Illness

- A. Each regional authority shall develop and implement outreach programs that identify individuals within the authority's geographic area, including persons who reside in jails, homeless shelters, or other settings, who are seriously mentally ill.
1. Inpatient facilities shall identify individuals in their respective facilities who are seriously mentally ill.
 2. An individual identified under this subsection shall be referred in writing to the appropriate regional authority for a determination of eligibility as provided in this Article.
- B. An individual desiring behavioral health services or community services under this Article may apply to the appropriate regional authority for a determination of eligibility. Application may be made by the individual or on the individual's behalf by the person's guardian, designated representative, or other appropriate individuals such as a family member or staff of a mental health agency. Individuals may apply for behavioral health services or community services regardless of whether they reside in the community, an inpatient facility, a county jail, a homeless shelter, or any other location within the state of Arizona.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective

October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-303. Eligibility Determination and Initial Assessment

- A. Upon receipt of a request or referral for a determination of whether an individual is eligible for services under this Chapter, a regional authority shall schedule an appointment for an initial meeting with the applicant by a qualified clinician, to occur no later than seven days after the regional authority receives the request or referral.
- B. During the initial meeting with an applicant by a qualified clinician, the qualified clinician shall:
1. Obtain consent to an assessment of the applicant from the applicant or, if applicable, the applicant's guardian;
 2. Provide to the applicant and, if applicable, the applicant's guardian, the information required in R9-21-301(D)(2), a client rights brochure, and the notice required by R9-21-401(B);
 3. Determine whether the applicant is competent, according to R9-21-206;
 4. If, during the initial meeting with an applicant by a qualified clinician, the qualified clinician is unable to obtain sufficient information to determine whether the applicant is eligible for services under this Chapter:
 - a. Obtain authorization from the applicant or, if applicable, the applicant's guardian, for release of information, if applicable;
 - b. Request the additional information the qualified clinician needs in order to make a determination of whether the applicant is eligible for services under this Chapter; and
 5. Initiate an assessment according to R9-21-305.
- C. The qualified clinician in subsection (B) shall obtain information necessary to make an eligibility determination, including:
1. Identifying data and residence, including a social security number if available;
 2. The reasons for the request or referral for services;
 3. The individual's psychiatric diagnosis;
 4. The individual's present level of functioning, based upon the criteria set forth in the definition of "seriously mentally ill";
 5. The individual's history of mental health treatment;
 6. The individual's abilities, needs, and preferences for services; and
 7. A preliminary determination as to the individual's need for special assistance.
- D. If at any time during the course of the eligibility process the qualified clinician determines that the individual has a current case manager, a current assessment, or an ISP, the clinician shall notify the client's case manager and terminate the eligibility process.
- E. To be eligible for behavioral health services or community services according to this Chapter the individual must be:
1. A resident of the state of Arizona, and
 2. Seriously mentally ill.
- F. The qualified clinician in subsection (B) shall determine whether an applicant is eligible for services under this Chapter and provide written notice of the SMI eligibility determination to the applicant or, if applicable, the applicant's guardian according to the following time-frames:
1. If the qualified clinician obtains sufficient information during the initial meeting with the applicant to determine whether the applicant is eligible for services under this

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Chapter, within three days of the initial meeting with the applicant by the qualified clinician;

2. If the qualified clinician does not obtain sufficient information during the initial meeting with the applicant to determine whether the applicant is eligible for services under this Chapter, at the earliest of:
 - a. Within three days of obtaining sufficient information to determine whether the applicant is eligible for services under this Chapter, or
 - b. The time provided according to R9-21-301(E).
- G. At the time a qualified clinician provides an applicant with written notice of an SMI eligibility determination according to subsection (F), the qualified clinician shall:
 1. Provide written notice to the applicant:
 - a. That the applicant has the right to appeal the SMI eligibility determination according to R9-21-401, including the right to an administrative hearing according to A.R.S. § 41-1092.03; and
 - b. That, if the applicant is not eligible for services according to this Chapter, the applicant may reapply at any time; and
 2. If the applicant is eligible for services under this Chapter:
 - a. Serve as the client's case manager or arrange for the provision of case management services for the client; and
 - b. Initiate with the client the development of a clinical team that may include:
 - i. Behavioral health professionals,
 - ii. Professionals other than behavioral health professionals,
 - iii. Behavioral health technicians,
 - iv. Family members,
 - v. Paraprofessionals, and
 - vi. Any individual whom the qualified clinician and the client deem appropriate and necessary to ensure that the assessment is comprehensive and meets the needs of the client.
- H. Nothing in this rule shall be construed to require the qualified clinician to make the determination of whether the applicant is eligible for services under the Arizona Health Care Cost Containment System Administration (AHCCCSA) according to A.R.S. Title 36, Chapter 29.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

R9-21-304. Interim and Emergency Services

- A. At an applicant's first visit with a qualified clinician and after a determination of eligibility the qualified clinician shall:
 1. Determine whether the applicant or client needs interim services prior to the development and acceptance of the ISP;
 2. If the applicant or client needs interim services, identify the interim services that are consistent with the applicant's or client's preferences and needs and the findings in the assessment;

3. Arrange for the provision of the interim services identified by the qualified clinician; and
4. Document in the client's record the interim services that shall be provided to the applicant or client.

- B. If a qualified clinician determines that an emergency exists necessitating immediate intervention, emergency or crisis services shall be provided immediately.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-305. Assessments

- A. The following individuals may participate in and contribute to the assessment of a client:
 1. The client;
 2. The qualified clinician in R9-21-303(B);
 3. The client's case manager;
 4. Each individual on the client's clinical team, including:
 - a. Behavioral health professionals,
 - b. Professionals other than behavioral health professionals,
 - c. Behavioral health technicians,
 - d. Family members,
 - e. Paraprofessionals, and
 - f. Any individual whom the qualified clinician and the client deem appropriate and necessary to ensure that the assessment is comprehensive and meets the needs of the client.
- B. The individuals contributing to the assessment of a client shall not consider the availability of services, but shall consider the client's circumstances and evaluate all available information including:
 1. The information obtained during the initial meeting with the client by a qualified clinician according to R9-21-303(B);
 2. Written information such as the client's clinical history, records, tests, and other evaluations;
 3. Information from family, friends, and other individuals.
- C. An assessment shall include:
 1. An evaluation of the client's:
 - a. Presenting concerns;
 - b. Behavioral health treatment;
 - c. Medical conditions and treatment;
 - d. Sexual behavior and, if applicable, sexual abuse;
 - e. Substance abuse, if applicable;
 - f. Living environment;
 - g. Educational and vocational training;
 - h. Employment;
 - i. Interpersonal, social, and cultural skills;
 - j. Developmental history;
 - k. Criminal justice history;
 - l. Public and private resources;
 - m. Legal status and apparent capacity;
 - n. Need for special assistance; and
 - o. Language and communication capabilities;
 2. A risk assessment of the client;
 3. A mental status examination of the client;
 4. A summary, impressions, and observations;
 5. Recommendations for next steps;
 6. Diagnostic impressions of the qualified clinician; and

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7. Other information determined to be relevant.
- D.** Within 45 days of a request or referral for an SMI eligibility determination, a qualified clinician shall prepare an assessment report based on the information obtained according to R9-21-303 and this Section, including:
1. The development of a long-term view by the client with assistance from the clinical team that establishes a method of integration for living, employment and social conditions that the client wishes to achieve over the next three years;
 2. A summary of the information gathered during the eligibility and assessment processes;
 3. An identification of the client's legal status, resources, and assessed strengths and actual needs, regardless of the availability of services to meet that need, in each area of assessment identified in subsection (C) above;
 4. An analysis of the major findings of the mental health assessment, including a description of the nature and severity of any illness and a diagnosis in terms set forth in the DSM;
 5. The client's preferences regarding services to be provided;
 6. A description of any additional interim services which are required and plans for the referral of the client to additional interim services or the continuation of interim services already provided;
 7. An identification of further evaluations which the clinical team deem necessary to determine the services appropriate to the client's needs;
 8. An identification of information that could not be obtained due to the client's circumstances or unavailability; and
 9. A functional assessment of the client's current status in terms of independent living, employment (or retirement), and social integration and analysis of the support or skills, if any, necessary to achieve the client's long-term view.
- E.** The qualified clinician shall arrange for any further evaluations recommended by the clinical team. If the client needs assessment in an area beyond the ability or expertise of the clinical team, such assessment shall be conducted by professionals with appropriate credentials, with the client's consent. The need for further evaluations shall not unreasonably delay the preparation of the ISP.
- F.** If a qualified clinician determines that the client is a client who needs special assistance, the case manager shall:
1. Notify the regional authority, the Office of Human Rights, and the appropriate human rights committees of the client's need so that the client can be provided special assistance from the human rights advocate or special review by the human rights committee; and
 2. If the client does not have a guardian, identify a friend, relative or other person who is willing to serve as a designated representative of the client.
- G.** Upon completion of the assessment report, copies shall be sent to the client, the designated representative, if any, the guardian, and all service providers who have been identified by the case manager or regional authority to serve the client.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to

Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-306. Identification of Potential Service Providers

- A.** As soon as needs of the client for particular services are identified through the eligibility determination, assessment, or further evaluation processes, the clinical team in conjunction with the client shall begin considering and choosing potential service providers to participate in the development of the client's ISP.
1. Within five days of the completion of the assessment report, the clinical team and the client shall complete the identification of service providers most appropriate to meet the client's needs.
 2. The case manager shall promptly contact the identified providers to determine their ability to serve the client.
 3. Within 10 days of the completion of the assessment report, the case manager shall request identified providers able to serve the client to participate in the development of the client's Individual Service Plan. All identified providers shall be provided notice of the time and place of the ISP meeting.
- B.** The clinical team, in conjunction with the client, shall determine which provider(s) are the most appropriate to serve the client. The determination of appropriateness shall consider:
1. The client's preferences for the type, intensity, and location of services;
 2. The capacity and experience of the provider in meeting the client's assessed needs;
 3. The proximity of the provider to the client's family and home community;
 4. The availability and quality of services offered by the provider; and
 5. Other factors deemed relevant by the case manager and clinical team.
- C.** The clinical team shall provide sufficient information to the identified service providers to allow them to understand the client's long-term view, strengths, needs, and required services and to take an active role in the ISP meeting.
- D.** All mental health agencies currently providing services to the client shall bring to the ISP meeting a written description of the nature, type, and frequency of services provided or to be provided by the agency.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-307. The Individual Service Plan

- A.** General provisions.
1. An individual service plan (ISP) shall be developed by the clinical team and each client.
 2. The ISP shall include the most appropriate and least restrictive services, consistent with the client's needs and preferences, as identified in the assessment conducted according to R9-21-305, and without regard to the availability of services or resources.

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3. The ISP shall identify those services which maximize the client's strengths, independence, and integration into the community.
 4. Generic services available to the general public should be utilized, to the maximum extent possible, when adequate to meet the client's needs and if access can be arranged by the case manager or client.
 5. If all needed services are not available, a plan for alternative services shall detail those services which are, to the maximum extent possible, adequate, appropriate, consistent with the client's needs, and least restrictive of the client's freedom.
 6. The clinical team shall solicit and actively encourage the participation of the client and guardian.
 7. The clinical team shall inform the client of the right to have a designated representative throughout the ISP process and to invite family members or other persons who could contribute to the development of the ISP. The case manager shall seek to obtain a representative for clients who need special assistance or otherwise have limited capacity to articulate their own preferences and to protect their own interests in the ISP process and shall advise the relevant human rights committee that the client has been determined to need special assistance.
 8. The ISP shall contain goals and objectives which are measurable and which facilitate meaningful evaluation of the progress toward attaining those goals and objectives.
 9. The ISP shall incorporate a specific description of the client objectives, services, and interventions for each mental health agency which will provide services to the client. Each existing service provider will bring to the ISP meeting a detailed written description of the objectives and services currently in effect for the client.
 10. For residents of an inpatient facility, the facility's treatment and discharge plan shall be developed according to R9-21-312 and shall be incorporated in the ISP.
 11. Prior to the planned discharge of a new client from an inpatient facility, the clinical team shall develop an ISP which describes the community services, including alternative housing and residential supports, that will be provided when the client leaves the facility.
 12. The ISP shall be written in language which can be easily understood by a lay person.
 13. In developing the ISP, the case manager shall facilitate resolution of differences among service providers and, if resolution is not achieved, shall refer the matter to the regional authority, which shall resolve the matter in accordance with the Administration's policy.
- B.** The individual service plan meeting.
1. Within 20 days of the completion of the assessment report, the case manager shall convene an ISP meeting at a convenient time and place for the client, guardian, clinical team, and potential service providers.
 2. The case manager shall arrange for the client's transportation, if needed, to the ISP meeting.
 3. The case manager shall notify in writing the following persons of the time, date and location of the ISP meeting at least 10 days prior:
 - a. The client, any designated representative and guardian, including an invitation to submit relevant information in writing if their attendance is impossible;
 - b. Clinicians involved in the assessment or further evaluation;
 - c. All current and potential service providers;
 - d. All members of the client's clinical team;
 - e. Family members, with the client's permission;
 - f. Other persons familiar with the client whose presence at the meeting is requested by the client;
 - g. Any other person whose participation is not objected to by the client and who, in the judgment of the case manager, will contribute to the ISP.
 4. The case manager shall chair the ISP meeting which shall include a discussion of:
 - a. The client's supports or skills necessary to achieve the client's long-term view in each of the areas listed in R9-21-305(B);
 - b. The findings and conclusions obtained during the assessment, further evaluations, including a list of further evaluations to be completed, and any interim services provided;
 - c. Any existing ITDP according to R9-21-312;
 - d. The client's preferences regarding services;
 - e. Recommended long-term or alternative services;
 - f. Current or proposed service providers, including the need to have service providers with staff who have language and communications skills other than English if necessary to communicate with the client;
 - g. Recommended dates for commencement of each service or date each service commenced;
 - h. The methods and persons to ensure that services are provided as set forth in the ISP, adequately coordinated, and regularly monitored for effectiveness;
 - i. The procedure for completion and implementation of the ISP process, including the procedures for accepting, rejecting, or appealing the ISP; and
 - j. The procedure for clients or service providers to request changes in the ISP.
- C.** The individual service plan shall include:
1. A description of the client's long-term view and the client's preferences, strengths, and needs in all relevant areas listed in R9-21-305(C), including present functioning level and medical condition, with documentation of any chronic medical condition which requires regular monitoring or intervention.
 2. A description of the most appropriate and least restrictive services consistent with the client's needs and without reference to existing resources.
 3. A statement of whether the client requires service providers with staff who are competent in any language other than English in order to communicate with the client.
 4. Target dates for commencement of each service or date each service commenced and their anticipated duration.
 5. Long range goals for each service which will assist the client in attaining the most self-fulfilling, age-appropriate, and independent style of living possible for the client, consistent with the client's preference, stated in terms which allow objective measurement of progress and which the client, to the maximum extent possible, both understands and adopts.
 6. Short-term objectives that lead to attainment of overall goals stated in terms which allow objective measurement of progress and which the client, to the maximum extent possible, both understands and accepts.
 7. Expected dates of completion for each objective;
 8. Persons and service providers responsible for each objective.
 9. Identification of each generic or service provider responsible for providing the specific service required to meet

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each of the client's needs, including the name and address and telephone number of the provider and the location where the service will be provided.

10. A detailed description of the client objectives and services for each mental health agency which will provide services to the client.
 11. Identification of any need for alternative housing or residential setting, including the support and monitoring to be provided after any change in housing or residential setting as provided in R9-21-310(D).
 12. Based upon assessments and other available information, a determination of:
 - a. The client's capacity to:
 - i. Make competent decisions on matters such as medical and mental health treatment, finances, and releasing confidential information;
 - ii. Participate in the development of the ISP; and
 - iii. Independently exercise the client's rights under this Chapter.
 - b. The client's need for guardianship or other protective services or assistance.
 - c. The client's need for special assistance.
 13. A list of the assessments which were not completed due to the client's current mental or physical condition or due to the clinical team's inability to access records together with a statement of the causes and plans to obtain these assessments.
 14. A description of the methods and persons responsible for ensuring that services are:
 - a. Provided as set forth in the ISP;
 - b. Adequately coordinated; and
 - c. Regularly monitored for effectiveness.
 15. A statement of the right of the client, designated representative, or guardian to accept or reject the ISP, request other services, or appeal the ISP or any aspect of the ISP.
 16. A statement that the client's acceptance of the ISP constitutes consent to the services enumerated in the ISP.
- D. Preparation and distribution of the individual service plan.**
1. Within seven days of the ISP meeting, but no later than 90 days from the date of a referral or request for an SMI eligibility determination, the case manager shall prepare and distribute the ISP as provided herein.
 2. The case manager or other clinical team member shall personally deliver to and review the ISP with the client.
 3. The ISP shall be mailed or otherwise distributed to the following persons:
 - a. The client's designated representative and/or guardian;
 - b. The members of the clinical team; and
 - c. All existing or potential service providers.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

R9-21-308. Acceptance or Rejection of the Individual Service Plan

- A.** Within seven days of the distribution of the ISP, the case manager shall contact the client concerning acceptance or rejection of all or any portion of the ISP, or request for other services, if there has not been acceptance, rejection or a request prior to that date.
- B.** If the client or guardian does not object to the ISP within 30 days of receipt of the plan, the client shall be deemed to have accepted the ISP.
- C.** If the client or guardian rejects some or all of the services identified in the ISP, or requests other services, the case manager shall provide written notice to the client or guardian of the right to immediately appeal the ISP according to R9-21-401 or to meet with the clinical team within seven days of the rejection to discuss the plan and suggest modifications. The case manager shall arrange the meeting at a convenient time and place for the client, any designated representative and/or guardian, and the clinical team.
- D.** If the client's proposed modifications are adopted by the clinical team, the case manager shall arrange for approval of the modifications by all service providers.
- E.** If the matter is not resolved to the client's or guardian's satisfaction, the case manager shall again inform the client or guardian of the right to appeal the ISP.
- F.** A client or guardian who rejects the ISP may accept some or all of the identified services pending the outcome of the meeting with the clinical team or an appeal.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-309. Selection of Service Providers

- A.** Within seven days of the distribution of the ISP to the service providers identified in the ISP, the case manager, after consultation with the clinical team and the provider, shall determine whether each of these providers are capable of serving the client.
 1. A contracted service provider shall not refuse to serve a client except for good cause related to the inability of the service provider to safely and professionally meet the client's needs as identified in the ISP.
 2. If a contracted service provider believes it is incapable of meeting the client's needs or of implementing the ISP, the provider shall inform the case manager in writing within five days of receipt of the ISP. A contracted service provider shall specify the reasons for its conclusion.
- B.** If the clinical team determines that a housing, residential or vocational service provider identified in the ISP is not capable of serving the client, the case manager shall, with the approval of the clinical team, identify another provider who is qualified to provide the services identified in the client's ISP, introduce the client to the new service provider, and modify the ISP as needed.
- C.** If the clinical team determines that an identified provider, other than a housing, residential or vocational service provider, is not capable of serving a client, the case manager shall, with the approval of the clinical team, identify another provider that is qualified to provide the services identified in the client's

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ISP. The case manager shall promptly distribute the ISP to the alternative service provider.

- D. All selected service providers shall sign the ISP and implement the identified services.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

R9-21-310. Implementation of the Individual Service Plan

- A. Upon acceptance of the ISP by the client or as defined in a court order, services shall be initiated in accordance with the timetable identified in the ISP.
- B. If all or a portion of the ISP is rejected by the client or guardian, the plan shall not be implemented and services shall not be provided unless the client or guardian consents to specific services.
- C. For each client who is identified as needing alternative housing, a new residential setting, or a residential support service, the case manager shall inform the client of the need for an alternative living arrangement and shall use the case manager's best efforts to obtain appropriate housing or residential supports. These efforts may include showing the client the house or apartment in which the client could reside, introducing the client to other residents of the residential setting, as appropriate, and permitting the client to live in the alternative setting on a trial basis. All clients shall be informed that they may elect to move at any time in the future subject to the terms of any lease, mortgage, contract, or other legal agreement between the client and the housing provider.
- D. For at least the first two months after a client moves to a new residential setting, the case manager shall coordinate and monitor support services, as identified in the client's ISP, in order to foster the maintenance of the client's key relationships with others, to provide necessary orientation, and to ensure a smooth and successful transition into the new setting.
- E. All contracts with service providers shall include:
1. A provision that the service provider shall abide by the rules contained in this Chapter and shall not alter, terminate, or otherwise interrupt services required under the ISP except parts of the ISP that have been modified according to R9-21-314;
 2. A provision that the service provider shall cooperate with the Administration in collecting data necessary to determine if the Administration is meeting its obligations under this Chapter and A.R.S. Title 36, Chapter 5, Article 10; and
 3. A provision that the service provider agrees to maintain current client records that document progress toward achievement of ISP goals and objectives and that meet applicable requirements of law, contract, and professional standards.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9

A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

R9-21-311. Alternative Services

- A. If the services identified in the ISP are not currently available, the clinical team shall develop an alternative plan for alternative services, based upon the client's strengths, needs, and preferences as set forth in the assessment conducted according to R9-21-305. The plan for alternative services shall be developed after the preparation of the ISP.
- B. The plan for alternative services shall be developed according to the same procedures for the preparation of an ISP and may be developed at the same meeting with the ISP if the clinical team is aware that appropriate services are not currently available. If at an ISP meeting the clinical team does not know whether the appropriate services are available, the clinical team shall use diligent efforts to locate the identified services. If appropriate services are determined to be unavailable, the ISP meeting shall be reconvened to develop an ISP for alternative services.
- C. The plan for alternative services shall identify those available mental health and generic services which are, to the maximum extent possible, adequate, appropriate, consistent with the client's needs and least restrictive of the client's freedom.
- D. The plan for alternative services shall contain a list of appropriate but unavailable services and the projected date for the initiation of each service.
- E. If the clinical team determines that a recommended service is unavailable or does not exist, it shall forward a description of that service to the director of the regional authority. The director shall:
1. Use best efforts to locate the needed service through existing services or reallocated resources;
 2. Forward a description of the unmet service need to the Administration, if the appropriate service cannot be located or developed through existing services or reallocated resources; and
 3. maintain a list of unmet service needs.
- F. The Administration shall use information concerning unmet service needs to provide the appropriate service through existing services or reallocated resources or, if necessary, to plan for the development of the needed services.
- G. Nothing in this rule shall effect or modify any provision of Arizona law with respect to a client's right to appropriate services.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4).

R9-21-312. Inpatient Treatment and Discharge Plan

- A. General provisions.
1. Every client of an inpatient facility shall have an Inpatient Treatment and Discharge Plan (ITDP).
 2. An ITDP shall be developed by the inpatient facility's treatment team, the case manager and other members of the clinical team, as appropriate.

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3. The ITDP shall include the most appropriate and least restrictive services available at the inpatient facility, as well as a plan for the client's discharge to the community.
 4. The ITDP shall identify those treatment interventions and services which maximize the client's strengths, independence, and integration into the community.
 5. The ITDP shall be developed with the fullest possible participation of the client and any designated representative and/or guardian.
 6. The ITDP shall contain goals and objectives which are measurable and which facilitate meaningful evaluation of the progress toward attaining those goals and objectives.
 7. The ITDP shall be written in language which can be easily understood by a lay person.
 8. Delays in the assignment of a case manager or in the development or modification of an ISP or ITDP shall not be construed to prevent the appropriate discharge of a client from an inpatient facility.
- B. The individual treatment and discharge plan meeting.**
1. The case manager shall encourage the client to have a designated representative assist the client at the meeting and to have other persons, including family members, attend the meeting. The case manager shall ensure that the human rights advocate is notified of the time and date of the ITDP for clients who need special assistance.
 2. The following persons shall be invited to attend the ITDP meeting:
 - a. The client;
 - b. Any designated representative and/or guardian;
 - c. Family members, with the client's permission;
 - d. Members of the client's inpatient facility treatment team;
 - e. The case manager and other members of the clinical team, as appropriate;
 - f. Other persons familiar with the client whose presence at the meeting is requested by the client; and
 - g. Any other person whose participation is not objected to by the client and who will, in the judgment of the case manager, contribute to the ITDP meeting.
 3. The ITDP meeting shall include a discussion of:
 - a. A review of the ISP's long-term view;
 - b. If necessary, a new functional assessment of the supports or skills necessary to achieve the client's long-term view;
 - c. The client's needs in terms of assessed strengths and needs;
 - d. The client's preferences regarding services;
 - e. Existing services if any;
 - f. The procedure for completion and implementation of the ITDP process, including the procedures for accepting, rejecting, or appealing the ITDP;
 - g. The procedure for clients or the inpatient facility to request changes in the ITDP; and
 - h. The methods to ensure that services are provided as set forth in the ITDP and regularly monitored for effectiveness.
- C. Inpatient treatment and discharge plan.**
1. The facility treatment team, the case manager, and other representatives of the clinical team, as appropriate, shall develop a preliminary ITDP within three days, and a full ITDP within seven days thereafter, of the client's admission. Where a client's anticipated stay is less than seven days, an acute inpatient facility shall develop a preliminary ITDP within one day and a full ITDP within three days of a client's admission.
 2. The ITDP shall be consistent with the goals, objectives, and services set forth in the client's ISP and shall be incorporated into the ISP.
 3. The ITDP shall include:
 - a. The client's preferences, strengths, and needs;
 - b. A description of appropriate services to meet the client's needs;
 - c. For non-acute facilities, long-range goals which will assist the client in attaining the most self-fulfilling, age-appropriate, and independent style of living possible, stated in terms which allow objective measurement of progress and which the client, to the maximum extent possible, both understands and accepts;
 - d. Short-term objectives that lead to attainment of overall goals stated in terms which allow objective measurement of progress and which the client, to the maximum extent possible, both understands and accepts;
 - e. Expected dates of completion for each objective;
 - f. Persons responsible for each objective;
 - g. The person responsible for ensuring that services are actually provided and are regularly monitored; and
 - h. The right of the client or guardian to accept or reject the ITDP, request other services, or appeal the ITDP or any aspect of the ITDP.
- D. Preparation and distribution of the ITDP.**
1. Within three days of the ITDP meeting, the treatment team coordinator shall prepare and distribute the ITDP.
 2. The ITDP shall be personally presented and explained to the client by the case manager.
 3. The ITDP shall be mailed or otherwise distributed to the following persons:
 - a. The client's designated representative and guardian, if any;
 - b. The case manager and members of the clinical team; and
 - c. The members of the inpatient facility's treatment team.
- E. Acceptance or rejection of the ITDP.**
1. Within two days of the date when the ITDP was distributed, the client shall be contacted by the case manager concerning acceptance or rejection of the ITDP, if there has not been acceptance or rejection prior to that date.
 2. If the client or guardian does not object to the ITDP within 10 days of the date when the ITDP was distributed, the client shall be deemed to have accepted the ITDP.
 3. If the client or guardian rejects some or all of the treatment interventions or services identified in the ITDP or requests other services, the case manager shall provide written notice to the client of the right to meet with the treatment team coordinator within five days of the rejection to discuss the plan and to suggest modifications, or to immediately appeal the plan according to R9-21-401.
 4. If modifications are agreed to by the treatment team coordinator and the client or guardian, the treatment team coordinator shall arrange for approval of the modifications by all members of the inpatient facility's treatment team, the case manager, and members of the clinical team, as appropriate.

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5. If the matter is not resolved to the client's or guardian's satisfaction, the case manager shall again inform the client and guardian of the right to appeal according to R9-21-401. The client or guardian may appeal findings or recommendations in the ITDP within 30 days of receipt of the plan.
 6. A client or guardian who rejects the ITDP may accept some or all of the identified treatment interventions or services pending the outcome of the meeting with the treatment team coordinator or an appeal.
- F.** The updated ITDP. The facility treatment team, the case manager, and other representatives of the clinical team, as appropriate, shall review the ITDP as frequently as necessary, but at least once within the first 30 days of completing the plan, every 60 days thereafter during the first year, and every 90 days thereafter during any subsequent years that the client remains a resident of the facility.
- G.** Incorporation into the individual service plan.
1. If the clinical team determines that the ITDP is appropriate to meet the client's needs, least restrictive of the client's freedom, and consistent with the ISP, it shall approve the ITDP by incorporating it into the ISP. If the clinical team disapproves the ITDP, it shall convene an ISP meeting, which includes the inpatient facility treatment team, to prepare a revised ITDP.
 2. The clinical team, with the assistance of the inpatient facility's treatment team, shall be responsible for implementing the plan for the client's discharge.
 3. The case manager will provide notice to those providers identified in the client's ISP three days prior to the client's actual discharge, except that the failure to provide such notice shall not delay discharge.
 4. The case manager shall meet with the client within five days of the client's discharge to ensure that the ISP is being implemented.
 5. The case manager shall review the ISP with the clinical team within 30 days of the discharge to determine whether any modifications are appropriate, consistent with the standards and requirements set forth in R9-21-314.
- Historical Note**
- Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).
- R9-21-313. Periodic Review of Individual Service Plans**
- A.** General provisions.
1. Where an ISP includes residential, vocational, or other primary service providers that do not currently serve the client, the first ISP review shall be held within 30 days from the date on which all such providers have initiated services to client. Each service provider shall bring to the review a detailed description of the objectives and services currently in effect for the client.
 2. Where the ISP includes only primary service providers that currently serve the client, the first ISP review shall be held within six months of the date the ISP is accepted by the client or the date on which any appeal is concluded.
 3. Thereafter, ISP reviews shall be conducted at least every six months and more frequently as needed. The ISP review shall be chaired by the case manager.
 4. The purpose of the ISP review is to ensure that services continue to be, to the maximum extent possible, appropriate to the client's needs and least restrictive of the client's freedom.
 5. The review shall be conducted with the fullest possible participation of the client and any designated representative and/or guardian.
- B.** The ISP review.
1. At least 10 days prior to the ISP review meeting, the case manager shall invite, in writing, the following persons to attend the meeting:
 - a. The client and any designated representative and/or guardian;
 - b. Family members, with the permission of the client;
 - c. Members of the client's clinical team;
 - d. Representatives of each of the client's service providers;
 - e. Any other person familiar with the client whose participation is requested by the client; and
 - f. Any other person whose participation is not refused by the client and who, in the judgment of the case manager, will contribute to the ISP review.
 2. The ISP review shall, to the extent possible given the circumstances of the client and the availability of information, consider:
 - a. Whether there has been any change in the clinical, social, training, medical, vocational, educational and personal needs of the client;
 - b. Whether the client needs any further assessment or evaluations;
 - c. Whether the services being provided to the client continue to be appropriate to meet the client's needs, least restrictive of the client's freedom, consistent with the client's preferences, and as integrated as possible in the client's home community;
 - d. Whether there has been progress towards attainment of the long-term view, and each of the goals and objectives stated in the ISP;
 - e. Whether to reaffirm, modify or delete each goal and objective, together with the reasons for these actions;
 - f. Whether there has been any change in the legal status of the client, in the necessity or advisability of having a guardian or conservator appointed or removed, or in the client's need for special assistance;
 - g. Whether any change in the client's circumstances should result in a modification of the client's priority of need for services not currently provided; and
 - h. Whether there has been any change in the availability of services formerly determined to be needed but not then available.
 3. The client, any designated representative and/or guardian, and clinical team will review each service provider's detailed description of current objectives and services to determine whether it is consistent with client's needs, least restrictive of the client's freedom, and designed to maximize the client's independence and integration into the community.
 - a. If the detailed description is approved and accepted by the client, any designated representative and/or

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guardian, and the clinical team, it shall be incorporated into the updated ISP.

- b. If the description of services is rejected, it shall be revised with the assistance of the service provider and, as revised, incorporated into the updated ISP.

C. The updated ISP.

1. Within seven days of the ISP review meeting, the case manager shall prepare an updated ISP which includes all of the elements set forth in R9-21-307(C).
2. The case manager shall personally meet with the client or guardian to explain the updated ISP. The updated ISP shall be mailed or otherwise distributed to the other participants of the review meeting.
3. The updated ISP is subject to the client acceptance, rejection, and requests for other service provisions of R9-21-308 and the appeal provisions of R9-21-401.
4. The updated ISP shall be implemented consistent with the provisions of R9-21-310.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-314. Modification or Termination of Plans

- A. Requests for modifications or termination of an ISP or any portion of an ISP may be initiated at the ISP review or at any other time by:
 1. The client;
 2. Any designated representative and/or guardian;
 3. A service provider; or
 4. Any member of the clinical team.
- B. A request for modification or termination of an ISP shall be directed to the case manager.
- C. The case manager shall give the client, the client's guardian and designated representative, appropriate service providers, and the client's clinical team written notice of any request for modification or termination of the ISP.
- D. An ISP may be modified in order to more appropriately meet the client's needs, goals, and objectives. An ISP shall be modified where:
 1. The client withdraws consent to the ISP or any portion of the ISP;
 2. The client consents to services recommended as more suitable but previously refused by the client;
 3. The needs of the client have changed due to progress or lack of progress in meeting the client's goals and objectives;
 4. The proposed change will permit the client to receive services which are more consistent with the client's needs, less restrictive of the client's freedom, more integrated in the community, or more likely to maximize the client's ability to live independently;
 5. The client wants to change the long-term view and the focus of the ISP or no longer needs a service or services; or
 6. The client is no longer eligible for services according to R9-21-303.
- E. The clinical team shall:

1. Be notified by a service provider of any proposed termination or modification of services in the ISP as soon as possible and always prior to its implementation;
2. Promptly inform the client and any designated representative and/or guardian of the requested modification and seek the client's consent to implement such modification or termination; and
3. Within 20 days of any request for modification or termination of an ISP, approve the request only if the request meets the requirements of subsection (D).
4. Provide written notice of the right to appeal to the client and any designated representative and guardian in accordance with R9-21-401(B) whenever service to the client is to be terminated, suspended or reduced.

F. The case manager shall:

1. Incorporate the approved modification in the current ISP or prepare a revised ISP, as appropriate.
2. Within five days of any approval by the clinical team, distribute the modified or revised ISP to the client, any designated representative and/or guardian, the members of the clinical team, and all service providers.
3. Meet with the client or guardian to explain the modification or revision and the client's right to appeal according to R9-21-401.

G. If the client or any designated representative and/or guardian does not reject or appeal the termination or modification within 30 days of the date the modified ISP is distributed, the client shall be deemed to have accepted the termination or modification.

H. The client for whom a modification or termination is proposed or any designated representative and/or guardian may appeal a modification or termination according to R9-21-401.

I. If the clinical team denies the client's or guardian's request to modify or terminate an ISP, the client or the designated representative and/or guardian may appeal the denial according to R9-21-401.

J. No modification or termination of an ISP shall be made without the acceptance of the client or any designated representative and/or guardian, unless a qualified clinician determines that the modification or termination is required to avoid a serious or immediate threat to the health or safety of the client or others.

1. Except in an emergency, no requested termination of a client from a particular service or provider may be considered unless the standards and procedures set forth in R9-21-210 and the provisions of this rule are satisfied.
2. The client may not be transferred from one program or location to another while an appeal is pending.

K. If a qualified clinician determines that the client is no longer eligible for services according to R9-21-303, the qualified clinician shall make a determination of non-eligibility, move to terminate services under the ISP and this rule, and notify in writing the client of the non-eligibility determination and of the right to appeal such determination, in accordance with R9-21-401. When appropriate, referral and provision for further treatment shall be made by the case manager or clinical team.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993

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(Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-315. Renumbered**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Renumbered to R9-21-401 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

ARTICLE 4. APPEALS, GRIEVANCES, AND REQUESTS FOR INVESTIGATION FOR PERSONS WITH SERIOUS MENTAL ILLNESS**R9-21-401. Appeals**

- A.** A client or an applicant may file an appeal concerning decisions regarding eligibility for behavioral health services, including Title XIX services, fees and waivers; assessments and further evaluations; service and treatment plans and planning decisions; and the implementation of those decisions. Appeals regarding a determination of categorical ineligibility for Title XIX shall be directed to the agency that made the determination.
- Disagreements among employees of the Administration, the health plan, clinical teams, and service providers concerning services, placement, or other issues are to be resolved using the Administration's guidelines, rather than this Article.
 - The case manager shall attempt to resolve disagreements prior to utilizing this appeal procedure; however, the client's right to file an appeal shall not be interfered with by any mental health agency or the Administration.
 - The Office of Human Rights shall assist clients in resolving appeals according to R9-21-104.
 - If a client or, if applicable, an individual on behalf of the client, files an appeal of a modification to or termination of a behavioral health service according to this Section, the client's non-Title XIX services shall continue while the appeal is pending unless:
 - A qualified clinician, and, if applicable, the Department of Economic Security, determines that the modification or termination is necessary to avoid a serious or immediate threat to the health or safety of the client or another individual; or
 - The client or, if applicable, the client's guardian agrees in writing to the modification or termination.
- B.** Applicants and clients shall be informed of their right to appeal at the time an application for services is made, when an eligibility determination is made, when a decision regarding fees or the waiver of fees is made, upon receipt of the assessment report, during the ISP, ITDP, and review meetings, at the time an ISP, ITDP, and any modification to the ISP or ITDP is distributed, when any service is suspended or terminated, and at any other time provided by this Chapter. The notice shall be in writing in English and Spanish and shall include:
- The client's right to appeal and to an administrative hearing according to A.R.S. § 41-1092.03;
 - The method by which an appeal and an administrative hearing may be obtained;
 - That the client may represent himself or use legal counsel or other appropriate representative;
 - The services available to assist the client from the Office of Human Rights, Independent Oversight Committees, State Protection and Advocacy System, and other peer support and advocacy services;
 - What action the mental health agency or health plan intends to take;
 - The reasons for the intended action;
 - The specific rules or laws that support such action; and
 - An explanation of the circumstances under which services will continue if an appeal or an administrative hearing is requested.
- C.** The right to appeal in this Section does not include the right to appeal a court order entered according to A.R.S. Title 36, Chapter 5, Articles 4 and 5. The following issues may be appealed:
- Decisions regarding the individual's eligibility for behavioral health services;
 - The sufficiency or appropriateness of the assessment or any further evaluation;
 - The long-term view, service goals, objectives, or time-lines stated in the ISP or ITDP;
 - The recommended services identified in the assessment report, ISP, or ITDP;
 - The actual services to be provided, as described in the ISP, plan for interim services, or ITDP;
 - The access to or prompt provision of services provided under Title XIX;
 - The findings of the clinical team with regard to the client's competency, capacity to make decisions, need for guardianship or other protective services, or need for special assistance;
 - A denial of a request for a review of, the outcome of a review of, a modification to or failure to modify, or a termination of an ISP, ITDP, or portion of an ISP or ITDP;
 - The application of the procedures and timetables as set forth in this Chapter for developing the ISP or ITDP;
 - The implementation of the ISP or ITDP;
 - The decision to provide service planning, including the provision of assessment or case management services, to a client who is refusing such services, or a decision not to provide such services to such a client; or
 - Decisions regarding a client's fee assessment or the denial of a request for a waiver of fees;
 - Denial of payment for a client; and
 - Failure of the health plan or the Administration to act within the time frames for appeal established in this Chapter.
- D.** Initiation of the appeal.
- An appeal may be initiated by the client or by any of the following persons on behalf of a client or applicant requesting behavioral health services or community services:
 - The client's or applicant's guardian,
 - The client's or applicant's designated representative, or
 - A service provider of the client, if the client or, if applicable, the client's guardian gives permission to the service provider;
 - An appeal is initiated by notifying the health plan of the decision, report, plan or action being appealed, including a brief statement of the reasons for the appeal and the current address and telephone number, if available, of the

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applicant or client and designated representative if one is provided.

3. An appeal shall be initiated within 60 days of the decision, report, plan, or action being appealed. However, the health plan shall accept a late appeal for good cause. If the health plan refuses to accept a late appeal or determines that the issue is not appealable under subsection (C) of this Article, health plan shall notify the individual or client in writing, with a statement of reasons for the decision. Within 10 days of the notification, the client or applicant may request review of that decision by the Administration, which shall act within 15 days of receipt of the request for review. The decision of the Administration shall be final.
 4. Within five days of receipt of an appeal, the health plan shall inform the client in writing that the appeal has been received and of the procedures that shall be followed during the appeal.
- E. Informal conference with the health plan.**
1. Within seven days of receipt of the notice of appeal, the health plan shall hold an informal conference with the client, any designated representative and/or guardian, the case manager and representatives of the clinical team, and a representative of the service provider, if appropriate.
 - a. The health plan shall schedule the conference at a convenient time and place and shall inform all participants in writing of the time, date, and location two days before the conference.
 - b. Individuals may participate in the conference by telephone.
 2. The health plan shall chair the informal conference and shall seek to mediate and resolve the issues in dispute. To the extent that resolution satisfactory to the client or guardian is not achieved, the health plan shall clarify issues for further appeal and shall determine the agreement, if any, of the participants as to the material facts of the case.
 3. Except to the extent that statements of the participants are reduced to an agreed statement of facts, all statements made during the informal conference shall be considered as offers in compromise and shall be inadmissible in any subsequent hearing or court proceedings under this Section.
 4. If the informal conference with the health plan does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are not related to the client's eligibility for behavioral health services, the client or, if applicable, the client's guardian shall be informed that the matter may be further appealed to the Administration, and of the procedure for requesting a waiver of the informal conference with the Administration.
 5. If a client or, if applicable, the client's guardian waives the right to an informal conference with the Administration according to subsection (E)(4) or, if the informal conference with the health plan does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are related to the client's eligibility for behavioral health services, the health plan shall, at the informal conference:
 - a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
 - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the health plan to request an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.
 - c. For a client who needs special assistance, send a copy of the notice in subsection (5)(a) to the appropriate Independent Oversight Committee in the Office of Human Rights.
- F. Informal conference with the Administration.**
1. Within three days of the conclusion of an informal conference with the health plan according to subsection (E)(4), the health plan shall notify the Administration and shall immediately forward the client's notice of appeal, all documents relevant to the resolution of the appeal and any agreed statements of fact.
 2. Within 15 days of the notification from the health plan, the Administration shall hold an informal conference with the client, any designated representative and/or guardian, the case manager, and representatives of the clinical team, the service provider, if appropriate, for the purpose of mediating and resolving the issues being appealed.
 - a. The Administration shall schedule the conference at a convenient time and place and shall inform the participants in writing of the time, date, and location five days prior to the conference.
 - b. Individuals may participate in the conference by telephone.
 - c. If a client is unrepresented at the conference but needs/requests assistance, or if for any other reason the Administration determines the appointment of a representative to be in the client's best interest, the Administration may designate a human rights advocate or other person to assist the client in the appeal.
 3. To the extent that resolution satisfactory to the client or guardian is not achieved, the Administration shall clarify issues for further appeal and shall determine the agreement, if any, of the participants as to the material facts of the case.
 4. If resolution satisfactory to the client or guardian is achieved, the Administration shall issue a dated written notice to all parties which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved, and the date by which the resolution will be implemented.
 5. Except to the extent that statements of the participants are reduced to an agreed statement of facts, all statements made during the informal conference shall be considered as offers in compromise and shall be inadmissible in any subsequent hearing or court proceedings under this Section.

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6. If all issues in dispute are not resolved to the satisfaction of the client or guardian at the informal conference with the Administration, the Administration shall, at the informal conference:
 - a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
 - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the Administration to file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.
 - c. For all clients including clients who needs special assistance, send a copy of the notice in subsection (6)(a) to the Office of Human Rights and make the notice available to the appropriate Independent Oversight Committee.
 7. If, at the informal conference, a client or, if applicable, the client's guardian requests that the Administration file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the Administration shall file the request within three days of the informal conference according to subsection (G).
- G. The state fair hearing.**
1. Within three days of the informal conference with the Administration, if the conference failed to resolve the appeal, or within five days of the date the conference was waived, the Administration shall forward a request to schedule a state fair hearing.
 2. Within five days of the notification, the Administration shall send a written notice of state fair hearing to all parties, informing them of the time and place of the hearing, the name, address, and telephone number of the Administrative Law Judge, and the issues to be resolved. The notice shall also be sent to the appropriate Independent Oversight Committee in the Office of Human Rights for all clients who need special assistance.
 3. A state fair hearing shall be held on the appeal in a manner consistent with A.R.S. § 41-1092 et seq., and those portions of 9 A.A.C. 1 which are consistent with this Article.
 4. During the pendency of the appeal, the client, any designated representative and/or guardian, the clinical team, and representatives of any service providers may agree to implement any part of the ISP or ITDP or other matter under appeal without prejudice to the appeal.
 5. The client or applicant shall have the right to be represented at the hearing by a person chosen by the client or applicant at the client's or applicant's own expense, in accordance with Rule 31, Rules of the Supreme Court.
 6. The client, any designated representative and/or guardian, and the opposing party shall have the right to present any evidence relevant to the issues under appeal and to call and examine witnesses. The Administration shall have the right to appear to present legal argument.
 7. The client and any designated representative and/or guardian shall have the right to examine and copy at a reasonable time prior to the hearing all records held by the Administration, health plan, or service provider pertaining to the client and the issues under appeal, including all records upon which the ISP or ITDP decisions were based.
 8. Any portion of the hearing may be closed to the public if the client requests or if the Administrative Law Judge determines that it is necessary to prevent the unwarranted invasion of a client's privacy or that public disclosure would pose a substantial risk of harm to a client.
- H. Expedited appeal.**
1. At the time an appeal is initiated, the applicant, client, or mental health agency may request orally or in writing an expedited appeal on issues related to crisis or emergency services or for good cause. Any appeal from a decision denying admission to or continued stay at an inpatient psychiatric facility due to lack of medical necessity shall be accompanied by all medical information necessary to resolution of the appeal and shall be expedited.
 2. An expedited appeal shall be conducted in accordance with the provisions of this Section, except as provided for in this subsection.
 3. Within one day of receipt of an expedited appeal, the health plan shall inform the client in writing that the appeal has been received.
 4. The health plan shall accept an expedited appeal on issues related to crisis or emergency services. The health plan shall also accept an expedited appeal for good cause. If the regional authority refuses to expedite the appeal based on a determination that good cause does not exist, the health plan shall notify the applicant or client in writing within one day of the initiation of the appeal, with a statement of reasons for the decision, and shall proceed with the appeal in accordance with the provisions of this Section. Within three days of the notification of refusal to expedite the appeal for good cause, the client or applicant may request review of the decision by the Administration, who shall act within one day. The decision of the Administration shall be final.
 5. If the health plan accepts the appeal for expedited consideration, the health plan shall hold the informal conference according to R9-21-401(E) within two days of the initiation of the appeal. The health plan shall schedule the conference at a convenient time and place and shall inform all participants of the time, date and location prior to the conference.
 6. If the informal conference with the health plan does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are not related to the client's eligibility for behavioral health services, the client or, if applicable, the client's guardian shall be informed that the matter may be further appealed to the Administration, and of the procedure for requesting waiver of the informal conference with the Administration.
 7. If a client or, if applicable, the client's guardian waives the right to an informal conference with the Administration or, if the informal conference with the health plan does not resolve the issues in dispute to the satisfaction of the client or, if applicable, the client's guardian, and the issues in dispute are related to the client's eligibility for behavioral health services, the health plan shall, at the informal conference:
 - a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
 - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the health plan to request an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.

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- c. Send a copy of the notice in subsection (H)(7)(a) to the Office of Human Rights.
 8. If, at the informal conference, a client or, if applicable, the client's guardian requests that the health plan file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the Administration shall file the request within one day of the informal conference.
 9. Within one day of the conclusion of an informal conference with the health plan, the health plan shall notify the Administration if the informal conference failed to resolve the appeal and shall immediately forward the client's notice of appeal and any agreed statements of fact unless the client or, if applicable, the client's guardian waived the client's right to an informal conference with the Administration or the issues in dispute are related to the client's eligibility for behavioral health services.
 10. Within two days of the notification from the health plan, the Administration shall hold the informal conference pursuant to subsection (F).
 11. If all issues in dispute are not resolved to the satisfaction of the client or if applicable, the client's guardian at the informal conference with the Administration, the Administration shall, at the informal conference:
 - a. Provide written notice to the client or, if applicable, the client's guardian according to A.R.S. § 41-1092.03, and
 - b. Ask the client or, if applicable, the client's guardian whether the client or, if applicable, the client's guardian would like the Administration to file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client.
 - c. For a client who needs special assistance, send a copy of the notice in subsection (H)(11)(a) to the Office of Human Rights.
 12. If, at the informal conference, a client or, if applicable, the client's guardian requests that the Administration file a request for an administrative hearing according to A.R.S. § 41-1092.03 on behalf of the client, the Administration shall file the request within one day of the informal conference.
 13. Within one day of the informal conference with the Administration, if the conference failed to resolve the appeal, or within two days of the date the conference was waived, the Administration shall forward a request to schedule a state fair hearing.
 14. Within one day of notification, the Administration shall send a written notice of an expedited state fair hearing in accordance with subsection (G)(2) and A.R.S. 41-1092, et seq.
 15. An expedited state fair hearing shall be held on the appeal in accordance with subsection (G)(3) and A.R.S. 41-1092, et seq.
- I. Standard and burden of proof.**
1. The standard of proof on all issues shall be by a preponderance of the evidence.
 2. The burden of proof on the issue of the need for or appropriateness of behavioral health services or community services shall be on the person appealing.
 3. The burden of proof on the issue of the sufficiency of the assessment and further evaluation, and the need for guardianship, conservatorship, or special assistance shall be on the agency which made the decision.
4. The burden of proof on issues relating to services or placements shall be on the party advocating the more restrictive alternative.
- J. Implementation of final decision.** Within five days after a satisfactory resolution is achieved at an informal conference or after the expiration of an appeal period when no appeal is taken, or after the exhaustion of all appeals and subject to the final decision thereon, the health plan shall implement the final decision and shall notify the client, any designated representative and/or guardian, and Administration of such action.
- K. Appeal log.**
1. The Administration and health plan shall maintain logs of appeals filed under this Section.
 2. The log maintained by the Administration shall not include personally identifiable information and shall be a public record, available for inspection and copying by any person.
 3. With respect to each entry, the logs shall contain:
 - a. A unique docket number or matter number;
 - b. A substantive but concise description of the appeal including whether the appeal related to the provision of Title XIX services;
 - c. The date of the filing of appeal;
 - d. The date of the initial decision appealed from;
 - e. The date, nature and outcome of all subsequent decisions, appeals, or other relevant events; and
 - f. A substantive but concise description of the final decision and the action taken by the agency director and the date the action was taken.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-401 renumbered to R9-21-402; new Section R9-21-401 renumbered from R9-21-315 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-402. General

- A.** It is the policy of the Administration to conduct investigations and bring matters to a resolution in four circumstances: first, in the event of a death of a client; second, whenever there is alleged to have occurred a rights violation; third, whenever there is alleged to exist a condition requiring investigation because it is dangerous, illegal or inhumane; and fourth, in any other case where an investigation would be in the public interest, as determined by the Administration. The purpose of R9-21-402 through R9-21-410 is to implement that policy. All investigations according to R9-21-402 through R9-21-410 shall be carried out in a prompt and equitable manner and with due regard for the dignity and rights of all persons involved. R9-21-402 through R9-21-410 do not obviate the need for systematically reporting, where appropriate, accidents and injuries involving clients.
- B.** This grievance and investigation procedure applies to any allegation that a rights violation or a condition requiring investigation, as defined in R9-21-101, has occurred or currently exists.
1. A grievance may be filed by a client, guardian, human rights advocate, Independent Oversight Committee, State Protection and Advocacy System, designated representa-

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tive, or any other concerned person when a violation of the client's rights or of the rights of several clients has occurred.

2. A request for an investigation may be filed by any person whenever a condition requiring investigation occurs or has occurred.
3. Allegations about the need for or appropriateness of behavioral health services or community services should be addressed according to the Individual Service Planning Sections R9-21-301 through R9-21-314 and according to R9-21-401, as applicable.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-402 renumbered to R9-21-403; new Section R9-21-402 renumbered from R9-21-401 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-403. Initiating a Grievance or Investigation

- A. Any individual may file a grievance regarding an abridgement by a mental health agency of one or more of a client's rights in Article 2 of this Chapter.
- B. Any individual may request an investigation regarding a condition requiring investigation.
- C. An employee of or individual under contract with one of the following shall file a grievance if the employee has reason to believe that a mental health agency has abridged one or more of a client's rights in Article 2 of this Chapter or that a condition requiring investigation exists, and shall receive disciplinary action for failure to comply with this subsection:
 1. A service provider,
 2. A health plan,
 3. An inpatient facility, or
 4. The Administration.
- D. A service provider or health plan shall file a grievance if it:
 1. Receives a non-frivolous allegation that:
 - a. A mental health agency has abridged one or more of a client's rights in Article 2 of this Chapter, or
 - b. A condition requiring investigation exists; or
 2. Has reason to believe that there exists or has occurred a condition requiring investigation in a mental health agency or program.
- E. The Administration shall request an investigation if:
 1. The Administration determines that it would be in the best interests of a client, the Administration, or the public; or
 2. The Administration receives a non-frivolous allegation or has reason to believe that:
 - a. A mental health agency has abridged one or more of a client's rights in Article 2 of this Chapter, or
 - b. A condition requiring investigation exists.
- F. To file a grievance, an individual shall communicate the grievance orally or submit the grievance in writing to a mental health agency who shall forward the grievance to the appropriate person as identified in R9-21-404. If asked to do so by a client, an employee shall assist the client in making an oral or written grievance or shall direct the client to the available

supervisory or managerial staff who shall assist the client in making an oral or written grievance.

- G. Any grievance or request for investigation shall be accurately and completely reduced to writing on an Administration-provided grievance or request for investigation form by:
 1. The individual filing the grievance or request for investigation, or
 2. The mental health agency to whom the grievance or request for investigation is made.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-403 renumbered to R9-21-404; new Section R9-21-403 renumbered from R9-21-402 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-404. Persons Responsible for Resolving Grievances and Requests for Investigation

- A. Allegations involving rights violations, except those involving physical abuse, sexual abuse, or sexual misconduct of a mental health agency, or as a result of an employee of a mental health agency, shall be addressed to and initially decided by the appropriate health plan.
 1. If the mental health agency is operated exclusively by a governmental entity, then the allegation shall be addressed to and initially decided by the agency.
 2. Allegations of physical abuse, sexual abuse, or sexual misconduct that occurred in a mental health agency, or as a result of an action of a person employed by a mental health agency, shall be addressed to and decided by the Administration.
- B. Allegations involving conditions requiring investigation shall be addressed to and initially decided by the appropriate health plan.
 1. If the mental health agency is operated exclusively by a governmental entity, the allegation shall be addressed to and initially decided by that agency.
 2. Allegations of a client death, which occurred in a mental health agency, or as a result of an action of a person employed by a mental health agency, shall be addressed to and decided by the Administration.
- C. Within five days of receipt by a mental health agency of a grievance or request for investigation:
 1. The mental health agency shall inform the person filing the grievance or request, in writing, that the grievance or request has been received;
 2. If the mental health agency is operated exclusively by a governmental entity, the mental health agency shall provide a copy of the grievance to the appropriate health plan; and
 3. If the client is in need of special assistance, the mental health agency shall immediately send a copy of the grievance or request to the Office of Human Rights and the Independent Oversight Committee with jurisdiction over the agency.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective

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October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Former Section R9-21-404 renumbered to R9-21-405; new Section R9-21-404 renumbered from R9-21-403 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-405. Preliminary Disposition

- A. The agency director before whom a grievance or request for investigation has been initiated shall immediately take whatever action may be reasonable to protect the health, safety and security of any client, witness, individual filing the grievance or request for investigation, or individual on whose behalf the grievance or request for investigation is filed.
- B. Summary disposition.
 1. A mental health agency or the Administration may summarily dispose of any grievance or a request for an investigation where the alleged rights violation or condition occurred more than one year immediately prior to the date on which the grievance or request is made.
 2. A mental health agency or the Administration who receives a grievance or request which is primarily directed to the level or type of mental health treatment provided to a client, which can be fairly and efficiently addressed within the procedures set forth in Article 3 and in R9-21-401, and which do not directly or indirectly involve any rights set forth in A.R.S. Title 36 or Article 2, may refer the grievance for resolution through the Individual Service Plan process or the appeal process in R9-21-401.
- C. Disposition without investigation.
 1. Within seven days of receipt of a grievance or request for an investigation, a mental health agency or the Administration may promptly resolve a grievance or request without conducting a full investigation, where the matter:
 - a. Involves no dispute as to the facts;
 - b. Is patently frivolous; or
 - c. Is resolved fairly and efficiently within seven days without a formal investigation.
 2. Within seven days of receipt of the grievance or request described in subsection (C)(1), the mental health agency or the Administration shall prepare a written, dated decision.
 - a. The decision shall explain the essential facts, why the mental health agency or the Administration believes that the matter is appropriately resolved without the appointment of an investigator, and the resolution of the matter.
 - b. The mental health agency or the Administration shall send copies of the decision to the parties, together with a notice of appeal rights according to A.R.S. § 41-1092.03, and to anyone else having a direct interest in the matter.
 3. After the expiration of the appeal period without appeal by any party, or after the exhaustion of all appeals and subject to the final decision on the appeal, the mental health agency or the Administration shall promptly take appropriate action and prepare and add to the case record

a written, dated report of the action taken to resolve the grievance or request.

D. Matters requiring investigation.

1. If the matter complained of cannot be resolved without a formal investigation according to the criteria set forth in subsection (C)(1), within seven days of receipt of the grievance or request the mental health agency or the Administration shall prepare a written, dated appointment of an impartial investigator who, in the judgment of the mental health agency or the Administration, is capable of proceeding with the investigation in an objective manner but who shall not be:
 - a. Any of the persons directly involved in the rights violation or condition requiring investigation; or
 - b. A staff person who works in the same administrative unit as, except a person with direct line authority over, any person alleged to have been involved in the rights violation or condition requiring investigation.
 2. Immediately upon the appointment of an investigator, the mental health agency or the Administration shall notify the person filing the grievance or request for investigation in writing of the appointment. The notice shall contain the name of the investigator, the procedure by which the investigation will be conducted and the method by which the person may obtain assistance or representation.
- E.** If a client is a client who needs special assistance, the mental health agency or the Administration shall immediately send a copy of the grievance or request to the Office of Human Rights and the Independent Oversight Committee with jurisdiction over the agency and shall send a copy of all decisions required by this Chapter made by the mental health agency or the Administration regarding the grievance or request to the Office of Human Rights and the Independent Oversight Committee with jurisdiction over the agency.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Former Section R9-21-405 renumbered to R9-21-406; new Section R9-21-405 renumbered from R9-21-404 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-406. Conduct of Investigation

- A. Within 10 days of the appointment, the investigator shall hold a private, face-to-face conference with the person who filed the grievance or request for investigation to learn the relevant facts that form the grounds for the grievance or request, unless the grievance or request has been initiated by a mental health agency or the Administration according to R9-21-403(D) or (E).
 1. In scheduling such conference, and again at the conference, if the client appears without a designated representative, the investigator shall advise the client that:
 - a. The client may be represented by a designated representative of the client's own choice. The investigator

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shall also advise the client of the availability of assistance from the State Protection and Advocacy System, the Office of Human Rights, and the relevant Independent Oversight Committee.

- b. The client may make an audio tape of the conference and all future conferences, meetings or hearings to which the client may be a party during the investigation, provided that the client notify all other parties not later than the beginning of the meeting or hearing that the client intends to do so.
 - c. In any case where the person initiating the grievance or request, or the person(s) who is alleged to have been responsible for the rights violation or condition, is a client and is in need of special assistance and is unrepresented, the investigator shall give the Office of Human Rights notice of the need for representation.
2. Where the grievance has been initiated by the mental health agency or the Administration, the investigator shall promptly determine which persons have relevant information concerning the occurrence of the alleged rights violation or condition requiring investigation and proceed to interview such individuals.
- B.** Within 15 days of the appointment, but only after the conference with the person initiating the grievance or request for investigation, the investigator shall hold a private, face-to-face conference with the person(s) complained of or thought to be responsible for the rights violation or condition requiring investigation to discuss the matter and, in scheduling the conference with such person(s) or with any other witness, the investigator shall advise the person(s) or any other witness that:
1. The individual may make a recording of the conference and all future conferences, meetings or hearings during the course of the investigation, provided that the individual must notify all other parties to such meetings or hearings not later than the beginning of the meeting or hearing if the individual intends to so record.
 2. An employee of an inpatient facility, service provider, health plan or the Administration has an obligation to cooperate in the investigation.
 3. Failure of an employee to cooperate may result in appropriate disciplinary action.
- C.** The investigator shall gather relevant and appropriate information, including interviewing additional witnesses, requesting and reviewing documents, and examining other evidence or locations.
- D.** Within 10 days of completing all interviews with the parties but not later than 30 days from the date of the appointment, the investigator shall prepare a written, dated report briefly describing the investigation and containing findings of fact, conclusions, and recommendations
- E.** Within five days of receiving the investigator's report, the agency director shall review the report and the case record and prepare a written, dated decision which shall either:
1. Accept the investigator's report in whole or in part, at least with respect to the facts as found, and state a summary of findings and conclusions and the intended action of the agency director; and send:
 - a. A copy of the decision to:
 - i. The investigator;
 - ii. The individual who filed the grievance or request for investigation;
 - iii. The individual who is the subject of the grievance or request for investigation, if applicable;
 - iv. The Office of Human Rights; and
 - v. The appropriate Independent Oversight Committee.
- b.** A notice to the individual who filed the grievance or request for investigation and, if applicable, the client who is the subject of the grievance or request for investigation or, if applicable, the client's guardian, of:
- i. If the decision is from an agency director, the client's right to appeal to the Administration according to R9-21-406 and to an administrative hearing according to A.R.S. § 41-1092.03; and
 - ii. If the decision is from the Administration, the client's right to an administrative hearing according to A.R.S. § 41-1092.03; or
2. Reject the report for insufficiency of facts and return the matter for further investigation. In such event, the investigator shall complete the further investigation and deliver a revised report to the agency director within 10 days. Upon receipt of the report, the agency director shall proceed as provided in subsection (E)(I).
- F.** Actions that an agency director may take according to subsection (E)(I) include:
1. Identifying training or supervision for or disciplinary action against an individual responsible for a rights violation or condition requiring investigation identified during the course of investigating a grievance or request for investigation;
 2. Developing or modifying a mental health agency's policies and procedures;
 3. Notifying the regulatory entity that licensed or certified an individual according to A.R.S. Title 32, Chapter 33 of the findings from the investigation; or
 4. Imposing sanctions, including monetary penalties, according to terms of a contract, if applicable.
- G.** After the expiration of the appeal period set forth in R9-21-407, or after the exhaustion of all appeals and subject to the final decision on the appeal, the agency director shall promptly take the action set forth in the decision and add to the case record a written, dated report of the action taken. A copy of the report shall be sent to the Office of Human Rights and the Independent Oversight Committee if the client is in need of special assistance.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Former Section R9-21-406 renumbered to R9-21-407; new Section R9-21-406 renumbered from R9-21-405 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-407. Administrative Appeal

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- A.** Any grievant or the client who is the subject of the grievance who is dissatisfied with the final decision of the agency director may, within 30 days of receipt of the decision, file a notice of appeal with the Administration. The appealing party shall send copies of the notice to the other parties and their representatives and to the agency director who shall forward the full case record to the Administration.
- B.** The Administration shall review the notice of appeal and the case record, and may discuss the matter with any of the persons involved or convene an informal conference. Within 15 days of the filing of the appeal, the Administration shall prepare a written, dated decision which shall either:
1. Accept the investigator's report, in whole or in part, at least with respect to the facts as found, and affirm, modify or reject the decision of the agency director with a statement of reasons; or
 2. Reject the investigator's report for insufficiency of facts and return the matter with instructions to the agency director for further investigation and decision. In such event, the further investigation shall be completed and a revised report and decision shall be delivered to the Administration within 10 days. Upon receipt of the report and decision, the Administration shall render a final decision, consistent with the procedures set forth in subsection (B)(1).
 3. A designated representative shall be afforded the opportunity to be present at any meeting or conference convened by the Administration to which the represented party is invited.
 4. The Administration shall send copies of the decision to:
 - a. The parties, together with a notice of appeal rights according to A.R.S. § 41-1092.03;
 - b. The agency director; and
 - c. The Office of Human Rights and the applicable Independent Oversight Committee for all clients, including clients who are in need of special assistance.
- and the Independent Oversight Committee for clients who are in need of special assistance.
- B.** The hearing shall be conducted consistent with A.R.S. § 41-1092 et seq., and those portions of 9 A.A.C. 1 which are consistent with this Article.
1. The client shall have the right to be represented at the hearing by an individual chosen by the client at the client's own expense, in accordance with Rule 31, Rules of the Supreme Court. If the client has not designated a representative to assist the client at the hearing and is in need of special assistance, the human rights committee, or the human rights advocate unless refused by the client, shall make all reasonable efforts to represent the client.
 2. Any portion of the hearing may be closed to the public if the client requests or if the Administrative Law Judge determines that it is necessary to prevent an unwarranted invasion of the client's privacy or that public disclosure would pose a substantial risk of harm to the client.
 3. The Administration shall explain the Director's decision to the client at the client's request, together with the right to seek rehearing and judicial review.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Section repealed; new Section R9-21-408 renumbered from R9-21-407 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-409. Notice and Records

- A.** Notice to clients. All clients shall be informed of their right to file a grievance or request for investigation under this Article.
1. Notice of this grievance and investigation process shall be included in the information posted or otherwise provided to every current and new client and employee. Special efforts shall be made to inform current and new residents of mental health facilities of this process and of the right to file a grievance or request for investigation;
 2. A copy of a brief memorandum explaining these rules shall be given to every current and new resident of a inpatient facility;
 3. Such memorandum and blank copies of the forms for filing a grievance, request for investigation, and appeal shall be posted in a prominent place in plain sight on every unit of an inpatient facility or in a program operated by a service provider; and
 4. Such memoranda, forms and copies of these rules shall be available at each inpatient facility, health plan and service provider upon request by any person at any time.
- B.** Notice and oversight by the Office of Human Rights and Independent Oversight Committees.
1. Upon receipt of any grievance or request for investigation involving a client, including a client who is in need of special assistance, the agency director shall immediately forward a copy of such grievance or request to the Office of Human Rights and the appropriate regional Independent Oversight Committee.
 2. Upon receipt of such a grievance from the agency director, at the request of a client, or on its own initiative, the

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Former Section R9-21-407 renumbered to R9-21-408; new Section R9-21-407 renumbered from R9-21-406 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-408. Further Appeal to Administrative Hearing

- A.** Any grievant or the client who is the subject of the grievance who is dissatisfied with the Director's decision of the Administration may request a state fair hearing before an Administrative Law Judge.
1. Within 30 days of the date of the Director's decision, the appealing party shall file with the Administration a notice requesting a state fair hearing.
 2. Upon receipt of the notice, the Administration shall send a copy to the parties, and to the Office of Human Rights

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Office of Human Rights and/or the appropriate Independent Oversight Committee shall assist a client in filing a grievance or request, if necessary. The Office and/or committee shall use its best efforts to see that such client is represented by an attorney, human rights advocate, committee member, or other person to protect the individual's interests and present information on the client's behalf. The Office and/or committee shall maintain a list of attorneys and other representatives, including the state protection and advocacy system, available to assist clients.

3. Whenever the Independent Oversight Committee has reason to believe that a rights violation involving abuse or a dangerous condition requiring investigation, including a client death, has occurred or currently exists, or that any rights violation or condition requiring investigation occurred or exists which involves a client who is in need of special assistance, it may, upon written notice and a release signed by the member, or designated representative, giving permission for the IOC to join, sent to the official before whom the matter is pending, become a party to the grievance or request. As a party it shall receive copies of all reports, plans, appeals, notices and other significant documents relevant to the resolution of the grievance or request and be able to appeal any finding or decision.
 4. The Office of Human Rights shall assist clients in resolving grievances according to R9-21-104.
- C. Notification of other persons.**
1. Whenever any rule, regulation, statute, or other law requires notification of a law enforcement officer, public official, medical examiner, or other person that an incident involving the death, abuse, neglect, or threat to a client has occurred, or that there exists a dangerous condition or event, such notice shall be given as required by law.
 2. A mental health agency shall immediately notify the Administration when:
 - a. A client brings criminal charges against an employee;
 - b. An employee brings criminal charges against a client;
 - c. An employee or client is indicted or convicted because of any action required to be investigated by this Article;
 - d. A client of an inpatient facility, a mental health agency, or a service provider dies. The agency director shall report such death according to the Administration's policy on the reporting and investigation of deaths;
 - e. A client of an inpatient facility, a mental health agency, or a service provider allegedly is physically or sexually abused.
 3. The investigation by the Administration provided for by this Article is independent of any investigation conducted by police, the county attorney, or other authority.
- D. Case records.**
1. A file, known as the case record, shall be kept for each grievance or request for investigation which is received by the Administration, ASH, health plan or service provider under contract or subcontract with the Administration. The record shall include the grievance or request, the docket number or matter number assigned, the names of all persons interviewed and the dates of those inter-

views, either a taped or written summary of those interviews, a summary of documents reviewed, copies of memoranda generated by the investigation, the investigator's report, the agency director's decision, and all documents relating to any appeal.

2. The investigator shall maintain possession of the case record until the investigation report is submitted. Thereafter, the agency director shall maintain control over the case record, except when the matter is on appeal. During any appeal, the record will be in the custody of the official who hears or decides the appeal.
- E. Public logs.**
1. The Administration and health plan shall maintain logs of deaths and non-frivolous grievances or requests for investigation for inpatient facilities, agencies, service providers, and mental health agencies which it operates, funds, or supervises.
 2. The log maintained by the Administration shall not include personally identifiable information and shall be a public record, available for inspection and copying by any person.
 3. With respect to each grievance or request for investigation, the Administration's log shall contain:
 - a. A unique docket number or matter number;
 - b. A substantive but concise description of the grievance or request for investigation;
 - c. The date of the filing of grievance;
 - d. The date of the initial decision or appointment of investigator;
 - e. The date of the filing of the investigator's final report;
 - f. A substantive but concise description of the investigator's final report;
 - g. The date of all subsequent decisions, appeals, or other relevant events; and
 - h. A substantive but concise description of the final decision and the action taken by the mental health agency or the Administration.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-410. Miscellaneous

- A. Disqualification of official.** The agency director, investigator, or any other official with authority to act on a grievance or request for investigation shall disqualify himself from acting, if such official cannot act on the matter impartially and objectively, in fact or in appearance. In the event of such disqualification, the official shall forthwith prepare and forward a written, dated memorandum explaining the reasons for the decision to the Administration, as appropriate, who shall, within 10 days of receipt of the memorandum make a determination upon the appropriateness of the disqualification and notify.

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- B. Request for extension of time.**
1. The investigator or any other official of a mental health agency acting according to this Article may secure an extension of any time limit provided in this Article with the permission of the health plan.
 2. The investigator or any other official of an inpatient facility operated exclusively by an governmental entity acting according to this Article may secure an extension of any time limit provided in this Article with the permission of the CEO of the entity or his designee.
 3. The investigator or any other official of the Administration acting according to this Article may secure an extension of any time limit provided in this Article with the permission of the Administration or designee.
 4. An extension of time may only be granted upon a showing of necessity and a showing that the delay will not pose a threat to the safety or security of the client.
 5. A request for extension shall be in writing, with copies to all parties. The request shall explain why an extension is needed and propose a new time limit which does not unreasonably postpone a final resolution of the matter.
 6. Such request shall be submitted to and acted upon prior to the expiration of the original time limit. Failure of the relevant official to act within the time allowed shall constitute a denial of the request for an extension.
- C. Procedural irregularities.**
1. Any party may protest the failure or refusal of any official with responsibility to take action in accord with the procedural requirements of this Article, including the time limits, by filing a written protest with the Administration.
 2. Within 10 days of the filing of such a protest, the Administration shall take appropriate action to ensure that if there is or was a violation of a procedure or timeline, it is promptly corrected, including, if appropriate, disciplinary action against the official responsible for the violation or by removal of an investigator and the appointment of a substitute.
- D. Special Investigation.**
1. The Administration may at any time order that a special investigator review and report the facts of a grievance or condition requiring investigation, including a death or other matter.
 2. The special investigator and the Administration shall comply with the time limits and other procedures for an investigation set forth in this Article.
3. Any final decision issued by the Administration based on such an investigation under this Section is appealable as provided in R9-21-408.
 4. Nothing in this Article shall prevent the Administration from conducting an investigation independent of this Chapter.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 22 A.A.R. 2019, effective July 12, 2016 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

ARTICLE 5. COURT-ORDERED EVALUATION AND TREATMENT**R9-21-501. Court-ordered Evaluation**

- A.** An application for court-ordered evaluation shall, according to A.R.S. § 36-521, be made on AHCCCS form MH-100, Titled "Application for Involuntary Evaluation," set forth in Exhibit A.
- B.** Any mental health agency or service provider that receives an application for court-ordered evaluation shall immediately refer the applicant for pre-petition screening and petitioning for court-ordered evaluation, provided for in A.R.S. Title 36, Chapter 5, Article 4, to:
1. A health plan; or
 2. If a county has not contracted with a health plan for pre-petition screening and petitioning for court-ordered evaluation, the county.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Section repealed; new Section R9-21-501 renumbered from R9-21-502 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

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FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Exhibit A. Application for Involuntary Evaluation

APPLICATION FOR INVOLUNTARY EVALUATION
(Pursuant to A.R.S. § 36-520)

STATE OF ARIZONA)
)
COUNTY OF)

To the _____
(Regional or Screening Authority)

1. The undersigned applicant requests that the above agency conduct a pre-petition screening of the person named herein.
2. The undersigned applicant alleges that there is now in the County a person whose name and address are:

(Name) (Address)

and that s/he believes that the person has a mental disorder and as a result of said mental disorder, is:

- ☐ a danger to self; ☐ a danger to others;
☐ gravely disabled; ☐ persistently or acutely disabled

and is:

- ☐ unwilling to undergo voluntary evaluation, as evidenced by the following facts: _____

- ☐ unable to undergo voluntary evaluation, as demonstrated by the following facts: _____

and who is believed to be in need of supervision, care, and treatment because of the following facts: _____

3. The conclusion that the person has a mental disorder is based on the following facts: _____

4. The conclusion that the person is dangerous or disabled is based on the following facts: _____

PERSONAL DATA OF PROPOSED PATIENT:

Age Date of Birth Sex Race
Weight Height Hair Color Eye Color
Marital Status Number of Children
Social Security No. Religion
Distinguishing Marks _____
Occupation _____
Present Location _____
Dates and Places of Previous Hospitalization _____
How Long in Arizona State Last From
Veteran? C-No. Education

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES
FOR PERSONS WITH SERIOUS MENTAL ILLNESS

NAME, ADDRESS AND TELEPHONE NUMBER OF:

- 1) Guardian
- 2) Spouse
- 3) Next of Kin
- 4) Significant Other Persons _____

DATE_____
SIGNATURE OF APPLICANT

Printed or Typed Name of Applicant

Relationship to Proposed Patient

Applicant's Address

Applicant's Telephone

SUBSCRIBED AND SWORN to before me this _____ day of _____, 19 _____

Notary PublicMy Commission Expires:

ADHS/BHS Form MH-100 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit A repealed, new Exhibit A adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Renumbered from a position after R9-21-502 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES
FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Exhibit B. Petition for Court-ordered Evaluation

PETITION FOR COURT-ORDERED EVALUATION

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF _____

In the Matter of)
)
) MH
)
)
) PETITION FOR COURT-
) ORDERED EVALUATION
) (Pursuant to A.R.S. § 36-523)
)

re: Mental Health Services)

_____)

STATE OF ARIZONA)

)

COUNTY OF)

Petitioner, _____
(Medical Director)

being first duly sworn/affirmed, alleges that:

1. There is now in this County a person whose name and address are as follows:

_____ (Name) _____ (Address)

2. The person may presently be found at: _____

3. There is reasonable cause to believe that the person has a mental disorder and is as a result:

☐ A danger to self; ☐ A danger to others;

☐ Gravely disabled; ☐ Persistently or acutely disabled and is:

4. The person is unwilling to undergo voluntary evaluation, as evidenced by the following facts: _____

5. The person is unable to undergo voluntary evaluation, as demonstrated by the following reasons: _____

6. The person is believed to be in need of supervision, care, and treatment because of the following facts: _____

7. The conclusion that the person has a mental disorder is based on the following facts: _____

8. The conclusion that the person is dangerous or disabled is based on the following facts: _____

9. The conclusion that all available alternatives have been investigated and deemed inappropriate is based on the following facts: _____

10. Applicant information: _____

Name of Applicant: _____

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES
FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Address of Applicant: _____

Relationship to or Interest in the Proposed Patient: _____

11. In the opinion of the Petitioner, the person is _____ is not _____ in such a condition that, without immediate or continuing hospitalization, s/he is likely to suffer serious physical harm or inflict serious physical harm upon another person.
12. In the opinion of the Petitioner, evaluation should _____ should not _____ take place on an outpatient basis, based upon the following reasons: _____
- _____
- _____

PETITIONER REQUESTS THAT THE COURT:

Issue an Order requiring the person to be given an _____ Inpatient _____ Outpatient evaluation.

DATE _____ Signature Of Petitioner

Printed or Typed Name

SUBSCRIBED AND SWORN to before me this _____ day of _____, 19 _____.

Notary Public

My Commission Expires:

ADHS/BHS Form MH-105 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit B repealed, new Exhibit B adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Renumbered from a position after R9-21-502 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES
FOR PERSONS WITH SERIOUS MENTAL ILLNESS**R9-21-502. Emergency Admission for Evaluation**

- A.** An application for emergency evaluation pursuant to A.R.S. § 36-524 may be made to any evaluation agency licensed and approved by the Administration to provide such services on AHCCCS form MH-104, Titled “Application for Emergency Admission for Evaluation,” set forth in Exhibit C.
- B.** Prior to admission of an individual under this Section, the evaluation agency shall notify the appropriate health plan of the potential admission so that the health plan may first:
 - 1. Offer and provide services or treatment to the individual as an alternative to admission; or
 - 2. Authorize admission of the individual.
- C.** If the evaluation agency does not provide notice pursuant to subsection (B), the health plan shall not be obligated to pay for the services provided.

- D.** Only a mental health agency licensed by the Administration to provide emergency services according to A.R.S. Title 36, Chapter 4 may provide court-ordered emergency admission services under A.R.S. Title 36, Chapter 5, Article 4.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-502 renumbered to R9-21-501; new Section R9-21-502 renumbered from R9-21-503 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Exhibit C. Application for Emergency Admission for Evaluation

APPLICATION FOR EMERGENCY ADMISSION FOR EVALUATION
(Pursuant to A.R.S. § 36-524)

STATE OF ARIZONA)
) ss
COUNTY OF)
)

The undersigned applicant, being first duly sworn/affirmed, hereby requests that
(Evaluation Agency)
admit the person named herein for evaluation.

1. The undersigned applicant alleges that there is now in the County a person whose name and address are:

_____ (Name) _____ (Address)

and that s/he believes that the person has a mental disorder and, as a result of said mental disorder, is:

☐ A danger to self; ☐ A danger to others; ☐ Persistently or Acutely Disabled; Gravely Disabled;

and that, during the time necessary to complete pre-petition screening under A.R.S. §§ 36-520 and 36-521, the person is likely without immediate hospitalization to suffer serious physical harm or serious illness or is likely to inflict serious physical harm upon another person.

2. The conclusion that the person has a mental disorder is based on the following facts:

3. The specific nature of the danger posed by this person is:

4. A summary of the personal observations upon which this statement is based is as follows:

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES
FOR PERSONS WITH SERIOUS MENTAL ILLNESS
PERSONAL DATA OF PROPOSED PATIENT:

Age Date of Birth Sex Race

Weight Height Hair Color Eye Color

Marital Status Number of Children

Social Security No. Religion

Distinguishing Marks _____

Occupation _____

Present Location _____

Dates and Places of Previous Hospitalization _____

How Long in Arizona State Last From _____

Veteran? C-No. Education _____

NAME, ADDRESS AND TELEPHONE NUMBER OF:

- 1) Guardian _____
- 2) Spouse _____
- 3) Next of Kin _____
- 4) Significant Other Persons _____

DATE

SIGNATURE OF APPLICANT

Printed or Typed Name of Applicant _____

Relationship to Proposed Patient _____

Applicant's Address _____

Applicant's Telephone _____

SUBSCRIBED AND SWORN to before me this _____ day of _____, 19____.

Notary Public

My Commission Expires:

ADHS/BHS Form MH-104 (9/93)**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit C repealed, new Exhibit C adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Renumbered from a position after R9-21-503 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by emergency rulemaking at 28 A.A.R. 3848 (December 16, 2022), with an immediate effective date of November 28, 2022, for 180 days (Supp. 22-4). Emergency to expire May 27, 2023; amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

R9-21-503. Voluntary Admission for Evaluation

- A.** An application for voluntary evaluation pursuant to A.R.S. § 36-522 shall be submitted on AHCCCS form MH-103, Titled “Application for Voluntary Evaluation,” set forth in Exhibit D to a mental health agency.
- B.** If a health plan receives an application according to subsection (A), the health plan shall provide for such evaluation under A.R.S. § 36-522 for any individual who:
 - 1. Voluntarily makes application as provided in subsection (A);
 - 2. Gives informed consent; and
 - 3. Has not been adjudicated as an incapacitated person pursuant to A.R.S. Title 14, Chapter 5, or Title 36, Chapter 5.
- C.** Any mental health agency, which is not a health plan under R9-21-501, that receives an application for voluntary evaluation shall immediately refer the individual to:
 - 1. The county responsible for voluntary evaluations; or
 - 2. If the county has contracted with a health plan for voluntary evaluations, the appropriate health plan.
- D.** Any mental health agency providing voluntary evaluation services pursuant to this Article shall place in the medical record of the individual to be evaluated the following:
 - 1. A completed copy of the application for voluntary treatment;
 - 2. A completed informed consent form pursuant to R9-21-511; and
 - 3. A written statement of the individual’s present mental condition.
- E.** Voluntary evaluation shall proceed only after the individual to be evaluated has given informed consent on AHCCCS form MH-103 and received information that the patient-physician privilege does not apply and that the evaluation may result in a petition for the individual to undergo court-ordered treatment or for guardianship in the method prescribed by A.R.S. § 36-522.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-503 renumbered to R9-21-502; new Section R9-21-503 renumbered from R9-21-504 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Exhibit D. Application for Voluntary Evaluation

APPLICATION FOR VOLUNTARY EVALUATION
(Pursuant to A.R.S. § 36-522)

The undersigned hereby requests a mental health evaluation to be performed by psychiatrists, psychologists, and social workers at

(Regional Authority)

on the following terms:

INPATIENT. I agree to remain as an inpatient in the above agency for a period of not more than 72 hours. I understand that, at the end of that period, the agency must release me or file a Petition for Court-Ordered Treatment, in which case I may be held until the court holds a hearing, which shall be no longer than six days from the date of filing the petition, excluding weekends and holidays. If such a Petition is filed, I will have the right to representation by a lawyer, and the court will appoint one for me if I cannot afford one.

OUTPATIENT. I agree to keep all scheduled appointments required for a complete evaluation, to the best of my ability. I understand that if I fail to appear, a Petition for Court-Ordered Evaluation or Treatment may be filed, in which case I may be detained and required to undergo involuntary evaluation and treatment. If such a Petition is filed, I will have the right to representation by a lawyer, and the court will appoint one for me if I cannot afford one.

_____ I understand that the physician-patient privilege does not apply, and information I give during this evaluation may be used in court in a civil hearing for court-ordered treatment.

_____ I understand that this evaluation may lead to a court hearing to determine if I need further treatment and that such treatment, or an investigation into the need for a guardianship, may be ordered by a court.

_____ I understand that an application for my examination has been filed and I choose to be evaluated voluntarily rather than by court order.

_____ I understand that my evaluation must take place within five days of my application.

_____ I understand that I have a right to require the person who has applied for my evaluation to present evidence of the need for such evaluation to a court of law for approval or disapproval and I waive my right to require prior court review of the application.

_____ I understand that I have a right, upon written request, to be discharged within 24 hours of that request (excluding weekends and holidays) unless the medical director of the evaluation agency files a petition for court-ordered evaluation.

Presented By

Signature of Applicant

Printed or Typed Name of Applicant

Date

ADHS/BHS Form MH-103 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit D repealed, new Exhibit D adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Renumbered from a position after R9-21-504 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

R9-21-504. Court-ordered Treatment

- A.** The health plan shall perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and this Article. In order to perform these functions, the health plan or its contractor must be licensed by the Department of Health Services.
- B.** A mental health agency may provide court-ordered treatment pursuant to A.R.S. Title 36, Chapter 5, Article 5, other than through contract with the health plan, provided that:
1. The mental health agency is licensed by the Department to provide the court-ordered treatment;
 2. The mental health agency complies with all applicable requirements under A.R.S. Title 36, Chapter 5, Article 5; and
 3. The individual ordered to undergo treatment is not a client of the health plan.
- C.** Upon a determination that an individual is a danger to self or others, gravely disabled, or persistently or acutely disabled, and if no alternatives to court-ordered treatment exist, the medical director of the agency that provided the court-ordered evaluation shall file the appropriate affidavits on AHCCCS form MH-112, set forth in Exhibit E, with the court, together with one of the following petitions:
1. A petition for court-ordered treatment for an individual alleged to be gravely disabled, which shall be filed on AHCCCS form MH-110, set forth in Exhibit F.
 2. A petition for court-ordered treatment for an individual alleged to be a danger to self or others, which shall be filed on AHCCCS form MH-110, set forth in Exhibit F.
 3. A petition for court-ordered treatment for an individual alleged to be persistently or acutely disabled, which shall be filed on AHCCCS form MH-110, set forth in Exhibit F.
- D.** Any mental health agency filing a petition for court-ordered treatment of a client pursuant to subsection (A) shall do so in consultation with the client and the client's clinical team prior to filing the petition.
- E.** With respect to inpatient and outpatient treatment, the petition filed with the court shall request that the individual be committed to the care and supervision of the health plan, if the individual is a client, or to an appropriate mental health treatment agency, if the individual is not a client.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-504 renumbered to R9-21-503; new Section R9-21-504 renumbered from R9-21-505 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES
FOR PERSONS WITH SERIOUS MENTAL ILLNESS

5. The conclusion that the person is dangerous or disabled is based on the following: _____

6. The conclusion that all available alternatives have been investigated and deemed inappropriate is based on the following: _____

Physician's Signature

SUBSCRIBED AND SWORN to before me this _____ day of _____, 19____.

Notary Public

My Commission Expires: _____

ADHS/BHS Form MH-112 (9/93)

PERSISTENTLY OR ACUTELY DISABLED (EXHIBIT E, ADDENDUM NO. 1)

RE: _____

IF PERSISTENTLY OR ACUTELY DISABLED:

1. Does the person have a severe mental disorder that, if not treated, has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional, or physical harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality?
Yes ____ No ____

If yes, provide the facts that support this conclusion: _____

2. Does the severe mental disorder substantially impair the person's capacity to make an informed decision regarding treatment?
Yes ____ No ____

If yes, provide the facts that support this conclusion: _____

- 2a. Does this impairment cause the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment, and understanding and expressing an understanding of the alternatives to the particular treatment offered?
Yes ____ No ____

If yes, provide the facts that support this conclusion: _____

- 2b. Were the advantages and disadvantages of accepting treatment explained to the person?

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Yes ____ No ____

2c. Were the alternatives to treatment and the advantages and disadvantages of such alternatives explained to the person?

Yes ____ No ____

2d. Explain the specific reasons why the person is incapable of understanding and expressing an understanding of the explanations described in 2a, 2b, and 2c: _____

3. Is there a reasonable prospect that the severe mental disorder is treatable by outpatient, inpatient, or combined inpatient and outpatient treatment?

Yes ____ No ____

If yes, please provide the facts that support this conclusion: _____

ADHS/BHS Form MH-112 Addendum No. 1 (9/93)

GRAVELY DISABLED (EXHIBIT E, ADDENDUM NO. 2)

RE: _____

IF GRAVELY DISABLED:

1. Is the person's condition evidenced by behavior in which s/he, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because s/he would be unable to provide for his/her basic physical needs without hospitalization?

Yes ____ No ____

2. If Yes, explain how his/her mental disability affects his/her ability to do the following and how any inability might harm him/her. Provide examples, if available, to support your conclusion:

a. Provide for food: _____

b. Provide for clothing and maintain hygiene: _____

c. Provide for shelter: _____

d. Obtain and maintain steady employment: _____

e. Respond in an emergency: _____

f. Care for present or future medical problems: _____

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES
FOR PERSONS WITH SERIOUS MENTAL ILLNESS

g. Manage money: _____

h. Other: _____

ADHS/BHS Form MH-112 Addendum No. 2 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit E repealed, new Exhibit E with Addenda 1 and 2 adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Renumbered from a position after R9-21-505 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES
FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Exhibit F. Petition for Court-ordered Treatment

PETITION FOR COURT-ORDERED TREATMENT
Gravely Disabled Person

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA IN AND FOR THE COUNTY OF

In the Matter of)
) MH
)
) PETITION FOR COURT-
) ORDERED TREATMENT
) (Pursuant to A.R.S. § 36-533)
re: Mental Health Services) Danger to Self/Others or
) Persistently or Acutely Disabled or
) Gravely Disabled
_____)

STATE OF ARIZONA)
) ss
COUNTY OF _____)
_____)

Petitioner _____, being first duly sworn/affirmed, alleges that:
(Medical Director)

1. _____ is, as a result of a mental disorder:
☐ danger to self ☐ danger to others
☐ persistently or acutely disabled
☐ gravely disabled
and in need of treatment.
2. The court-ordered treatment alternatives that are appropriate and available are:
☐ outpatient treatment [A.R.S. § 36-540(A)(1)].
☐ combined inpatient and outpatient treatment [A.R.S. § 36-540(A)(2)].
☐ inpatient treatment [A.R.S. § 36-540(A)(3)] at.
3. The person is unwilling or is unable to accept treatment voluntarily.
4. A summary of the facts supporting the above allegations is in the attached reports of examining physicians.
5. The person is residing or present in this county, or is admitted to an institution pursuant to an order of a court of competent jurisdiction sitting in this county, or who was committed by an Arizona tribal court, which order of commitment was duly domesticated pursuant to A.R.S. § 12-1702 et seq.
6. The person is entitled to notice of hearing of the petition and may be found at _____
(location)
7. Petitioner believes the person requires a:
_____ Title 14 guardian; _____ Conservator; _____ Title 36 guardian
and requests the Court to order an investigation and report to be made to the Court regarding this need. Said need exists
because: _____

8. Petitioner believes the proposed person needs the immediate services of a temporary _____ guardian _____ conservator
and requests that the Court appoint the same because: _____

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

9. Petitioner believes that _____ address: _____, is the person's guardian/conservator, who should receive notice of any hearing.
10. A copy of this Petition has been mailed to the Public Fiduciary of _____ County and (other guardian, if any) _____

PETITIONER requests that the Court:

1. Set a date for a hearing; and
2. After notice and hearing find that the person is suffering from a mental disorder the result of which renders him/her dangerous to self or others, persistently or acutely disabled, or gravely disabled and order a period of treatment, all as set forth in paragraphs (1) and (2) above.
3. Check if applicable;
 - ☐ Order an independent investigation and report to the Court regarding the need for a Title 14 guardian or conservator or Title 36 guardian.
 - ☐ Appoint the following-named person as temporary guardian and/or conservator of the person, who Petitioner believes to be a fit and proper person to serve in that capacity:

(Proposed Temporary Guardian/Conservator)

(Relation to Patient)

(Address of Proposed Temporary Guardian/Conservator)

- ☐ Impose the duties of a Title 36 guardian upon the person's A.R.S. Title 14 guardian who is _____

DATE _____

Signature of Petitioner
Medical Director

SUBSCRIBED AND SWORN to before me this _____ day of _____, 19____.

NOTARY PUBLIC OR DEPUTY CLERK OF THE SUPERIOR COURT

My Commission Expires:

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit F repealed, new Exhibit F adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Renumbered from a position after R9-21-505 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

TITLE 9. HEALTH SERVICES

CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS

R9-21-505. Coordination of Court-ordered Treatment Plans with ISPs and ITDPs

- A.** All inpatient and outpatient treatment plans prepared for clients according to A.R.S. §§ 36-533, 36-540 and 36-540.01, and any modifications to the treatment plans, shall be developed and implemented according to the individual service planning procedures in Article 3 of this Chapter, including the right of the client to request different services and to appeal the treatment plan.
- B.** If a client's ISP or ITDP is inconsistent with an inpatient or outpatient treatment plan ordered by the court, the mental health agency or health plan, whichever is appropriate, shall recommend to the court that the court-ordered plan be amended so that it is consistent with the client's ISP or ITDP.
- C.** If, during the period a client is on outpatient status, an emergency occurs that satisfies the standards for emergency admission under A.R.S. §§ 36-524 and 36-526, and that requires immediate revocation or modification of an outpatient order, a modification may be submitted to the court in consultation with the client's clinical team without complying with the individual service planning procedures, provided that the client and clinical team subsequently review any such modification according to the individual service planning procedures in Article 3 of this Chapter.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Former Section R9-21-505 renumbered from R9-21-504; new Section R9-21-505 renumbered from R9-21-506 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-506. Review of Court-ordered Individual

- A.** The mental health treatment agency that provides care for an individual ordered by a court to undergo treatment shall:
1. Assure that an examination and review of a court-ordered individual is accomplished in an effective and timely fashion, but not less than 30 days prior to expiration of any treatment portion of the order.
 2. Require written documentation of the examination and review.
 3. Maintain a special record that shall include:
 - a. The expiration date of any treatment portion of the court-ordered treatment; and
 - b. The date by which the review and examination must be initiated.
 4. Establish specific dates by which the review and examination will be accomplished.
 5. Conduct the review and examination by the specified dates.
- B.** In addition to subsection (A), the examination and review process for court-ordered clients shall, at a minimum, include the following:
1. The client's clinical team shall hold an ISP meeting pursuant to R9-21-307, not less than 30 days prior to the expiration of any treatment portion of the court order, which shall include the treatment team of the treatment agency providing behavioral health services under the

court order. The ISP meeting shall include a determination by the clinical team of:

- a. Whether the client continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled;
 - b. That no alternatives to court-ordered treatment are appropriate; and
 - c. Whether court-ordered treatment should continue.
- 2.** If, upon conclusion of the ISP meeting, the clinical team determines that the client:
- a. Continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled;
 - b. That no alternatives to court-ordered treatment are appropriate; and
 - c. That court-ordered treatment should continue, the medical director of the mental health treatment agency providing care for the client committed by court order shall appoint two physicians (one of whom must be a psychiatrist) and the mental health worker assigned to the case to conduct an examination to determine whether the client continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled.
- 3.** After such examination, the examining physicians shall enter a note in the progress sheet of the medical record stating the findings, decision, and the basis for that decision.
- 4.** If the medical finding is that the client continues to be a danger to self, a danger to others, gravely disabled, or persistently or acutely disabled, and if no alternatives to court-ordered treatment exist, the mental health treatment agency shall file a petition and affidavit(s) as provided in R9-21-505.
- C.** In addition to subsection (A), the examination and review process for non-clients shall, at a minimum, include the following:
1. A person designated by the mental health agency providing treatment shall notify the medical director of the agency in writing of the expiration date 30 days prior to expiration of the court-ordered treatment.
 2. The medical director shall within five days notify one or more physicians (at least one of whom must be a psychiatrist) and the mental health worker assigned to the case of the expiration date of the court-ordered treatment and appoint them to determine whether the non-client continues to be a danger to others, a danger to self, gravely disabled, or persistently or acutely disabled.
 3. After such examination, the examining physician(s) shall enter a note in the progress sheet of the medical record stating the findings, decision, and the basis for that decision.
 4. If the medical finding is that the non-client continues to be a danger to self, a danger to others, gravely disabled, or persistently or acutely disabled, and if no alternatives to court-ordered treatment exist, the mental health treatment agency shall file a petition and affidavits as provided in R9-21-505.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-506 renumbered to R9-21-505; new Section R9-21-506 renumbered from R9-21-507 and amended by

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exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-507. Transfers of Court-ordered Persons

- A.** For the purpose of this Section, “non-client” means an individual who have a qualifying serious mental illness but is not currently being evaluated or treated for a mental disorder by or through a health plan.
- B.** An individual ordered by the court to undergo treatment and without a guardian may be transferred from a mental health agency to another mental health agency, provided that the medical director of the mental health agency initiating the transfer has established that:
 - 1. There is no reason to believe the individual will suffer more serious physical harm or serious illness as a result of the transfer; and
 - 2. The individual is being transferred to a level and kind of treatment more appropriate to the individual’s treatment needs and has been accepted for transfer by the medical director of the receiving mental health agency pursuant to subsection (D).
- C.** The medical director of the mental health agency initiating the transfer shall:
 - 1. Be the medical director of the mental health agency to which the court committed the individual; or
 - 2. Obtain the court’s consent to the transfer as necessary.
- D.** All clients shall be transferred according to the procedures in Article 3 of this Chapter. With regard to non-clients, the medical director of the mental health agency initiating the transfer may not transfer a non-client to, or use the services of, any other mental health agency, unless the medical director of the other mental health agency has agreed to provide such services to a non-client to be transferred, and the Department has licensed and approved the mental health agency to provide those services.
- E.** The medical director of the mental health agency initiating the transfer shall notify the receiving mental health agency in sufficient time for the intended transfer to be accomplished in an orderly fashion, but not less than three days. This notification shall include:
 - 1. A summary of the individual’s needs.
 - 2. A statement that, in the medical director’s judgment, the receiving mental health agency can adequately meet the individual’s needs.
 - 3. If the individual is a client, a modification of a client’s ISP according to R9-21-314, when applicable.
 - 4. Documentation of the court’s consent, when applicable.
- F.** The medical director of the transferring mental health agency shall present a written compilation of the individual’s clinical

needs and suggestions for future care to the medical director of the receiving mental health agency, who shall accept and approve it before an individual can be transferred according to subsection (B).

- G.** The transportation of individuals transferred from one mental health agency to another shall be the responsibility of the mental health agency initiating the transfer, irrespective of the allocation of the cost of the transportation defined elsewhere.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-507 renumbered to R9-21-506; new Section R9-21-507 renumbered from R9-21-508 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

R9-21-508. Requests for Notification

- A.** At any time during a specified period of court-ordered treatment in which an individual has been found to be a danger to others, a relative or victim wishing to be notified in the event of a individual being released prior to the expiration of the period of court-ordered treatment shall file a demand, according to A.R.S. § 36-541.01(D), on AHCCCS form MH-127 in Exhibit G.
- B.** At any time during a specified period of court-ordered treatment in which an individual has been found to be a danger to others, a person other than a relative or victim wishing to be notified in the event of an individual being released prior to the expiration of the period of court-ordered treatment shall file a petition and form of order, to A.R.S. § 36-541.01(D) on AHCCCS form MH-128 in Exhibit H.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended by exempt rulemaking at 9 A.A.R. 530, effective January 29, 2003 (Supp. 03-1). Former Section R9-21-508 renumbered to R9-21-507; new Section R9-21-508 renumbered from R9-21-509 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

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Exhibit G. Demand for Notice by Relative or Victim

DEMAND FOR NOTICE BY RELATIVE OR VICTIM
(Pursuant to A.R.S. § 36-541.01)

REGARDING: _____
(Full Name of Patient)

Pursuant to A.R.S. § 36-541.01, with respect to the above-named patient, a person who was ordered to undergo treatment for a mental disorder as a danger to others pursuant to A.R.S. § 36-540 by a court order of the Superior Court of _____ County, Case Number _____, or who was committed by an Arizona tribal court, which order of commitment was duly domesticated pursuant to A.R.S. §§ 12-1702 et seq., the undersigned _____ relative _____ victim does hereby demand that the medical director of _____, the mental health treatment agency providing court-ordered treatment for said person, provide the undersigned with written notice of intention to release or discharge said person prior to the expiration of the period for treatment ordered by the Court, as provided for in A.R.S. § 36-541.01(D).

The undersigned person demanding notice hereby agrees to advise the treatment agency in writing, by certified mail, return receipt requested, of any change in the address to which notice is to be mailed.

Signature of Applicant

Printed or Typed Name of Applicant

Date

Address to Mail Notice

Telephone Number of Applicant

ADHS/BHS Form MH-127 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit G repealed and a new Exhibit G adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Renumbered from a position after R9-21-509 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

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FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Exhibit H. Petition for Notice

PETITION FOR NOTICE

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA IN AND FOR THE COUNTY OF _____

In the matter of)
) MH _____
)
) PETITION FOR NOTICE
)
) (Pursuant to A.R.S. § 36-541.01)
 re: Mental Health Services)
)
 _____)

REGARDING: _____
 (Full Name of Patient)

Pursuant to A.R.S. § 36-541.01, with respect to the above-named patient, a person who was ordered to undergo treatment for a mental disorder as a danger to others pursuant to A.R.S. § 36-540 by a court order of the Superior Court of _____ County, Case Number _____, the undersigned, a person other than a relative or victim of the person hereby asserting a legitimate reason for receiving such notice, does hereby petition the Court to require that the medical director of _____, the mental health treatment agency providing court-ordered treatment for said person, provide the undersigned with written notice of intention to release or discharge said person prior to the expiration of the period for treatment ordered by the Court, as provided for in A.R.S. § 36-541.01, and does hereby provide the following information required by A.R.S. § 36-541.01(D):

Legitimate reason for receiving notice: _____

The undersigned person demanding notice hereby agrees to advise the treatment agency in writing, by certified mail, return receipt requested, of any change in the address to which notice is to be mailed.

Signature of Person Petitioning_____
Printed or Typed Name of Petitioner_____
Date_____
Address to Send Notice_____
Telephone Number of Applicant

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FOR PERSONS WITH SERIOUS MENTAL ILLNESS
IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF _____

In the Matter of)
)
) MH
)
) ORDER FOR NOTICE
)
)
)
)
)
 re: Mental Health Services)
)
)
)

1. The Court having received a demand by _____, a relative or victim of _____, a patient ordered by the Court to undergo treatment for a mental disorder as a danger to others, for written notice from the medical director of _____, the mental health treatment agency providing court-ordered treatment for said patient, of intention to release or discharge said patient prior to the expiration of the period ordered by the Court, as provided for in A.R.S. § 36-541.01, which demand included all information required by A.R.S. § 36-541.01(D);
2. The Court having received a petition by _____, a person other than a relative or victim of _____, a patient ordered by this Court to undergo treatment for a mental disorder as a danger to others, asserting that the petitioner has a legitimate reason for receiving such notice and petitioning the Court to require that the medical director of _____, the mental health treatment agency providing court-ordered treatment for said patient, provide the petitioner with written notice of intention to release or discharge said patient prior to the expiration of the period for treatment ordered by the Court, as provided for in A.R.S. § 36-541.01, which petition included all information required by A.R.S. § 36-541.01(D); and the Court, after considering said petition, having found that the petitioner has a legitimate reason for receiving prior notice.

THEREFORE IT IS ORDERED that the medical director of _____, a mental health treatment agency, shall not release or discharge the above-named patient from court-ordered inpatient treatment without first giving written notice of the intention to do so, in accordance with A.R.S. § 36-541.01(F), to:

- _____ The above-named relative of the patient
- _____ The above-named victim of the patient
- _____ The above-named petitioner found by the Court to have a legitimate reason for receiving prior notice.

IT IS FURTHER ORDERED that a copy of this Order for Notice shall be delivered to the above-named mental health treatment agency and shall be filed with the patient's clinical record, and if the patient is transferred to another agency or institution, any orders for notice shall be transferred with the patient.

DATED this _____ day of _____, 19 _____

SUPERIOR COURT JUDGE/COMMISSIONER

ADHS/BHS Form MH-128 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit H repealed, new Exhibit H adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Renumbered from a position after R9-21-509 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

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R9-21-509. Voluntary Admission for Treatment

- A.** Application for admission for voluntary treatment according to A.R.S. § 36-518 shall be made to a mental health agency on AHCCCS form MH-210, Titled “Application for Voluntary Treatment,” in Exhibit I, by any individual who:
1. Voluntarily makes application as provided in subsection (A);
 2. Gives informed consent;
 3. Has not been adjudicated as an incapacitated person according to A.R.S. Title 14, Chapter 5, or Title 36, Chapter 5; and
 4. If a minor, is appropriately admitted according to A.R.S. § 36-518.
- B.** Any mental health agency that is not a health plan under R9-21-501 and that receives an application for voluntary treatment by a client shall immediately refer the client to the appropriate health plan for treatment as provided under this Section, except that in the case of an emergency, a mental health treatment agency licensed by the Department to provide treatment under A.R.S. § 36-518 may accept an application for voluntary treatment and admit the client for treatment as follows:
1. Prior to admission of a client under this Section, the agency shall notify the appropriate health plan of the potential admission and treatment so that the health plan may first:
 - a. Provide other services or treatment to the client as an alternative; or
 - b. Authorize treatment of the client.
 2. If the agency does not provide notice according to subsection (B)(1), the health plan shall not be obligated to pay for the treatment provided.
- C.** Any mental health agency providing treatment according to A.R.S. § 36-518 shall place in the medical record of the individual to be treated the following:
1. A completed copy of the application for voluntary treatment;
 2. A completed informed consent form according to R9-21-511; and
 3. A written statement of the individual’s present mental condition.
- D.** If the client admitted under this rule does not have an ISP, the health plan shall prepare one in accordance with Article 3 of this Chapter. If the client already has an ISP, the health plan shall commence a review of the ISP as provided in R9-21-313 and, if necessary, take steps to modify the ISP in accordance with R9-21-314.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Former Section R9-21-509 renumbered to R9-21-508; new Section R9-21-509 renumbered from R9-21-510 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2). Amended by final rulemaking at 29 A.A.R. 898 (April 21, 2023), effective May 30, 2023 (Supp. 23-1).

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CHAPTER 21. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) - BEHAVIORAL HEALTH SERVICES
FOR PERSONS WITH SERIOUS MENTAL ILLNESS**Exhibit I. Application for Voluntary Treatment****APPLICATION FOR VOLUNTARY TREATMENT**

(Pursuant to A.R.S. § 36-518)

I, _____, hereby request that the
(Person's Name)
_____ place me in a program or agency for mental health treatment.
(Mental Health Agency)

I understand that my capacity to give informed consent to treatment will be determined before I am allowed to voluntarily consent to treatment. My informed consent to treatment will be given on a separate form.

Further, I am aware that I am entitled to:

1. Withdraw or modify my consent to treatment at any time.
2. Receive a booklet explaining my rights under Arizona law and assistance from a human rights advocate if I desire.
3. A fair explanation of the treatment I am to receive and the purposes of that treatment.
4. A description of any material and substantial risk reasonably to be expected as a result of the treatment.
5. An answer to my inquiries concerning treatment.
6. Revoke my consent to treatment at any time.
7. Discharge within 24 hours of my written request (excluding weekends and holidays) unless the medical director of the treatment agency files a petition for court-ordered treatment.

Person's Signature_____
Date

ADHS/BHS Form MH-210 (9/93)

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Exhibit I repealed, new Exhibit I adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Renumbered from a position after R9-21-510 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-510. Informed Consent in Voluntary Application for Admission and Treatment

- A.** Prior to beginning any course of medication or other treatment for an individual who is subject to voluntary admission under A.R.S. §§ 36-518 and 36-522, a mental health agency shall obtain an informed consent to treatment and enter it in the medical record. For all clients, the informed consent shall be obtained according to R9-21-206.01.
- B.** For clients, the mental health agency shall make reasonable inquiry into an individual's capacity to give informed consent, record these findings, and enter these findings in the client's ISP or record pursuant to Articles 2 and 3 of this Chapter. For non-clients, the agency shall adopt admission procedures that shall include the following:
1. The medical director or the medical director's designee shall make reasonable inquiry into an individual's capacity to give informed consent.
 2. The medical director or the medical director's designee shall record his findings regarding the individual's capacity to give and of having given informed consent.
 3. That the findings of the medical director or the medical director's designee shall be entered into the individual's record.
- C.** Informed consent to treatment may be revoked at any time by a reasonably clear statement in writing.
1. An individual shall receive assistance in writing the revocation as necessary.
 2. If informed consent to treatment is revoked, treatment shall be promptly discontinued, provided that a course of treatment may be concluded or phased out where necessary to avoid the harmful effects of abrupt withdrawal.
- D.** An informed consent form shall be signed by the individual and shall state that the following information was presented to the individual:
1. A fair explanation of the treatments and their purposes.
 2. A description of any material and substantive risk reasonably to be expected.
 3. An offer to answer any inquiries concerning the treatments.
 4. Notice that the individual is free to revoke informed consent to treatment; and

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5. For clients, all information required by R9-21-206.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Former Section R9-21-510 renumbered to R9-21-509; new Section R9-21-510 renumbered from R9-21-511 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

Exhibit J. Repealed**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

Exhibit K. Repealed**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4).

R9-21-511. Use of Psychotropic Medication

- A. Psychotropic medications may only be ordered for individuals undergoing court-ordered evaluation according to R9-21-204 or R9-21-207.
- B. Psychotropic medications may not be ordered for and administered to individuals undergoing court-ordered treatment, except as follows:
 - 1. In an emergency involving the safety of the individual or another, as documented in the individual's medical record;
 - 2. If the individual or guardian gives an informed consent to use the medication;
 - 3. If provision for use of the medications shall be contained in the individual's treatment plan or ISP. At a minimum, the plan shall specify:
 - a. A description of the circumstances under which the medication may be used.
 - b. A description of the objectives that are expected to be achieved by use of the medication. This description must indicate how the individual's condition would be improved by using the medication and

indicate what result would be expected if the medication were not used; or

- 4. According to R9-21-204 or R9-21-207.
- C. The agency shall have the capability to detect drug side effects or toxic reactions that may result from the medications used.
- D. The agency shall have written policies and procedures governing the use of psychotropic medication. These policies and procedures shall specify:
 - 1. Protective measures that will ensure the individual's safety and promote the avoidance or mitigation of short and long-term deleterious effects on the individual.
 - 2. Periodic individual care monitoring, i.e., evaluating and updating the treatment plan and reviewing problem areas such as failure of the individual to achieve treatment plan objectives.
 - 3. Recordkeeping requirements.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-511 renumbered to R9-21-510; new Section R9-21-511 renumbered from R9-21-512 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-512. Seclusion and Restraint

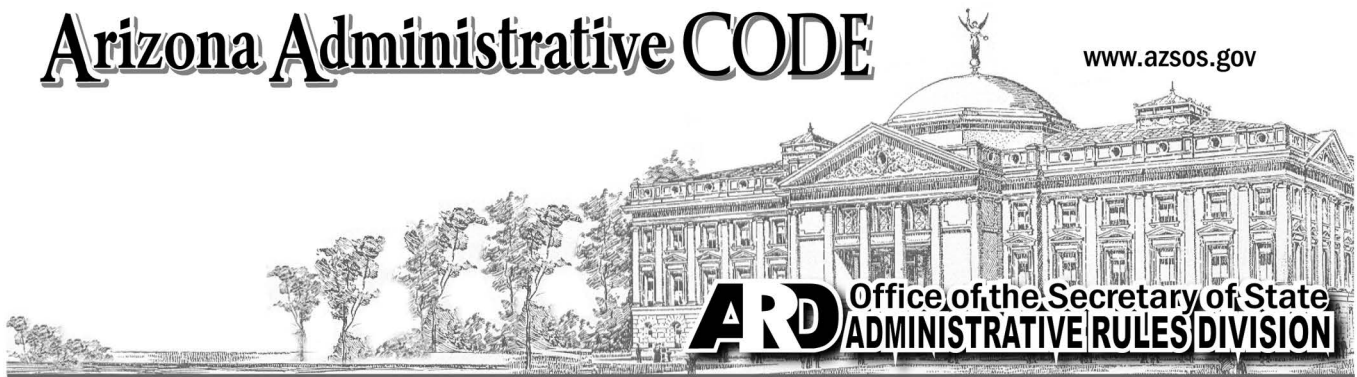
Individuals undergoing court-ordered evaluation or court-ordered treatment shall not be placed in seclusion or restraint except as permitted by Article 2 of this Chapter, and specifically R9-21-204.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Former Section R9-21-512 renumbered to R9-21-511; new Section R9-21-512 renumbered from R9-21-513 and amended by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).

R9-21-513. Renumbered**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 301, § 61, effective October 7, 1992; received in the Office of the Secretary of State October 14, 1992 (Supp. 92-4). Renumbered to R9-21-512 by exempt rulemaking at 9 A.A.R. 3296, effective June 30, 2003 (Supp. 03-2).



9 A.A.C. 22

Supp. 21-3

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CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of
January 1, 2023 through March 31, 2023

[R9-22-712.06. Supplemental Graduate Medical Education Fund Allocation 70](#)

Questions about these rules? Contact:

Office: AHCCCS
Office of the General Counsel
Address: 801 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
[Website:](#) www.azahcccs.gov
Name: Nicole Fries
Telephone: (602) 417-4232
Fax: (602) 253-9115
[Email:](#) AHCCCSRules@azahcccs.gov

The release of this Chapter in Supp. 21-3 replaces Supp. 22-4, 1-144 pages.

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, www.azsos.gov under Services-> Legislative Filings.

EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.

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Administrative Rules Division

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TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

Authority: A.R.S. § 36-2901.08

Supp. 21-3

Editor's Note: Historical notes for Sections made, repealed or amended in Supp. 14-1 were updated to reflect the effective date as immediate per the original notice filed by the agency. A number of other publication errors have been corrected in Supplement 20-4 that should have been made in Supp. 14-1. These include: adding new Sections R9-22-301 and R9-22-302; correcting a punctuation error in R9-22-1401; repealing Sections R9-22-1407 and R9-22-1443; and the amending of R9-22-1501 (Supp. 20-4).

Editor's Note: The Office of the Secretary of State prints all Code Chapters on white paper (Supp 01-3).

Editor's Note: This Chapter contains rules which were adopted or amended under an exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6), under Laws 1992, Ch. 301, § 61 and Ch. 302, § 13, and Laws 1993, Ch. 6, § 34. Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review these rules; AHCCCS was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper.

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Article 13, consisting of Sections R9-22-1301 through R9-22-1309, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).

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Article 15, consisting of Sections R9-22-1501 through R9-22-1508, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

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Article 16, consisting of Sections R9-22-1601 through R9-22-1636, repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

Article 16, consisting of Sections R9-22-1601 through R9-22-1613, R9-22-1615 through R9-22-1620, R9-22-1622 through R9-22-1631, R9-22-1633, R9-22-1634, and R9-22-1636, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

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CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

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

Definition	Section or Citation
"Accommodation"	R9-22-701
"Active treatment"	R9-22-1301
"ADHS"	R9-22-101
"Administration"	A.R.S. § 36-2901
"Adult behavioral health therapeutic home"	9 A.A.C. 10, Article 1
"Adverse action"	R9-22-101
"Affiliated corporate organization"	R9-22-101
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501
"Agency"	R9-22-1201
"Aggregate"	R9-22-701
"AHCCCS"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-701
"AHCCCS registered provider"	R9-22-101
"Ambulance"	A.R.S. § 36-2201
"Ancillary service"	R9-22-101
"Anticipatory guidance"	R9-22-201
"Annual enrollment choice"	R9-22-1701
"APC"	R9-22-701
"Applicant"	R9-22-101 or R9-22-301
"Application"	R9-22-101
"Assessment"	R9-22-1101 or R9-22-1201
"Assignment"	R9-22-101
"Attending physician"	R9-22-101 or R9-22-202
"Authorized representative"	R9-22-101
"Authorization"	R9-22-202
"Auto-assignment algorithm"	R9-22-1701
"AZ-NBCCEDP"	R9-22-2001
"Behavior management services"	R9-22-1201
"Behavioral health therapeutic home care services"	R9-22-1201
"Behavioral health paraprofessional"	R9-22-101
"Behavioral health professional"	R9-22-101
"Behavioral health recipient"	R9-22-201
"Behavioral health services"	R9-22-1201
"Behavioral health technician"	R9-22-1201
"Benefit year"	R9-22-201
"BHS"	R9-22-301
"Billed charges"	R9-22-701
"Blind"	R9-22-1501
"Burial plot"	R9-22-1401
"Business agent"	R9-22-701
"Calculated inpatient costs"	R9-22-712.07
"Capital costs"	R9-22-701
"Capped fee-for-service"	R9-22-101
"Caretaker relative"	R9-22-1401
"Case management"	R9-22-1201
"Case record"	R9-22-101
"Cash assistance"	R9-22-1401
"Certified psychiatric nurse practitioner"	R9-22-1201
"Charge master"	R9-22-712
"Child"	R9-22-1503
"Children's Rehabilitative Services" or "CRS"	R9-22-101 or R9-22-301
"Chronic"	R9-22-1301
"Claim"	R9-22-1101
"Claims paid amount"	R9-22-712.07
"Clean claim"	A.R.S. § 36-2904
"Clinical oversight"	9 A.A.C. 10
"CMDP"	R9-22-1701
"CMS"	R9-22-101
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contract year"	R9-22-101
"Contractor"	A.R.S. § 36-2901 or R9-22-210.01

"Copayment"	R9-22-701
"Cost avoid"	R9-22-1201
"Cost-To-Charge Ratio" or "CCR"	R9-22-701 or R9-22-712
"Court-ordered evaluation"	R9-22-1201
"Court-ordered pre-petition screening"	R9-22-1201
"Court-ordered treatment"	R9-22-1201
"Covered charges"	R9-22-701
"Covered services"	R9-22-101
"CPT"	R9-22-701
"Creditable coverage"	R9-22-2003 and 42 U.S.C. 300gg(c)
"Crisis services"	R9-22-1201
"Critical Access Hospital"	R9-22-701
"CRS application"	R9-22-1301
"CRS condition"	R9-22-1301
"CRS provider"	R9-22-1301
"Cryotherapy"	R9-22-2001
"Customized DME"	R9-22-212
"Day"	R9-22-101 and R9-22-1101
"Date of the Notice of Adverse Action"	R9-22-1441
"DBHS"	R9-22-101
"DCSS"	R9-22-301
"Department"	A.R.S. § 36-2901
"Dependent child"	A.R.S. § 46-101 or R9-22-1401
"DES"	R9-22-101
"Diagnostic services"	R9-22-101
"Direct graduate medical education costs" or "direct program costs"	R9-22-701
"Direct supervision"	R9-22-1201
"Director"	R9-22-101
"Disabled"	R9-22-1501
"Discussion"	R9-22-101
"Disenrollment"	R9-22-1701
"DME"	R9-22-101
"DRI inflation factor"	R9-22-701
"E.P.S.D.T. services"	42 CFR 440.40(b)
"Eligibility posting"	R9-22-701
"Eligible person"	A.R.S. § 36-2901
"Emergency behavioral health condition for a non-FES member"	R9-22-201
"Emergency behavioral health services for a non-FES member"	R9-22-201
"Emergency medical condition for a non-FES member"	R9-22-201
"Emergency medical services for a non-FES member"	R9-22-201
"Emergency medical services provider"	R9-22-1201
"Emergency medical or behavioral health condition for a FES member"	R9-22-217
"Emergency services costs"	A.R.S. § 36-2903.07
"Emergency services for a FES member"	R9-22-217
"Encounter"	R9-22-701
"Enrollment"	R9-22-1701
"Equity"	R9-22-101
"Experimental services"	R9-22-203
"Existing outpatient service"	R9-22-701
"Expansion funds"	R9-22-701
"FAA"	R9-22-301
"Facility"	R9-22-101
"Factor"	R9-22-701 and 42 CFR 447.10
"FBR"	R9-22-101
"Federal financial participation" or "FFP"	42 CFR 400.203
"Federal poverty level" or "FPL"	A.R.S. § 36-2981
"Fee-For-Service" or "FFS"	R9-22-101
"FES member"	R9-22-101
"FESP"	R9-22-101
"First-party liability"	R9-22-1001
"File"	R9-22-1101
"Fiscal agent"	R9-22-210
"Fiscal intermediary"	R9-22-701
"Foster care maintenance payment"	42 U.S.C. 675(4)(A)
"FQHC"	R9-22-101

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"Freestanding Children's Hospital"	R9-22-701	"Ownership change"	R9-22-701
"Functionally limiting"	R9-22-1301	"Ownership interest"	42 CFR 455.101
"Fund"	R9-22-712.07	"Partial Care"	R9-22-1201
"Graduate medical education (GME) program"	R9-22-701	"Participating institution"	R9-22-701
"GME program approved by the Administration"		"Peer group"	R9-22-701
or "approved GME program"	R9-22-701	"Peer-reviewed study"	R9-22-2001
"Grievance"	A.A.C. Chapter 34	"Penalty"	R9-22-1101
"GSA"	R9-22-101	"Person"	R9-22-1101
"HCAC"	R9-22-701	"Pharmaceutical service"	R9-22-201
"HCPCS"	R9-22-701	"Physical therapy"	R9-22-201
"Health care institution"	A.R.S. § 36-401	"Physician"	R9-22-101
"Health care practitioner"	R9-22-1201	"Physician assistant"	R9-22-1201
"Hearing aid"	R9-22-201	"Post-stabilization services"	R9-22-201 or 42 CFR 422.113
"HIPAA"	R9-22-701	"PPS bed"	R9-22-701
"Home health services"	R9-22-201	"Practitioner"	R9-22-101
"Hospital"	R9-22-101	"Pre-enrollment process"	R9-22-301
"ICU"	R9-22-701	"Prescription"	R9-22-101
"IHS"	R9-22-101	"Primary care provider" or "PCP"	R9-22-101
"IHS enrolled" or "enrolled with IHS"	R9-22-708	"Primary care provider services"	R9-22-201
"IMD" or "Institution for Mental Diseases"	42 CFR 435.1010 and R9-22-101	"Prior authorization"	R9-22-101
"Income"	R9-22-301	"Prior period coverage" or "PPC"	R9-22-101
"Indirect program costs"	R9-22-701	"Procedure code"	R9-22-701
"Individual"	R9-22-211	"Procurement file"	R9-22-601
"In-kind income"	R9-22-1420	"Proposal"	R9-22-101
"Inmate of a public institution"	42 CFR 435.1010	"Prospective rates"	R9-22-701
"Inpatient covered charges"	R9-22-712.07	"Psychiatrist"	R9-22-1201
"Intermediate Care Facility for the Mentally Retarded" or "ICF-MR"	42 U.S.C. 1396d(d)	"Psychologist"	R9-22-1201
"Intern and Resident Information System"	R9-22-701	"Psychosocial rehabilitation services"	R9-22-201
"LEEP"	R9-22-2001	"Public hospital"	R9-22-701
"Legal representative"	R9-22-101	"Qualified alien"	A.R.S. § 36-2903.03
"Level I trauma center"	R9-22-2101	"Qualified behavioral health service provider"	R9-22-1201
"License" or "licensure"	R9-22-101	"Quality management"	R9-22-501
"Licensee"	R9-22-1201	"Radiology"	R9-22-101
"MAGI-based income"	R9-22-1401	"RBHA" or "Regional Behavioral Health Authority"	R9-22-201
"Mailing date"	R9-22-101	"Reason to know" or "had reason to know"	R9-22-1101
"Medical education costs"	R9-22-701	"Rebase"	R9-22-701
"Medical expense deduction" or "MED"	R9-22-1401	"Redetermination"	R9-22-1301
"Medical practitioner"	R9-22-1201	"Referral"	R9-22-101
"Medical record"	R9-22-101	"Rehabilitation services"	R9-22-101
"Medical review"	R9-22-701	"Reinsurance"	R9-22-701
"Medical services"	A.R.S. § 36-401	"Remittance advice"	R9-22-701
"Medical supplies"	R9-22-101	"Resident"	R9-22-701
"Medical support"	R9-22-301	"Residual functional deficit"	R9-22-201
"Medically eligible"	R9-22-1301	"Resources"	R9-22-301
"Medically necessary"	R9-22-101	"Respiratory therapy"	R9-22-201
"Medicare claim"	R9-22-101	"Respite"	R9-22-1201
"Medicare Urban or Rural Cost-to-Charge Ratio (CCR)"	R9-22-701	"Responsible offeror"	R9-22-101
"Member"	A.R.S. § 36-2901 or R9-22-301	"Responsive offeror"	R9-22-101
"Mental disorder"	A.R.S. § 36-501	"Revenue Code"	R9-22-701
"Milliman study"	R9-22-712.07	"Review"	R9-22-101
"Monthly equivalent"	R9-22-1401	"Review month"	R9-22-101
"Monthly income"	R9-22-1401	"RFP"	R9-22-101
"National Standard code sets"	R9-22-701	"Rural Contractor"	R9-22-718
"New hospital"	R9-22-701	"Rural Hospital"	R9-22-718
"NICU"	R9-22-701	"Scope of services"	R9-22-201
"Noncontracted Hospital"	R9-22-718	"Section 1115 Waiver"	A.R.S. § 36-2901
"Noncontracting provider"	A.R.S. § 36-2901	"Service location"	R9-22-101
"Non-FES member"	R9-22-101	"Service site"	R9-22-101
"Non-IHS Acute Hospital"	R9-22-701	"SOBRA"	R9-22-101
"Nursing facility" or "NF"	42 U.S.C. 1396r(a)	"Specialist"	R9-22-101
"Observation day"	R9-22-701	"Specialty facility"	R9-22-701
"Occupational therapy"	R9-22-201	"Speech therapy"	R9-22-201
"Offeror"	R9-22-101	"Spendthrift restriction"	R9-22-1401
"Operating costs"	R9-22-701	"Sponsor"	R9-22-301
"OPPC"	R9-22-701	"Sponsor deemed income"	R9-22-301
"Organized health care delivery system"	R9-22-701	"Sponsoring institution"	R9-22-701
"Outlier"	R9-22-701	"Spouse"	R9-22-101
"Outpatient hospital service"	R9-22-701	"SSA"	42 CFR 1000.10
		"SSI"	42 CFR 435.4
		"SSN"	R9-22-101

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"Stabilize"	42 U.S.C. 1395dd
"Standard of care"	R9-22-101
"Sterilization"	R9-22-201
"Subcontract"	R9-22-101
"Submitted"	A.R.S. § 36-2904
"Substance abuse"	R9-22-201
"SVES"	R9-22-301
"Tax dependent"	42 CFR 435.4
"Taxi"	A.R.S. § 28-101(53)
"Taxpayer"	R9-22-1401
"Third-party"	R9-22-1001
"Third-party liability"	R9-22-1001
"Tier"	R9-22-701
"Tiered per diem"	R9-22-701
"Title IV-D"	R9-22-1401
"Title IV-E"	R9-22-1401
"Total Inpatient payments"	R9-22-712.07
"Trauma and Emergency Services Fund"	A.R.S. § 36-2903.07
"TRBHA" or "Tribal Regional Behavioral Health Authority"	R9-22-1201
"Treatment"	R9-22-2004
"Tribal Facility"	A.R.S. § 36-2981
"Unrecovered trauma center readiness costs"	R9-22-2101
"Urban Contractor"	R9-22-718
"Urban Hospital"	R9-22-718
"USCIS"	R9-22-301
"Utilization management"	R9-22-501
"WWHP"	R9-22-2001

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

"ADHS" means the Arizona Department of Health Services.

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

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

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

"AHCCCS registered provider" means a provider or non-contracting provider who:

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

Meets license or certification requirements to provide covered services.

"Ancillary service" means all hospital services for patient care other than room and board and nursing services, including but not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).

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

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

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

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

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

"Behavioral health paraprofessional" means an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

If the behavioral health services were provided in a setting other than a licensed health care institution,

If the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33,

If the behavioral health services were provided in a setting other than a licensed health care institution; and

Are provided under supervision by a behavioral health professional R9-10-101.

"Behavioral Health Professional" has the same meaning as defined A.A.C. R9-10-101 excluding subsection (g).

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

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

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

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

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

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

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

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

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“Day” means a calendar day unless otherwise specified.

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

“DES” means the Department of Economic Security.

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

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

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

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

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

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

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

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

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

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

“FQHC” means federally qualified health center.

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

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

“IHS” means Indian Health Service.

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

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

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

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

Shown on the postmark;

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

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

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

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

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

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

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

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

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

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

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

“Primary care provider” or “PCP” means an individual who meets the requirements of A.R.S. § 36-2901 (14), and who is responsible for the management of a member’s health care.

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

“Prior period coverage” means the period prior to the member’s enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, which-

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ever is later, and continues until the day the member is enrolled with a contractor.

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

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

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

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

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

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

“Review” means a review of all factors affecting a member’s eligibility.

“Review month” means the month in which the individual’s or family’s circumstances and case record are reviewed.

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

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

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

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

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

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

“SSN” means Social Security number.

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

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

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

A marketing organization, or

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

“Taxi” is as defined in A.R.S. § 28-101(53).

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-101 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-101 repealed, former Sections R9-22-102 and R9-22-301 renumbered as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency by adding new paragraphs (24), (46), (84) and (91) and renumbering accordingly effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency by adding new paragraphs (2) and (15) and renumbering accordingly effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment added paragraphs (2) and (15) and renumbered accordingly effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended paragraphs (10) and (15) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended by deleting paragraphs (39) and (62) and renumbering accordingly effective July 1, 1988 (Supp. 88-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted effective December 8, 1997 (Supp. 97-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking

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at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3830, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 461, effective April 1, 2012 (Supp. 12-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-102. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-102 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1092 (Supp. 82-4). Former Section R9-22-102 renumbered together with former Section R9-22-301 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section adopted effective December 8, 1997 (Supp. 97-4). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Section repealed by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3).

R9-22-103. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-104. Reserved**R9-22-105. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final

rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-106. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

R9-22-107. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-108. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-109. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. effective 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-110. Repealed**Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

R9-22-111. Reserved**R9-22-112. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Repealed by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1).

R9-22-113. Reserved**R9-22-114. Repealed****Historical Note**

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New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

R9-22-115. Repealed**Historical Note**

Final Section adopted at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

R9-22-116. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-117. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-118. Reserved**R9-22-119. Reserved****R9-22-120. Repealed****Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

ARTICLE 2. SCOPE OF SERVICES**R9-22-201. Scope of Services-related Definitions**

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

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

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

“Benefit year” means a one-year time period of October 1st through September 30th.

“Emergency behavioral health condition for a non-FES member” means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health

and medicine could reasonably expect the absence of immediate medical attention to result in:

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

Serious impairment to bodily functions;

Serious dysfunction of any bodily organ or part; or

Serious physical harm to another person.

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

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

Placing the member’s health in serious jeopardy,

Serious impairment to bodily functions, or

Serious dysfunction of any bodily organ or part.

“Emergency medical services for a non-FES member” means services provided for the treatment of an emergency medical condition.

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

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

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

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

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

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

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

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

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Living skills training,
Cognitive rehabilitation,
Health promotion,
Supported employment, and

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

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

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

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

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

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

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

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

Prolong life and promote physical health.

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

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-201 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3217, effective October 1, 2005 (Supp. 05-3). Section repealed; new Section made by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-202. General Requirements

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

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

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

1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
2. Covered services for the federal emergency services program (FESP) are under R9-22-217.
3. The Administration or a contractor may waive the covered services referral requirements of this Article.
4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
6. A member may receive physical and behavioral health services as specified in Articles 2 and 12.
7. The Administration or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
8. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
9. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
 - a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
 - b. Services or items furnished gratuitously, and
 - c. Personal care items except as specified under R9-22-212.
10. Medical or behavioral health services are not covered services if provided to:
 - a. An inmate of a public institution; or
 - b. A person who is in residence at an institution for the treatment of tuberculosis.

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

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- D. Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.
- E. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.
- F. A service is not a covered service if provided outside the GSA unless one of the following applies:
 - 1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;
 - 2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family;
 - 3. The contractor authorizes placement in a nursing facility located out of the GSA; or
 - 4. Services are provided during prior period coverage or during the prior quarter coverage.
- G. If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.
- H. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.
- I. The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care and cost effectiveness.
- J. The restrictions, limitations, and exclusions in this Article do not apply to a contractor electing to provide noncovered services.
 - 1. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
 - 2. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.
 - 3. If a member requests a service that is not covered or is not authorized by a contractor, or the Administration, an AHCCCS-registered service provider may provide the service according to R9-22-702.
- K. Subject to CMS approval, the restrictions, limitations, and exclusions specified in the following subsections do not apply to American Indians receiving services through IHS or a tribal health program operating under P.L. 93-638 when those services are eligible for 100 percent federal financial participation:
 - 1. R9-22-205(A)(8),
 - 2. R9-22-206,
 - 3. R9-22-207,
 - 4. R9-22-212(C),
 - 5. R9-22-212(D),
 - 6. R9-22-212(E)(8),
 - 7. R9-22-215(C)(5), (C)(6), and
 - 8. R9-22-215(C)(4).

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-202 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Amended effective July 1, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1994, Ch. 322, § 21; filed with the Office of the Secretary of State June 22, 1995 (Supp. 95-3). Amended effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3). New Section made by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4). Amended by final rulemaking at 21 A.A.R. 1225, effective July 7, 2015 (Supp. 15-3).

R9-22-203. Experimental Services

- A. Experimental services are not covered. A service is not experimental if:
 - 1. It is generally and widely accepted as a standard of care in the practice of medicine in the United States and is a safe and effective treatment for the condition for which it is intended or used.
 - 2. The service does not meet the standard in subsection (A)(1), but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of the evidence in peer-reviewed articles in medical journals published in the United States.
 - 3. The service does not meet the standard in subsection (A)(2) because the condition for which the service is intended or used is rare, but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of opinions from specialists who provide the service or related services.
- B. The following factors shall be considered when evaluating the weight of peer-reviewed articles or the opinions of specialists:
 - 1. The mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services.
 - 2. The types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services.
 - 3. The frequency with which the service has been performed in the past.
 - 4. Whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits.

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5. The reputation and experience of the authors and/or specialists and their record in related areas.
6. The extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future.
7. Whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-203 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2).

Amended effective April 13, 1990 (Supp. 90-2).

Amended effective September 29, 1992 (Supp. 92-3).

Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed effective September 22, 1997 (Supp. 97-3). New Section made by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Section amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014 (Supp. 14-3).

R9-22-204. Inpatient General Hospital Services

- A. The following limitations apply to inpatient general hospital services that are provided by FFS providers.
 1. Providers shall obtain prior authorization from the Administration for the following inpatient hospital services:
 - a. Nonemergency and elective admission, including psychiatric hospitalization;
 - b. Elective surgery; and
 - c. Services or items provided to cosmetically reconstruct or improve personal appearance after an illness or injury.
 2. The Administration or a contractor may deny a claim if a provider fails to obtain prior authorization.
 3. Providers are not required to obtain prior authorization from the Administration for the following inpatient hospital services:
 - a. Voluntary sterilization,
 - b. Dialysis shunt placement,
 - c. Arteriovenous graft placement for dialysis,
 - d. Angioplasties or thrombectomies of dialysis shunts,
 - e. Angioplasties or thrombectomies of arteriovenous graft for dialysis,
 - f. Hospitalization for vaginal delivery that does not exceed 48 hours,
 - g. Hospitalization for cesarean section delivery that does not exceed 96 hours, and
 - h. Other services identified by the Administration through the Provider Participation Agreement.
 4. The Administration may perform concurrent review for hospitalizations of non-FES members to determine whether there is medical necessity for the hospitalization. A provider shall notify the Administration no later than 72 hours after an emergency admission.
- B. Coverage of in-state and out-of-state inpatient hospital services is limited to 25 days per benefit year for members age 21

and older for claims with discharge dates on or before September 30, 2014. The limit applies for all inpatient hospital services with dates of service during the benefit year regardless of whether the member is enrolled in Fee for Service, is enrolled with one or more contractors, or both, during the benefit year.

1. For purposes of calculating the limit:
 - a. Inpatient days are counted towards the limit if paid by the Administration or a contractor;
 - b. Inpatient days will be counted toward the limit in the order of the adjudication date of a paid claim;
 - c. Paid inpatient days are allocated to the benefit year in which the date of service occurs;
 - d. Each 24 hours of paid observation services is counted as one inpatient day if the patient is not admitted to the same hospital directly following the observation services,
 - e. Observation services, which are directly followed by an inpatient admission to the same hospital are not counted towards the inpatient limit; and
 - f. After 25 days of inpatient hospital services have been paid as provided for in this rule Section:
 - i. Outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered.
 - ii. Continuous periods of observation services of less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered.
 - iii. For continuous periods of observation services of 24 hours or more that are not directly followed by an inpatient admission to the same hospital, 23 hours of observations services are covered.
2. The following inpatient days are not included in the inpatient hospital limitation described in this Section:
 - a. Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract;
 - b. Days related to Behavioral Health:
 - i. Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or
 - ii. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or
 - iii. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.
 - c. Days related to treatment for burns and burn late effects at an American College of Surgeons verified burn center;
 - d. Same Day Admit Discharge services are excluded from the 25 day limit; and
 - e. Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-204 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective Octo-

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ber 1, 1985 (Supp. 85-5). Amended subsection (A) effective December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1745, effective October 1, 2012 (Supp. 12-2). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014 (Supp. 14-3). The incorrect label C was changed to B (Supp. 22-3).

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

- A.** A primary care provider, attending physician, or practitioner shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:
 1. Periodic health examination and assessment;
 2. Evaluation and diagnostic workup;
 3. Medically necessary treatment;
 4. Prescriptions for medication and medically necessary supplies and equipment;
 5. Referral to a specialist or other health care professional if medically necessary;
 6. Patient education;
 7. Home visits if medically necessary; and
 8. Preventive health services, such as, well visits, immunizations, colonoscopies, mammograms and PAP smears.
- B.** The following limitations and exclusions apply to attending physician and practitioner services and primary care provider services:
 1. Specialty care and other services provided to a member upon referral from a primary care provider, or to a member upon referral from the attending physician or practitioner are limited to the service or condition for which the referral is made, or for which authorization is given by the Administration or a contractor.
 2. A member's physical examination is not covered if the sole purpose is to obtain documentation for one or more of the following:
 - a. Qualification for insurance,
 - b. Pre-employment physical evaluation,
 - c. Qualification for sports or physical exercise activities,
 - d. Pilot's examination for the Federal Aviation Administration,
 - e. Disability certification to establish any kind of periodic payments,
 - f. Evaluation to establish third-party liabilities, or
 - g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
 3. Orthognathic surgery is covered only for a member who is less than 21 years of age;

4. The following services are excluded from AHCCCS coverage:
 - a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgeries;
 - b. Pregnancy termination counseling services;
 - c. Pregnancy terminations, unless required by state or federal law.
 - d. Services or items furnished solely for cosmetic purposes; and
 - e. Hysterectomies unless determined medically necessary.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-205 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A), paragraph (15) and added paragraph (20) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(2) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

Editor's Note: The following Section was renumbered and a new Section adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not published as a proposed rule in the Arizona Administrative Register; the rule was not reviewed or approved by the Governor's Regulatory Review Council; and the agency was not required to hold public hearings on the rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-206. Organ and Tissue Transplant Services

- A.** Organ and tissue transplant services are covered for a member if prior authorized and coordinated with the member's contractor, or the Administration. Only the following transplants are covered for individuals 21 years of age or older:
 1. Heart, including transplants for the treatment of non-ischemic cardiomyopathy;
 2. Liver, including transplants for patients with hepatitis C;
 3. Kidney (cadaveric and live donor);
 4. Simultaneous Pancreas/Kidney (SPK);
 5. Autologous and Allogeneic related and unrelated Hematopoietic Cell transplants;
 6. Cornea;
 7. Bone;
 8. Lung; and
 9. Pancreas after a kidney transplant (PAK).
- B.** The following transplants are not covered for members 21 years of age or older:

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1. Pancreas only transplants if it is not performed simultaneously with or following a kidney transplant. Partial pancreas transplants and autologous and allogeneic pancreas islet cell transplants are not covered even if performed simultaneously with or following a kidney transplant.
 2. Intestine transplants, and
 3. Any other type of transplant not specifically listed in subsection (A).
- C. When there is a transplant of multiple organs, reimbursement will only be made for those covered.
- D. Organ and tissue transplant services are not covered for non-qualified aliens or noncitizens members of FESP under A.R.S. § 36-2903.03(D).

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-206 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-206 renumbered to R9-22-218, new Section R9-22-206 adopted effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by exempt rulemaking at 16 A.A.R. 1386, effective July 15, 2010 (Supp. 10-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by exempt rulemaking at 17 A.A.R. 1122, April 1, 2011 (Supp. 11-2).

R9-22-207. Dental Services

- A. The Administration or a contractor shall cover dental services for a member less than 21 years of age under R9-22-213.
- B. For individuals age 21 years of age or older, the Administration or a contractor shall cover medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician.
1. Except as specified in subsection (C), such services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. Covered dental services include examination of the oral cavity, radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate level of anesthesia and the prescription of pain medication and antibiotics.
 2. Such services do not include services that physicians are not generally competent to perform such as dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.

- C. For the purposes of this subsection, simple restorations means silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns. In addition, dental services for an individual 21 years of age or older include:
1. The elimination of oral infections and the treatment of oral disease, which includes dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations as a medically necessary pre-requisite to covered transplantation; and
 2. Prophylactic extraction of teeth in preparation for covered radiation treatment of cancer of the jaw, neck or head.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-207 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-207 repealed, new Section R9-22-207 adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3).

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

Laboratory, radiology, and medical imaging services are covered services if:

1. Prescribed by the member's attending physician, practitioner, primary care provider or a dentist, or prescribed by a physician or practitioner upon referral from the primary care provider or dentist.
2. Provided by licensed health care providers in a:
 - a. Hospital,
 - b. Clinic,
 - c. Physician's office, or
 - d. Other health care facility.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-208 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-208 repealed, new Section R9-22-208 adopted effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

R9-22-209. Pharmaceutical Services

- A. An inpatient or outpatient provider, including a hospital, clinic, other appropriately licensed health care facility, and pharmacy may provide covered pharmaceutical services.
- B. The Administration or a contractor shall require a provider to make pharmaceutical services:
1. Available during customary business hours, and
 2. Located within reasonable travel distance of a member's residence.
- C. Pharmaceutical services are covered if:

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1. Prescribed for a member by the member's primary care provider, attending physician, practitioner, or dentist;
 2. Prescribed by a specialist upon referral from the primary care provider or attending physician; or
 3. The contractor or its designee authorizes the service.
- D.** The following limitations apply to pharmaceutical services:
1. A medication personally dispensed by a physician, dentist, or a practitioner within the individual's scope of practice is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed.
 2. A new prescription or refill in excess of a 30 day supply is not covered unless:
 - a. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed a 90 day supply; or
 - b. The Contractor authorizes the prescription for an extended time period not to exceed a 90-day supply.
 3. An over-the-counter medication, in place of a covered prescription medication, is covered only if the over-the-counter medication is appropriate, equally effective, safe, and less costly than the covered prescription medication.
- E.** A contractor shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well being.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-209 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 24, 1986 (Supp. 86-5). Amended subsections (A) and (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(3), effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

R9-22-210. Emergency Medical Services for Non-FES Members**A. General provisions.**

1. Applicability. This Section applies to emergency medical services for non-FES members. Provisions regarding emergency behavioral health services for non-FES members are in R9-22-210.01. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definitions.
 - a. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS or a subcontractor of ADHS/DBHS.

- b. For the purposes of this Section and R9-22-210.01, "fiscal agent" means a person who bills and accepts payment for a hospital or emergency room provider.
 3. Verification. A provider of emergency medical services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor.
 4. Prior authorization.
 - a. Emergency medical services. A provider is not required to obtain prior authorization for emergency medical services.
 - b. Non-emergency medical services. If a non-FES member's medical condition does not require emergency medical services, the provider shall obtain prior authorization as required by the terms of the provider agreement under R9-22-714(A) or the provider's subcontract with the contractor, whichever is applicable.
 5. Prohibition against denial of payment. Neither the Administration nor a contractor shall:
 - a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms,
 - b. Deny or limit payment because the provider failed to obtain prior authorization for emergency services,
 - c. Deny or limit payment because the provider does not have a subcontract.
 6. Grounds for denial. The Administration and a contractor may deny payment for emergency medical services for reasons including but not limited to:
 - a. The claim was not a clean claim;
 - b. The claim was not submitted timely; and
 - c. The provider failed to provide timely notification under subsection (B)(4) to the contractor or the Administration, as appropriate, and the contractor does not have actual notice from any other source that the member has presented for services.
- B.** Additional requirements for emergency medical services for non-FES members enrolled with a contractor.
1. Responsible entity. A contractor is responsible for the provision of all emergency medical services to non-FES members enrolled with the contractor.
 2. Prohibition against denial of payment. A contractor shall not limit or deny payment for emergency medical services when an employee of the contractor instructs the member to obtain emergency medical services.
 3. Contractor notification. A contractor shall not deny payment to a hospital, emergency room provider, or fiscal agent for an emergency medical service rendered to a non-FES member based on the failure of the hospital, emergency room provider, or fiscal agent to notify the member's contractor within 10 days from the day that the member presented for the emergency medical service.
 4. Contractor notification. A hospital, emergency room provider, or fiscal agent shall notify the contractor no later than the 11th day after presentation of the non-FES member for emergency inpatient medical services. A contractor may deny payment for a hospital's, emergency room provider's, or fiscal agent's failure to provide timely notice, under this subsection.
- C.** Post-stabilization services for non-FES members enrolled with a contractor.
1. After the emergency medical condition of a member enrolled with a contractor is stabilized, a provider shall

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request prior authorization from the contractor for post-stabilization services.

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

D. Additional requirements for FFS members.

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

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-210 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-210 repealed, new Section R9-22-210 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), para-

graph (1) effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

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

A. General provisions.

1. Applicability. This Section applies to emergency behavioral health services for non-FES members. Provisions regarding emergency medical services for non-FES members are in R9-22-210. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definition. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS, a subcontractor of ADHS/DBHS, or Children's Rehabilitative Services.
3. Responsible entity for inpatient emergency behavioral health services.
 - a. Members enrolled with a contractor. ADHS/DBHS. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with the contractor.
 - b. FFS members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services for non-FES FFS members with psychiatric or substance abuse diagnoses unless services are provided in an IHS or tribally operated 638 facility.
4. Responsible entity for non-inpatient emergency behavioral health services for non-FES members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all non-inpatient emergency behavioral health services for non-FES members.
5. Verification. A provider of emergency behavioral health services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is a member enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor, and determine whether the member is a behavioral health recipient as defined in R9-22-201.
6. Prior authorization.
 - a. Emergency behavioral health services. A provider is not required to obtain prior authorization for emergency behavioral health services.
 - b. Non-emergency behavioral health services. When a non-FES member's behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the prior authorization requirements of a contractor

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and ADHS/DBHS or a subcontractor of ADHS/DBHS.

7. Prohibition against limitation or denial of payment. A contractor, TRBHA, the Administration, ADHS/DBHS, or a subcontractor of ADHS/DBHS shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services to a non-FES member for the following reasons:
 - a. On the basis of lists of diagnoses or symptoms;
 - b. Prior authorization was not obtained;
 - c. The provider does not have a contract;
 - d. An employee of the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS instructs the member to obtain emergency behavioral health services; or
 - e. The failure of a hospital, emergency room provider, or fiscal agent to notify the member's contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS within 10 days from the day the member presented for the emergency service.
8. Grounds for denial. A contractor, the Administration, ADHS/DBHS, or a subcontractor of ADHS/DBHS may deny payment for emergency behavioral health services for reasons including but not limited to the following:
 - a. The claim was not a clean claim;
 - b. The claim was not submitted timely; or
 - c. The provider failed to provide timely notification under subsection (A)(9) to the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS or the Administration.
9. Notification.
 - a. A hospital, emergency room provider, or fiscal agent shall notify a contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, whichever is appropriate, no later than the 11th day from presentation of the non-FES member for emergency inpatient behavioral health services.
 - b. A hospital, emergency room provider, or fiscal agent shall notify the Administration no later than 72 hours after a FFS member receiving emergency behavioral health services presents to a hospital for inpatient services.
10. Transfer or discharge. The attending physician or the provider actually treating the non-FES member for the emergency behavioral health condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.

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

1. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have been prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.
2. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor, ADHS/DBHS, or a subcontractor for prior authorization of further post-stabilization services;

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

Historical Note

New Section made by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-211. Transportation Services

- A. Emergency ambulance services.**
1. A member shall receive medically necessary emergency transportation in a ground or air ambulance:
 - a. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
 - b. If no other appropriate means of transportation is available.
 2. The Administration or a member's contractor shall reimburse a ground or air ambulance transport that originates in response to a 911 call or other emergency response system:
 - a. If the member's medical condition justifies the medical necessity of the type of ambulance transportation received,
 - b. The transport is to the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
 - c. No prior authorization is required for reimbursement of these transports.
 3. The member's medical condition at the time of transport determines whether the transport is medically necessary.

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4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure of the provider to provide notification is cause for denial.
 5. Notification to the Administration of emergency transportation provided to a FFS member is not required, but the provider shall submit documentation with the claim that justifies the service.
- B.** The Administration or a contractor covers air ambulance services only if at least one criterion in subsection (B)(1) is met and at least one criterion in subsection (B)(2), or the criterion in subsection (B)(3) is met. The criteria are:
1. The air ambulance transport is initiated at the request of:
 - a. An emergency response unit,
 - b. A law enforcement official,
 - c. A clinic or hospital medical staff member, or
 - d. A physician or practitioner, and
 2. The point of pickup:
 - a. Is inaccessible by ground ambulance, or
 - b. Is a great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition and ground ambulance service will not suffice, or
 3. The medical condition of the member requires immediate intervention from emergency ambulance personnel or providers with the appropriate facilities to treat the member's condition.
- C.** Coverage of medically necessary nonemergency transportation is limited to the cost of transporting the member to an appropriate provider capable of meeting the member's medical needs.
1. As specified in contract, a contractor shall arrange or provide medically necessary nonemergency transportation services for a member who is unable to arrange transportation to a service site or location.
 2. For a fee-for-service member, the Administration shall authorize medically necessary nonemergency transportation for a member who is unable to arrange transportation to a service site or location.
- D.** For the purposes of this subsection, an individual means a person who is not in the business of providing transportation services such as a family or household member, friend, or neighbor. The Administration or a contractor shall cover expenses for transportation in traveling to and returning from an approved and prior authorized health care service site provided by an individual if:
1. The transportation services are authorized by the Administration or the member's contractor or designee,
 2. The individual is an AHCCCS registered provider, and
 3. No other means of appropriate transportation is available.
- E.** The Administration or a contractor shall cover expenses for meals, lodging, and transportation for a member traveling to and returning from an approved health care service site outside of the member's service area or county of residence.
- F.** The Administration or a contractor shall cover the expense of meals, lodging, and transportation for:
1. A family member accompanying a member if:
 - a. The member is traveling to or returning from an approved health care service site outside of the member's service area or county of residence; and
 - b. The meals, lodging, and transportation services are authorized by the Administration or the member's contractor or designee.
 2. An escort who is not a family member as follows:
 - a. If the member is traveling to or returning from an approved and prior authorized health care service site, including an inpatient facility, outside of the member's service area or county of residence;
 - b. If the escort services are authorized by the Administration or the member's contractor or designee; and
 - c. Wage paid to an escort as reimbursement shall not exceed the federal minimum wage.
- G.** A provider shall obtain prior authorization from the Administration for transportation services provided for a member for the following:
1. Medically necessary nonemergency transportation services not originated through a 911 call or other emergency response system when the distance traveled exceeds 100 miles (whether one way or round trip); and
 2. All meals, lodging, and services of an escort accompanying the member under this Section.
- H.** A charitable organization routinely providing transportation service at no cost to an ambulatory or chairbound person shall not charge or seek reimbursement from the Administration or a contractor for the provision of the service to a member but may enter into a subcontract with a contractor for medically necessary transportation services provided to a member.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-211 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3).

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

- A.** Durable medical equipment, orthotic and prosthetic devices, and medical supplies, including incontinence briefs as specified in subsection (E), are covered services to the extent permitted in this Section if provided in compliance with requirements of this Chapter; and
1. Prescribed by the primary care provider, attending physician, or practitioner; or
 2. Prescribed by a specialist upon referral from the primary care provider, attending physician, or practitioner; and
 3. Authorized as required by the Administration, contractor, or contractor's designee.
- B.** Covered medical supplies are consumable items that are designed specifically to meet a medical purpose, are disposable, and are essential for the member's health.
- C.** Covered DME is any item, appliance, or piece of equipment that is not a prosthetic or orthotic; and
1. Is designed for a medical purpose, and is generally not useful to a person in the absence of an illness or injury, and
 2. Can withstand repeated use, and
 3. Is generally reusable by others.
- D.** Prosthetics are devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed or malfunctioning portion of the body. Only those prosthetics

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that are medically necessary for rehabilitation are covered, except as otherwise provided in R9-22-215.

E. The following limitations on coverage apply:

1. The DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased.
2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair or adjustment is less than the cost of renting or purchasing another unit.
3. A change in, or addition to, an original order for DME is covered if approved by the prescriber in subsection (A), or prior authorized by the Administration or contractor, and the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for DME may be made after a claim for services is submitted to the member's contractor, or the Administration, without prior written notification of the change or addition to the Administration or the contractor.
4. Reimbursement for rental fees shall terminate:
 - a. No later than the end of the month in which the prescriber in subsection (A) certifies that the member no longer needs the DME;
 - b. If the member is no longer eligible for AHCCCS services; or
 - c. If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified in R9-22-509.
5. Except for incontinence briefs for persons over 3 years old and under 21 years old as provided in subsection (E)(6), personal care items including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition. Personal care items are not covered services if used solely for preventive purposes.
6. Incontinence briefs, including pull-ups are covered to prevent skin breakdown and enable participation in social, community, therapeutic and educational activities under the following circumstances:
 - a. The member is over 3 years old and under 21 years old;
 - b. The member is incontinent due to a documented disability that causes incontinence of bowel or bladder, or both;
 - c. The PCP or attending physician has issued a prescription ordering the incontinence briefs;
 - d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder;
 - e. The member obtains incontinence briefs from providers in the contractor's network;
 - f. Prior authorization has been obtained as required by the Administration, contractor, or contractor's designee. Contractors may require a new prior authorization to be issued no more frequently than every 12 months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. Prior authorization will be permitted to ascertain that:

- i. The member is over age 3 and under age 21;
- ii. The member has a disability that causes incontinence of bladder or bowel, or both;
- iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the contractor; and
- iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.

7. First aid supplies are not covered unless they are provided in accordance with a prescription.
8. The following services are not covered for individuals 21 years of age or older:
 - a. Hearing aids;
 - b. Prescriptive lenses unless they are the sole visual prosthetic device used by the member after a cataract extraction;
 - c. Bone Anchor Hearing Aid (BAHA);
 - d. Cochlear implant;
 - e. Percussive vest;
 - f. Insulin pump;
 - g. Microprocessor-controlled lower limbs or microprocessor-controlled joints for lower limbs; and
 - h. Orthotics, which are defined as devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body.

F. Liability and ownership.

1. Purchased DME that is provided to a member and no longer needed by the member may be disposed of in accordance with each contractor's policy.
2. The Administration shall retain title to purchased DME provided to a member who becomes ineligible or no longer requires use of the DME.
3. If customized DME is purchased by the Administration or contractor for a member, the equipment shall remain with the person during times of transition to a different contractor, or upon loss of eligibility. For purposes of this subsection, customized DME refers to equipment that is altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.
4. A member shall return DME obtained fraudulently to the Administration or the contractor.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-212 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-212 repealed, new Section R9-22-212 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (2), and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3).

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

- A.** The following E.P.S.D.T. services are covered for a member less than 21 years of age:
1. Screening services including:
 - a. Comprehensive health and developmental history;
 - b. Comprehensive unclothed physical examination;
 - c. Appropriate immunizations according to age and health history;
 - d. Laboratory tests; and
 - e. Health education, including anticipatory guidance;
 2. Vision services including:
 - a. Diagnosis and treatment for defects in vision;
 - b. Eye examinations for the provision of prescriptive lenses;
 - c. Prescriptive lenses; and
 - d. Frames.
 3. Hearing services including:
 - a. Diagnosis and treatment for defects in hearing;
 - b. Testing to determine hearing impairment; and
 - c. Hearing aids;
 4. Dental services including:
 - a. Emergency dental services as specified in R9-22-207;
 - b. Preventive services including screening, diagnosis, and treatment of dental disease; and
 - c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
 5. Orthognathic surgery;
 6. Medically necessary, nutritional assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;
 7. Behavioral health services under 9 A.A.C. 22, Article 12;
 8. Hospice services do not include home-delivered meals or services provided and covered through Medicare. The following hospice services are covered:
 - a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
 - b. Services available to a member receiving hospice care are limited to those allowable under 42 CFR 418.202, October 1, 2006, incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments;
 9. Incontinence briefs as specified under R9-22-212; and
 10. Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5).
- B.** Providers of E.P.S.D.T. services shall meet the following standards:
1. Ensure that services are provided by or under the direction of the member's primary care provider, attending physician, practitioner, or dentist.
 2. Perform tests and examinations under 42 CFR 441 Subpart B, October 1, 2006, which is incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments.
 3. Refer a member as necessary for dental diagnosis and treatment and necessary specialty care.
 4. Refer a member as necessary for behavioral health evaluation and treatment services.

- C.** Contractors shall meet other E.P.S.D.T. requirements as specified in contract.
- D.** A primary care provider, attending physician, or practitioner shall refer a member with special health care needs under R9-7-301 to CRS.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-213 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-213 repealed, new Section R9-22-213 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007 (Supp. 07-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

R9-22-214. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-214 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-214 repealed, new Section R9-22-214 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (4) and added subsection (C), paragraph (2) effective October 1, 1986 (Supp. 86-5). Correction to subsection (C), paragraph (2) (Supp. 87-4). Section repealed effective September 22, 1997 (Supp. 97-3).

R9-22-215. Other Medical Professional Services

- A.** The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office:
1. Dialysis;
 2. The following family planning services if provided to delay or prevent pregnancy:
 - a. Medications,
 - b. Supplies,
 - c. Devices, and
 - d. Surgical procedures;
 3. Family planning services are limited to:
 - a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
 - b. Sterilization; and
 - c. Natural family planning education or referral;
 4. Midwifery services provided by a certified nurse practitioner in midwifery;
 5. Midwifery services for low-risk pregnancies and home deliveries provided by a licensed midwife;
 6. Respiratory therapy;
 7. Ambulatory and outpatient surgery facilities services;
 8. Home health services under A.R.S. § 36-2907(D);

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9. Private or special duty nursing services;
 10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
 11. Total parenteral nutrition services, which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract; and
 12. Chemotherapy.
- B.** Prior authorization from the Administration for a member is required for services listed in subsections (A)(3)(b), and (A)(4) through (11); except for:
1. Voluntary sterilization;
 2. Dialysis shunt placement;
 3. Arteriovenous graft placement for dialysis;
 4. Angioplasties or thrombectomies of dialysis shunts;
 5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis;
 6. Eye surgery for the treatment of diabetic retinopathy;
 7. Eye surgery for the treatment of glaucoma;
 8. Eye surgery for the treatment of macular degeneration;
 9. Home health visits following an acute hospitalization (limited up to five visits);
 10. Hysteroscopies (up to two, one before and one after) when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization;
 11. Physical therapy subject to the limitation in subsection (C);
 12. Facility services related to wound debridement,
 13. Apnea management and training for premature babies up to the age of 1; and
 14. Other services identified by the Administration through the Provider Participation Agreement.
- C.** The following are not covered services:
1. Occupational and speech therapies provided on an outpatient basis for a member age 21 or older;
 2. Abortion counseling;
 3. Services or items furnished solely for cosmetic purposes;
 4. Services provided by a podiatrist; or
 5. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of restoring a skill or level of function and maintaining that skill or level of function once restored.
 6. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of acquiring a new skill or a new level of function and maintaining that skill or level of function once acquired.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-215 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

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

- A.** Services provided in a NF, including room and board, an alternative HCBS setting as defined in R9-28-101, or a HCBS as defined in A.R.S. § 36-2939 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.
- B.** Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:
1. Nursing services, including:
 - a. Administering medication;
 - b. Tube feedings;
 - c. Personal care services, including but not limited to assistance with bathing and grooming;
 - d. Routine testing of vital signs; and
 - e. Maintenance of a catheter;
 2. Basic patient care equipment and sickroom supplies, including:
 - a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
 - b. Bathing and grooming supplies;
 - c. Identification device;
 - d. Skin lotion;
 - e. Medication cup;
 - f. Alcohol wipes, cotton balls, and cotton rolls;
 - g. Rubber gloves (non-sterile);
 - h. Laxatives;
 - i. Bed and accessories;
 - j. Thermometer;
 - k. Ice bags;
 - l. Rubber sheeting;
 - m. Passive restraints;
 - n. Glycerin swabs;
 - o. Facial tissue;
 - p. Enemas;
 - q. Heating pad; and
 - r. Incontinence briefs.
 3. Dietary services including preparation and administration of special diets, and adaptive tools for eating;
 4. Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal or state licensure standard or county certification requirement;
 5. Physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
 6. Physical therapy prescribed only as a maintenance regimen; and
 7. Assistive devices and non-customized durable medical equipment.
- C.** A provider shall obtain prior authorization from the Administration for a NF admission for a FFS member.

Historical Note

Adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Subsection (C) amended to correct a typographical error (Supp. 00-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007 (Supp. 07-3). Amended by final rulemaking at 13 A.A.R. 4122, effective November 6, 2007 (Supp. 07-4).

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

- A.** Definition. Notwithstanding the definition in R9-22-201, for the purposes of this Section, an emergency medical or behavioral health condition for a FES member means a medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. Placing the member's health in serious jeopardy,
 2. Serious impairment to bodily functions,
 3. Serious dysfunction of any bodily organ or part, or
 4. Serious physical harm to another person.
- B.** Services. "Emergency services for a FES member" mean those medical or behavioral health services provided for the treatment of an emergency condition. Emergency services include outpatient dialysis services for a FES member with End Stage Renal Disease (ESRD) where a treating physician has certified for the month in which services are received that in the physician's opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in:
1. Placing the member's health in serious jeopardy, or
 2. Serious impairment of bodily function, or
 3. Serious dysfunction of a bodily organ or part.
- C.** Covered services. Services are considered emergency services if all of the criteria specified in subsection (A) are satisfied at the time the services are rendered. The Administration shall determine whether an emergency condition exists on a case-by-case basis.
- D.** Prior authorization. A provider is not required to obtain prior authorization for emergency services for FES members. Prior authorization for outpatient dialysis services is met when the treating physician has completed and signed a monthly certification as described in subsection (B).
- E.** Services rendered through the Federal Emergency Services Program are subject to all exclusions and limitation on services in this Article including but not limited to the limitations on inpatient hospital services in R9-22-204.

Historical Note

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1868, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-218. Repealed**Historical Note**

Section R9-22-218 renumbered from R9-22-206 effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3).

ARTICLE 3. GENERAL ELIGIBILITY REQUIREMENTS**R9-22-301. General Eligibility Definitions**

Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article, Article 14 and Article 15 have the following meanings unless the context explicitly requires another meaning:

"Applicant," notwithstanding R9-22-101, means a person listed on an application for whom AHCCCS coverage is being sought.

"BHS" means the division of Behavioral Health Services within the Arizona Department of Health Services.

"CRS" means the program administered by the Administration or its designee that provides covered medical services and covered support services in accordance with A.R.S. 36-261.

"DCSS" means the Division of Child Support Services, which is the division within the Department that administers the Title IV-D program and includes a contract agent operating a child support enforcement program on behalf of the Department.

"FAA" means the Family Assistance Administration, the administration within the Department's Division of Benefits and Medical Eligibility with responsibility for providing cash and food stamp assistance to a member and for determining eligibility for AHCCCS medical coverage.

"Income" means combined earned and unearned income.

"Medical support" means to provide health care coverage in the form of health insurance or court-ordered payment for medical care.

"Member" means an applicant who has been determined to qualify for AHCCCS coverage by the Administration or its designee.

"Pre-enrollment process" means the process that provides an applicant the opportunity to choose an AHCCCS health plan before the determination of eligibility is completed.

"Resources" means real and personal property, including liquid assets.

"Sponsor" means an individual who signs the USCIS I-864 Affidavit of Support agreeing to support a non-citizen as a condition of the non-citizen's admission for permanent residence in the United States.

"Sponsor deemed income" means the unearned income deemed available to the applicant named on the USCIS I-864 Affidavit of Support.

"SVES" means the State Verification and Exchange System, a system through which the Department exchanges income and benefit information with the Internal Revenue Service, Social Security Administration, and State Wage and Unemployment Insurance Benefit data files.

"USCIS" means the United States Citizen and Immigration Services.

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Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-301 renumbered together with former Section R9-22-102 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section R9-22-301 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (8), subsection (E), paragraph (3), and subsection (J), paragraph (5) effective October 1, 1986 (Supp. 86-5). Amended subsections (C) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective October 1, 1987; amended subsection (D) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section reserved by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). New Section made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; the adoption of this Section was slated to be codified in Supp. 14-1 but due to a clerical error, was not published. The new Section was published in Supp. 20-4 and no additional amendments have been made to this Section since January 7, 2014 (Supp. 20-4).

R9-22-302. AHCCCS Eligibility Application**Application Process**

1. Right to apply. A person may apply for AHCCCS medical coverage by submitting an Administration-approved application to the Administration or its designee, an FAA office, or one of the following outstation locations:
 - a. A BHS site;
 - b. A Federally Qualified Health Center or disproportionate share hospital under 42 U.S.C. 1396r-4; or
 - c. Any other site, including a hospital, approved by the Administration or its designee.
2. Application. To initiate the application process, the Administration or its designee will accept an application from the applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in section 36B(d)(1) of the Internal Revenue Service (IRS) Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant by submitting a written or online application under 42 CFR 435.907.
 - a. A phone or written application must contain at least the following to be submitted to the Administration or its designee:
 - i. Applicant's legible name,
 - ii. Address or location where the applicant can be reached,
 - iii. Signature of the person submitting the application,
 - iv. Date the application was signed.
 - v. The Administration or its designee shall require that a third party witness the signing and attest by signing the application if the individual signing the application signs with a mark.
 - b. An online application must be completed in full in order to be submitted to the Administration or its designee.

3. Incomplete application. If the application is incomplete, the Administration or its designee shall do at least one of the following:
 - a. Contact an applicant or an applicant's representative by telephone or electronic medium to obtain the missing information required for an eligibility determination;
 - b. Mail a request for additional information to an applicant or an applicant's representative, allowing 10 days from the date of the request to provide the required additional information; or
 - c. Meet with the applicant, representative, or household member.
4. Date of application. The date of application is the date application is received by the Administration or its designee either on-line or at a location listed in subsection (1).
5. Complete application form. The Administration or its designee shall consider an application complete when all questions are answered. The same person as listed under subsection (2) is the person that must sign the completed application. The application shall be witnessed and signed by a third party if the individual signing the application signs with a mark.
6. Assistance with application. The Administration or its designee shall allow a person of the applicant's choice to accompany, assist, and represent the applicant in the application process.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-302 repealed, new Section R9-22-302 adopted effective November 20, 1984 (Supp. 84-6). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section reserved by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). New Section made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; the adoption of this Section was slated to be codified in Supp. 14-1 but due to a clerical error, was not published. The new Section was published in Supp. 20-4 and no additional amendments have been made to this Section since January 7, 2014 (Supp. 20-4).

R9-22-303. Prior Quarter Eligibility

- A. Subject to CMS approval, prior quarter coverage eligibility shall be limited to applicants who meet the requirements in subsection (B) and who also:
 1. Are eligible during any of the three months prior to application; and
 2. Received one or more covered services described in 9 A.A.C. 22, Article 2 and Article 12, and 9 A.A.C. 28, Article 2 during the month; and
 3. Would have qualified for Medicaid at the time services were received if the person had applied regardless of whether the person is alive when the application is made.
- B. Prior quarter coverage eligibility is limited to applicants who are:
 1. Under the age of 19, or
 2. Pregnant, or

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3. In the 60 day post-partum period beginning with the last day of the pregnancy.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-303 repealed, new Section R9-22-303 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section made by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 1849, with an immediate effective date of July 1, 2019 (Supp. 19-3).

R9-22-304. Verification of Eligibility Information

- A. Except as provided in subsection (E), if information provided by or on behalf of an applicant or member on an application, renewal form or otherwise does not conflict with information obtained by the agency through an electronic data match, the Administration or its designee shall determine or renew eligibility based on such information.
- B. The Administration or its designee shall not require an applicant, member, or representative to provide additional verification unless the verification cannot be obtained electronically or the verification obtained electronically conflicts with information provided by or on behalf of the applicant or member.
- C. If information provided by or on behalf of an applicant or member does conflict with information obtained through an electronic data match, the applicant or member shall provide the Administration or its designee with information or documentation necessary to verify eligibility, including evidence originating from an agency, organization, or an individual with actual knowledge of the information.
- D. Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both meet or both exceed the applicable income limit.
- E. The Administration or its designee shall not accept the applicant's or member's statement by itself as verification of:
 1. SSN;
 2. Qualified alien status, except as described under 42 USC 1320b-7(d)(4)(A); or
 3. Citizenship, except as described under 42 USC 1396a(ee)(1).
- F. The Administration or its designee shall give an applicant or member at least 10 days from the date of a written or electronic request for information to provide required verification. The Administration or its designee may deny the application or discontinue eligibility if an applicant or a member does not provide the required information timely.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-304 repealed, new Section R9-22-304 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-304 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-305. Eligibility Requirements

As a condition of eligibility, the Administration or its designee must require applicants, and members to do the following:

1. Take all necessary steps to obtain any annuities, pensions, retirement, disability benefits to which they are entitled, unless they can show good cause for not doing so.
2. Furnish a SSN under 42 CFR 435.910 and 435.920, or in the absence of an SSN, provide proof of a submitted application of SSN. The Administration or its designee will assist in obtaining or verifying the applicant's SSN under 42 CFR 435.910 if an applicant cannot recall the applicant's SSN or has not been issued a SSN. An applicant is not required to furnish an SSN if the applicant is not able to legally obtain a SSN. The Administration or its designee shall determine eligibility notwithstanding the applicant's lack of a SSN, if the applicant is cooperating with the Administration or its designee to obtain a SSN and obtain a SSN prior to the next scheduled review of eligibility.
3. Provide proof of residency of Arizona. An applicant or a member is not eligible unless the applicant or member is a resident of Arizona under 42 CFR 435.403 effective October 1, 2012, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
4. A written declaration, signed under penalty of perjury, must be provided for each person for whom benefits are being sought stating whether the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is a qualified alien. The declaration must be provided by the individual for whom eligibility is being sought or an adult member of the individual's family or household.
5. Each applicant who claims qualified alien status must provide either:
 - a. Alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or
 - b. Other documents that the Administration or its designee accepts as evidence of immigration status, such as:
 - i. A Form I-94 Departure Record issued by the USCIS,
 - ii. A Foreign Passport,
 - iii. A USCIS Parole Notice,
 - iv. A Victim of Trafficking Certification or Eligibility Letter issued by the US DHHS Office of Refugee Resettlement,
 - v. Other documentation consistent with 42 CFR 435.406 or 435.407.
 - c. Sufficient information for the Administration or its designee to obtain electronic verification of immigration status from the USCIS.
6. If a person for whom eligibility is being sought, states that they are an alien, that person is not required to comply with subsections (4) and (5); however, if they do not comply with those sections, and if they meet all other eli-

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gibility criteria, benefits will be limited to those necessary to treat an emergency medical condition.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-305 repealed, new Section R9-22-305 adopted effective November 20, 1984 (Supp. 84-6). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-305 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-306. Administration, Administration's designee or Member Responsibilities

A. The Administration or its designee is responsible for the following:

1. The Administration or its designee shall determine eligibility within 90 days for an applicant applying on the basis of disability and 45 days for all other applicants, unless:
 - a. The agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or
 - b. When there is an administrative or other emergency beyond the agency's control.
2. If an applicant dies while an application is pending, the Administration or its designee shall complete an eligibility determination for the deceased applicant.
3. The Administration or its designee shall complete an eligibility determination on an application filed on behalf of a deceased applicant.
4. During the application process the Administration or its designee shall provide information to the applicant or member explaining the requirements to:
 - a. Cooperate with DCSS in establishing paternity and enforcing medical support, except in circumstances when good cause under 42 CFR 433.147 exists for not cooperating;
 - b. Establish good cause for not cooperating with DCSS in establishing paternity and enforcing medical support, when applicable;
 - c. Report a change listed under subsection (B)(3)(c) no later than 10 days from the date the applicant or member knows of the change;
 - d. Send to the Administration or its designee any medical support payments resulting from a court order;
 - e. Cooperate with the Administration or its designee's assignment of rights and securing payments received from any liable party for a member's medical care.
5. Offer to help the applicant or member to complete the application form and to obtain the required verification;
6. Provide the applicant or member with information explaining:
 - a. The eligibility and verification requirements for AHCCCS medical coverage;
 - b. The requirement that the applicant or member obtain and provide a SSN to the Administration or its designee;
 - c. How the Administration or its designee uses the SSN;
7. Explain to the applicant or member the practice of exchange of eligibility and income information through the electronic service established by the Secretary;
8. Explain to the applicant and member the right to appeal an adverse action under R9-22-315;
9. Use any information provided by the member to complete data matches with potentially liable parties;
10. Explain the eligibility review process;
11. Explain the AHCCCS pre-enrollment process;
12. Use the Systematic Alien Verification for Entitlements (SAVE) process to verify qualified alien status;
13. Provide information regarding the penalties for perjury and fraud on the application;
14. Review any verification items provided by the applicant or member and inform the member of any additional verification items and time-frames within which the applicant or member shall provide information to the Administration or its designee;
15. Explain to the applicant or member the applicant's and member's responsibilities under subsection (B);
16. Transfer the applicant's information to other insurance affordability programs as described under 42 CFR 435.1200(e) when the applicant does not qualify for Medicaid;
17. Attain a written record of a collateral contact: such as a verbal statement from a representative of an agency or organization, or an individual with actual knowledge of the information;
18. Complete a review of eligibility:
 - a. Any time there is a change in a member's circumstance that may affect eligibility,
 - b. For a member approved for the MED program under R9-22-1435 through R9-22-1440 before the end of the six-month eligibility period,
 - c. Of each member's continued eligibility for AHCCCS medical coverage once every 12 months;
19. The Administration or its designee shall discontinue eligibility and notify the member of the discontinuance under R9-22-307 if the member:
 - a. Fails to comply with the review of eligibility,
 - b. Fails to comply under 42 CFR 433.148 with the requirements and conditions of eligibility under this Article regarding assignment of rights and cooperation of establishing paternity and obtaining medical support, or
 - c. Does not meet the eligibility requirements; and
20. Redetermine eligibility for a person terminated from the SSI cash program.
 - a. Continuation of AHCCCS medical coverage. The Administration shall continue AHCCCS medical coverage for a person terminated from the SSI cash program until a redetermination of eligibility is completed.
 - b. Coverage group screening. Before terminating a person from the SSI cash program, the Administration shall determine if the person is eligible for coverage as a person described in A.R.S. §§ 36-2901(6)(a)(i) through (vi) or 36-2934.
 - c. Eligibility decision.
 - i. If a person is eligible under this Article or 9 A.A.C. 28, Article 4, the Administration shall send a notice informing the applicant that AHCCCS medical coverage is approved.

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- ii. If a person is ineligible, the Administration shall send a notice to deny AHCCCS medical coverage.
- B. Applicant and Member Responsibilities.
 - 1. An applicant or a member shall authorize the Administration or its designee to obtain verification for initial eligibility or continuation of eligibility.
 - 2. As a condition of eligibility, an applicant or a member shall:
 - a. Provide the Administration or its designee with complete and truthful information. The Administration or its designee may deny an application or discontinue eligibility if:
 - i. The applicant or member fails to provide information necessary for initial or continuing eligibility;
 - ii. The applicant or member fails to provide the Administration or its designee with written authorization or electronic authorization to permit the Administration or its designee to obtain necessary initial or continuing eligibility verification;
 - iii. The applicant or member fails to provide verification under R9-22-304 after the Administration or its designee made an effort to obtain the necessary verification but has not obtained the necessary information; or
 - iv. The applicant or member does not assist the Administration or its designee in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility;
 - b. Cooperate with the Division of Child Support Services (DCSS) in establishing paternity and enforcing medical support obligations when requested unless good cause exists for not cooperating under 42 CFR 433.147 as of October 1, 2012, which is incorporated by reference, on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments. The Administration or its designee shall not deny AHCCCS eligibility to an applicant who would otherwise be eligible, is a minor child, and whose parent or legal representative does not cooperate with the medical support requirements or first- and third-party liability requirements under Article 10 of this Chapter; and
 - c. Provide the information needed to pursue third party coverage for medical care, such as:
 - i. Name of policyholder,
 - ii. Policyholder's relationship to the applicant or member,
 - iii. Name and address of the insurance company, and
 - iv. Policy number.
 - 3. A member or an applicant shall:
 - a. Send to the Administration or its designee any medical support payments received while the member is eligible that result from a medical support order;
 - b. Cooperate with the Administration or its designee regarding any issues arising as a result of Eligibility
- Quality Control described under A.R.S. § 36-2903.01; and
 - c. Inform the Administration or its designee of the following changes within 10 days from the date the applicant or member knows of a change:
 - i. In address;
 - ii. In the household's composition;
 - iii. In income;
 - iv. In resources, when required under the Medical Expense Deduction (MED) program;
 - v. In Arizona state residency;
 - vi. In citizenship or immigrant status;
 - vii. In first- or third-party liability that may contribute to the payment of all or a portion of the person's medical costs;
 - viii. That may affect the member's or applicant's eligibility, including a change in a woman's pregnancy status;
 - ix. Death;
 - x. Change in marital status; or
 - xi. Change in school attendance.
 - 4. As a condition of eligibility, an applicant or a member shall cooperate with the assignment of rights as required by R9-22-311. If the applicant or member receives medical care and services for which a first or third party is or may be liable, the applicant or member shall cooperate with the Administration or its designee in assisting, identifying and providing information to assist the Administration or its designee in pursuing any first or third party who is or may be liable to pay for medical care and services.
 - 5. A pregnant woman under A.R.S. § 36-2901(6)(a)(ii) is not required to provide the Administration or its designee with information regarding paternity or medical support from a father of a child born out of wedlock.
- C. Administration or its designee responsibilities at Eligibility Renewal.
 - 1. The Administration or its designee shall renew eligibility without requiring information from the individual if able to do so based on reliable information available to the agency, including through an electronic data match. If able to renew eligibility based on such information, the Administration or its designee shall send the member notice of:
 - a. The eligibility determination; and
 - b. The member's requirement to notify the Administration or its designee if any of the information contained in the renewal notice is inaccurate.
 - 2. If unable to renew eligibility, the Administration or its designee shall:
 - a. Send a pre-populated renewal form listing the information needed to renew eligibility,
 - b. Give the member 30 days from the date of the renewal form to submit the signed renewal form and the information needed,
 - c. Send the member notice of the renewal decision under R9-22-312 or R9-22-1413(B) as applicable.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-306 repealed, new Section R9-22-306 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraphs (1) and (6) effective October 1, 1986 (Supp. 86-5). Amended subsection (B),

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paragraph (1) and added a new subsection (N) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6).

Amended subsection (B) effective October 1, 1987; amended subsection (N) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-306 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-307. Approval or Denial of Eligibility

A. Approval. If the applicant meets all the eligibility requirements and conditions of eligibility of this Article, the Administration or its designee shall approve the application and provide the applicant with an approval notice. The approval notice shall contain:

1. The name of each approved applicant,
2. The effective date of eligibility for each approved applicant,
3. The reason and the legal citations if a member is approved for only emergency medical services, and
4. The applicant's right to appeal the decision.

B. Denial. If an applicant fails to meet the eligibility requirements or conditions of eligibility of this Article, the Administration or its designee shall deny the application and provide the applicant with a denial notice. The denial notice shall contain:

1. The name of each ineligible applicant,
2. The specific reason why the applicant is ineligible,
3. The income and resource calculations for the applicant compared to the income or resource standards for eligibility when the reason for the denial is due to the applicant's income or resources exceeding the applicable standard,
4. The legal citations supporting the reason for the ineligibility,
5. The location where the applicant can review the legal citations,
6. The date of the application being denied; and
7. The applicant's right to appeal the decision and request a hearing.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (C), added subsection (G) and (H) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-307 repealed, new Section R9-22-307 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5).

Amended subsection (A) as an emergency effective December 4, 1985 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 85-6). Permanent amendment to subsection (A) effective February 5, 1986 (Supp. 86-1).

Amended subsections (E) and (F) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1).

Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Pro-

cedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-307 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-308. Reinstating Eligibility

The Administration or its designee shall reopen an application or reinstate eligibility of a member when any of the following conditions are met:

1. The denial or discontinuance of eligibility was due to an administrative error,
2. The discontinuance of eligibility was due to noncompliance with a condition of eligibility and the applicant or member complies prior to the effective date of the discontinuance,
3. The member informs the Administration or its designee of a change of circumstances prior to the effective date of the discontinuance, that would allow for continued eligibility, or
4. Following a discontinuance, the member qualifies for continuation of medical coverage pending an appeal.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4).

Amended effective October 1, 1983 (Supp. 83-5).

Amended by adding subsection (C) effective March 2, 1984 (Supp. 84-2). Former Section R9-22-308 repealed, new Section R9-22-308 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-308 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-309. Confidentiality and Safeguarding of Information

The Administration or its designee shall maintain the confidentiality of an applicant or member's records and limit the release of safeguarded information under R9-22-512 and 6 A.A.C. 12, Article 1. In the event of a conflict between R9-22-512 and 6 A.A.C. 12, Article 1, R9-22-512 prevails.

Historical Note

Adopted effective August 30, 1984 (Supp. 82-4).

Amended (D)(1)(d) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-309 repealed, new Section R9-22-309 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5).

Amended effective October 1, 1986 (Supp. 86-5).

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Amended subsection (F) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A), (B) and (C) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-309 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-310. Ineligible Person

A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution, or
2. Over age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except as allowed in 42 USC 1396d(h) or as allowed under the Administration's Section 1115 waiver.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended (B)(7) and added subsections (C) and (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-310 repealed, new Section R9-22-310 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (7) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-310 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-311. Assignment of Rights Under Operation of Law
By operation of law and under A.R.S. § 36-2903, a person determined eligible assigns rights to the system medical benefits to which the person is entitled.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-311 repealed, new Section R9-22-311 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-311 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-312. Member Notices

- A.** Contents of notice. The Administration or its designee shall issue a notice by mail, personal delivery, or electronic means when an action is taken regarding a person's eligibility or premiums. The notice shall contain the following information:
1. The date of the notice issued;

2. A statement of the action being taken;
3. The effective date of the action;
4. The specific reason for the intended action;
5. If eligibility is being discontinued due to income in excess of the income standards, the actual figures used in the eligibility determination and the amount by which the person exceeds income standards;
6. If a premium is imposed or increased, the actual figures used in determining the premium amount;
7. The specific law or regulation that supports the action, or a change in federal or state law that requires an action;
8. An explanation of the member's rights to an appeal and continued benefits.

B. Advance notice of changes in eligibility or premiums. "Advance notice" means a notice that is issued to a person at least 10 days before the effective date of the change. Except as specified in subsection (C), advance notice shall be issued whenever the following adverse action is taken:

1. To discontinue or suspend or reduce eligibility or covered services; or
2. To impose a premium or increase a person's premium.

C. The Administration or its designee shall issue a Notice of Adverse Action to a member no later than the effective date of action if:

1. The Administration or its designee receives a request to withdraw;
2. A person provides information that requires termination of eligibility or an increase or imposition of the premium and the person signs a clear written statement waiving advance notice;
3. A person cannot be located and mail sent to that person has been returned as undeliverable;
4. A person has been admitted to a public institution where the person is ineligible under R9-22-310;
5. A person has been approved for Medicaid or CHIP in another state; or
6. The Administration or its designee has information that confirms the death of the person.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (B), added subsection (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-312 repealed, new Section R9-22-312 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-312 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-313. Withdrawal of Application

- A.** An applicant may withdraw an application at any time before the Administration or its designee completes an eligibility determination by making an oral or written request for withdrawal to the Administration or its designee and stating the reason for withdrawal.

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- B. If an applicant orally requests withdrawal of the application, the Administration or its designee shall document the:
 1. Date of the request,
 2. Name of the applicant for whom the withdrawal applies, and
 3. Reason for the withdrawal.
- C. An applicant may withdraw an application in writing by:
 1. Completing an Administration-approved voluntary withdrawal form; or
 2. Submitting a written, signed, and dated request to withdraw the application.
- D. The effective date of the withdrawal is the date of the application.
- E. If an applicant requests to withdraw an application, the Administration or its designee shall:
 1. Deny the application, and
 2. Notify the applicant of the denial following the notice requirements under R9-22-307.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4).
 Amended effective October 1, 1983 (Supp. 83-5).
 Amended subsections (C) and (D) as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended subsections (D) and (E) as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-313 repealed, new Section R9-22-313 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E) and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4).
 Amended effective December 13, 1993 (Supp. 93-4).
 Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-313 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-314. Withdrawal from AHCCCS Medical Coverage

- A. A member may withdraw from AHCCCS medical coverage at any time by giving oral or written notice of withdrawal to the Administration or its designee. The member or the member's legal or authorized representative shall provide the Administration or its designee with:
 1. The reason for the withdrawal,
 2. The date the notice is effective, and
 3. The name of the member for whom AHCCCS medical coverage is being withdrawn.
- B. If a notice of withdrawal does not identify specific members the Administration or its designee shall discontinue eligibility

for any members that the person submitting the withdrawal has legal authority to act on behalf of.

- C. The Administration or its designee shall notify the member of the discontinuance as required by R9-22-312.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4).
 Amended subsection (A) and added subsection (F) as an emergency effective February 28, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1).
 Amended subsection (A) and added subsection (F) as a permanent rule effective May 16, 1983; text of the amended rule identical to the emergency (Supp. 83-3).
 Former Section R9-22-314 repealed, new Section R9-22-314 adopted effective November 20, 1984 (Supp. 84-6).
 Amended effective October 1, 1985 (Supp. 85-5).
 Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-314 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-315. Notice of Adverse Action

- A. Adverse actions. An applicant or member may appeal, as described under Chapter 34, by requesting a hearing from the Administration or its designee concerning any of the following adverse actions:
 1. Complete or partial denial of eligibility under R9-22-307 and R9-22-313(E);
 2. Suspension, termination, or reduction of AHCCCS medical coverage under R9-22-307, R9-22-312 and R9-22-314;
 3. Delay in the eligibility determination beyond the timeframes under this Article;
 4. The imposition of or increase in a premium or copayment; or
 5. The effective date of eligibility.
- B. Notice of Adverse Action. The Administration or its designee shall personally deliver or send, by mail, or electronic means a Notice of Adverse Action to the person affected by the action. For the purpose of this Section, the date of the Notice of Adverse Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.
- C. Automatic change and hearing rights.
 1. An applicant or a member is not entitled to a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
 2. An applicant or a member is entitled to a hearing if a federal or state law requires an automatic change and the applicant or member timely files an appeal that alleges a misapplication of the facts to the law.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-315 repealed, new Section R9-22-315 adopted effective November 20, 1984 (Supp. 84-6).
 Repealed effective October 1, 1985 (Supp. 85-5). New Section R9-22-315 adopted effective February 5, 1986 (Supp. 86-1). Amended effective February 26, 1988 (Supp. 88-1). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking

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at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-315 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-316. Exemptions from Sponsor Deemed Income

- A.** An applicant shall provide proof to the Administration or its designee when claiming an exemption from sponsor deemed income.
- B.** The Administration or its designee shall grant an exemption from deeming a sponsor's income for a Lawful Permanent Resident applicant if the applicant:
 1. Adjusted immigration status to Lawful Permanent Resident from status as a refugee or asylee;
 2. Is the spouse or dependent child of the sponsor and lives with the sponsor;
 3. Is indigent as specified in subsection (C);
 4. Is a victim of domestic violence or extreme cruelty as specified in subsection (D); or
 5. Has acquired 40 qualified quarters of work credit based on earnings as specified in subsection (E).
- C.** Exemption from sponsor deeming based on indigence.
 1. The Administration or its designee shall consider the applicant indigent and grant an exemption from sponsor deemed income for an applicant, for a period of 12 months beginning with the first month of eligibility if all the following are met:
 - a. An applicant is indigent if all of the following are met:
 - i. The applicant does not reside with the applicant's sponsor;
 - ii. The applicant does not receive free room and board; and
 - iii. The applicant's total gross income including monies received from the sponsor and the value of any vendor payments received for food, utilities, or shelter does not exceed 100% of the FPL for the size of the income group.
 2. The Administration or its designee shall send a notice under 8 U.S.C. 1631(e)(2) to the Attorney General's Office when approving an applicant who is exempt from sponsor deemed income due to indigence.
- D.** The Administration or its designee shall grant an exemption from sponsor deemed income for an applicant who is a victim of domestic violence or extreme cruelty under 8 CFR 204.2 for a period of 12 months beginning with the first month of eligibility. The Administration or its designee shall redetermine the exemption status at each renewal.
 1. The Administration or its designee considers an applicant to be a victim of domestic violence or extreme cruelty when all of the following are met:
 - a. The applicant is the victim, the parent of a child victim, or the child of a parent victim;
 - b. The perpetrator of the domestic violence or extreme cruelty was the spouse or parent of the victim or other family member related by blood, marriage or adoption to the victim;
 - c. The perpetrator was residing in the same household as the victim when the abuse occurred;
 - d. The abuse occurred in the United States;
 - e. The applicant did not participate in the domestic violence or cruelty; and
 - f. The victim does not currently live with the perpetrator.
2. The applicant shall provide proof that the applicant or the applicant's child is a victim of domestic violence or extreme cruelty by presenting one of the following:
 - a. USCIS form I-360 Petition for Amerasian, Widow, or Special Immigrant;
 - b. USCIS form I-797 USCIS approval of the I-360 petition;
 - c. Reports or affidavits concerning the domestic violence or cruelty documented by police, judges, or other court officials, medical personnel, school officials, clergy, social workers, counseling or mental health personnel, or other social service agency personnel;
 - d. Legal documentation, such as an order of protection against the perpetrator or an order convicting the perpetrator of committing an act of domestic violence or extreme cruelty that chronicles the existence of domestic violence or extreme cruelty;
 - e. Evidence that indicates that the applicant sought safe haven in a battered women's shelter or similar refuge because of the domestic violence or extreme cruelty against the applicant or the applicant's child; or
 - f. Photographs of the applicant or applicant's child showing visible injury.
- E.** The Administration or its designee shall grant an exemption from sponsor deemed income for an applicant who has reached 40 qualifying quarters of work credit.
 1. The Administration or its designee shall not count quarters credited after January 1, 1997 that were earned while the applicant was receiving any federal means-tested benefits.
 2. The Administration or its designee shall not count the 40 qualifying quarters of work credit unless the credited quarters are:
 - a. Quarters that the applicant worked;
 - b. Quarters worked by the applicant's spouse or deceased spouse during their marriage; or
 - c. Quarters worked by the applicant's parents when the applicant was under age 18.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as an emergency effective February 9, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of permanent rule identical to the emergency (Supp. 83-3). Amended effective October 1, 1983 (Supp. 83-5). Correction subsection (A), paragraph (1) amended effective October 1, 1983, (Supp. 83-6). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-316 repealed, new Section R9-22-316 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective October 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-316

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made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-317. Sponsor Deemed Income

- A. The Administration or its designee shall use income of a USCIS sponsor to determine eligibility for a non-citizen applicant, whether or not the income is available, to the non-citizen applicant unless exempt under R9-22-316.
- B. Counting the income from a sponsor.
 1. This Section applies to non-citizen applicants who:
 - a. Are Lawful Permanent Residents under 8 CFR 101.3;
 - b. Applied for Lawful Permanent Resident Status on or after December 19, 1997;
 - c. Are sponsored by an individual who signed a USCIS I-864 Affidavit of Support; and
 - d. Are eligible for full AHCCCS medical coverage.
 2. Sponsor deemed income shall be considered the income of the non-citizen applicant only.
 3. The Administration or its designee shall not use the provisions of this Section when:
 - a. The applicant becomes a naturalized U.S. citizen;
 - b. The applicant qualifies for an exemption listed in R9-22-316; or
 - c. The sponsor dies.
- C. Determining income from a sponsor.
 1. For an applicant who is exempt from sponsor deeming under R9-22-316, only cash contributions actually received from the sponsor are countable income to the applicant.
 2. For an applicant to whom the sponsor's income is deemed, the Administration or its designee shall exclude any cash contributions received from the sponsor.
- D. Calculation of income from a sponsor.
 1. The Administration or its designee shall include the total gross income of the sponsor and the sponsor's spouse, when living with the sponsor;
 2. The Administration or its designee shall subtract an amount equal to 100% of the FPL for the sponsor's household size from the total gross income under (D)(1); and
 3. The amount calculated under subsection (D)(2) is deemed as income to the applicant for purposes of determining eligibility.

Historical Note

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-317 repealed, new Section R9-22-317 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-317 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-318. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-318 repealed, new Section R9-22-318 adopted

effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) and added subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective October 1, 1987; amended subsection (A) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective December 13, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-319. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-319 repealed, new Section R9-22-319 adopted effective November 20, 1984 (Supp. 84-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-320. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-320 repealed, new Section R9-22-320 adopted effective November 20, 1984 (Supp. 84-6). Amended effective April 13, 1990 (Supp. 90-2). Repealed effective December 13, 1993 (Supp. 93-4).

R9-22-321. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-321 repealed, new Section R9-22-321 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (E) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-322. Repealed**Historical Note**

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Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 27, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-3). Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-323. Repealed**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (B) and (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B), (D) and (E) effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-324. Repealed**Historical Note**

Adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-4). Former Section R9-22-324 adopted as an emergency renumbered as Section R9-22-327. New Section R9-22-324 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-324 repealed, former Section R9-22-323 renumbered as Section R9-22-324 and adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Former Section R9-22-324 repealed, new Section R9-22-324 adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-324 repealed, new Section R9-22-324 adopted effective November 20, 1984 (Supp. 84-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective Septem-

ber 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-325. Repealed**Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-325 repealed, new Section R9-22-325 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-326. Repealed**Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-326 repealed, new Section R9-22-326 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-327. Repealed**Historical Note**

Former Section R9-22-324 adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days renumbered as Section R9-22-327 and adopted as a permanent rule effective October 1, 1983 (Supp. 83-5). Former Section R9-22-327 repealed, new Section R9-22-327 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A), (D), (E), (G), (H), and (I) effective October 1, 1986 (Supp. 86-5). Amended subsection (D) and added a new subsection (J) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A) and (E) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-328. Repealed**Historical Note**

Adopted as an emergency effective October 6, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-5). Emergency Expired. New Section R9-22-328 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (D) effective October 1, 1987 (Supp. 87-4). Amended subsection (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2).

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Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-329. Repealed**Historical Note**

Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-329 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-330. Repealed**Historical Note**

Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-330 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-331. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-332. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-333. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-334. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-335. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-336. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective September 16, 1987 (Supp. 87-3). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-337. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Correction to subsection (B), paragraph (1) (Supp. 87-3). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-338. Repealed**Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Heading changed effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-339. Repealed**Historical Note**

Adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

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R9-22-340. Reserved**Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-341. Repealed**Historical Note**

Adopted effective March 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-342. Repealed**Historical Note**

Adopted effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-343. Repealed**Historical Note**

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

R9-22-344. Repealed**Historical Note**

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

ARTICLE 4. PENALTY FOR OBTAINING ELIGIBILITY BY FRAUD**R9-22-401. Definitions**

Definitions. The following definitions apply specifically to terms used within this Article:

“Amounts incurred by the system” include capitation payments, costs incurred by any contractor in excess of capitation, reinsurance, and other administrative, legal or investigative costs associated with a person who obtained eligibility contrary to A.R.S. §§ 36-2905.04 and/or A.R.S. § 36-2991.

“Application for eligibility” means any request for benefits administered by AHCCCS under the authority of A.R.S. Title 36, Chapter 29, including applications for presumptive eligibility submitted to hospitals as described under Article 16 of this Chapter.

“Penalty” means an amount not to exceed the amounts incurred by the system during any time period that the person would have been ineligible for benefits but for the false or fraudulent information provided on the application for eligibility. A penalty does not include, and does not need to be reduced by, the amount of any overpayments that AHCCCS may be entitled to recoup from a person who violated A.R.S. § 36-2905.04 and/or A.R.S. § 36-2991.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-401 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 31, 1997 (Supp. 97-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-402. Determining the Amount of the Penalty

- A. AHCCCS shall determine the amount of a penalty according to A.R.S. § 36-2905.04(B) or A.R.S. § 36-2991(B), whichever is applicable, and this Article.
- B. In addition to any penalty imposed pursuant to ARS §§ 36-2905.04 or 36-2991, and this Article, the Administration may also recoup from the person the amounts incurred by the system as a part of the notice and appeal process described in this Article.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-402 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-403. Mitigating and Aggravating Circumstances

- A. AHCCCS shall consider any of the following to be mitigating circumstances when determining the amount of a penalty for obtaining eligibility by fraud.
 1. Degree of culpability. The degree of culpability of a person is a mitigating circumstance if the person did not intend to provide or cause to be provided false information on the application for eligibility but was negligent as to the truthfulness of the information provided.
 2. Prior Offenses. At the time of the submittal of the application the person:
 - a. Did not have any prior criminal convictions; and
 - b. Had not been held civilly liable for defrauding a public assistance program.
 3. Financial condition. The financial condition of a person who violates A.R.S. §§ 36-2905.04 or 36-2991 is a mitigating circumstance if the imposition of a penalty without reduction will render the person incapable of obtaining necessities of life such as food, clothing, and shelter. AHCCCS may consider the resources available to the person when determining the amount of the penalty.
 4. Other matters as justice may require. AHCCCS shall take into account other circumstances of a mitigating nature, if in the interest of justice; the circumstances require a reduction of the penalty.
- B. AHCCCS shall consider any of the following to be aggravating circumstances when determining the amount of a penalty for obtaining eligibility by fraud.

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1. Degree of culpability. The degree of culpability of a person who provides or causes to be provided false information on the application for eligibility is an aggravating circumstance if the person knows or had reason to know that the information provided on the application for eligibility was false, or the person failed to correct the false information prior to AHCCCS incurring a financial loss as a result of the application for eligibility.
2. Prior offenses. At any time before the submittal of the application for eligibility, the person was held criminally or civilly liable for committing any fraud, waste, or abuse against any public assistance program.
3. Financial Loss. The person's violation of A.R.S. §§ 36-2905.04 or 36-2991 caused a loss to the system equal to or exceeding \$5,000.00.
4. Other matters as justice may require. AHCCCS shall take into account other circumstances of an aggravating nature, if in the interest of justice; the circumstances require an increase of the penalty.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-403 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-404. Notice of Intent

- A. If AHCCCS imposes a penalty pursuant to this Article, AHCCCS shall hand deliver or send by certified mail, return receipt requested, or Federal Express to the person, a written Notice of Intent to impose a penalty.
- B. The Notice of Intent shall include:
 1. The legal and factual basis for AHCCCS' determination that there has been a violation of A.R.S. §§ 36-2905.04 and/or 36-2991;
 2. The penalty;
 3. The amounts incurred by the system as a result of the violation of A.R.S. §§ 36-2905.04 and/or 36-2991, if AHCCCS intends to recoup those amounts through this process; and
 4. The procedure for requesting a State Fair Hearing.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-404 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-405. Failure to Respond to the Notice of Intent

If a person fails to respond to the Notice of Intent within the time frame described in A.A.C. § R9-22-406(A), AHCCCS shall uphold the penalty and recoupment amounts described in the Notice of Intent.

Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-405 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the amended rule similar to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-406. Request for State Fair Hearing

- A. To dispute the agency action described in the Notice of Intent, the person shall file a written Request for State Fair Hearing with AHCCCS within sixty (60) days from the date of receipt of the Notice of Intent.
- B. If AHCCCS receives a timely request for a State Fair Hearing from the person, AHCCCS shall mail a Notice of Hearing pursuant to the Uniform Administrative Hearing Procedures described in A.R.S. Title 41, Chapter 6, Article 10.
- C. AHCCCS shall accept a written request for withdrawal of a hearing request if the written request for withdrawal is received from the person before AHCCCS mails a Notice of Hearing under the Uniform Administrative Hearing Procedures described in A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-406 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-406 repealed, new Section R9-22-406 adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of the Section identical to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

R9-22-407. Burden of Proof

- A. In any State Fair Hearing conducted under this Article, AHCCCS shall prove a violation of A.R.S. §§ 36-2905.04 and/or 36-2991, and any aggravating circumstances by a preponderance of the evidence.
- B. AHCCCS does not have to prove any specific intent to defraud.
- C. A person shall bear the burden of producing and proving by a preponderance of the evidence any affirmative defense or any circumstance that would justify reducing the amount of the penalty.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

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R9-22-408. Rescission of the Notice of Intent

AHCCCS may rescind the Notice of Intent at any time prior to the State Fair Hearing without prejudice.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS**R9-22-501. General Provisions and Standards - Related Definitions**

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

“Quality management” means a process used by professional health personnel through a formal program involving multiple organizational components and committees to:

- Assess the degree to which services provided conform to desired medical standards and practices; and
- Quality improvement or maintenance of care and services.

“Quality Improvement” means a process designed to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time, in the areas of clinical care and non-clinical care and is expected to have a favorable effect on health outcomes and member satisfaction. Quality Improvement includes focusing organizational efforts on improving performance and utilizing data to develop intervention strategies to improve performance and outcomes.

“Utilization management/review” means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided. Utilization management applies to a contractor’s process to evaluate and approve or deny the medical necessity, appropriateness, efficacy and efficiency of health care services, procedures, or settings. Utilization review includes processes for prior authorization, concurrent review, retrospective review, and case management.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-501 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-501 repealed, former Section R9-22-502 renumbered and adopted without change as Section R9-22-501 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-501 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-502. Pre-existing Conditions

- A. A contractor shall not impose a pre-existing condition exclusion with respect to covered services.
- B. A contractor or subcontractor shall not adopt or use any procedure to identify a person who has an existing or anticipated medical or psychiatric condition in order to discourage or exclude the person from enrolling in the contractor’s health plan or encourage the person to enroll in another health plan.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-502 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-502 renumbered without change as Section R9-22-501, former Section R9-22-503 renumbered and amended as Section R9-22-502 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-502 repealed, new Section R9-22-502 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4). Amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

R9-22-503. Provider Requirements Regarding Records

The provider shall maintain records that meet uniform accounting standards and generally accepted practices for maintenance of medical records, including detailed specification of all patient services delivered, the rationale for delivery, and the service date. A provider shall maintain and upon request, make available to a contractor and to the Administration, financial and medical records relating to payment for not less than five years from the date of final payment, or for records relating to costs and expenses to which the Administration has taken exception, five years after the date of final disposition or resolution of the exception. Providers shall provide one copy of a medical record at no cost if requested by the member.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-503 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-503 renumbered and amended as Section R9-22-502, new Section R9-22-503 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective May 30, 1986 (Supp. 86-3). Amended subsection (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (F) and (G) effective December 22, 1987 (Supp. 87-4). Amended subsection (I) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). New Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-504. Marketing; Prohibition Against Inducements; Misrepresentations; Discrimination; Sanctions

- A. A contractor or the contractor’s marketing representative shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure AHCCCS enrollment with the contractor. Any marketing solicitation offering a benefit, good, or service in excess of the covered services in Article 2 is deemed an inducement.
- B. A marketing representative shall not misrepresent itself, the contracting health plan represented, or the AHCCCS program,

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through false advertising, false statements, or in any other manner to induce a member of another contractor to enroll in the represented health plan. Violations of this subsection include, but are not limited to, false or misleading claims, inferences, or representations such as:

1. A member will lose benefits under the AHCCCS program or lose any other health or welfare benefits to which a member is legally entitled, if the member does not enroll in the represented contracting health plan;
 2. Marketing representatives are employees of the state or representatives of the Administration, a county, or any health plan other than the health plan by which they are employed, or by which they are reimbursed; and
 3. The represented health plan is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the health plan and the Administration.
- C. A marketing representative shall not engage in any marketing or pre-enrollment practice that discriminates against a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.
- D. The Administration shall hold a contractor responsible for a violation of this Section resulting from the performance of any marketing representative, subcontractor, agent, program, or process under the contractor's employ or direction and shall impose contract sanctions on the contractor as specified in contract.
- E. A contractor shall produce and distribute informational materials that are approved by the Administration to each enrolled member or designated representative after the contractor receives notification of enrollment from the Administration. The contractor shall ensure that the informational materials include, at a minimum:
1. A description of all covered services as specified in contract;
 2. An explanation of service limitations and exclusions;
 3. An explanation of the procedure for obtaining services;
 4. An explanation of the procedure for obtaining emergency services;
 5. An explanation of the procedure for filing a grievance and appeal; and
 6. An explanation of when plan changes may occur as specified in contract.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-504 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-504 repealed, former Section R9-22-505 renumbered and adopted without change as Section R9-22-504 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-504 repealed, former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-505. Standards, Licensure, and Certification for**Providers of Hospital and Medical Services**

A provider shall not provide hospital or medical services to a member unless the provider is licensed by the Arizona Department of Health Services and meets the requirements in 42 CFR 441 and 482, as of October 1, 2007, and 42 CFR 456 Subpart C, as of October 1, 2007, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation contains no future editions or amendments. An Indian Health Service (IHS) hospital and a Veterans Administration hospital shall not provide services to a member unless accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-505 adopted as an emergency expired, former Section R9-22-506 adopted as an emergency now adopted, amended and renumbered as Section R9-22-505 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-505 renumbered without change as Section R9-22-504, new Section R9-22-505 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-505 renumbered and amended as Section R9-22-509, former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5). Editorial correction, spelling of "paraphernalia" in subsection (A) (Supp. 87-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). New Section made by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-506. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-506 adopted as an emergency adopted, amended and renumbered as Section R9-22-505, former Section R9-22-507 adopted as an emergency now adopted, amended and renumbered as Section R9-22-506 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (D) effective December 22, 1987 (Supp. 87-4). Repealed effective April 13, 1990 (Supp. 90-2). New Section adopted effective December 13, 1993 (Supp. 93-4). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-507. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-507 adopted as an emergency adopted, amended and renumbered as Section R9-22-506, former Section R9-22-508 adopted as an emergency now adopted, amended and renumbered as Section R9-22-507 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-507 repealed, new Section R9-22-507 adopted effective October 1, 1985 (Supp. 85-5).

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Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-508. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-508 adopted as an emergency adopted, amended and renumbered as Section R9-22-507, former Section R9-22-509 adopted as an emergency now adopted, amended and renumbered as Section R9-22-508 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-509. Transition and Coordination of Member Care

A. A contractor shall assist in the transition of members to and from other AHCCCS contractors.

1. Both the receiving and relinquishing contractor shall:
 - a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. If requested by the Administration, a contractor shall submit the policies and procedures regarding transition of members to the Administration for review and approval;
 - b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
 - c. Develop policies and procedures to be followed when transitioning members who have significant medical conditions; are receiving ongoing services; or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract;
3. The relinquishing contractor shall forward medical records and other relevant materials to the receiving contractor. The relinquishing contractor shall bear the cost of reproducing and forwarding medical records and other relevant materials;
4. Within the timelines specified in contract, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
 - a. Information regarding the contractor's providers,
 - b. Emergency numbers, and
 - c. Instructions about how to obtain services.

B. A contractor shall not use a county or noncontracting provider health resource alternative to diminish the contractor's contractual responsibility or accountability for providing the full scope of covered services. The Administration may impose sanctions as described in contract if a contractor makes referrals to other agencies or programs to reduce expenses incurred by the contractor on behalf of its members.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-509 adopted as an emergency adopted, amended and renumbered as Section R9-22-508, former Section R9-22-510 adopted as an emergency now adopted and renumbered as Section R9-22-509 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-509 repealed, former Section R9-22-505 renumbered and amended as Section R9-22-509 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-510. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-510 adopted as an emergency adopted and renumbered as Section R9-22-509, former Section R9-22-511 adopted as an emergency now adopted, amended and renumbered as Section R9-22-510 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-510 repealed, new Section R9-22-510 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-511. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-511 adopted as an emergency adopted, amended and renumbered as Section R9-22-510, former Section R9-22-512 adopted as an emergency now adopted, amended and renumbered as Section R9-22-511 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-511 repealed, new Section R9-22-511 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-512. Release of Safeguarded Information

- A. The Administration, contractors, providers, and noncontracting providers shall limit the release of safeguarded information to persons or agencies for the following purposes in accordance with 45 CFR 160 and 45 CFR 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments:
1. Official purposes directly related to the administration of the AHCCCS program including:
 - a. Establishing eligibility and post-eligibility treatment of income, as applicable;
 - b. Determining the amount of medical assistance;
 - c. Providing services for members;
 - d. Performing evaluations and analysis of AHCCCS operations;
 - e. Filing liens on property as applicable;
 - f. Filing claims on estates, as applicable; and

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- g. Filing, negotiating, and settling medical liens and claims.
- 2. Law enforcement. The Administration may release safeguarded information without the applicant's or member's written or verbal consent, for the purpose of conducting or assisting an investigation, prosecution, or criminal or civil proceeding related to the administration of the AHC-CCS program.
- 3. The Administration may release safeguarded member information to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant or member.
- B. Except as provided in subsection (A), the Administration, contractors, providers, and noncontracting providers shall disclose safeguarded information only to:
 - 1. An applicant;
 - 2. A member;
 - 3. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
 - a. An Administration employee, authorized representative, or responsible caseworker is present during the examination of the safeguarded information; or
 - b. After written notification to the provider, and at a reasonable time and place.
 - 4. Persons authorized by the applicant or member; or
 - 5. A court order or subpoena compliant with 45 CFR 164.512(e), October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments.
- C. The Administration, contractors, providers, and noncontracting providers shall safeguard identifiable information, protected health information as specified in 45 CFR 160, and information obtained in the course of application for or redetermination of eligibility concerning an applicant or member, that includes, but is not limited to the following:
 - 1. Name and address;
 - 2. Social Security number;
 - 3. Social and economic conditions or circumstances;
 - 4. Agency evaluation of personal information;
 - 5. Medical data and information concerning medical services received, including diagnosis and history of disease or disability;
 - 6. State Data Exchange (SDX) tapes, and other types of information received from outside sources for the purpose of verifying income eligibility and amount of medical assistance payments; and
 - 7. Any information received in connection with the identification of legally liable third-party resources.
- D. The restriction upon disclosure of information in this Section does not apply to:
 - 1. De-identified information as described by 45 CFR 164.514, October 1, 2004, incorporated by reference in subsection (A); or
 - 2. A disclosure, in response to a request for information, that complies with 45 CFR 160 and 45 CFR 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference in subsection (A).
- E. A provider shall furnish records requested by the Administration or a contractor to the Administration or the contractor at no charge.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-512 adopted as an emergency adopted, amended and renumbered as Section R9-22-511, former Section R9-22-513 adopted as an emergency now adopted and renumbered as Section R9-22-512 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-512 repealed, new Section R9-22-512 adopted effective October 1, 1985 (Supp. 85-5).

Amended effective December 13, 1993 (Supp. 93-4).

Amended effective December 8, 1997 (Supp. 97-4).

Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-513. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-513 adopted as an emergency adopted and renumbered as Section R9-22-512, former Section R9-22-514 adopted as an emergency now adopted, amended and renumbered as Section R9-22-513 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-513 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-513 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-514. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-514 adopted as an emergency adopted, amended and renumbered as Section R9-22-513, former Section R9-22-515 adopted as an emergency now adopted, amended and renumbered as Section R9-22-514 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-514 repealed, former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-515. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-515 adopted as an emergency adopted, amended and renumbered as Section R9-22-514, former Section R9-22-517 adopted as an emergency now adopted, amended and renumbered as Section R9-22-515 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-515 repealed, former Section R9-22-522 renumbered and amended as Section R9-22-515 effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-516. Renumbered**Historical Note**

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Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-516 adopted as an emergency expired, former Section R9-22-518 adopted as an emergency now adopted, amended and renumbered as Section R9-22-516 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-516 renumbered as Section R9-22-513 effective October 1, 1985 (Supp. 85-5).

R9-22-517. Renumbered**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-517 adopted as an emergency adopted, amended and renumbered as Section R9-22-515, former Section R9-22-519 adopted as an emergency now adopted and renumbered and amended as Section R9-22-517 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5).

R9-22-518. Information to Enrolled Members

- A. Each contractor shall produce and distribute printed informational materials to each member or family unit no later than 10 days of receipt of notification of enrollment from the Administration. The contractor shall ensure that the informational materials meet the requirements specified in the contractor's current contract.
- B. A contractor shall provide a member with the name, address, and telephone number of the member's primary care provider no later than 10 days from the date of enrollment. The contractor shall include information on how the member may change primary care providers.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-518 adopted as an emergency adopted, amended and renumbered as Section R9-22-516, former Section R9-22-520 adopted as an emergency now adopted, amended and renumbered as Section R9-22-518 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-518 repealed, new Section R9-22-518 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-519. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-519 adopted as an emergency adopted, amended and renumbered as Section R9-22-517, former Section R9-22-521 adopted as an emergency now adopted, amended and renumbered as Section R9-22-519 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-519 repealed, new Section R9-22-519 adopted effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

R9-22-520. Expired**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-520 adopted as an emergency adopted, amended and renumbered as Section R9-22-518, former Section R9-22-522 adopted as an emergency now adopted, amended and renumbered as Section R9-22-520 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-520 repealed, new Section R9-22-520 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

R9-22-521. Program Compliance Audits

- A. The Administration shall conduct an onsite program compliance audit of a contractor at least once every three years during the term of the Administration's contract with the contractor. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit.
- B. An audit team may perform any or all of the following procedures:
 1. Conduct private interviews and group conferences with members, physicians, other health professionals, and members of the contractor's administrative staff including, but not limited to, the contractor's principal management persons;
 2. Examine records, books, reports, and papers of the contractor and any management company, and all providers or subcontractors providing health care and other services. The examination may include, but need not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the health plan, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-521 adopted as an emergency adopted, amended and renumbered as Section R9-22-519, former Section R9-22-523 adopted as an emergency now adopted, amended and renumbered as Section R9-22-521 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-521 repealed, new Section R9-22-521 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not

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required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements

- A. A contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.
- B. In addition to any requirements specified in contract, a contractor shall:
 1. Submit to the Administration a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
 - a. Monitoring and evaluating the types of services provided,
 - b. Identifying the numbers and costs of services provided,
 - c. Assessing and improving the quality and appropriateness of care and services,
 - d. Evaluating the outcome of care provided to members, and
 - e. Determining the actions necessary to improve service delivery;
 2. Submit the QM/UM plan to the Administration on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan to the Administration before implementation;
 3. Receive approval from the Administration before implementing the initial or revised QM/UM plan;
 4. Ensure that a QM/UM committee operates under the control of the contractor's medical director and includes representation from medical and executive management personnel. The committee shall:
 - a. Oversee the development, revision, and implementation of the QM/UM plan; and
 - b. Ensure that there are qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities; and
 5. Ensure that the QM/UM activities include at least:
 - a. Prior authorization for non-emergency or scheduled hospital admissions;
 - b. Concurrent review of inpatient hospitalization;
 - c. Retrospective review of hospital claims;
 - d. Program and provider audits designed to detect over- or under-utilization, service delivery effectiveness, and outcome;
 - e. Medical records audits;
 - f. Surveys to determine satisfaction of members;
 - g. Assessment of the adequacy and qualifications of the contractor's provider network;
 - h. Review and analysis of QM/UM data;
 - i. Measurement of performance using objective quality indicators;
 - j. Ensuring individual and systemic quality of care;
 - k. Integrating quality throughout the organization;
 - l. Process improvement;
 - m. Credentialing a provider network;
 - n. Resolving quality of care grievances; and
 - o. Quality improvement activities focused on improving the quality of care and the efficient, cost-effective delivery and utilization of services.

- C. A member's primary care provider shall maintain medical records that:
 1. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data;
 2. Facilitate follow-up treatment; and
 3. Permit professional medical review and medical audit processes.
- D. Within 30 days following termination of the contract between a subcontractor and a contractor, the subcontractor or the subcontractor's designee shall forward to the primary care provider medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services.
- E. The Administration shall monitor each contractor and the contractor's providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor's QM/UM plan.
 1. A contractor and the contractor's providers shall cooperate with the Administration in the performance of the Administration's QM/UM monitoring activities; and
 2. A contractor and the contractor's providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-522 adopted as an emergency adopted, amended and renumbered as Section R9-22-520, former Section R9-22-524 adopted as an emergency now adopted and renumbered as Section R9-22-522 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-522 renumbered and amended as Section R9-22-515, new Section R9-22-522 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

R9-22-523. Expired

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-523 adopted as an emergency adopted, amended and renumbered as Section R9-22-521, former Section R9-22-525 adopted as an emergency now adopted, amended and renumbered as Section R9-22-523 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

R9-22-524. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-524 adopted as an emergency

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adopted and renumbered as Section R9-22-522, former Section R9-22-526 adopted as an emergency now adopted, amended and renumbered as Section R9-22-524 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-524 repealed, new Section R9-22-524 adopted effective October 1, 1985 (Supp. 85-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

R9-22-525. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-525 adopted as an emergency adopted, amended and renumbered as Section R9-22-523, former Section R9-22-527 adopted as an emergency now adopted, amended and renumbered as Section R9-22-525 as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1985 (Supp. 85-5).

R9-22-526. Renumbered**Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of the permanent rule identical to the emergency (Supp. 83-3). Former Section R9-22-526 repealed, new Section R9-22-526 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-1).

R9-22-527. Renumbered**Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5).

R9-22-528. Renumbered**Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5).

R9-22-529. Renumbered**Historical Note**

Adopted as Section R9-22-529 effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5).

ARTICLE 6. RFP AND CONTRACT PROCESS**R9-22-601. General Provisions**

- A. The Director has full operational authority to adopt rules for the RFP process and the award of contracts under A.R.S. § 36-2906.
- B. This Article applies to the award of contracts under A.R.S. §§ 36-2904 and 36-2906 to provide services under A.R.S. § 36-2907 and the expenditure of public monies by the Administration pertaining to covered services when the procurement so states. The Administration shall establish conflict-of-interest safeguards for officers and employees of this state with

responsibilities relating to contracts that comply with 42 U.S.C. 1396u-2(d)(3).

- C. The Administration is exempt from the procurement code under A.R.S. § 41-2501.
- D. The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2903 and dispose of the records under A.R.S. § 41-2550.
- E. The following terms are defined as related to this Article: "Procurement file" means the official records file of the Director whether located in the Office of the Director or at the public procurement unit. The procurement file shall include in electronic or paper form a list of notified vendors, final solicitation, solicitation amendments, bids/offers, final proposal revisions, clarifications, and final evaluation report.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-601 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

R9-22-602. RFP

- A. RFP content. The Administration shall include the following items in any RFP under this Article:
 1. Instructions and information to an offeror concerning the proposal submission including:
 - a. The deadline for submitting a proposal,
 - b. The address of the office at which a proposal is to be received,
 - c. The period during which the RFP remains open, and
 - d. Any special instructions and information;
 2. The scope of covered services under Article 2 of this Chapter and A.R.S. §§ 36-2906 and 36-2907, covered populations, geographic coverage, service and performance requirements, and a delivery or performance schedule;
 3. The contract terms and conditions, including bonding or other security requirements, if applicable;
 4. The factors used to evaluate a proposal;
 5. The location and method of obtaining documents that are incorporated by reference in the RFP;
 6. A requirement that the offeror acknowledge receipt of all RFP amendments issued by the Administration;
 7. The type of contract to be used and a copy of a proposed contract form or provisions;
 8. The length of the contract service;
 9. A requirement for cost or pricing data;
 10. The minimum RFP requirements; and
 11. A provision requiring an offeror to certify that a submitted proposal does not involve collusion or other anti-competitive practices.
- B. Proposal process.
 1. After the deadline for submitting proposals, the Administration may open a proposal publicly and announce and record the name of the offeror. The Administration shall keep all other information contained in a proposal confi-

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dential. The Administration shall open a proposal for public inspection after contract award unless the Administration determines that disclosure is not in the best interest of the state.

2. The Administration shall evaluate a proposal based on the GSA and the evaluation factors listed in the RFP.
3. The Administration may initiate discussions with a responsive and responsible offeror to clarify and assure full understanding of an offeror's proposal. The Administration shall provide an offeror fair treatment with respect to discussion and revision of a proposal. The Administration shall not disclose information derived from a proposal submitted by a competing offeror.
4. The Administration shall allow for the adjustment of covered services by expansion, deletion, segregation, or combination in order to secure the most financially advantageous proposals for the state.
5. The Administration may conduct an investigation of a person or organization who has ownership or management interests in corporate offerors or affiliated corporate organizations of an offeror.
6. The Administration may issue a written request for best and final offers. The Administration shall state in the request the date, time, and place for the submission of best and final offers.
7. The Administration shall not request best and final offers more than once unless the Administration determines that it is advantageous to the state to request additional best and final offers. The Administration shall state in the written request for best and final offers that if the offeror does not submit a notice of withdrawal or a best and final offer, the Administration shall take the most recent offer as the offeror's best and final offer.

C. Proposal rejection.

1. The Administration may reject an offeror's proposal if the offeror fails to supply the information requested by the Administration.
2. The offeror shall not disclose information pertaining to its proposal to any other offeror prior to contract award. The offeror may disclose proposal information to a person other than another offeror if the recipient agrees to keep the information confidential until contract award. Disclosure in violation of this subsection may be grounds for rejecting a proposal.
3. The Administration shall provide written notification to an offeror whose proposal is rejected. The rejection notice shall be part of the contract file and a public record.
4. If the Administration determines that it is in the best interest of the state, the Administration may reject any and all proposals, in whole or in part, under the RFP. The reasons for rejection shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a proposal is rejected in whole or in part.

- D. Proposal cancellation.** If the Administration determines that it is in the best interest of the state, the Administration may cancel a RFP. The reasons for cancellation shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a RFP is cancelled.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-

- 3). Former Section R9-22-602 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-603. Contract Award

The Administration shall award a contract to the responsible and responsive offeror whose proposal is determined most advantageous to the state under A.R.S. § 36-2906. If the Administration determines that multiple contracts are in the best interest of the state, the Administration may award multiple contracts. The contract file shall contain the basis on which the award is made.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-603 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-604. Contract or Proposal Protests; Appeals

- A.** Disputes related to contract performance. This Section does not apply to a dispute related to contract performance. A contract performance dispute is governed by 9 A.A.C. 34.
- B.** Resolution of a proposal protest. The procurement officer issuing a RFP shall have the authority to resolve proposal protests. An appeal from the decision of the procurement officer shall be made to the Director.
- C.** Filing of a protest.
 1. A person may file a protest with the procurement officer regarding:
 - a. A RFP issued by the Administration,
 - b. A proposed award, or
 - c. An award of a contract.
 2. A protester shall submit a written protest and include the following information:
 - a. The name, address, and telephone number of the protester;
 - b. The signature of the protester or protester's representative;
 - c. Identification of a RFP or contract number;
 - d. A detailed statement of the legal and factual grounds of the protest including copies of any relevant documents; and
 - e. The relief requested.
- D.** Time for filing a protest.
 1. A protester filing a protest alleging improprieties in an RFP or an amendment to an RFP shall file the protest at least 14 days before the due date of receipt of proposals.
 2. Any protest alleging improprieties in an amendment issued 14 or fewer days before the due date of the proposal shall be filed before the due date for receipt of proposals.
 3. In cases other than those covered in subsections (D)(1) and (2), a protester shall file a protest no later than 10

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days after the procurement officer makes the procurement file available for public inspection.

- E. Stay of procurement during the protest. If a protester files a protest before the contract award, the procurement officer may issue a written stay of the contract award. In considering whether to issue a written stay of contract, the procurement officer shall consider but is not limited to considering whether:
 1. A reasonable probability exists that the protest will be sustained, and
 2. The stay of the contract award is in the best interest of the state.
- F. Stay of contract award during an appeal to the Director. The Director shall automatically continue the stay of a contract award if:
 1. An appeal is filed before a contract award, and
 2. The procurement officer issues a stay of the contract award under subsection (E), unless
 3. The Director issues a written determination that the contract award is necessary to protect the best interest of the state.
- G. Decision by the procurement officer.
 1. The procurement officer shall issue a written decision no later than 14 days after a protest has been filed. The decision shall contain an explanation of the basis of the decision.
 2. The procurement officer shall furnish a copy of the decision to the protester by:
 - a. Certified mail, return receipt requested; or
 - b. Any other method that provides evidence of receipt.
 3. The Administration may extend, for good cause, the time-limit for decisions in subsection (G)(1) for a time not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.
 4. If the procurement officer fails to issue a decision within the time-limits in subsection (G)(1) or (G)(3), the protester may proceed as if the procurement officer issued an adverse decision.
- H. Remedies.
 1. If the procurement officer sustains the protest in whole or in part and determines that the RFP, proposed contract award, or contract award does not comply with applicable statutes and rules, the procurement officer shall order an appropriate remedy.
 2. In determining an appropriate remedy, the procurement officer shall consider all the circumstances of the procurement or proposed procurement, including:
 - a. Seriousness of the procurement deficiency,
 - b. Degree of prejudice to other interested parties or to the integrity of the RFP process,
 - c. Good faith of the parties,
 - d. Extent of performance,
 - e. Costs to the state, and
 - f. Urgency of the procurement.
 - g. Best interest of the state.
 3. An appropriate remedy may include one or more of the following:
 - a. Terminating the contract;
 - b. Reissuing the RFP;
 - c. Issuing a new RFP;
 - d. Awarding a contract consistent with statutes, rules, and the terms of the RFP; or

- e. Any relief determined necessary to ensure compliance with applicable statutes and rules.

- I. Appeals to the Director.
 1. A person may file an appeal of a procurement officer's decision with both the Director and the procurement officer no later than five days from the date the decision is received. The date the decision is received shall be determined under subsection (G)(2).
 2. The appeal shall contain:
 - a. The information required in subsection (C)(2),
 - b. A copy of the procurement officer's decision,
 - c. The alleged factual or legal error in the decision of the procurement officer on which the appeal to the Director is based, and
 - d. A request for hearing unless the person requests that the Director's decision be based solely upon the procurement file.
- J. Dismissal. The Director shall not schedule a hearing and shall dismiss an appeal with a written determination if:
 1. The appeal does not state a basis for protest,
 2. The appeal is untimely under subsection (I)(1), or
 3. The appeal is moot.
- K. Hearing. Hearings under this Section shall be conducted using the Arizona Administrative Procedure Act under A.R.S. Title 41, Ch. 6.

Historical Note

Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

R9-22-605. Waiver of Contractor's Subcontract with Hospitals

If a contractor is unable to obtain a subcontract with a hospital as contractually required, the contractor may request in writing a waiver from the Administration as allowed by A.R.S. § 36-2906. The contractor shall state in the request the reasons a waiver is believed to be necessary and all efforts the contractor has made to secure a subcontract.

Historical Note

Adopted effective January 31, 1986 (Supp. 86-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

R9-22-606. Contract Compliance Sanction

- A. The Director may impose sanctions upon a contractor for violation of any provision of this Chapter or of a contract. Sanctions include but are not limited to:
 1. Suspension of any or all further member enrollment, by choice and/or assignment for a period of time.
 2. Imposition of a monetary sanction.
- B. The Director shall consider the nature, severity, and length of the violation when determining a sanction.
- C. The Director shall provide a contractor with written notice specifying grounds and terms for the sanction.

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- D. Nothing contained in this Section shall be construed to prevent the Administration from imposing sanctions as provided in contract under A.R.S. § 36-2903.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

ARTICLE 7. STANDARDS FOR PAYMENTS**R9-22-701. Standards for Payments Related Definitions**

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

“Accommodation” means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is semi-private except when the member must be isolated for medical reasons. Types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which room and board are provided.

“Aggregate” means the combined amount of hospital payments for covered services provided within and outside the GSA.

“AHCCCS inpatient hospital day or days of care” means each day of an inpatient stay for a member beginning with the day of admission and including the day of death, if applicable, but excluding the day of discharge, provided that all eligibility, medical necessity, and medical review requirements are met.

“Ancillary service” means all hospital services for patient care other than room and board and nursing services, including but not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).

“APC” means the Ambulatory Payment Classification system under 42 CFR 419.31 used by Medicare for grouping clinically and resource-similar procedures and services.

“Billed charges” means charges for services provided to a member that a hospital includes on a claim consistent with the rates and charges filed by the hospital with Arizona Department of Health Services (ADHS).

“Business agent” means a company such as a billing service or accounting firm that renders billing statements and receives payment in the name of a provider.

“Capital costs” means costs as reported by the hospital to CMS as required by 42 CFR 413.20.

“Copayment” means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.

“Cost-to-charge ratio” (CCR) means a hospital’s costs for providing covered services divided by the hospital’s charges for the same services. The CCR is the percentage derived from the cost and charge data for each revenue code provided to AHCCCS by each hospital.

“Covered charges” means billed charges that represent medically necessary, reasonable, and customary items of expense

for covered services that meet medical review criteria of AHCCCS or a contractor.

“CHC” means a Community Health Center, which includes both Federally Qualified Health Centers and Rural Health Clinics.

“CPT” means Current Procedural Terminology, published, and updated by the American Medical Association. CPT is a nationally-accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians that provide a uniform language to accurately designate medical, surgical, and diagnostic services.

“Critical Access Hospital” is a hospital certified by Medicare under 42 CFR 485 Subpart F and 42 CFR 440.170(g).

“Direct graduate medical education costs” or “direct program costs” means the costs that are incurred for the education activities of an approved graduate medical education program that are the proximate result of training medical residents in the hospital, including resident salaries and fringe benefits, the portion of teaching physician salaries and fringe benefits that are related to the time spent in teaching and supervision of residents, and other related GME overhead costs.

“DRI inflation factor” means Global Insights Prospective Hospital Market Basket.

“Eligibility posting” means the date a member’s eligibility information is entered into the AHCCCS Pre-paid Medical Management Information System (PMMIS).

“Encounter” means a record of a medically-related service rendered by an AHCCCS-registered provider to a member enrolled with a contractor on the date of service.

“Existing outpatient service” means a service provided by a hospital before the hospital files an increase in its charge master as defined in R9-22-712(G), regardless of whether the service was explicitly described in the hospital charge master before filing the increase or how the service was described in the charge master before filing the increase.

“Expansion funds” means funds appropriated to support GME program expansions as described under A.R.S. § 36-2903.01(G)(9)(b) and (c)(i).

“Factor” means a person or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business agent.

“Fiscal intermediary” means an organization authorized by CMS to make determinations and payments for Part A and Part B provider services for a given region.

“Freestanding Children’s Hospital” means a separately standing hospital with at least 120 pediatric beds that is dedicated to providing the majority of the hospital’s services to children.

“GME program approved by the Administration” or “approved GME program” means a graduate medical education program that has been approved by a national organization as described in 42 CFR 415.152.

“Graduate medical education (GME) program” means an approved residency or fellowship program that prepares a physician for independent practice of medicine by providing

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didactic and clinical education in a medical environment to a medical student who has completed a recognized undergraduate medical education program.

“HCAC” means a health care acquired condition described under 42 CFR 447.26 but does not include Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

“HCPCS” means the Health Care Procedure Coding System, published, and updated by Center for Medicare and Medicaid Services (CMS). HCPCS is a listing of codes and descriptive terminology used for reporting the provision of physician services, other health care services, and substances, equipment, supplies, or other items used in health care services.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as specified under 45 CFR 162, that establishes standards and requirements for the electronic transmission of certain health information by defining code sets used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

“ICU” means the intensive care unit of a hospital.

“Indirect program costs” means the marginal increase in operating costs that a provider experiences as a result of having an approved graduate medical education program and that is not accounted for by the direct program costs.

“Intern and Resident Information System” means a software program used by teaching providers and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

“Medical education costs” means direct costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, as described in the Medicare Provider Reimbursement Manual.

“Medical review” means a clinical evaluation of documentation conducted by AHCCCS or a contractor for purposes of prior authorization, concurrent review, post-payment review, or determining medical necessity. The criteria for medical review are established by AHCCCS or a contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

“Medicare Urban or Rural Cost-to-Charge Ratio (CCR)” means statewide average capital cost-to-charge ratio published annually by CMS added to the urban or rural statewide average operating cost-to-charge ratio published annually by CMS.

“National Standard code sets” means codes that are accepted nationally in accordance with federal requirements under 45 CFR 160 and 45 CFR 164.

“New hospital” means a hospital for which Medicare Cost Report claim and encounter data are not available for the fiscal year used for initial rate setting or rebasing.

“NICU” means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

“Non-IHS Acute Hospital” means a hospital that is not run by Indian Health Services, is not a free-standing psychiatric hospital, such as an IMD, and is paid under ADHS rates.

“Observation day” means a physician-ordered evaluation period of less than 24 hours to determine whether a person needs treatment or needs to be admitted as an inpatient. Each observation day consists of a period of 24 hours or less.

“Operating costs” means AHCCCS-allowable accommodation costs and ancillary department hospital costs excluding capital and medical education costs.

“OPPC” means an Other Provider Preventable Condition that is: (1) a wrong surgical or other invasive procedure performed on a patient, (2) a surgical or other invasive procedure performed on the wrong body part, or (3) a surgical or other invasive procedure performed on the wrong patient.

“Organized health care delivery system” means a public or private organization that delivers health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

“Outlier” means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described under this Article and A.R.S. § 36-2903.01(G).

“Outpatient hospital service” means a service provided in an outpatient hospital setting that does not result in an admission.

“Ownership change” means a change in a hospital’s owner, lessor, or operator under 42 CFR 489.18(a).

“Participating institution” means an institution at which portions of a graduate medical education program are regularly conducted and to which residents rotate for an educational experience for at least one month.

“Peer group” means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services, including specialty hospitals that limit the provision of services to specific patient populations, such as rehabilitative patients or children.

“PPC” means prior period coverage. PPC is the period of time, prior to the member’s enrollment, during which a member is eligible for covered services. The time-frame is the first day of the month of application or the first eligible month, whichever is later, until the day a member is enrolled with a contractor.

“PPS bed” means Medicare-approved Prospective Payment beds for inpatient services as reported in the Medicare cost reports for the most recent fiscal year for which the Administration has a complete set of Medicare cost reports for every rural hospital as determined as of the first of February of each year.

“Primary care GME program” means a graduate medical education program that prepares a physician for the practice of internal medicine, family medicine, pediatrics, obstetrics, geriatrics, or psychiatry.

“Procedure code” means the numeric or alphanumeric code listed in the CPT or HCPCS manual by which a procedure or service is identified.

“Prospective rates” means inpatient or outpatient hospital rates set by AHCCCS in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-party payments regardless of billed charges or individual hospital costs.

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“Public hospital” means a hospital that is owned and operated by county, state, or hospital health care district.

“Qualifying health information exchange organization” means a non-profit health information organization as defined in A.R.S. § 36-3801 that provides the statewide exchange of patient health information among disparate health care organizations and providers not owned, operated, or controlled by the health information exchange. A qualifying health information exchange organization must include representation by the administration on its board of directors, and have a significant number of health care participants, including hospitals, laboratories, payers, community physicians and Federally Qualified Health Centers.

“Rebase” means the process by which the most currently available and complete Medicare Cost Report data for a year and AHCCCS claim and encounter data for the same year are collected and analyzed to reset the Inpatient Hospital Tiered per diem rates, or the Outpatient Hospital Capped Fee-For-Service Schedule.

“Reinsurance” means a risk-sharing program provided by AHCCCS to contractors for the reimbursement of specified contract service costs incurred by a member beyond a certain monetary threshold.

“Remittance advice” means an electronic or paper document submitted to an AHCCCS-registered provider by AHCCCS to explain the disposition of a claim.

“Resident” means a physician engaged in postdoctoral training in an accredited graduate medical education program, including an intern and a physician who has completed the requirements for the physician’s eligibility for board certification.

“Revenue code” means a numeric code, that identifies a specific accommodation, ancillary service, or billing calculation, as defined by the National Uniform Billing committee for UB04 forms.

“Sub-acute services” means inpatient care for a patient with an acute illness, injury, or exacerbation of a disease process when the patient does not require acute inpatient hospitalization. Sub-acute care is rendered immediately after, or instead of, acute inpatient hospitalization.

“Specialty facility” means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.

“Sponsoring institution” means the institution or entity that is recognized by the GME accrediting organization and designated as having ultimate responsibility for the assurance of academic quality and compliance with the terms of accreditation.

“Tier” means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure, or revenue codes, peer group, NICU classification level, or any combination of these items.

“Tiered per diem” means an AHCCCS capped fee schedule in which payment is made on a per-day basis depending upon the tier (or tiers) into which an AHCCCS inpatient hospital day of care is assigned.

“Trip” means a one-way transport each time a taxi is called. If the taxi waits for the member, then the transport continues to

be part of the one-way trip. If the taxi leaves and is called to pick up the member, that is considered a new one-way trip.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-701 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-701 repealed, new Section R9-22-701 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Section repealed; new Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 1782, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by exempt rulemaking at 13 A.A.R. 4032, effective November 1, 2007 (Supp. 07-4). Amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014; amended by exempt rulemaking at 20 A.A.R. 2755, effective January 1, 2015 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 28 A.A.R. 837 (April 29, 2022), with an immediate effective date of April 5, 2022 (Supp. 22-2).

R9-22-701.01. Reserved

R9-22-701.02. Reserved

R9-22-701.03. Reserved

R9-22-701.04. Reserved

R9-22-701.05. Reserved

R9-22-701.06. Reserved

R9-22-701.07. Reserved

R9-22-701.08. Reserved

R9-22-701.09. Reserved

R9-22-701.10 Scope of the Administration’s and Contractor’s Liability

The Administration shall bear no liability for providing covered services for any member beyond the date of termination of the member’s eligibility or during the member’s enrollment with a contractor. A contractor has no financial responsibility for services provided to a member beyond the last date of enrollment except as provided in Articles 2 and 5 of this Chapter and as specified in contract.

Historical Note

New Section made by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

R9-22-702. Charges to Members

- A.** For purposes of this subsection, the term “member” includes the member’s financially responsible representative as described under A.R.S. § 36-2903.01.
- B.** Registered providers must accept payment from the Administration or a contractor as payment in full.

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- C. Except as provided in subsection (D) a registered provider shall not request or collect payment from, refer to a collection agency, or report to a credit reporting agency an eligible person or a person claiming to be an eligible person.
- D. An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment from a member:
 1. To collect the copayment described in R9-22-711;
 2. To recover from a member that portion of a payment made by a third party to the member for an AHCCCS covered service if the member has not transferred the payment to the Administration or the contractor as required by the statutory assignment of rights to AHCCCS;
 3. To obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused payment to the provider to be reduced or denied;
 4. For a service that is excluded by statute or rule, or provided in an amount that exceeds a limitation in statute or rule, if the member signs a document in advance of receiving the service stating that the member understands the service is excluded or is subject to a limit and that the member will be financially responsible for payment for the excluded service or for the services in excess of the limit;
 5. When the contractor or the Administration has denied authorization for a service if the member signs a document in advance of receiving the service stating that the member understands that authorization has been denied and that the member will be financially responsible for payment for the service;
 6. For services requested for a member enrolled with a contractor, and rendered by a noncontracting provider under circumstances where the member's contractor is not responsible for payment of "out of network" services under R9-22-705(A), if the member signs a document in advance of receiving the service stating that the member understands the provider is out of network, that the member's contractor is not responsible for payment, and that the member will be financially responsible for payment for the excluded service;
 7. For services rendered to a person eligible for the FESP if the provider submits a claim to the Administration in the reasonable belief that the service is for treatment of an emergency medical condition and the Administration denies the claim because the service does not meet the criteria of R9-22-217; or
 8. If the provider has received verification from the Administration that the person was not an eligible person on the date of service.
- E. The signature requirement of subsections (D)(4), (D)(5), and (D)(6) do not apply if:
 1. The member is unable or incompetent to sign such a document, or
 2. When services are rendered for the purpose of treating an emergency medical condition as defined in R9-22-217 and a delay in providing treatment to obtain a signature would have a significant adverse affect on the member's health.
- F. Except as provided for in this Section, registered providers shall not bill a member when the provider could have received reimbursement from the Administration or a contractor but for

the provider's failure to file a claim in accordance with the requirements of AHCCCS statutes, rules, the provider agreement, or contract, such as, but not limited to, requirements to request and obtain prior authorization, timely filing, and clean claim requirements.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-702 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text identical to the emergency (Supp. 83-3). Former Section R9-22-702 repealed, new Section R9-22-702 adopted effective October 1, 1983 (Supp. 83-5). Amended by adding subsection (B) effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3217, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3).

R9-22-703. Payments by the Administration

- A. General requirements. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of October 1, 2012, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
- B. Timely submission of claims.
 1. Under A.R.S. § 36-2904, the Administration shall deem a paper claim to be submitted on the date that it is received by the Administration. An electronic claim is deemed received by the Administration when the claim enters the information processing system designated by the Administration for electronic claims in a form that is capable of being processed by the designated information processing system. The Administration shall do one or more of the following for each claim it receives:
 - a. Place a date stamp on the face of the claim,
 - b. Assign a system-generated claim reference number, or
 - c. Assign a system-generated date-specific number.
 2. Unless a shorter time period is specified in contract, the Administration shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
 - a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
 - b. Six months from the date of eligibility posting.
 3. Unless a shorter time period is specified in contract, the Administration shall not pay a clean claim for a covered

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service unless the claim is submitted within one of the following time limits, whichever is later:

- a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
 - b. Twelve months from the date of eligibility posting.
4. Unless a shorter time period is specified in contract, the Administration shall not pay a claim submitted by an HIS or tribal facility for a covered service unless the claim is initially submitted within 12 months from the date of service, date of discharge, or eligibility posting, whichever is later.

C. Claims processing.

1. The Administration shall notify the AHCCCS-registered provider with a remittance advice when a claim is processed for payment.
2. The Administration shall reimburse a hospital for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and in the manner and at the rate described in A.R.S. § 36-2903.01:
 - a. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
 - b. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
 - c. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a fee of one percent per month for each month or portion of a month following the 60th day of receipt of the bill until date of payment.
3. A claim is paid on the date indicated on the disbursement check.
4. A claim is denied as of the date of the remittance advice.
5. The Administration shall process a hospital claim under this Article.

D. Prior authorization.

1. An AHCCCS-registered provider shall:
 - a. Obtain prior authorization from the Administration for non-emergency hospital admissions, covered services as specified in Articles 2 and 12 of this Chapter, and for administrative days as described in R9-22-712.75,
 - b. Notify the Administration of hospital admissions under Article 2 of this Chapter, and
 - c. Make records available for review by the Administration upon request.
2. The Administration may deny a claim if the provider fails to comply with subsection (D)(1).
3. If the Administration issues prior authorization for an inpatient hospital admission, a specific service, or level of care but subsequent medical review indicates that the admission, the service, or level of care was not medically appropriate, the Administration shall adjust the claim payment.

E. Review of claims and coverage for hospital supplies.

1. The Administration may conduct prepayment and post-payment review of any claims, including but not limited to hospital claims.
2. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
 - a. Patient care kit,
 - b. Toothbrush,
 - c. Toothpaste,

- d. Petroleum jelly,
- e. Deodorant,
- f. Septi soap,
- g. Razor or disposable razor,
- h. Shaving cream,
- i. Slippers,
- j. Mouthwash,
- k. Shampoo,
- l. Powder,
- m. Lotion,
- n. Comb, and
- o. Patient gown.

3. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:

- a. Arm board,
- b. Diaper,
- c. Underpad,
- d. Special mattress and special bed,
- e. Gloves,
- f. Wrist restraint,
- g. Limb holder,
- h. Disposable item used instead of a durable item,
- i. Universal precaution,
- j. Stat charge, and
- k. Portable charge.

4. The Administration shall determine in a hospital claims review whether services rendered were:

- a. Covered services as defined in Article 2;
- b. Medically necessary;
- c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
- d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2903.01.

5. If the Administration adjudicates a claim, a person may file a claim dispute challenging the adjudication under 9 A.A.C. 34.

F. Overpayment for AHCCCS services.

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

G. For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

H. Prior quarter reimbursement. A provider shall:

1. Bill the Administration for services provided during a prior quarter eligibility period upon verification of eligibility or upon notification from a member of AHCCCS eligibility.
2. Reimburse a member when payment has been received from the Administration for covered services during a prior quarter eligibility period. All funds paid by the member shall be reimbursed.

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3. Accept payment received by the Administration as payment in full.
- I. Payment for in-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. The Administration shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article.
- J. Payment for out-of-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. The Administration shall reimburse an out-of-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b).
- K. Payment for inpatient hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. The Administration shall reimburse an in-state or out-of-state provider of inpatient hospital services rendered with a discharge date on or after October 1, 2014, the DRG rate established by the Administration.
- L. The Administration may enter into contracts for the provisions of transplant services.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R-22-703 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-703 repealed, new Section R9-22-703 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (1) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective September 16, 1987 (Supp. 87-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 19 A.A.R. 3309, November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 27 A.A.R. 237, effective April 4, 2021 (Supp. 21-1).

R9-22-704. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-704 adopted as an emergency now adopted and amended as a permanent rule effective August 30 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended subsection A., Paragraph 2. effective October 1, 1985 (Supp. 85-5).

Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

R9-22-705. Payments by Contractors

- A. General requirements. A contractor shall contract with providers to provide covered services to members enrolled with the contractor. The contractor is responsible for reimbursing providers and coordinating care for services provided to a member. Except as provided in subsection (A)(2), a contractor is not required to reimburse a noncontracting provider for services rendered to a member enrolled with the contractor.
 1. Providers. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
 2. A contractor shall reimburse a noncontracting provider for services rendered to a member enrolled with the contractor as specified in this Article if:
 - a. The contractor referred the member to the provider or authorized the provider to render the services and the claim is otherwise payable under this Chapter, or
 - b. The service is emergent under Article 2 of this Chapter.
- B. Timely submission of claims.
 1. Under A.R.S. § 36-2904, a contractor shall deem a paper or electronic claim as submitted on the date that the claim is received by the contractor. The contractor shall do one or more of the following for each claim the contractor receives:
 - a. Place a date stamp on the face of the claim,
 - b. Assign a system-generated claim reference number, or
 - c. Assign a system-generated date-specific number.
 2. Unless a shorter time period is specified in subcontract, a contractor shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
 - a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
 - b. Six months from the date of eligibility posting.
 3. Unless a shorter time period is specified in subcontract, a contractor shall not pay a claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
 - a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
 - b. Twelve months from the date of eligibility posting.
- C. Date of claim.
 1. A contractor's date of receipt of an inpatient or an outpatient hospital claim is the date the claim is received by the contractor as indicated by the date stamp on the claim, the system-generated claim reference number, or the system-generated date-specific number assigned by the contractor.
 2. A hospital claim is considered paid on the date indicated on the disbursement check.

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3. A denied hospital claim is considered adjudicated on the date of the claim's denial.
 4. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the contractor shall assign a new date of receipt upon receipt of the additional documentation.
 5. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the contractor shall not assign a new date of receipt.
 6. A contractor and a hospital may, through a contract approved as specified in R9-22-715, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.
- D.** Payment for in-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. A contractor shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, at either a rate specified by subcontract or, in absence of the subcontract, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715. This subsection does not apply to an urban contractor as specified in R9-22-718 and A.R.S. § 36-2905.01.
- E.** Payment for Inpatient out-of-state hospital payments for claims with discharge dates on or before September 30, 2014. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b).
- F.** Payment for inpatient hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. Subject to R9-22-718 and A.R.S. § 36-2905.01 regarding urban hospitals, a contractor shall reimburse an in-state or out-of-state provider of inpatient hospital services, at either a rate specified by subcontract or, in absence of a subcontract, the DRG rate established by the Administration and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
- G.** Payment for in-state outpatient hospital services.
A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other Sections of this Article. The terms of the subcontract are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
- H.** Outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the contractor shall pay the claim by multiplying the covered charges for the outpatient services by the statewide outpatient cost-to-charge ratio.
- I.** Payment for observation days. A contractor shall reimburse a provider and a noncontracting provider for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, as prescribed under R9-22-712, R9-22-712.10, and R9-22-712.45.
- J.** Review of claims and coverage for hospital supplies.
1. A contractor may conduct a review of any claims submitted and recoup any payments made in error.
 2. A hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. When issuing prior authorization, a contractor shall consider the medical necessity of the service, and the availability and cost effectiveness of an alternative treatment. Failure to obtain prior authorization when required is cause for nonpayment or denial of a claim. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the subcontract regarding utilization control activities. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and shall make the hospital's medical records pertaining to a member enrolled with a contractor available for review.
 3. Regardless of prior authorization or concurrent review activities, a contractor may make prepayment or post-payment review of all claims, including but not limited to a hospital claim. A contractor may recoup an erroneously paid claim. If prior authorization was given for an inpatient hospital admission, a specific service, or level of care but subsequent medical review indicates that the admission, the service, or level of care was not medically appropriate, the contractor shall adjust the claim payment.
 4. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures if the subcontract meets the requirements of R9-22-715.
 5. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
 - a. Patient care kit,
 - b. Toothbrush,
 - c. Toothpaste,
 - d. Petroleum jelly,
 - e. Deodorant,
 - f. Septi soap,
 - g. Razor,
 - h. Shaving cream,
 - i. Slippers,
 - j. Mouthwash,
 - k. Disposable razor,
 - l. Shampoo,
 - m. Powder,
 - n. Lotion,
 - o. Comb, and
 - p. Patient gown.
 6. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
 - a. Arm board,
 - b. Diaper,
 - c. Underpad,
 - d. Special mattress and special bed,
 - e. Gloves,
 - f. Wrist restraint,
 - g. Limb holder,
 - h. Disposable item used instead of a durable item,
 - i. Universal precaution,
 - j. Stat charge, and

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- k. Portable charge.
- 7. The contractor shall determine in a hospital claims review whether services rendered were:
 - a. Covered services as defined in R9-22-201;
 - b. Medically necessary;
 - c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
 - d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2904.
- 8. If a contractor adjudicates a claim or recoups payment for a claim, a person may file a claim dispute challenging the adjudication or recoupment as described under 9 A.A.C. 34.
- K.** Non-hospital claims. A contractor shall pay claims for non-hospital services in accordance with contract, or in the absence of a contract, at a rate not less than the Administration's capped fee-for-service schedule or at a lower rate if negotiated between the two parties.
- L.** Payments to hospitals. A contractor shall pay for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and as described in A.R.S. § 36-2904:
 - 1. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
 - 2. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
 - 3. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a 1 percent penalty of the rate for each month or portion of the month following the 60th day of receipt of the bill until date of payment.
- M.** Interest payment. In addition to the requirements in subsection (L), a contractor shall pay interest for late claims as defined by contract.
- N.** For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-705 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the amended rule identical to emergency (Supp. 83-3). Former Section R9-22-705 repealed, new Section R9-22-705 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (C) effective October 1, 1987; amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure

Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-706. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-706 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-706 repealed, new Section R9-22-706 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (D), (E), (F), and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (F) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (F) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 10 A.A.R. 4656, effective January 1, 2005 (Supp. 04-4).

R9-22-707. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-707 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Repealed as a permanent action effective May 16, 1983 (Supp. 83-3). New Section R9-22-707 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective

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tive October 1, 1985 (Supp. 85-5). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

R9-22-708. Payments for Services Provided to Eligible American Indians

- A. For purposes of this Article "IHS enrolled" or "enrolled with IHS" means an American Indian who has elected to receive covered services through IHS instead of a contractor.
- B. For an American Indian who is enrolled with IHS, AHCCCS shall pay IHS the most recent all-inclusive inpatient, outpatient or ambulatory surgery rates published by Health and Human Services (HHS) in the *Federal Register*, or a separately contracted rate with IHS, for AHCCCS-covered services provided in an IHS facility. AHCCCS shall reimburse providers for the Medicare coinsurance and deductible amounts required to be paid by the Administration or contractor in A.A.C. Chapter 29, Article 3 of this Title.
- C. When IHS refers an American Indian enrolled with IHS to a provider other than an IHS or tribal facility, the provider to whom the referral is made shall obtain prior authorization from AHCCCS for services as required under Articles 2, 7 or 12 of this Chapter.
- D. For an American Indian enrolled with a contractor, AHCCCS shall pay the contractor a monthly capitation payment.
- E. Once an American Indian enrolls with a contractor, AHCCCS shall not reimburse any provider other than IHS or a Tribal facility.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-708 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-708 repealed, new Section R9-22-708 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-708 renumbered and amended as Section R9-22-709, new Section R9-22-708 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended by final rulemaking at 10 A.A.R. 4656, effective January 1, 2005 (Supp. 04-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-709. Contractor's Liability to Hospitals for the Provision of Emergency and Post-stabilization Care

A contractor is liable for emergency hospitalization and post-stabilization care as described in R9-22-210 and R9-22-210.01.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-709 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-709 repealed, new Section R9-22-709 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-709 renumbered and amended as Section R9-22-713, former Section R9-22-708 renumbered and amended as Section

R9-22-709 effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-710. Payments for Non-hospital Services

- A. Capped fee-for-service. The Administration shall provide notice of changes in methods and standards for setting payment rates for services in accordance with 42 CFR 447.205, December 19, 1983, incorporated by reference and on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
 1. Non-contracted services. In the absence of a contract that specifies otherwise, a contractor shall reimburse a provider or noncontracting provider for non-hospital services according to the Administration's capped-fee-for-service schedule.
 2. Procedure codes. The Administration shall maintain a current copy of the National Standard Code Sets mandated under 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004), incorporated by reference and on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
 - a. A person shall submit an electronic claim consistent with 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004).
 - b. A person shall submit a paper claim using the National Standard Code Sets as described under 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004).
 - c. The Administration may deny a claim for failure to comply with subsection (A) (2) (a) or (b).
 3. Fee schedule. The Administration shall pay providers, including noncontracting providers, at the lesser of billed charges or the capped fee-for-service rates specified in subsections (A)(3)(a) through (A)(3)(d) unless a different fee is specified in a contract between the Administration and the provider, or is otherwise required by law.
 - a. Physician services. Fee schedules for payment for physician services are on file at the central office of the Administration for reference use during customary business hours.
 - b. Dental services. Fee schedules for payment for dental services are on file at the central office of the Administration for reference use during customary business hours.

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- c. Transportation services. Fee schedules for payment for transportation services are on file at the central office of the Administration for reference use during customary business hours. For dates of service beginning:
 - i. October 1, 2012 through September 30, 2013, the Administration and its contractors shall reimburse ambulance services at 68.59 percent of the ADHS rates that are in effect as of August 2, 2012.
 - ii. October 1, 2013 through September 30, 2014, the Administration and its contractors shall reimburse ambulance services at 68.59 percent of the ADHS rates that are in effect as of August 2, 2013.
 - iii. October 1, 2014 through September 30, 2015, the Administration and its contractors shall reimburse ambulance services at 74.74 percent of the ADHS rates that are in effect as of August 2, 2014.
 - d. Medical supplies and durable medical equipment (DME). Fee schedules for payment for medical supplies and DME are on file at the central office of the Administration for reference use during customary business hours. The Administration shall reimburse a provider once for purchase of DME during any two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless prior authorized by the Administration, no more than one repair and adjustment of DME shall be reimbursed during any two-year period.
- B. Pharmacy services.** The Administration shall not reimburse pharmacy services unless the services are provided by a pharmacy having a subcontract with a Pharmacy Benefit Manager (PBM) contracted with AHCCCS. Except as specified in subsection (C), the Administration shall reimburse pharmacy services according to the terms of the contract.
- C. FQHC Pharmacy reimbursement.**
1. For purposes of this Section the following terms are defined:
 - a. "340B Drug Pricing Program" means the discount drug purchasing program described in 42 U.S.C 256b.
 - b. "340B Ceiling Price" means the maximum price that drug manufacturers can charge covered entities participating in the 340B Drug Pricing Program as reported by the drug manufacturer to HRSA.
 - c. "340B entity" means a covered entity, eligible to participate in the 340B Drug Pricing Program, as defined by the Health Resources and Human Services Administration.
 - d. "Actual Acquisition Cost (AAC)" means the purchase price of a drug paid by a pharmacy net of discounts, rebates, chargebacks and other adjustments to the price of the drug. The AAC excludes dispensing fees.
 - e. "Contracted Pharmacy" means an arrangement through which a 340B entity may contract with an outside pharmacy to provide comprehensive pharmacy services utilizing medications subject to 340B pricing.
 - f. "Dispensing Fee" means the amount paid for the professional services provided by the pharmacist for dispensing a prescription. The Dispensing Fee does not include any payment for the drugs being dispensed.
 - g. "Federally Qualified Health Center" means a public or private non-profit health care organization that has been identified by HRSA and certified by CMS as meeting the criteria under sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receives funds under section 330 of the Public Health Service Act.
 - h. "Federally Qualified Health Center Look-Alike" means a public or private non-profit health care organization that has been identified by HRSA and certified by CMS as meeting the definition of "health center" under section 330 of the Public Health Service Act, but does not receive grant funding under section 330.
 - i. "FQHC or FQHC Look-Alike pharmacy" means a pharmacy that dispenses drugs to FQHC or FQHC-LA patients and that is owned and/or operated by an FQHC/FQHC-LA or by an entity that reports the costs of an FQHC/FQHC-LA on its Medicare Cost Report, whether or not collocated with an FQHC or an FQHC Look-Alike.
 2. Effective the later of February 1, 2012, or CMS approval of a State Plan Amendment, an FQHC or FQHC Look-Alike shall:
 - a. Notify the AHCCCS provider registration unit of its status as a 340B covered entity no later than:
 - i. 30 days after the effective date of this Section;
 - ii. 30 days after registration with the Health Resources and Services Administration (HRSA) for participation in the 340B program, or
 - iii. The time of application to become an AHCCCS provider.
 - b. Provide the 340B pricing file to the AHCCCS Administration upon request. The 340B pricing file shall be provided in the file format as defined by AHCCCS.
 - c. Identify 340B drug claims submitted to the AHCCCS FFS PBM or the Managed Care Contractors' PBMs for reimbursement. The 340B drug claim identification and claims processing for a drug claim submission shall be consistent with claim instructions issued and required by AHCCCS to identify such claims.
 3. The FQHC and the FQHC Look-Alike pharmacies shall submit claims for AHCCCS members for drugs that are identified in the 340B pricing file, whether or not purchased under the 340B pricing file, with the lesser of:
 - a. The actual acquisition cost, or
 - b. The 340B ceiling price.
 4. The AHCCCS Fee-for-Service and Managed Care Contractors' PBMs shall reimburse claims for drugs which are identified in the 340B pricing file dispensed by FQHC and FQHC Look -Alike pharmacies, whether or not purchased under the 340B pricing file, at the amount submitted under subsection (C)(3) plus a dispensing fee listed in the AHCCCS Capped Fee-For-Service Schedule unless a contract between the 340B entity and a Managed Care Contractor's PBM specifies a different dispensing fee.

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5. Contracted pharmacies shall not submit claims for drugs dispensed under an agreement with the 340B entity as part of the 340B drug pricing program, and the AHCCCS Administration and Managed Care Contractors shall not reimburse such claims.
 6. The AHCCCS Administration and Managed Care Contractors shall reimburse contracted pharmacies for drugs not dispensed under an agreement with the 340B entity as part of the 340B program at the price and dispensing fee set forth in the contract between the contracted pharmacy and the AHCCCS or its Managed Care Contractors' PBMs. Neither the Administration nor its Managed Care Contractors will reimburse a contracted pharmacy that does not have a contract with the Administration or MCO's PBM.
 7. The AHCCCS Administration and its Managed Care Contractors shall reimburse FQHC and FCHC Look-Alike pharmacies for drugs that are not eligible under the 340B Drug Pricing Program at the price and dispensing fee set forth in their contract with the AHCCCS or its Managed Care Contractors' PBMs.
 8. AHCCCS may periodically conduct audits to ensure compliance with this Section.
2. An eligible individual is assigned to a hierarchy established in subsections (B) through (E), for the purposes of establishing a copayment amount.
 3. No refunds shall be made for a retroactive period if there is a change in an individual's status that alters the amount of a copayment.
- B.** The following services are exempt from AHCCCS copayments for all members:
1. Family planning services and supplies,
 2. Services related to a pregnancy or any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for a pregnant woman,
 3. Emergency services as described in 42 CFR 447.56(2)(i),
 4. All services paid on a fee-for-service basis,
 5. Preventive services, such as well visits, immunizations, pap smears, colonoscopies, and mammograms,
 6. Provider preventable services.
- C.** The following individuals are exempt from AHCCCS copayments:
1. An individual under age 19, including individuals eligible for the KidsCare Program in A.R.S. § 36-2982;
 2. An individual determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services;
 3. An individual eligible for the Arizona Long-Term Care Program in A.R.S. § 36-2931;
 4. An individual eligible for QMB under Chapter 29;
 5. An individual eligible for the Children's Rehabilitative Services program under A.R.S. § 36-2906(E);
 6. An individual receiving nursing facility or HCBS services under R9-22-216;
 7. An individual receiving hospice care as defined in 42 U.S.C. 1396d(o);
 8. An American Indian individual enrolled in a health plan and has received services through an IHS facility, tribal 638 facility or urban Indian health program;
 9. An individual eligible in the Breast and Cervical Cancer program as described under Article 20;
 10. An individual who is pregnant and through the postpartum period following the pregnancy;
 11. An individual with respect to whom child welfare services are made available under Part B of Title IV of the Social Security Act on the basis of being a child in foster care, without regard to age;
 12. An individual with respect to whom adoption or foster care assistance is made available under Part E of Title IV of the Social Security Act, without regard to age; and
 13. An adult eligible under R9-22-1427(E), with income at or below 106% of the FPL.
- D.** Non-mandatory copayments. Unless otherwise listed in subsection (B) or (C), individuals under subsections (D)(1) through (6) are subject to the copayments listed in this subsection. A provider shall not deny a service when a member states to the provider an inability to pay a copayment.
1. A caretaker relative eligible under R9-22-1427(A);
 2. An individual eligible for Young Adult Transitional Insurance (YATI) in A.R.S. § 36-2901(6)(a)(iii);
 3. An individual eligible for State Adoption Assistance in R9-22-1433;
 4. An individual eligible for Supplemental Security Income (SSI);
 5. An individual eligible for SSI Medical Assistance Only (SSI/MAO) in Article 15; and
 6. An individual eligible for the Freedom to Work program in A.R.S. § 36-2901(6)(g).

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-710 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of amended rule identical to emergency (Supp. 83-3). Former Section R9-22-710 repealed, new Section R9-22-710 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985. The capped fee-for-service schedules, deleted from Section R9-22-710, are now on file at the central office of the Administration (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective July 1, 1988 (Supp. 88-3). Amended subsection (B) effective April 27, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 11 A.A.R. 3830, effective November 12, 2005 (Supp. 05-3). Amended by exempt rulemaking at 18 A.A.R. 212, effective February 1, 2012 (Supp. 12-1). Amended by exempt rulemaking at 18 A.A.R. 1971, effective August 1, 2012 (Supp. 12-3). Amended by exempt rulemaking at 18 A.A.R. 2630, effective October 1, 2012 (Supp. 12-4). Amended by final rulemaking at 19 A.A.R. 1681, effective August 9, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3525, effective October 18, 2013 (Supp. 13-4)

R9-22-711. Copayments**A.** For purposes of this Article:

1. A copayment is a monetary amount that a member pays directly to a provider at the time a covered service is rendered.

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7. Copayment amount per service:
 - a. \$2.30 per prescription drug.
 - b. \$3.40 per outpatient visit, excluding an emergency room visit, if any of the services rendered during the visit are coded as evaluation and management services or non-emergent surgical procedures according to the National Standard Code Sets. An outpatient visit includes any setting where these services are performed such as a physician's office, an Ambulatory Surgical Center (ASC), or a clinic.
 - c. \$2.30 per visit, if a copayment is not being imposed under subsection (D)(7)(b) and any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets.
- E. Mandatory copayments.**
1. Copayments for individuals eligible for Transitional Medical Assistance (TMA) under R9-22-1427(B)(1)(c)(i). Unless otherwise listed in subsection (C), an individual is required to pay the following copayments for prescription drugs and outpatient services unless the service is provided during an emergency room visit or the service is otherwise exempt under subsection (B). An outpatient visit includes any setting where these outpatient services are performed such as, an outpatient hospital, a physician's provider's office, HCBS setting, an Ambulatory Surgical Center (ASC), or a clinic:
 - a. \$2.30 per prescription drug.
 - b. \$4.00 per outpatient visit, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
 - c. If a copayment is not being imposed under subsection (E)(1)(b), \$3.00 per visit if any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets.
 - d. If a copayment is not being imposed under subsection (E)(1)(b) or (c), \$3.00 per visit, if any of the services rendered during the visit are coded as non-emergent surgical procedures according to the National Standard Code Sets.
 2. Copayments for persons eligible under R9-22-1427(E) with income above 106% of the FPL and for persons eligible under A.R.S. §§ 36-2907.10 and 36-2907.11. Subject to CMS approval, unless otherwise listed in subsection (C), these individuals are required to pay the following copayments for prescription drugs and outpatient services unless the service is provided during an emergency room visit or the service is otherwise exempt under subsection (B). An outpatient visit includes any setting where these outpatient services are performed such as, an outpatient hospital, a physician's provider's office, HCBS setting, an Ambulatory Surgical Center (ASC), or a clinic:
 - a. \$4.00 per prescription drug.
 - b. \$5.00 per outpatient visit when the AHCCCS fee schedule for the visit code is a rate from \$50 to less than \$100, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
 - c. \$10.00 per outpatient visit when the AHCCCS fee schedule for the visit code is a rate of \$100 or greater, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
 - d. If a copayment is not being imposed under subsection (E)(2)(b) or (E)(2)(c), for services coded as physical, occupational or speech therapy services according to the National Standard Code Sets.
 - i. \$2.00 if the rate on the fee schedule is \$20 to \$39.99,
 - ii. \$4.00 if the rate on the fee schedule is \$40 to \$49.99, or
 - iii. \$5.00 if the rate on the fee schedule is \$50 and above per visit.
 - e. If a copayment is not being imposed under subsection (E)(2)(b) – (E)(2)(d), for services coded as non-emergent surgical procedures according to the National Standard Code Sets,
 - i. \$30.00 if the rate on the fee schedule is \$300 to \$499.99, or
 - ii. \$50.00 if the rate on the fee schedule is \$500 and above per visit.
 - f. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay \$2.00 per trip for non-emergency transportation in an urban area.
 - g. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay \$8.00 for non-emergency use of the emergency room.
 - h. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay \$75 for an Inpatient stay.
 3. The provider may deny a service if the member does not pay the copayment required by subsection (E), however, a provider may choose to reduce or waive copayments under this subsection on a case-by-case basis.
- F.** A provider is responsible for collecting any copayment imposed under this Section.
- G.** The total aggregate amount of copayments under subsections (D) or (E) may not exceed 5% of the family's income as applied on a quarterly basis. The member may establish that the aggregate limit has been met on a quarterly basis by providing the Administration with records of copayments incurred during the quarter. In addition, the Administration shall also use claims and encounters information available to the Administration to establish when a member's copayment obligation has reached 5% of the family's income.
- H.** Reduction in payments to providers. The Administration and its contractors shall reduce the payment it makes to any provider by the amount of a member's copayment obligation under subsection (E), regardless of whether the provider successfully collects the copayments described in this Section.

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Sections R9-22-711 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-711 repealed, new Section R9-22-711 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an

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exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4).

Amended effective September 22, 1997 (Supp. 97-3).

Amended by final rulemaking at 6 A.A.R. 2435, effective

June 9, 2000 (Supp. 00-2). Amended by final rulemaking

at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3).

Amended by exempt rulemaking at 9 A.A.R. 4557, effective

October 1, 2003 (Supp. 03-4). Amended by exempt

rulemaking at 10 A.A.R. 2194, effective May 3, 2004

(Supp. 04-2). Amended by exempt rulemaking at 10

A.A.R. 4266, effective October 1, 2004 (Supp. 04-3).

Amended by final rulemaking at 16 A.A.R. 1449, effective

October 1, 2010 (Supp. 10-3). Section amended by

exempt rulemaking at 18 A.A.R. 461, effective April 1,

2012 (Supp. 12-1). Section amended by final rulemaking

at 19 A.A.R. 2954, effective November 11, 2013 (Supp.

13-3). Amended by exempt rulemaking at 20 A.A.R. 128,

effective December 30, 2013 (Supp. 13-4). Amended by

exempt rulemaking at 20 A.A.R. 2755, effective January

1, 2015 (Supp. 14-3).

Editor's Note: The following Section was adopted and amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-712. Reimbursement: General

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

B. Inpatient and outpatient in-state or out-of-state hospital payments.

1. Payment for inpatient out-of-state hospital services for claims with discharge dates on or before September 30, 2014. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(d).

2. Payment for inpatient in-state hospital services for claims with discharge dates on or before September 30, 2014. AHCCCS shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, at the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article.

3. Payment for inpatient in-state or out-of-state hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. Subject to R9-22-718 and A.R.S. § 36-2905.01 regarding urban hospitals, a contractor shall reimburse an in-state or out-of-state provider of inpatient hospital services, at either a rate specified by subcontract or, in the absence of a subcontract, the DRG rate established by the Administration and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.

4. Outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse an out-of-state hospital for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the Administration shall pay the claim by multiplying the covered charges for the outpatient services by the statewide outpatient cost-to-charge ratio.

5. Outpatient in-state hospital payments. A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other Sections of this Article. The terms of the subcontract are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.

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

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

E. Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers, to prepayment medical review or post-payment review, or both. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims.

F. Claim receipt.

1. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number.

2. Hospital claims are considered paid on the date indicated on disbursement checks.

3. A denied claim is considered adjudicated on the date the claim is denied.

4. Claims that are denied and are resubmitted are assigned new receipt dates.

5. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation.

6. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.

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

1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient

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operating and capital costs are included in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calculate the outpatient hospital cost-to-charge ratio annually for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in R9-22-712.01. The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:

- a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital by taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
- b. Cost-to-charge limit. To comply with 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in a specialty facility.
4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than zero. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. Services provided in the emergency room, observation area, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every four years but no more than once a year using

updated Medicare Cost Reports and claim and encounter data.

6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which represents an aggregate increase in charges of more than 4.7%, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (5) by applying the following formula:

$$CCR * [1.047 / (1 + \% \text{ increase})]$$

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

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

Historical Note

Adopted as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to emergency (Supp. 83-3). Former Section R9-22-712 repealed, new Section R9-22-712 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). New Section R9-22-712 adopted under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective January 14, 1997 (Supp. 97-1). Amended by exempt rulemaking at 10 A.A.R. 3831, effective August 25, 2004 (Supp. 04-3). Amended by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 17 A.A.R. 1337, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.01. Inpatient Hospital Reimbursement for claims with admission dates and discharge dates from October 1, 1998 through September 30, 2014

Inpatient hospital reimbursement. The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons for claims with admission dates and discharge dates from October 1, 1998 through September 30, 2014, on a prospective reimbursement basis. The prospective rates represent payment in full, excluding quick-pay discounts, slow-pay penalties, and third-party payments for both accommodation and ancillary department services. The rates include reimbursement for operating and capital costs. The Administration shall make reimbursement for direct graduate medical education as described in A.R.S. § 36-2903.01. For payment purposes, the Administration shall classify each AHC-CCS inpatient hospital day of care into one of several tiers appro-

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priate to the services rendered. The rate for a tier is referred to as the tiered per diem rate of reimbursement. The number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier claims, transplant claims, or payment to out-of-state hospitals, freestanding psychiatric hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.

1. Tier rate data. The Administration shall base tiered per diem rates effective on and after October 1, 1998 on Medicare Cost Reports for Arizona hospitals for the fiscal year ending in 1996 and a database consisting of inpatient hospital claims and encounters for dates of service matching each hospital's 1996 fiscal year end.
 - a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation, the Administration shall inflate all the costs to a common point in time as described in subsection (2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than one hospital, the Administration shall allocate the costs to each of the respective hospitals. A hospital shall submit information to assist the Administration in this allocation.
 - b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed for rates effective on and after October 1, 1998. The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude from the database or adjust claims and encounters that fail these edits. The Administration shall also exclude from the database the following claims and encounters:
 - i. Those missing information necessary for the rate calculation,
 - ii. Medicare crossovers,
 - iii. Those submitted by freestanding psychiatric hospitals, and
 - iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.
2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on the sum of the operating and capital components. The rate for the operating component is a statewide rate for each tier except for the NICU and Routine tiers, which are based on peer groups. The rate for the capital component is a blend of statewide and hospital-specific values, as described in A.R.S. § 36-2903.01. The Administration shall use the following methodologies to establish the rates for each of these components.
 - a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the Administration shall compute the rate for the operating component as follows:
 - i. Data preparation. The Administration shall identify and group into department categories,

the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.

- ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports are grouped. The ancillary department cost-to-charge ratios for a particular hospital are multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters are multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day do not include medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1996, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs. The Administration shall further inflate operating costs to the midpoint of the rate year (March 31, 1999).
- iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these. For the NICU tier, the Administration shall further assign claims and encounters to NICU Level II or NICU Level III peer groups, based on the hospital's certification by the Arizona Perinatal Trust. For the Routine tier, the Administration shall further assign claims and encounters to the general acute care hospital or rehabilitation hospital peer groups, based on state licensure by the Department of Health Services. For claims and encounters assigned to more than one tier, the Administration shall allocate ancillary department costs to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (6).

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- iv. Operating rate calculation. The Administration shall set the rate for the operating component for each tier by dividing total statewide or peer group hospital costs identified in this subsection within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.
- b. Capital component. For rates effective October 1, 1999 the capital component is calculated as described in A.R.S. § 36-2903.01.
- c. Statewide inpatient hospital cost-to-charge ratio. For dates of service prior to October 1, 2007, the statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, as described in subsections (4), (5), and (6), and out-of-state hospitals, as described in R9-22-712(B). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (1) and used to determine the tiered per diem rates. For each hospital, the covered inpatient days of care on the claims and encounters are multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters are multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital are determined in the same way described in subsection (2)(a) but include costs for operating and capital. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.
- d. Unassigned tiered per diem rates. If a hospital has an insufficient number of claims to set a tiered per diem rate, the Administration shall pay that hospital the statewide average rate for that tier.
- 3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure, or revenue codes, peer group, NICU classification level, or a combination of these.
 - a. Tier hierarchy. In assigning claims for AHCCCS inpatient hospital days of care to a tier, the Administration shall follow the Hierarchy for Tier Assignment through September 30, 2014 in R9-22-712.09. The Administration shall not pay a claim for inpatient hospital services unless the claim meets medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that are submitted by the hospital.
 - b. Tier exclusions. The Administration shall not assign to a tier or pay AHCCCS inpatient hospital days of care that do not occur during a period when the person is eligible. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. The Administration shall pay same day admit and discharge claims that qualify for either the maternity or nursery tiers based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.
- c. Seven tiers. The seven tiers are:
 - i. Maternity. The Administration shall identify the Maternity Tier by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the Administration shall pay the AHCCCS inpatient hospital days of care on the claim at the maternity tiered per diem rate.
 - ii. NICU. The Administration shall identify the NICU Tier by a revenue code. A hospital does not qualify for the NICU tiered per diem rate unless the hospital is classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier and have a NICU revenue code at the NICU tiered per diem rate. The Administration shall pay any remaining AHCCCS inpatient hospital day on the claim that does not meet NICU Level II or NICU Level III medical review criteria at the nursery tiered per diem rate.
 - iii. ICU. The Administration shall identify the ICU Tier by a revenue code. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meets the medical review criteria for the ICU tier and has an ICU revenue code at the ICU tiered per diem rate. The Administration may classify any AHCCCS inpatient hospital days on the claim without an ICU revenue code, as surgery, psychiatric, or routine tiers.
 - iv. Surgery. The Administration shall identify the Surgery Tier by a revenue code and a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list identifies minor procedures such as sutures that do not require the same hospital resources as other procedures. The Administration shall only split a surgery tier with an ICU tier. AHCCCS shall pay at the surgery tier rate only when the surgery occurs on a date during which the member is eligible.
 - v. Psychiatric. The Administration shall identify the Psychiatric Tier by either a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the psychiatric tier with any tier other than the ICU tier.

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- vi. Nursery. The Administration shall identify the Nursery Tier by a revenue code. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the nursery tier with any tier other than the NICU tier.
- vii. Routine. The Administration shall identify the Routine Tier by revenue codes. The routine tier includes AHCCCS inpatient hospital days of care that are not classified in another tier or paid under any other provision of this Section. The Administration shall not split the routine tier with any tier other than the ICU tier.
- 4. Annual update. The Administration shall annually update the inpatient hospital tiered per diem rates through September 30, 2011.
- 5. New hospitals. For rates effective on and after October 1, 1998, the Administration shall pay new hospitals the statewide average rate for each tier, as appropriate. The Administration shall update new hospital tiered per diem rates through September 30, 2011.
- 6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers under this Section by multiplying the covered charges on a claim by the Medicare Urban or Rural Cost-to-Charge Ratio. The Urban cost-to-charge ratio will be used for hospitals located in a county of 500,000 residents or more. The Rural cost-to-charge ratio will be used for hospitals located in a county of fewer than 500,000 residents.
 - a. Outlier criteria. For rates effective on and after October 1, 1998, the Administration set the statewide outlier cost threshold for each tier at the greater of three standard deviations from the statewide mean operating cost per day within the tier, or two standard deviations from the statewide mean operating cost per day across all the tiers. If the covered costs per day on a claim exceed the urban or rural cost threshold for a tier, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the applicable Medicare Urban or Rural CCR. The resulting amount will be the outlier payment. If there are two tiers on a claim, the Administration shall determine whether the claim is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying each tier rate by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital. Routine maternity stays shall be excluded from outlier reimbursement. A routine maternity is any one-day stay with a delivery of one or two babies. A routine maternity stay will be paid at tier.
 - b. Update. The CCR is updated annually by the Administration for dates of service beginning October 1, using the most current Medicare cost-to-charge ratios published or placed on display by CMS by August 31 of that year. The Administration shall update the outlier cost thresholds for each hospital through September 30, 2011 as described under A.R.S. § 36-2903.01. For inpatient hospital admissions with begin dates of service on and after October 1, 2011, AHCCCS will increase the outlier cost thresholds by 5% of the thresholds that were effective on September 30, 2011.
- c. Medicare Cost-to-Charge Ratio Phase-In. AHCCCS shall phase in the use of the Medicare Urban or Rural Cost-to-Charge Ratios for outlier determination, calculation and payment. The three-year phase-in does not apply to out-of-state or new hospitals.
 - i. Medicare Cost-to-Charge Ratio Phase-In outlier determination and threshold calculation. For outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. For outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. The adjusted hospital specific inpatient cost-to-charge ratios shall be used for all calculations using the Medicare Urban or Rural Cost-to-Charge Ratios, including outlier determination, and threshold calculation.
 - ii. Medicare Cost-to-Charge Ratio Phase-In calculation for payment. For payment of outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio. For payment of outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio.
 - iii. Medicare Cost-to-Charge Ratio for outlier determination, threshold calculation, and payment. For outlier claims with dates of service on or after October 1, 2009, the full Medicare Urban or Rural Cost-to-Charge Ratios shall be utilized for all outlier calculations.
- d. Cost-to-Charge Ratio used for qualification and payment of outlier claims.
 - i. For qualification and payment of outlier claims with begin dates of service on or after April 1, 2011 through September 30, 2011,

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- the CCR will be equal to 95% of the ratios in effect on October 1, 2010.
- ii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011, the CCR will be equal to 90.25% of the most recent published Urban or Rural Medicare CCR as described in subsection (6)(b).
 - iii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011 through September 30, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after April 1, 2011 by an additional percentage equal to the total percent increase reported on the charge master.
 - iv. Subject to approval by CMS, for qualification and payment of outlier claims with begin dates of service on or after October 1, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after June 1, 2012 by an additional percentage equal to the total percent increase reported on the charge master.
7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered transplant as described in R9-22-206 is performed through the terms of the relevant contract. If the Administration and a hospital that performs transplant surgery on an eligible person do not have a contract for the transplant surgery, the Administration shall not reimburse the hospital more than what would have been paid to the contracted hospital for that same surgery.
 8. Ownership change. The Administration shall not change any of the components of a hospital's tiered per diem rates upon an ownership change.
 9. Psychiatric hospitals. The Administration shall pay free-standing psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Department of Health Services.
 10. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section as provided by A.R.S. § 36-2903.01. For purposes of this subsection, "specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.
 11. Outliers for new hospitals. Outliers for new hospitals will be calculated using the Medicare Urban or Rural Cost-to-Charge Ratio times covered charges. If the resulting cost is equal to or above the cost threshold, the claim will be paid at the Medicare Urban or Rural Cost-to-Charge ratio.
 12. Reductions to tiered per diem payment for inpatient hospital services. Inpatient hospital admissions with begin dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the tiered per diem rates in effect on September 30, 2011.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by exempt rulemaking at 17 A.A.R. 1337, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.02. Reserved**R9-22-712.03. Reserved****R9-22-712.04. Reserved****R9-22-712.05. Graduate Medical Education Fund Allocation**

- A. Graduate medical education (GME) reimbursement as of September 30, 1997. Subject to legislative appropriation, the Administration shall make a distribution based on direct graduate medical education costs as described in A.R.S. § 36-2903.01(G)(9)(a).
- B. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for the expansions of GME programs approved by the Administration to hospitals for direct program costs eligible for funding under A.R.S. § 36-2903.01(G)(9)(b). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (B)(3).
 1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (B) if all of the following apply:
 - a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona;
 - b. It incurs direct costs for the training of residents in the GME programs, which costs are or will be reported on the hospital's Medicare Cost Report;
 - c. It is not administered by or does not receive its primary funding from an agency of the federal government.
 2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (B)(4) the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (B)(1)(c):
 - a. Filled resident positions in approved programs established as of October 1, 1999 at hospitals that receive funding as described in A.R.S. § 36-2903.01(G)(9)(a) that are additional to the number of resident positions that were filled as of October 1, 1999; and
 - b. All filled resident positions in approved programs other than GME programs described in A.R.S. § 36-2903.01(G)(9)(a) that were established before July 1, 2006.
 3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (B) shall provide the applicable information listed in this subsection to the Administration:
 - a. A GME program shall provide all of the following:

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- i. The program name and number assigned by the accrediting organization;
 - ii. The original date of accreditation;
 - iii. The names of the sponsoring institution and all participating institutions current as of the date of reporting;
 - iv. The number of approved resident positions and the number of filled resident positions current as of the date of reporting;
 - v. For programs established as of October 1, 1999, the number of resident positions that were filled as of October 1, 1999, if the program has not already provided this information to the Administration;
 - b. A hospital seeking a distribution under subsection (B) shall provide all of the following that apply:
 - i. If the hospital uses the Intern and Resident Information System (IRIS) for tracking and reporting its resident activity to the fiscal intermediary, copies of the IRIS master and assignment files for the hospital's two most recently completed Medicare cost reporting years as filed with the fiscal intermediary;
 - ii. If the hospital does not use the IRIS or has less than two cost reporting years available in the form of the IRIS master and assignment files, the information normally contained in the IRIS master and assignment files in an alternative format for the hospital's two most recently completed Medicare cost reporting years;
 - iii. At the request of the Administration, a copy of the hospital's Medicare Cost Report or any part of the report for the most recently completed cost reporting year.
4. Allocation of expansion funds. Annually the Administration shall allocate available funds to each approved GME program in the following manner:
- a. Information provided by hospitals under subsection (B)(3)(b) shall be used to determine the program in which each eligible resident is enrolled and the number of days that each eligible resident worked in any area of the hospital complex or in a non-hospital setting under agreement with the reporting hospital during the period of assignment to that hospital. For this purpose, the Administration shall use data relating to the most recent 12-month period that is common to all information provided under subsections (B)(3)(b)(i) and (ii).
 - b. The number of eligible residents allocated to each participating institution within each approved GME program shall be determined as follows:
 - i. Total the number of days determined for each participating institution under subsection (B)(4)(a) and divide each total by 365.
 - ii. Proportionally adjust the result of subsection (B)(4)(b)(i) for each participating institution within each program according to the number of residents determined to be eligible under subsection (B)(2).
 - c. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) shall be adjusted for Arizona Medicaid utilization using the most recent Medicare Cost Report information on file with the Administration as of the date of reporting under subsection (B)(3) and the Administration's inpatient hospital claims and encounter data for the time period corresponding to the Medicare Cost Report information for each hospital. The Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were adjudicated by the Administration as of the date of reporting under subsection (B)(3). The Medicaid-adjusted eligible residents shall be determined as follows:
 - i. For each hospital, the total AHCCCS inpatient hospital days of care shall be divided by the total Medicare Cost Report inpatient hospital days, multiplied by 100 and rounded up to the nearest multiple of 5 percent.
 - ii. The number of allocated eligible residents determined for each participating hospital under subsection (B)(4)(b)(ii) shall be multiplied by the percentage derived under subsection (B)(4)(c)(i) for that hospital. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) for a participating institution that is not a hospital and not a health care facility made ineligible under subsection (B)(1)(c) shall be multiplied by the percentage derived under subsection (B)(4)(c)(i) for the program's sponsoring institution or, if the sponsoring institution is not a hospital, the sponsoring institution's affiliated hospital. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) for a participating institution that is made ineligible under subsection (B)(1)(c) shall be multiplied by zero percent.
 - d. The total allocation for each approved program shall be determined by multiplying the Medicaid-adjusted eligible residents determined under subsection (B)(4)(c)(ii) by the per-resident conversion factor determined below and totaling the resulting dollar amounts for all participating institutions in the program. The per-resident conversion factor shall be determined as follows:
 - i. Calculate the total direct GME costs from the most recent Medicare Cost Reports on file with the Administration for all hospitals that have reported such costs.
 - ii. Calculate the total allocated residents determined under subsection (B)(4)(b)(i) for those hospitals described under subsection (B)(4)(d)(i).
 - iii. Divide the total GME costs calculated under subsection (B)(4)(d)(i) by the total allocated residents calculated under subsection (B)(4)(d)(ii).
5. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (B)(4) in the following manner:
- a. The allocated amounts shall be distributed in the following order of priority:
 - i. To eligible hospitals that do not receive funding in accordance with A.R.S. § 36-

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- 2903.01(G)(9)(a) for the direct costs of programs established before July 1, 2006;
- ii. To eligible hospitals that receive funding in accordance with A.R.S. § 36-2903.01(G)(9)(a) for the direct costs of programs established before July 1, 2006;
 - b. The allocated amounts shall be distributed to the eligible hospitals in each approved program in proportion to the number of Medicaid-adjusted eligible residents allocated to each hospital within that program under subsection (B)(4)(c)(ii).
 - c. If funds are insufficient to cover all distributions within any priority group described under subsection (B)(5)(a), the Administration shall adjust the distributions proportionally within that priority group.
- C. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for the expansions of GME programs approved by the Administration to hospitals for direct program costs eligible for funding under A.R.S. § 36-2903.01(G)(9)(c)(i). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (C)(3).
1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (C) if it meets all the conditions of subsections (B)(1)(a) through (c).
 2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (C)(4), the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (B)(1)(c):
 - a. All filled resident positions in approved programs established on or after July 1, 2006; and
 - b. For approved programs established on or after July 1, 2006 that have been established for less than one year as of the date of reporting under subsection (C)(3) and have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match.
 3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (C) shall provide to the Administration:
 - a. A GME program shall provide all of the following:
 - i. The requirements of subsections (B)(3)(a)(i) through (iv);
 - ii. The academic year rotation schedule on file with the program current as of the date of reporting; and
 - iii. For programs described under subsection (C)(2)(b), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
 - b. A hospital seeking a distribution under subsection (C) shall provide the requirements of subsection (B)(3)(b).
 4. Allocation of expansion funds. Annually the Administration shall allocate available funds to approved GME programs in the following manner:
 - a. Information provided by hospitals in accordance with subsection (B)(3)(b) shall be used to determine the program in which each eligible resident is enrolled and the number of days that each eligible resident worked in any area of the hospital complex or in a non-hospital setting under agreement with the reporting hospital during the period of assignment to that hospital. For this purpose, the Administration shall use data relating to the most recent 12-month period that is common to all information provided in accordance with subsections (B)(3)(b)(i) and (ii).
 - b. For approved programs whose resident activity is not represented in the information provided in accordance with subsection (B)(3)(b), information provided by GME programs under subsection (C)(3)(a) shall be used to determine the number of days that each eligible resident is expected to work at each participating institution.
 - c. The number of eligible residents allocated to each participating institution for each approved GME program shall be determined by totaling the number of days determined under subsections (C)(4)(a) and (b) and dividing the totals by 365.
 - d. The number of allocated residents determined under subsection (C)(4)(c) shall be adjusted for Arizona Medicaid utilization in accordance with subsection (B)(4)(c).
 - e. The total allocation for each approved program shall be determined in accordance with subsection (B)(4)(d).
5. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (C)(4) to the eligible hospitals in each approved program in proportion to the number of Medicaid-adjusted eligible residents allocated to each within that program under subsection (C)(4)(d).
- D. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for GME programs approved by the Administration to hospitals for indirect program costs eligible for funding under A.R.S. § 36-2903.01(G)(9)(c)(ii). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (D)(3).
1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (D) if all of the following apply:
 - a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona or is the base hospital for one or more of the GME programs in Arizona whose sponsoring institutions are not hospitals;
 - b. It incurs indirect program costs for the training of residents in the GME programs, which are or will be calculated on the hospital's Medicare Cost Report or are reimbursable under the Children's Hospitals Graduate Medical Education Payment Program administered by HRSA;
 - c. It is not administered by or does not receive its primary funding from an agency of the federal government.

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2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (D)(4) the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (D)(1)(c):
 - a. Any filled resident position in an approved program that includes a rotation of at least one month per year in a county other than Maricopa or Pima whose population was less than 500,000 persons at the time the residency rotation was added to the academic year rotation schedule;
 - b. For approved programs that have been established for less than one year as of the date of reporting under subsection (D)(3) and have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match who will perform rotations of at least one month per year in a county other than Maricopa or Pima whose population was less than 500,000 persons at the time the residency rotation was added to the academic year rotation schedule.
 3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (D) shall provide to the Administration:
 - a. A GME program shall provide all of the following:
 - i. The requirements of subsections (B)(3)(a)(i) through (iv);
 - ii. The academic year rotation schedule on file with the program current as of the date of reporting;
 - iii. For programs described under subsection (D)(2)(c), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
 - b. A hospital seeking a distribution under subsection (D) shall provide the requirements of subsection (B)(3)(b)(iii).
 4. Allocation of funds for indirect program costs. Annually the Administration shall allocate available funds to approved GME programs in the following manner:
 - a. Using the information provided by programs under subsection (D)(3), the Administration shall determine for each program the number of residents in the program who are eligible under subsection (D)(2) and the number of months per year that each eligible resident will perform rotations in counties described by subsection (D)(2), multiply the number of eligible residents by the number of months and multiply the result by the per resident per month conversion factor determined under subsection (D)(4)(b).
 - b. Using the most recent Medicare Cost Reports on file with the Administration for all hospitals that have calculated a Medicare indirect medical education payment, the Administration shall determine a per resident per month conversion factor as follows:
 - i. Calculate each hospital's Medicare share by dividing the Medicare inpatient discharges on the Medicare Cost Report by the total inpatient hospital discharges on the Medicare Cost Report.
 - ii. Calculate the ratio of residents to beds by dividing the total allocated residents described in subsection (B)(4)(d)(ii) by the number of bed days available from the Medicare Cost Report and dividing the result by the number of days in the cost reporting period.
 - iii. Calculate the indirect medical education adjustment factor by adding 1 to the value calculated in (D)(4)(b)(ii), multiplying the result by the exponential value 0.405, subtracting 1 from the result, and multiplying that result by 1.35.
 - iv. Calculate each hospital's total indirect medical education cost by adding the DRG amounts other than outlier payments from the Medicare cost report and the managed care simulated payments from the Medicare Cost Report, multiplying the total by the indirect medical education adjustment factor determined in (D)(4)(b)(iii) and dividing the result by the Medicare share determined in (D)(4)(b)(i).
 - v. Calculate each hospital's Medicaid indirect medical education cost by multiplying the amount determined in (D)(4)(b)(iv) by the value determined in subsection (B)(4)(c)(i).
 - vi. Total the amounts determined in (D)(4)(b)(v) for all hospitals, divide the result by the total allocated residents described in subsection (B)(4)(d)(ii) for all hospitals, and divide that result by 12.
 5. Distribution of funds for indirect program costs. On an annual basis subject to available funds, the Administration shall distribute to each eligible hospital the amount calculated for the hospital at subsection (D)(4)(a).
- E.** Reallocation of funds. If funds appropriated for subsection (B) are not allocated by the Administration and funds appropriated for subsections (C) and (D) are insufficient to cover all distributions under subsections (C)(5) and (D)(5), the funds not allocated under subsection (B) shall be allocated under subsections (C) and (D) to the extent of the calculated distributions. If funds are insufficient to cover all distributions under subsections (C)(5) and (D)(5), the Administration shall adjust the distributions proportionally. If funds appropriated for subsections (C) and (D) are not allocated by the Administration and funds appropriated for subsection (B) are insufficient to cover all distributions under subsection (B)(5), the funds not allocated under subsections (C) and (D) shall be allocated under subsection (B) to the extent of the calculated distributions.
- F.** The Administration may enter into intergovernmental agreements with local, county, and tribal governments wherein local, county and tribal governments may transfer funds or certify public expenditures to the Administration. Such funds or certification, subject to approval by CMS, will be used to qualify for additional federal funds. Those funds will be used for the purposes of reimbursing hospitals that are eligible under subsection (D)(1) and specified by the local, county, or tribal government for indirect program costs other than those reimbursed under subsection (D). The Administration shall allocate available funds in accordance with subsection (D) except that reimbursement with such funds is not limited to resident positions or rotations in counties with populations of less than 500,000 persons. On an annual basis subject to avail-

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able funds, the Administration shall distribute to each eligible hospital the greatest among the following amounts, less any amounts distributed under subsection (D)(5):

1. The amount that results from multiplying the total number of eligible residents allocated to the hospital under subsection (B)(4)(d)(ii) by 12 by the per resident per month conversion factor determined under subsection (D)(4)(b);
2. The amount calculated for the hospital at subsection (D)(4)(b)(v);
3. The median of all amounts calculated at subsection (D)(4)(b)(v) if the hospital does not have an indirect medical education payment calculated on the Medicare Cost Report because it is a new training hospital; or
4. If the hospital does not have an indirect medical education payment calculated on the Medicare Cost Report because it is a children's hospital, the median Medicaid indirect medical education payment costs shall be calculated as follows:
 - a. For each hospital with indirect medical education costs on the Medicare Cost Report, determine a per resident total indirect medical education cost by dividing the total indirect medical education costs determined under subsection (D)(4)(b) by the number of filled resident positions under subsection (B)(2).
 - b. Determine the median per resident amount under subsection (F)(4)(a).
 - c. For each hospital without an indirect medical education component on the Medicare cost report, multiply the median per resident amount under subsection (F)(4)(b) by the number of filled resident positions under subsection (B)(2) for that hospital and by the Medicaid utilization percent for that hospital determined in subsection (B)(4)(c)(i).

Historical Note

New Section made by final rulemaking at 13 A.A.R. 1782, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 13 A.A.R. 4032, effective November 1, 2007 (Supp. 07-4). Amended by final rulemaking at 21 A.A.R. 3469, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 24 A.A.R. 185, effective January 9, 2018 (Supp. 18-1). Amended by final rulemaking at 24 A.A.R. 3321, effective January 5, 2019 (Supp. 18-4).

R9-22-712.06. Supplemental Graduate Medical Education Fund Allocation

A. Gradual Medical Education (GME) reimbursement as of July 1, 2020.

1. In addition to distributions according to Section R9-22-712.05, and subject to the availability of funds and approval by CMS, the Administration shall annually distribute monies appropriated for the GME programs approved by the Administration to hospitals for direct and indirect costs for graduate medical education programs which were established or expanded on or after July 1, 2020. The Administration shall estimate the distributions using information possessed by the Administration as of December 15 of each calendar year. The actual distributions will be made using information possessed by the Administration as of September first of the year in which the new residency or fellowship begins.

2. Eligible Hospitals. A hospital is eligible for distributions under this Section if all of the following apply:
 - a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona;
 - b. It incurs direct costs for the training of residents in the GME programs, which costs are or will be reported on the hospital's Medicare Cost Report;
 - c. It is not administered by or does not receive its primary funding from an agency of the federal government;
 - d. It has established a new GME program or expanded the number of residents or fellows in an existing GME program on or after July 1, 2020.
3. Eligible positions. For purposes of determining distributions under this Section the following resident and fellowship positions qualify to the extent that the training takes place in Arizona at an eligible health care facility:
 - a. Filled resident or fellow positions in approved programs which began on or after July 1, 2020;
 - b. Eligible positions do not include residents or fellows that receive payments for services under the Access to Professional Services Initiative (APSI) program established in the Contractors' prepaid capitation contracts with the Administration.
4. Annual Reporting
 - a. By December 15 of each year, a GME program shall provide all of the following information for GME programs and positions which are expected to be eligible for funding under this Section as of the upcoming academic year (i.e., July 1 to June 30 of each year):
 - i. The program name and number assigned by the accrediting organization if available;
 - ii. The original date of accreditation if available;
 - iii. The names of the sponsoring institution and all participating institutions expected as of the date of reporting;
 - iv. The number of anticipated resident and fellowship positions eligible for funding as of the upcoming academic year;
 - v. The number of months or partial months during the upcoming academic year that each resident or fellow is expected to work in each hospital or in a non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
 - vi. The academic year of anticipated resident and fellowship positions;
 - vii. The length of the program; and
 - viii. The names and other information requested by AHCCCS to ensure the total GME distributions for each eligible position are not greater than the costs for each eligible position in the Intern and Resident Information System (IRIS) file.
 - b. By December 15 of each year, a GME program located in a county with a population of less than 500,000 persons shall provide the estimated one-time and ongoing costs for each program which it expects to be eligible for funding.
 - c. By September 1 of each year, a GME program shall provide the actual name of residents and fellows hired in the current academic year and other information requested by AHCCCS to ensure that total

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GME distributions for the eligible position are not greater than the costs for each eligible position in the IRIS file.

- B. Preliminary allocation of funds for urban hospitals. Annually by January 15, the Administration shall estimate the annual GME distributions under this Section using the funds appropriated for hospitals in counties with a population of 500,000 persons or more based on the number of new residents and fellows in graduate medical education programs in the following manner:
 1. Each eligible resident and fellow is placed into tiers with the following priority:
 - a. Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this Section for the previous academic year and who is continuing in the same GME program.
 - b. Residents and fellows that are not a returning resident or fellow but are in a GME program for Family Medicine, Internal Medicine, General Pediatrics, Obstetrics and Gynecology, Psychiatry including Subspecialties, General Surgery, and any other program determined as high needs by the AHCCCS Administration.
 - c. Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this Section in a prior year.
 - d. All other residents and fellows.
 2. The amount of the distribution for each GME program for direct costs is calculated as the product of:
 - a. The number of eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospitals;
 - b. The Arizona Medicaid utilization as determined by R9-22-712.05(B)(4)(c)(i) in the previous calendar year; and,
 - c. The average direct cost per resident determined under R9-22-712.05(B)(4)(d) in the previous calendar year.
 3. If monies are still remaining after direct funding has been allocated, indirect funding shall be allocated based on the priority of each tier and sub-tier. The amount of the distribution for each GME program for indirect costs is calculated as the product of:
 - a. The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
 - b. The indirect cost per resident per month calculated in R9-22-712.05(D)(4)(b)(vi) in the previous calendar year; and
 - c. Twelve months.
 - d. Funds shall be allocated based on the priority of each tier and sub-tier. Distributions for eligible positions in a tier or sub-tier with a lower priority will not receive a distribution until distributions are allocated for the costs of all positions in a higher tier or sub-tier. If funding is insufficient to fully fund a tier or sub-tier, the remainder of funds will be prorated for eligible positions in that tier or sub-tier.
 4. Payments are made to participating hospitals based on the FTEs who worked at their hospitals per year.
- C. Preliminary allocation of funds for rural hospitals. Annually by January 15, the Administration shall estimate the annual GME distributions under this Section using the funds appropriated for rural hospitals based on the number of eligible resident and fellow positions in graduate medical education programs located in a county with a population of less than 500,000 persons in the following manner:
 1. Each resident and fellow will then be placed into a tier with the following priority:
 - a. Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this Section for the previous academic year and who is continuing in the same GME program.
 - b. Residents and fellows that are not a returning resident or fellow but are in a GME program for Family Medicine, Internal Medicine, General Pediatrics, Obstetrics and Gynecology, Psychiatry including Subspecialties, General Surgery, and any other program determined as high needs by the AHCCCS Administration.
 - c. Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this Section in a prior year.
 - d. All other residents and fellows.
 2. Residents and fellows in each tier are further divided into four sub-tiers with the following priority based on the location of the sponsoring or participating hospital:
 - a. Hospitals in a county designated by the Health Resource and Services Administration of the U.S. Department of Health & Human Services as a HPSA with a greater than 85 percent primary care shortage.
 - b. Hospitals in a county designated as a HPSA with a greater than 50 percent to 85 percent primary care shortage.
 - c. Hospitals in a county designated as a HPSA with a 25-50 percent primary care shortage.
 - d. Hospitals in a county designated as a HPSA with a less than 25 percent primary care shortage.
 3. Funds shall first be allocated for direct and indirect costs based in order of priority of each tier. If not enough funding is available to fully fund a tier or sub-tier, the remainder of funds will be prorated in a tier or sub-tier.
 4. The amount of the distribution for each GME program for direct costs is calculated as the product of:
 - a. The number of eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospitals;
 - b. The Arizona Medicaid utilization determined under R9-22-712.05(B)(4)(c)(i); and,
 - c. The actual direct cost per resident per year.
 5. The amount of the distribution for each GME program for indirect costs is calculated as the product of:
 - a. The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital;

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- b. The indirect cost per resident per month calculated in R9-22-712.05(D)(4)(b)(vi) in the previous calendar year; and
- c. Twelve months.
- 6. Payments are made to participating hospitals based on the FTEs who worked at their hospitals per year.
- D. Final allocation of funds. Annually no sooner than September 1 following the start of the academic year, the Administration will recalculate the allocation for urban and rural hospitals using the same methodology used to estimate distributions, but using the actual residents and fellows as reported in R9-22-712.06(A)(4)(c).
- F. Exclusions. To ensure that residents and fellows are not double counted residents/fellows which receive funding through R9-22-712.06 shall not receive funding through R9-22-712.05.

Historical Note

New Section made by final rulemaking at 27 A.A.R. 2496 (October 29, 2021), with an immediate effective date of October 6, 2021 (Supp. 21-4). Amended by final rulemaking at 29 A.A.R. 923 (April 21, 2023), with an immediate effective date of March 31, 2023 (Supp. 23-1).

R9-22-712.07. Rural Hospital Inpatient Fund Allocation

- A. For purposes of this Section, the following words and phrases have the following meanings unless the context specifically requires another meaning:
 - 1. "Calculated inpatient costs" means the sum of inpatient covered charges multiplied by the Milliman study's implied cost-to-charge ratio of .8959.
 - 2. "Claims paid amount" means the sum of all claims paid by the Administration and contractors, as reported by the contractor to the Administration, to a rural hospital for covered inpatient services rendered for dates of service during the previous state fiscal year.
 - 3. "Fund" means any state funds appropriated by the Legislature for the purposes set forth in A.R.S. § 36-2905.02 and any federal funds that are available for matching the state funds.
 - 4. "Inpatient covered charges" means the sum of all covered charges billed by a hospital to the Administration or contractors, as reported by the contractors to the Administration, for inpatient services rendered during the previous state fiscal year.
 - 5. "Milliman study" means the report issued by Milliman USA on March 11, 2004, to the Arizona Hospital and Healthcare Association that updated a portion of a cost study entitled "Evaluation of the AHCCCS Inpatient Hospital Reimbursement System" prepared by Milliman USA for AHCCCS on November 15, 2002. A copy of each report is on file with the Administration.
 - 6. "Rural hospital" means a health care institution that is licensed as an acute care hospital by the Arizona Department of Health Services for the previous state fiscal year and is not an IHS hospital or a tribally owned or operated facility and:
 - a. Has 100 or fewer PPS beds, not including beds reported as sub provider beds on the hospital's

- Medicare Cost Report, and is located in a county with a population of less than 500,000 persons, or
- b. Is designated as a critical access hospital for the majority of the previous state fiscal year.

- B. Each February, the Administration shall allocate the Fund to the following three pools for the fiscal year:
 - 1. Rural hospitals with 25 or fewer PPS beds not including sub provider beds and all Critical Access Hospitals, regardless of the number of beds in the Critical Access Hospital;
 - 2. Rural hospitals other than Critical Access Hospitals with 26 to 75 PPS beds not including sub provider beds; and
 - 3. Rural hospitals other than Critical Access Hospitals with 76 to 100 PPS beds not including sub provider beds.
- C. The Administration shall allocate the Fund to each pool according to the ratio of claims paid amount for all hospitals assigned to the pool to total claims paid amount for all rural hospitals.
- D. The Administration shall determine each hospital's claims paid amount and allocate the funds in each pool to each hospital in the pool based on the ratio of each hospital's claims paid amount to the sum of the claims paid amount for all hospitals assigned to the pool.
- E. The Administration shall not make a Fund payment to a hospital that will result in the hospital's claims paid amount plus that hospital's Fund payment being greater than that hospital's calculated inpatient costs.
 - 1. If a hospital's claims paid amount plus the hospital's Fund payment would be greater than the hospital's calculated inpatient costs, the Administration shall make a Fund payment to the hospital equal to the difference between the hospital's calculated inpatient costs and the hospital's claims paid amount.
 - 2. The Administration shall reallocate any portion of a hospital's Fund allocation that is not paid to the hospital due to the reason in subsection (E)(1) to the other eligible hospitals in the pool based upon the ratio of the claims paid amount for each hospital remaining in the pool to the sum of the claims paid amount for each hospital remaining in the pool.
- F. If funds remain in a pool after allocations to each hospital in the pool under subsections (D) and (E), the Administration shall reallocate the remaining funds to the other pools based upon the ratio of each pool's original allocation of the Fund as determined under subsection (C) to the sum of the remaining pools' original Fund allocations under subsection (C). The Administration shall allocate remaining funds to the hospitals in the remaining pools under subsection (D) and (E). See Exhibit 1 for an example.
- G. Subject to CMS approval of the method and distribution of the Fund, the administration or its contractors will distribute the Fund as a lump sum allocation to the rural hospitals in either one or two installments by the end of each state fiscal year.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2). Amended by final rulemaking at 22 A.A.R. 3476, effective January 30, 2016 (Supp. 15-4).

Exhibit 1. Pool Example

Pool A receives \$2,000,000. Pool B receives \$7,000,000. Pool C receives \$3,000,000.

If all of the funds in Pool B are paid to eligible hospitals and there is \$1,000,000 remaining, the remaining funds would be allocated to Pool A and Pool C based on the ratio of each pool's original allocation (original allocations of \$2,000,000 and \$3,000,000) to the total of their original allocation (\$2,000,000 + \$3,000,000 = \$5,000,000).

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Pool A would receive 2/5 of the remaining funds (\$400,000) and Pool C would receive 3/5 of the remaining funds (\$600,000).

Historical Note

Exhibit 1 made by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2).

R9-22-712.08. Federally Qualified Health Center and Rural Health Clinic Graduate Medical Education Program

- A.** Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for primary care GME programs approved by the Administration to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) for direct and indirect program costs eligible for funding under A.R.S. § 36-2907.06(I).
1. A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (D).
 2. For purposes of this subsection, the term "FQHC" includes Federally Qualified Health Center Look-Alikes.
- B.** Eligible health care facilities. A health care facility is eligible for a distribution under subsection (G) if all of the following apply:
1. It is an FQHC or RHC in Arizona that is the sponsoring institution of, or a full member of a consortium that is the sponsoring institution of, or a participating institution in, one or more approved primary care GME programs in Arizona;
 2. It incurs direct or indirect costs for the training of residents in Arizona in approved primary care GME programs;
 3. The GME program is not eligible for funding under R9-22-712.05; and
 4. The GME program is not fully funded by the federal government.
- C.** Eligible residents and resident positions. For purposes of determining program allocation amounts under subsections (E) and (F) the following residents and resident positions are eligible for consideration, to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (B):
1. All filled resident positions in approved primary care GME programs; or
 2. For approved primary care GME programs established for less than one year as of the date of annual reporting under subsection (D) and that have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match.
- D.** Annual reporting. By April 1st of each year, an FQHC or RHC seeking a distribution under this subsection shall:
1. Provide to the Administration the following information about each approved primary care GME program:
 - a. The program name and number assigned by the accrediting organization;
 - b. The original date of accreditation of the program;
 - c. The names of the sponsoring institution and all participating institutions current as of the date of reporting;
 - d. The number of approved resident positions and the number of filled resident positions current as of the date of reporting;
 - e. The academic year rotation schedule on file with the program current as of the date of reporting; and
 - f. For programs described under subsection (C)(2), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
2. Provide to the Administration the most recent Medicare Cost Report for the FQHC or RHC seeking the distribution, and
 3. For an FQHC or RHC that is a full member of a consortium that is the sponsoring institution of an approved primary care GME program, provide to the Administration a signed letter attesting to the responsibility of the full member FQHC or RHC for direct or indirect costs of training residents in the program.
- E.** Allocation of funds for direct graduate medical education costs. Annually the Administration shall allocate available funds for direct graduate medical education costs to each eligible FQHC or RHC in the following manner:
1. A Medicaid utilization percent for each FQHC or RHC seeking a distribution shall be calculated using the Medicare Cost Report submitted under subsection (D)(2), dividing the Title XIX visit count by the whole number of visits reported and rounding the result up to the nearest multiple of 5 percent.
 2. A total number of residents eligible for funding in each program shall be calculated using the information submitted under subsection (D)(1), dividing the number of resident rotations in the year that take place in Arizona and not at a health care facility made ineligible under subsection (B) by the total number of resident rotations in the program for that year, multiplying the result by the total number of filled resident positions in the program and rounding to two digits after the decimal.
 3. The allocation for direct graduate medical education costs for each eligible FQHC or RHC shall be calculated by multiplying the number of residents determined under subsection (E)(2) by the statewide average per-resident amount determined under this subsection and multiplying the result by the Medicaid utilization percent calculated for the FQHC or RHC under subsection (E)(1). The statewide average per-resident amount for the academic year ending June 30, 2022 is \$170,090. Annually thereafter, a statewide average per-resident amount shall be calculated by applying the Federally Qualified Health Center PPS Market Basket Update less Productivity Adjustment published by CMS for the calendar year in which the GME academic year begins.
- F.** Allocation of funds for indirect program costs. Annually the Administration shall allocate available funds for indirect program costs to each eligible FQHC or RHC in the following manner:
1. By multiplying the number of residents determined under subsection (E)(2) by the statewide average per-resident amount determined under this subsection and multiplying the result by the Medicaid utilization percent calculated for the FQHC or RHC under subsection (E)(1). The statewide average per-resident amount for the academic year ending June 30, 2022 is \$167,330;
 2. Annually thereafter, a statewide average per-resident amount shall be calculated by applying the Federally Qualified Health Center PPS Market Basket Update less

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Productivity Adjustment published by CMS for the calendar year in which the GME academic year begins.

- G.** Distribution of funds. On an annual basis subject to available funds, the Administration shall distribute to each eligible FQHC and RHC the sum of all amounts calculated for the FQHC or RHC under subsections (E)(3) and (F).
- H.** The Administration may enter into intergovernmental agreements with local, county, and tribal governments and any university under the jurisdiction of the Arizona Board of Regents wherein such entities may transfer funds or certify public expenditures to the Administration. Such funds or certification, subject to approval by CMS, will contribute to the state funding to qualify for federal matching funds. Those funds will be used for the purposes of reimbursing FQHCs and RHCs that are eligible under this rule and designated by the local, county, or tribal governments for receipt of the contributed funds. The Administration shall allocate available funds in accordance with subsections (E) and (F).

Historical Note

New Section made by final rulemaking at 28 A.A.R. 837 (April 29, 2022), with an immediate effective date of April 5, 2022 (Supp. 22-2).

R9-22-712.09. Hierarchy for Tier Assignment through September 30, 2014

TIER	IDENTIFICATION CRITERIA	ALLOWED SPLITS
MATERNITY	A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx.	None
NICU	Revenue Code of 174 and the provider has a Level II or Level III NICU.	Nursery
ICU	Revenue Codes of 200-204, 207-212, or 219.	Surgery Psychiatric Routine
SURGERY	Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list.	ICU
PSYCHIATRIC	Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND primary Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx - 316.xx, classify as a psychiatric claim.	ICU
NURSERY	Revenue Code of 17x, not equal to 174.	NICU
ROUTINE	Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.	ICU

Historical Note

New Section made by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.10. Outpatient Hospital Reimbursement: General

- A.** Effective rule. The outpatient hospital reimbursement rules apply to dates of service beginning July 1, 2005, subject to Laws 2004, Ch. 279, § 19.
- B.** Basis For Payment. Except as provided under R9-22-712.30, AHCCCS shall pay for designated outpatient procedures provided to AHCCCS members according to the AHCCCS Outpatient Capped Fee-For-Service Schedule as defined in R9-22-712.20.
- C.** Data. AHCCCS shall use Medicare Cost Report and adjudicated claim and encounter data from non-IHS acute care hospitals located in the state of Arizona to develop fees for the AHCCCS Outpatient Capped Fee-For-Service Schedule.
- D.** Hospital Services Subject To Fees. AHCCCS shall reimburse services, in the following outpatient hospital categories under the AHCCCS Outpatient Capped Fee-For-Service Schedule:
1. Surgery,
 2. Emergency Department,
 3. Laboratory,
 4. Radiology,
 5. Clinic, and
 6. Other services.
- E.** Reimbursement. AHCCCS shall reimburse outpatient hospital services by procedure codes, in proper combination with revenue codes, as prescribed by AHCCCS.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-712.11. Reserved

R9-22-712.12. Reserved

R9-22-712.13. Reserved

R9-22-712.14. Reserved

R9-22-712.15. Outpatient Hospital Reimbursement: Affected Hospitals

Except as provided in R9-22-712(G), the AHCCCS Outpatient Capped Fee-For-Service Schedule shall apply to AHCCCS payments for outpatient services in all non-IHS acute hospitals.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-712.16. Reserved

R9-22-712.17. Reserved

R9-22-712.18. Reserved

R9-22-712.19. Reserved

R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule

- A.** To establish the AHCCCS Outpatient Capped Fee-for-service Schedule for all claims with a begin date of service on or before September 30, 2011, AHCCCS shall:
1. Define the dataset of claims and encounters that shall be used to establish the AHCCCS Outpatient Capped Fee-for-service Schedule.
 2. Identify all the claims and encounters from non-IHS acute hospitals located in Arizona for services to be paid under the AHCCCS Outpatient Capped Fee-for-service Schedule.

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3. Match the revenue code on each detail of each claim and encounter to the ancillary line item CCR as reported on hospital-specific mapping documents and hospital-specific Medicare Cost Report for those hospitals that have submitted Medicare Cost Reports FYE 2002.
 4. Multiply the line item CCR from subsection (A)(3) by the covered billed charge for that revenue code to establish the cost for the service.
 5. Inflate the cost for the service from subsection (A)(4) using Global Insight Health-care Cost Review inflation factors from date of service month to the midpoint of the rate year in which the fees are initially effective.
 6. Include associated costs under R9-22-712.25 to calculate the rates for emergency room and surgery services.
 7. Combine data from all Arizona hospitals identified in subsection (A)(3) for each procedure code to establish the statewide median cost for each procedure.
 8. Group procedure codes according to the Ambulatory Payment Classification (APC) System groups as listed in 69 FR 65682, November 15, 2004, and establish a statewide median cost for each APC. Multiply each statewide median APC cost by 116 percent to establish the AHCCCS-based fee for each procedure in that specific APC group. AHCCCS shall assign each procedure in the group the same fee.
 9. For those procedure codes that are not grouped into any APC, establish a procedure-specific fee using either:
 - a. The AHCCCS Non-hospital Capped Fee-for-service Fee Schedule,
 - b. 116 percent of the procedure-specific median cost AHCCCS-based fee, or
 - c. The Medicare Clinical Laboratory Fee Schedule for laboratory services.
 10. Compare the AHCCCS-based fee established in subsections (A)(8) and (9) against the comparable Medicare fee established for the Medicare APC group as listed in the 69 FR 65682, November 15, 2004. The fee for each procedure shall be the greater of the AHCCCS-based fee or the Medicare fee but no more than 150 percent of the AHCCCS-based fee; however, for those laboratory services for which a limit is established in the Medicare Clinical Laboratory Fee Schedule, the fee shall not exceed that limit.
 11. Assign the 2005 Medicare fee in the AHCCCS Outpatient Capped Fee-for-service Schedule for those procedures for which there are fewer than 20 occurrences of the procedure code in the dataset, either independently, or, if applicable, for all procedure codes within an APC Group.
- B.** For all claims with a begin date of service on or after October 1, 2011, the AHCCCS Outpatient Capped Fee-for-Service Schedule shall be derived from the CMS Medicare Outpatient Prospective Payment System (OPPS) fee schedule modified by an Arizona conversion factor determined annually.
1. When clinic services are billed using 51X revenue codes, the reimbursement to the hospital is the difference between the facility and non-facility rates payable to the practitioner for the procedures listed in the Administration's Capped Fee-for-service Schedule under R9-22-710.
 2. Observation services, when not billed in conjunction with a service for which a single payment is made under R9-22-712.25, are reimbursed at an hourly rate published in the Outpatient Capped Fee-for-service Schedule. This hourly rate includes reimbursement for associated services.
- C.** The AHCCCS Outpatient Capped Fee-for-service Schedule including the effective date of any changes to the listing are on file and posted on AHCCCS' web site.
- Historical Note**
- New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4).
- R9-22-712.21. Reserved**
- R9-22-712.22. Reserved**
- R9-22-712.23. Reserved**
- R9-22-712.24. Reserved**
- R9-22-712.25. Outpatient Hospital Fee Schedule Calculations: Associated Service Costs**
- A.** AHCCCS shall include the costs of associated services, as defined by revenue codes and procedure codes, when determining the specific fees for the outpatient hospital procedures for emergency department and surgery services.
- B.** Payment made under subsection (A) or R9-22-712.20(B)(2) is inclusive of all services on the claim regardless of whether the services are provided on one or more days.
- C.** A complete listing of the revenue codes and procedure codes for associated costs included in the payment for emergency and surgery services including the effective date of any changes to the listing are on file and posted on AHCCCS' web site.
- Historical Note**
- New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3).
- R9-22-712.26. Reserved**
- R9-22-712.27. Reserved**
- R9-22-712.28. Reserved**
- R9-22-712.29. Reserved**
- R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule**
- A.** AHCCCS shall calculate a statewide CCR for a service where a specific fee cannot be determined under R9-22-712.20.
- B.** For claims with a begin date of service on or before September 30, 2011, the statewide CCR shall be calculated based on the costs and covered charges associated with a service under subsection (A) for all Arizona hospitals, using the method specified in R9-22-712.20(A)(3).
- C.** For all claims with a begin date of service on or after October 1, 2011, the statewide CCR calculation shall equal either the CMS Medicare Outpatient Urban Cost-to-charge Ratio or the CMS Medicare Outpatient Rural Cost-to-charge Ratio published by CMS for the state of Arizona. AHCCCS shall use the urban cost-to-charge ratio for hospitals located in a county of 500,000 residents or more and for out-of-state hospitals. AHCCCS shall use the rural cost-to-charge ratio for hospitals located in a county of fewer than 500,000 residents. On October 1st of each year, AHCCCS shall adjust urban and rural

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CCRs to the CCRs as published by CMS in the *Federal Register* on or before August 1st of that year.

- D. To determine the payment amount for procedures where a specific fee is not determined under R9-22-712.20, the statewide CCR is multiplied by the covered charges.
- E. Reductions to payments for outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule. Outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rate published by CMS pursuant to subsection (C) of this Section.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4).

R9-22-712.31. Reserved

R9-22-712.32. Reserved

R9-22-712.33. Reserved

R9-22-712.34. Reserved

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

- A. For all claims with a begin date of service on or before September 30, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:
 1. By 48 percent for public hospitals on July 1, 2005, and hospitals that were public anytime during the calendar year 2004;
 2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
 3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
 4. By 115 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the criteria during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
 5. By 113 percent for a Freestanding Children's Hospital with at least 110 pediatric beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective; or
 6. By 14 percent for a University Affiliated Hospital which is a hospital that has a majority of the members of its board of directors appointed by the Board of Regents during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective.
- B. For all claims with a begin date of service on or after October 1, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services) for the following hospitals. A hospi-

tal shall receive an increase from only one of the following categories:

1. By 73 percent for public hospitals;
 2. By 31 percent for hospitals in counties other than Maricopa and Pima with more than 100 licensed beds as of October 1 of that contract year;
 3. By 37 percent for hospitals in counties other than Maricopa and Pima with 100 or fewer licensed beds as of October 1 of that contract year;
 4. By 100 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the critical access criteria;
 5. By 78 percent for a Freestanding Children's Hospital with at least 110 pediatric beds as of October 1 of that contract year; or
 6. By 41 percent for a University Affiliated Hospital, this is a hospital that has a majority of the members of its board of directors appointed by the Arizona Board of Regents.
- C. In addition to subsections (A) and (B), an Arizona Level 1 trauma center as defined by R9-22-2101 shall receive a 50 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services and out-of-state hospital services) for Level 2 and 3 emergency department procedures.
 - D. Hospitals with greater than 100 pediatric beds not receiving an increase under subsection (B) shall receive an 18 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services).
 - E. For outpatient services with dates of service from October 1, 2022 through September 30, 2023, the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2022. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.
 1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in (1)(a), (b), (c) or (d):
 - a. By April 1, 2022, the hospital must have submitted a Letter of Intent (LOI) to the Health Information Exchange (HIE) in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved.
 - i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
 - ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
 - (1) Related to COVID-19 testing services,

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- submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system.
- (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
- iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf.
 - iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
 - v. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
 - vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.
 - vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
 - viii. No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
- ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
 - x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:
 - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
 - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
 - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
 - xi. DAP HIE Data Quality Standards CYE 2023 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 0.5% DAP increase for each category of the five measure categories, for a total potential increase of 2.5% if criteria are met for all categories.
 - (1) Data source and data site information must be submitted on all ADT transactions. (0.5%)
 - (2) Event type must be properly coded on all ADT transactions. (0%)
 - (3) Patient class must be properly coded on all appropriate ADT transactions. (0%)
 - (4) Patient demographic information must be submitted on all ADT transactions. (0%)
 - (5) Race must be submitted on all ADT transactions. (0.5%)
 - (6) Ethnicity must be submitted on all ADT transactions. (0.5%)
 - (7) Diagnosis must be submitted on all ADT transactions. (0.5%)
 - (8) Overall completeness of the ADT message. (0%)
 - b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates;
 - i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.
 - ii. No later than April 1, 2022:
 - (1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
 - (2) For hospitals without an active Participa-

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- tion Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
- (3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
- iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.
- c. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
- The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
 - The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
 - The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
 - AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.
 - The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.
 - Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
- d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:
- Number of ICU beds in use,
 - Number of ICU beds available for use,
 - Number of Medical-Surgical beds in use,
 - Number of Medical-Surgical beds available for use,
 - Number of Telemetry beds in use,
 - Number of Telemetry beds available for use.
2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in (2)(a),(b), (c) or (d):
- By April 1, 2022 the hospital must have submitted a LOI to the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:
 - No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
 - No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
 - Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
 - No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider

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- authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.
- iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
 - v. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
 - vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.
 - vii. No later than November 1, 2022, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
 - viii. No later than January 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
 - ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
 - x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:
 - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
 - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
 - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
 - xi. DAP HIE Data Quality Standards CYE 2023 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a DAP increase for select Data Quality Measures for a total of 8.0% if criteria are met for all categories indicating a DAP.
 - (1) Data source and data site information must be submitted on all ADT transactions. (1.0%)
 - (2) Event type must be properly coded on all ADT transactions. (1.0%)
 - (3) Patient class must be properly coded on all appropriate ADT transactions. (0%)
 - (4) Patient demographic information must be submitted on all ADT transactions. (0%)
 - (5) Race must be submitted on all ADT transactions. (2.0%)
 - (6) Ethnicity must be submitted on all ADT transactions. (2.0%)
 - (7) Diagnosis must be submitted on all ADT transactions. (2.0%)
 - (8) Overall completeness of the ADT message. (0%)
 - b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates;
 - i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.
 - ii. No later than April 1, 2022:
 - (1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
 - (2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
 - (3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
 - iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the

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- system by the hospital will be counted towards volume requirements.
- c. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
 - i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
 - ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
 - iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
 - iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.
 - v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.
 - vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
 - d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:
 - i. Number of ICU beds in use,
 - ii. Number of ICU beds available for use,
 - iii. Number of Medical-Surgical beds in use,
 - iv. Number of Medical-Surgical beds available for use,
 - v. Number of Telemetry beds in use, and
 - vi. Number of Telemetry beds available for use.
3. A hospital designated as type: hospital, subtype: long term, psychiatric, or rehabilitation by the Arizona Department of Health Services Division of Licensing Services will qualify for an increase if it meets the criteria specified in (3)(a), (b), (c), (d), (e), or (f):
 - a. In order to qualify, by April 1, 2022 the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:
 - i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
 - ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
 - (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
 - iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.
 - iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the facility has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge

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- instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
- v. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
 - vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization or an Advance Directives Registry platform operated by the qualifying HIE organization.
 - vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
 - viii. No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
 - ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
 - x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to DAP increases described below.
 - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
 - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
 - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
 - xi. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 0.5% DAP increase for each category of the five measure categories, for a total potential increase of 2.0% if criteria are met for all categories.
 - (1) Data source and data site information must be submitted on all ADT transactions. (0.5%)
 - (2) Event type must be properly coded on all ADT transactions. (0%)
 - (3) Patient class must be properly coded on all appropriate ADT transactions. (0%)
 - (4) Patient demographic information must be submitted on all ADT transactions. (0%)
 - (5) Race must be submitted on all ADT transactions. (0.5%)
 - (6) Ethnicity must be submitted on all ADT transactions. (0.5%)
 - (7) Diagnosis must be submitted on all ADT transactions. (0.5%)
 - (8) Overall completeness of the ADT message. (0%)
 - b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates;
 - i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.
 - ii. No later than April 1, 2022:
 - (1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
 - (2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
 - (3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
 - iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.
 - c. On March 15, 2022 is identified as a Medicare Annual Payment Update recipients on the QualityNet.org website. APU recipients are those facilities that satisfactorily met the requirements for the IPFQR program, which includes multiple clinical quality measures. Facilities identified as APU recipients will qualify for the DAP increase.
 - d. On March 15, 2022 meets or falls below the national average for the rate of pressure ulcers that are new or worsened from the Medicare Provider Data Catalog website for long-term care hospitals. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.
 - e. On March 15, 2022 meets or falls below the national average for the rate of pressure ulcers that are new or

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- worsened from the Medicare Provider Data Catalog website for rehabilitation hospitals. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.
- f. By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
 - i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
 - ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
 - iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
 - iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.
 - v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022, through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.
 - vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
 4. A hospital designated as type: hospital, subtype: long term or rehabilitation by the Arizona Department of Health Services Division of Licensing Services will qualify for an increase if it meets the following criteria. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:
 - i. Number of ICU beds in use,
 - ii. Number of ICU beds available for use,
 - iii. Number of Medical-Surgical beds in use,
 - iv. Number of Medical-Surgical beds available for use,
 - v. Number of Telemetry beds in use, and
 - vi. Number of Telemetry beds available for use.
 5. A hospital designated as type: hospital by the Arizona Department of Health Services Division of Licensing Services and is owned and/or operated by Indian Health Services (IHS) or under Tribal authority will qualify for an increase if it meets these criteria specified in (5)(a) or (b);
 - a. By April 1, 2022 the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:
 - i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
 - ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
 - (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
 - iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.
 - iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the facility has an emergency department; laboratory and radiology information (if the provider

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- has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If the hospital has ambulatory and/or behavioral health practices, then the facility must submit the following actual patient identifiable information to the production environment of a qualifying HIE: registration, encounter summary, and SMI data elements as defined by the qualifying HIE organization. For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
- v. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
 - vi. No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
 - vii. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
 - viii. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:
 - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
 - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
 - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
 - ix. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a DAP increase for select Data Quality Measures for a total of 2.5% if criteria are met for all categories indicating a DAP.
 - (1) Data source and data site information must be submitted on all ADT transactions. (0.5%)
 - (2) Event type must be properly coded on all ADT transactions. (0.5%)
 - (3) Patient class must be properly coded on all appropriate ADT transactions. (0.5%)
 - (4) Patient demographic information must be submitted on all ADT transactions. (0.5%)
 - (5) Overall completeness of the ADT message. (0.5%)
 - b. By March 15, 2022, the facility must submit a LOI to enter into a CCA with a non-HIS/638 facility (a fully signed copy of a CCA with a non-HIS/Tribal 638 facility is also acceptable). By April 30, 2021, the facility must have entered into a CCA with a non-IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities: The IHS/Tribal 638 facility will have in place a signed CCA with a non-IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
 - i. The IHS/Tribal 638 facility will have a valid referral template in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
 - ii. The IHS/Tribal 638 facility will continue to assume responsibility of the referred member, maintaining records and release of information protocol including clinical documentation of services provided by the non-IHS/Tribal 638 facility.
 - iii. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the IHS/Tribal 638 facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2021.
 - iv. The IHS/638 facility will submit a minimum of one referral and any supporting medical documentation to the non-IHS/Tribal 638 facility by September 1, 2022. During CYE 2023, from October 1, 2022, through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA referrals per month to the non-IHS/Tribal 638 facility.
 - v. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA referrals to the non-IHS/Tribal 638 facility by March 15, 2022, and submit an average of 5 CCA referrals per month by May 31, 2022.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 3584, effective October 1, 2007 (Supp. 07-4). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2338, effective October 1, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2851, effective October 1, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3114, effective October 1, 2019 (Supp. 19-4).

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Amended by final rulemaking at 26 A.A.R. 3025, with an immediate effective date of November 3, 2020 (Supp. 20-4). AHCCCS filed an incorrect version of a final rulemaking which made amendments to this Section published at 27 A.A.R. 2501 (October 29, 2021); AHCCCS filed the correct version of its final rulemaking on December 3, 2021, with this Section amended by final rulemaking at 27 A.A.R. 3015 (December 31, 2021), effective October 1, 2021 (Supp. 21-4). Amended by final rulemaking at 28 A.A.R. 3283 (October 14, 2022), with an immediate effective date of September 23, 2022 (Supp. 22-3).

R9-22-712.36. Reserved**R9-22-712.37. Reserved****R9-22-712.38. Reserved****R9-22-712.39. Reserved****R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update**

- A. Procedure codes. When procedure codes are issued by CMS and added to the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add to the Outpatient Capped Fee-for-Service Schedule the new procedure codes for covered outpatient services and shall either assign the default CCR under R9-22-712.40(F)(2), the Medicare rate, or calculate an appropriate fee.
- B. APC changes. AHCCCS may reassign procedure codes to new or different APC groups when APC groups are revised by CMS. AHCCCS may reassign procedure codes to a different APC group than Medicare. If AHCCCS determines that utilization of a procedure code within the Medicare program is substantially different from utilization of the procedure code in the AHCCCS program, AHCCCS may choose not to assign the procedure code to any APC group. For procedure codes not grouped into an APC by Medicare, AHCCCS may assign the code to an APC group when AHCCCS determines that the cost and resources associated with the non-assigned code are substantially similar to those in the APC group.
- C. Annual update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, through September 30, 2011, AHCCCS shall adjust outpatient fee schedule rates:
 1. Annually by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or
 2. In a particular year the director may substitute the increases in subsection (C)(1) by calculating the dollar value associated with the inflation index in subsection (C)(1), and applying the dollar value to adjust rates at varying levels.
- D. Reductions to the Outpatient Capped Fee-For-Service Schedule. Claims paid using the Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rates in effect on September 30, 2011, subject to the annual adjustments to procedure codes and APCs under this Section.
- E. Rebase. AHCCCS shall rebase the outpatient fees every five years.
- F. Statewide CCR:
 1. For begin dates of service on or before September 30, 2011, the statewide CCR calculated in R9-22-712.30 shall be recalculated at the time of rebasing. When rebasing, AHCCCS may recalculate the statewide CCR based

on the costs and charges for services excluded from the outpatient hospital fee schedule.

2. For begin dates of service on or after October 1, 2011, the statewide CCR shall be set under R9-22-712.30(C).

- G. Other Updates. In addition to the other updates provided for in this Section, the Administration may adjust the Outpatient Capped Fee-For-Service Fee Schedule and the Statewide CCR to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 3584, effective October 1, 2007 (Supp. 07-4). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.41. Reserved**R9-22-712.42. Reserved****R9-22-712.43. Reserved****R9-22-712.44. Reserved****R9-22-712.45. Outpatient Hospital Reimbursement: Outpatient Payment Restrictions**

- A. AHCCCS shall not reimburse hospitals for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis if the member is admitted as an inpatient to the same hospital directly from the emergency room, observation, or other outpatient department.
- B. AHCCCS shall include payment for the emergency room, observation, and other outpatient hospital services provided to the member before the hospital admission in the AHCCCS Inpatient Tiered Per Diem Capped Fee-For-Service Schedule under Article 7 of this Chapter.
- C. Same day admit and discharge.
 1. For discharges before September 30, 2014. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.
 2. For discharge dates on and after October 1, 2014. Same day admit and discharge claims are paid for through the outpatient fee schedule.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.46. Reserved**R9-22-712.47. Reserved****R9-22-712.48. Reserved****R9-22-712.49. Reserved**

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R9-22-712.50. Outpatient Hospital Reimbursement: Billing

To receive appropriate reimbursement, hospitals shall:

1. Bill outpatient hospital services on the CMS approved Uniform Billing Form or in electronic format using the appropriate HIPAA transaction.
2. Follow the UB Manual Guidelines, as published by the National Uniform Billing Committee, and use the appropriate revenue code and procedure code combination as prescribed by AHCCCS and on file and online with AHCCCS.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-712.51. Reserved

R9-22-712.52. Reserved

R9-22-712.53. Reserved

R9-22-712.54. Reserved

R9-22-712.55. Reserved

R9-22-712.56. Reserved

R9-22-712.57. Reserved

R9-22-712.58. Reserved

R9-22-712.59. Reserved

R9-22-712.60. Diagnosis Related Group Payments

- A. Inpatient hospital services with discharge dates on or after October 1, 2014, shall be reimbursed using the diagnosis related group (DRG) payment methodology described in this Section and R9-22-712.61 through R9-22-712.81.
- B. Payments made using the DRG methodology shall be the sole reimbursement to the hospital for all inpatient hospital services and related supplies provided by the hospital. Services provided in the emergency room, observation area, or other outpatient departments that are directly followed by an inpatient admission to the same hospital are not reimbursed separately. Are reimbursed through the DRG methodology and not reimbursed separately.
- C. Each claim for an inpatient hospital stay shall be assigned a DRG code and a DRG relative weight based on the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. The applicable version of the APR-DRG classification system shall be available on the agency's website.
- D. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to quick pay discounts and slow pay penalties under A.R.S. 36-2904.
- E. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to the Urban Hospital Reimbursement Program under R9-22-718.
- F. For purposes of this Section and Sections R9-22-712.61 through R9-22-712.81:
 1. "DRG National Average length of stay" means the national arithmetic mean length of stay published in the All Patient Refined Diagnosis Related Group (APR-DRG) classification established by 3M Health Information Systems.
 2. "Length of stay" means the total number of calendar days of an inpatient stay beginning with the date of admission through discharge, but not including the date of discharge (including the date of a discharge to another hospital, i.e., a transfer) unless the member expires.

3. "Medicare" means Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.
4. "Medicare labor share" means a hospital's labor costs as a percentage of its total costs as determined by CMS for purposes of the Medicare Inpatient Prospective Payment System.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.61. DRG Payments: Exceptions

- A. Notwithstanding section R9-22-712.60, claims for inpatient services from the following hospitals shall be paid on a per diem basis, including provisions for outlier payments, where rates and outlier thresholds are included in the capped fee schedule published by the Administration on its website and available for inspection during normal business hours at 801 E. Jefferson, Phoenix, Arizona. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The outlier CCR will be the sum of the urban or rural default operating CCR appropriate to the location of the hospital and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. The resulting amount will be the total reimbursement for the claim. There is no provision for outlier payments for hospitals described under subsection (A)(3).
 1. Hospitals designated as type: hospital, subtype; rehabilitation in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website in March of each year;
 2. Hospitals designated as type: hospital, subtype: long term in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
 3. Hospitals designated as type: hospital, subtype; psychiatric in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year.
- B. Notwithstanding Section R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the principal diagnosis on the claim is a behavioral health diagnosis, shall be reimbursed as prescribed by a per diem rate described by a fee schedule established by the Administration; however, if the principal diagnosis is a physical health diagnosis, the claim shall be processed under the DRG methodology described in this Section, even if behavioral health services are provided during the inpatient stay.
- C. Notwithstanding Section R9-22-712.60, claims for services associated with transplant services shall be paid in accordance with the contract between the AHCCCS administration and the transplant facility.
- D. Notwithstanding Section R9-22-712.60, claims from an IHS facility or 638 Tribal provider shall be paid the all-inclusive rate on a per visit basis in accordance with the rates published annually by IHS in the federal register.

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- E. For hospitals that have contracts with the Administration for the provision of transplant services, inpatient days associated with transplant services are paid in accordance with the terms of the contract.
- F. For inpatient services with a date of admission from October 1, 2022 through September 30, 2023, provided by a hospital in subsection (A) that qualifies, the administration shall pay the hospital an Inpatient Differential Adjusted Payment equal to the sum of the payment otherwise provided for in subsection (A) plus the product of the amount otherwise provided for in subsection (A) and a percentage published on the Administration's public website as part of its fee schedule, subsequent to a public notice published no later than September 1, 2022. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.
1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c), or (d):
 - a. By April 1, 2022, a hospital the hospital must have submitted a Letter of Intent (LOI) to AHCCCS and the Health Information Exchange (HIE), in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved.
 - i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
 - ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
 - (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
 - iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf.
 - iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
 - v. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
 - vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.
 - vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
 - viii. No later than January 1, 2023, the hospital must complete the data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
 - ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
 - x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:
 - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2022 data, to the final data quality profile, based on March 2022 data.
 - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
 - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria, regardless of the percentage improvement

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- from the baseline measurements.
- xi. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 0.5% DAP increase for each category of the five measure categories, for a total potential increase of 2.0% if criteria are met for all categories.
 - (1) Data source and data site information must be submitted on all ADT transactions. (0.5%)
 - (2) Event type must be properly coded on all ADT transactions. (0%)
 - (3) Patient class must be properly coded on all appropriate ADT transactions. (0%)
 - (4) Patient demographic information must be submitted on all ADT transactions. (0%)
 - (5) Race must be submitted on all ADT transactions. (0.5%)
 - (6) Ethnicity must be submitted on all ADT transactions. (0.5%)
 - (7) Diagnosis must be submitted on all ADT transactions. (0.5%)
 - (8) Overall completeness of the ADT message. (0%)
 - b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates;
 - i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.
 - ii. No later than April 1, 2022:
 - (1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
 - (2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
 - (3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
 - iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.
 - c. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
 - i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
 - ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
 - iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
 - iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.
 - v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.
 - vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
 - d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:
 - i. Number of ICU beds in use,
 - ii. Number of ICU beds available for use,
 - iii. Number of Medical-Surgical beds in use,
 - iv. Number of Medical-Surgical beds available for use,
 - v. Number of Telemetry beds in use, and
 - vi. Number of Telemetry beds available for use.
2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for

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an increase if it meets the criteria specified in subsection (2)(a), (b), (c), or (d):

- a. By April 1, 2022 the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:
 - i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
 - ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
 - (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
 - iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.
 - iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
- v. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
- vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.
- vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
- viii. No later than January 1, 2023, the hospital must complete the data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
- ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
- x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below.
 - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
 - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
 - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
- xi. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a DAP increase for select Data Quality Measures for a total of 8.0% if criteria are met for all categories indicating a DAP.
 - (1) Data source and data site information must be submitted on all ADT transactions. (2.0%)
 - (2) Event type must be properly coded on all ADT transactions. (0%)
 - (3) Patient class must be properly coded on all appropriate ADT transactions. (0%)
 - (4) Patient demographic information must be submitted on all ADT transactions. (0%)
 - (5) Race must be submitted on all ADT transactions. (2.0%)
 - (6) Ethnicity must be submitted on all ADT transactions. (2.0%)

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- (7) Diagnosis must be submitted on all ADT transactions. (2.0%)
 - (8) Overall completeness of the ADT message. (0%)
- b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates.
 - i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.
 - ii. No later than April 1, 2022:
 - (1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
 - (2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
 - (3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
 - iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.
- c. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
 - i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
 - ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
 - iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
 - iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.
 - v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.
 - vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
 - d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:
 - i. Number of ICU beds in use,
 - ii. Number of ICU beds available for use,
 - iii. Number of Medical-Surgical beds in use,
 - iv. Number of Medical-Surgical beds available for use,
 - v. Number of Telemetry beds in use, and
 - vi. Number of Telemetry beds available for use.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2338, effective October 1, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2851, effective October 1, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3111 and at 25 A.A.R. 3114, effective October 1, 2019 (Supp. 19-4). Amended by final rulemaking at 26 A.A.R. 3025, with an immediate effective date of November 3, 2020 (Supp. 20-4). AHCCCS filed an incorrect version of a final rulemaking which made amendments to this Section published at 27 A.A.R. 2501 (October 29, 2021); AHCCCS filed the correct version of its final rulemaking on December 3, 2021, with this Section amended by final rulemaking at 27 A.A.R. 3015 (December 31, 2021), effective October 1, 2021 (Supp. 21-4). Amended by final rulemaking at 28 A.A.R. 3283 (October 14, 2022), with an immediate effective date of September 23, 2022 (Supp. 22-3).

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R9-22-712.62. DRG Base Payment

- A. The initial DRG base payment is the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code assigned to the claim, and any applicable provider and service policy adjusters.
- B. The DRG base rate for each hospital is the statewide standardized amount of which the hospital's labor-related share of that amount is adjusted by the hospital's wage index. The hospital's labor share is determined based on the labor share for the Medicare inpatient prospective payment system published in 85 Fed. Reg. 59060 through 59061 (September 18, 2020). The hospital's wage index is determined based on the wage index tables reference in 85 Fed. Reg. 59059 (September 18, 2020). The statewide standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.
- C. Claims shall be assigned both a DRG code derived from all diagnosis and surgical procedure codes included on the claim (the "pre-HCAC" DRG code) and a DRG code derived excluding diagnosis and surgical procedure codes associated with the health care acquired conditions that were not present on admission or any other provider-preventable conditions (the "post-HCAC" DRG code). The DRG code with the lower relative weight shall be used to process claims using the DRG methodology.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4). Amended by final rulemaking at 27 A.A.R. 2512 (October 29, 2021), with an immediate effective date of October 6, 2021 (Supp. 21-4).

R9-22-712.63. DRG Base Payments Not Based on the Statewide Standardized Amount

- A. Notwithstanding Section R9-22-712.62, a select specialty hospital standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) to calculate the DRG base rate for the following hospitals:
 - 1. Hospitals located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2011 Medicare Cost Report are reimbursed by Medicare.
 - 2. Hospitals designated as type: hospital, subtype: short term that has a license number beginning "SH" in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year.
- B. The select specialty hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.
- C. Notwithstanding Section R9-22-712.62, a rural hospital standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) to calculate the DRG base rate for the following hospitals:
 - 1. A health care institution that is licensed as an acute care hospital, that has one hundred or fewer beds, and that is located in a county with a population of less than five hundred thousand persons; or
 - 2. A health care institution that is licensed as a critical access hospital.
- D. The rural hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.

- E. Notwithstanding Section R9-22-712.62 and R9-22-712.63(B), a hospital standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) or R9-22-712.63(B) to calculate the DRG base rate for a health care institution that is licensed as an acute care hospital, that has one hundred or fewer beds, that is located in a county with a population of less than five hundred thousand persons and has greater than twenty percent of Medicaid inpatient reimbursement with a primary diagnosis of behavioral health in the prior federal fiscal year as of April 30th.
- F. The hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.
- G. Notwithstanding Section R9-22-712.62 and R9-22-712.63(B), a hospital standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) or R9-22-712.63(B) to calculate the DRG base rate for a health care institution with two separate ADHS acute care hospital licenses, with one facility that has one hundred or fewer beds, that is located in a county with a population of less than five hundred thousand persons and has one single AHCCCS registration for both licenses.
- H. The hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4). Amended by final rulemaking at 29 A.A.R. 19 (January 6, 2023), with an immediate effective date of December 16, 2022 (Supp. 22-4).

R9-22-712.64. DRG Base Payments and Outlier CCR for Out-of-State Hospitals

- A. DRG Base payment:
 - 1. For high volume out-of-state hospitals defined in subsection (C), the wage adjusted DRG base payment is determined as described in R9-22-712.62.
 - 2. Notwithstanding subsection R9-22-712.62 the wage adjusted DRG base rate for out-of-state hospitals that are not high volume hospitals shall be included in the AHCCCS capped fee schedule available on the agency's website.
- B. Outlier CCR:
 - 1. Notwithstanding subsection R9-22-712.68, the CCR used for the outlier calculation for out-of-state hospitals that are not high volume hospitals shall be the sum of the statewide urban default operating cost-to-charge ratio and the statewide capital CCR in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
 - 2. The CCR used for the outlier calculation for high volume out-of-state hospitals is the same as in-state hospitals as described in R9-22-712.68.
- C. A high volume out-of-state hospital is a hospital not otherwise excluded under R9-22-712.61, that is located in a county that borders the State of Arizona and had 500 or more AHCCCS covered inpatient days for the fiscal year beginning October 1, 2015.
- D. Other than as required by this Section, DRG reimbursement for out-of-state hospitals is determined under R9-22-712.60 through R9-22-712.81.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final

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rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.65. DRG Provider Policy Adjustor

- A. After calculating the DRG base payment as required in R9-22-712.62, R9-22-712.63, or R9-22-712.64, for claims from a high-utilization hospital, the product of the DRG base rate and the DRG relative weight for the post-HCAC DRG code shall be multiplied by a provider policy adjustor that is included in the AHCCCS capped fee schedule available on the agency's website.
- B. A hospital is a high-utilization hospital if the hospital had:
 1. Covered inpatient days subject to DRG reimbursement, determined using adjudicated claim and encounter data during the fiscal year beginning October 1, 2015, equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals;
 2. A Medicaid inpatient utilization rate greater than 30 percent calculated as the ratio of AHCCCS-covered inpatient days to total inpatient days as reported in the hospital's Medicare Cost Report for the fiscal year ending 2016; and,
 3. Received less than \$2 million in add-on payment for outliers under R9-22-712.68, based on adjudicated claims and encounters for fiscal year beginning October 1, 2015.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.66. DRG Service Policy Adjustor

In addition to Section R9-22-712.65, for claims with DRG codes in the following categories, the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code, and the DRG provider policy adjustor shall be multiplied by the service policy adjustor listed in the AHCCCS capped fee schedule, available on the agency's website, corresponding to the following DRG codes:

1. Normal newborn DRG codes,
2. Neonates DRG codes,
3. Obstetrics DRG codes,
4. Psychiatric DRG codes,
5. Rehabilitation DRG codes,
6. Burn DRG codes.
7. Claims for members under age 19 assigned DRG codes other than listed above:
 - a. For dates of discharge occurring on or after October 1, 2014 and ending no later than December 31, 2015 regardless of severity of illness level,
 - b. For dates of discharge on or after January 1, 2016, for severity of illness levels 1 and 2,
 - c. For dates of discharge on or after January 1, 2016 and before January 1, 2017, for severity of illness levels 3 and 4.
 - d. For dates of discharge on or after January 1, 2017, and before January 1, 2018 for severity of illness levels 3 and 4.
 - e. For dates of discharge on or after January 1, 2018, for severity of illness levels 3 and 4.
8. Claims for members assigned DRG codes other than listed above.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.67. DRG Reimbursement: Transfers

- A. For purposes of this Section a "transfer" means the transfer of a member from a hospital to a short-term general hospital for inpatient care, a designated cancer center, children's hospital, or a critical access hospital except when a member is moved for the purpose of receiving sub-acute services.
- B. Designated cancer center or children's hospitals are those hospitals identified as such in the UB-04 billing manual published by the National Uniform Billing Committee.
- C. The hospital the member is transferred from shall be reimbursed either the initial DRG base payment or the transfer DRG base payment, whichever is less.
- D. The transfer DRG base payment is an amount equal to the initial DRG base payment, as determined after making any provider or service policy adjustors, divided by the DRG National Average length of stay for the DRG code multiplied by the sum of one plus the length of stay.
- E. The hospital the member is transferred to shall be reimbursed under the DRG payment methodology without a reduction due to the transfer.
- F. Unadjusted DRG base payment. The unadjusted DRG base payment is either the initial DRG base payment, as determined after making any provider or service policy adjustors, or the transfer DRG base payment, whichever is less.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4).

R9-22-712.68. DRG Reimbursement: Unadjusted Outlier Add-on Payment

- A. Claims for inpatient hospital services qualify for an outlier add-on payment if the claim cost exceeds the outlier cost threshold.
- B. The claim cost is determined by multiplying covered charges by an outlier CCR as described by the following subsections:
 1. For hospitals designated as type: hospital, subtype: children's in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year. The outlier CCR will be calculated by dividing the hospital total costs by the total charges using the most recent Medicare Cost Report available as of September 1 of that year.
 2. For Critical Access Hospitals the outlier CCR will be the sum of the statewide rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
 3. For all other hospitals the outlier CCR will be the sum of the operating cost-to-charge ratio and the capital cost-to-charge ratio established for each hospital in the impact file established as part of the Medicare Inpatient Prospective Payment System by CMS.
- C. AHCCCS shall update the CCRs described in subsection (B) to conform to the most recent CCRs established by CMS as of September 1 of each year, and the CCRs so updated shall be

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used for claims with dates of discharge on or after October 1 of that year.

- D. The outlier threshold is equal to the sum of the unadjusted DRG base payment plus the fixed loss amount. The fixed loss amount for critical access hospitals and for all other hospitals are included in the AHCCCS capped fee schedule available on the agency's website.
- E. For those inpatient hospital claims that qualify for an outlier add-on payment, the payment is calculated by subtracting the outlier threshold from the claim cost and multiplying the result by the DRG marginal cost percentage. The DRG marginal cost percentage for claims assigned DRG codes associated with the treatment of burns and for all other claims are included in the AHCCCS capped fee schedule available on the agency's website.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.69. DRG Reimbursement: Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment

Adjustments to the payments are made to account for days not covered by AHCCCS as follows:

1. A covered day reduction factor unadjusted is determined if the member is not eligible on the first day of the inpatient stay but is eligible for subsequent days during the inpatient stay. In this case, a covered day reduction factor unadjusted is calculated by dividing the number of AHCCCS covered days by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of days the member is eligible during the inpatient stay.
2. A covered day reduction factor unadjusted is also determined if the member is eligible on the first day of the inpatient stay but is determined ineligible for one or more days prior to the date of discharge. In this case, a covered day reduction factor unadjusted is calculated by adding one to the number of AHCCCS covered days and dividing the result by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of days the member is eligible during the inpatient stay.
3. If the covered day reduction factor unadjusted is greater than one, then the covered day reduction factor final is one; otherwise, the covered day reduction factor final is equal to the covered day reduction factor unadjusted.
4. The covered day adjusted DRG base payment is an amount equal to the product of the unadjusted DRG base payment and the covered day reduction factor final.
5. The covered day adjusted DRG outlier add-on payment is an amount equal to the product of the unadjusted DRG outlier add-on payment and the covered day reduction factor final.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.70. Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment for FES

members

In addition to the covered day reduction factor in R9-22-712.69, a covered day reduction factor unadjusted is determined for an inpatient stay during which an FES member receives services for the treatment of an emergency medical condition and also receives services once the condition no longer meets the criteria as an emergency medical condition described in R9-22-217.

1. A covered day reduction factor unadjusted is calculated by adding one to the AHCCCS covered days and dividing the result by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of inpatient days during which an FES member receives services for an emergency medical condition as described in R9-22-217. For purposes of this adjustment, any portion of a day during which the FES member receives treatment for an emergency medical condition is counted as an AHCCCS covered day.
2. If the covered day reduction factor unadjusted is greater than one, then the covered day reduction factor final is one; otherwise, the covered day reduction factor final is equal to the covered day reduction factor unadjusted.
3. The covered day adjusted DRG base payment is an amount equal to the product of the unadjusted DRG base payment and the covered day reduction factor final.
4. The covered day adjusted DRG outlier add-on payment is an amount equal to the product of the unadjusted DRG outlier add-on payment and the covered day reduction factor final.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.71. Final DRG Payment

- A. The final DRG payment is the sum of the final DRG base payment, the final DRG outlier add-on payment, and the Differential Adjusted Payment.
- B. The final DRG base payment is an amount equal to the product of the covered day adjusted DRG base payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.
- C. The final DRG outlier add-on payment is an amount equal to the product of the covered day adjusted DRG outlier add-on payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.
- D. The factor for each hospital and for each federal fiscal year is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS administration's website and is on file for public inspection at the AHCCCS administration located at 801 E. Jefferson Street, Phoenix, Arizona.
- E. For inpatient services with a date of discharge from October 1, 2022 through September 30, 2023, the Inpatient Differential Adjusted Payment is the sum of the final DRG base payment and the final DRG outlier add-on payment multiplied by a percentage published on the Administration's public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2022. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.

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1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria:
 - a. By April 1, 2022, a hospital the hospital must have submitted a Letter of Intent (LOI) to AHCCCS and the Health Information Exchange (HIE), in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved.
 - i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
 - ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
 - (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
 - iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf.
 - iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
 - v. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
 - vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.
 - vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
 - viii. No later than January 1, 2023, the hospital must complete the data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
 - ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
 - x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below.
 - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
 - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
 - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
 - xi. DAP HIE Data Quality Standards CYE 2023 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 0.5% DAP increase for each category of the five measure categories, for a total potential increase of 2.0% if criteria are met for all categories.
 - (1) Data source and data site information must be submitted on all ADT transactions. (0.5%)
 - (2) Event type must be properly coded on all ADT transactions. (0%)
 - (3) Patient class must be properly coded on all appropriate ADT transactions. (0%)
 - (4) Patient demographic information must be submitted on all ADT transactions. (0%)

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- (5) Race must be submitted on all ADT transactions. (0.5%)
 - (6) Ethnicity must be submitted on all ADT transactions. (0.5%)
 - (7) Diagnosis must be submitted on all ADT transactions. (0.5%)
 - (8) Overall completeness of the ADT message. (0%)
- b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates.
 - i. No later than April 1, 2022, submit registration form or forms for participation using the form or forms on the website of the qualifying HIE organization.
 - ii. No later than April 1, 2022:
 - (1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
 - (2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
 - (3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
 - iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.
- c. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
 - i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
 - ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
- iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
 - iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.
 - v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.
 - vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
- d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:
 - i. Number of ICU beds in use,
 - ii. Number of ICU beds available for use,
 - iii. Number of Medical-Surgical beds in use,
 - iv. Number of Medical-Surgical beds available for use,
 - v. Number of Telemetry beds in use,
 - vi. Number of Telemetry beds available for use.
- 2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets the criteria specified;
 - a. By April 1, 2022 the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:
 - i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
 - ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective

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- COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
- (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
 - (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
- iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.
 - iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
 - v. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
 - vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.
 - vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
 - viii. No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
 - ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
 - x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below.
 - (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
 - (2) Meet a minimum performance standard of at least 60% based on March 2022 data.
 - (3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
 - xi. DAP HIE Data Quality Standards CYE 2023 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a DAP increase for select Data Quality Measures for a total of 8.0% if criteria are met for all categories indicating a DAP.
 - (1) Data source and data site information must be submitted on all ADT transactions. (1.0%)
 - (2) Event type must be properly coded on all ADT transactions. (1.0%)
 - (3) Patient class must be properly coded on all appropriate ADT transactions. (0%)
 - (4) Patient demographic information must be submitted on all ADT transactions. (0%)
 - (5) Race must be submitted on all ADT transactions. (2.0%)
 - (6) Ethnicity must be submitted on all ADT transactions. (2.0%)
 - (7) Diagnosis must be submitted on all ADT transactions. (2.0%)
 - (8) Overall completeness of the ADT message. (0%)
 - b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates;
 - i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.
 - ii. No later than April 1, 2022:
 - (1) For hospitals with an active Participation

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- Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
- (2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
 - (3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.
- iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.
 - c. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
 - i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
 - ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
 - iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
 - iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.
 - v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.
 - vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
 - d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:
 - i. Number of ICU beds in use,
 - ii. Number of ICU beds available for use,
 - iii. Number of Medical-Surgical beds in use,
 - iv. Number of Medical-Surgical beds available for use,
 - v. Number of Telemetry beds in use, and
 - vi. Number of Telemetry beds available for use.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2338, effective October 1, 2017 (Supp. 17-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4). Amended by final rulemaking at 24 A.A.R. 2851, effective October 1, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3114, effective October 31, 2019 (Supp. 19-4). Amended by final rulemaking at 26 A.A.R. 3025, with an immediate effective date of November 3, 2020 (Supp. 20-4). AHCCCS filed an incorrect version of a final rulemaking which made amendments to this Section published at 27 A.A.R. 2501 (October 29, 2021); AHCCCS filed the correct version of its final rulemaking on December 3, 2021, with this Section amended by final rulemaking at 27 A.A.R. 3015 (December 31, 2021), effective October 1, 2021 (Supp. 21-4). Amended by final rulemaking at 28 A.A.R. 3283 (October 14, 2022), with an immediate effective date of September 23, 2022 (Supp. 22-3).

R9-22-712.72. DRG Reimbursement: Enrollment Changes During an Inpatient Stay

- A. If a member's enrollment changes during an inpatient stay, including changing enrollment from fee-for-service to a contractor, or vice versa, or changing from one contractor to another contractor, the contractor with whom the member is enrolled on the date of discharge shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in Sections R9-22-712.60 through R9-22-712.81. If the member is eligible but not enrolled with a contractor on the date of discharge, then the AHCCCS administration shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in Sections R9-22-712.60 through R9-22-712.81.
- B. When a member's enrollment changes during an inpatient stay, the hospital shall use the date of enrollment with the payer

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responsible on the date of discharge as the “from” date of service on the claim regardless of the date of admission.

- C. Interim claims submitted to a payer other than the payer responsible on the day of discharge shall be processed in the same manner as other interim claims as described in R9-22-712.76.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.73. DRG Reimbursement: Inpatient Stays for Members Eligible for Medicare

If the hospital receives less than the full Medicare payment for a member eligible for benefits under Part A of Medicare because the member has exceeded the maximum benefit permitted under Part A of Medicare, the hospital shall submit a separate claim for services performed after the date the maximum Medicare Part A benefit is exceeded. The claim may include all diagnosis codes for the entire inpatient stay, but the hospital is only required to include revenue codes, surgical procedure codes, service units, and charges for services performed after the date the Medicare Part A benefit is exceeded. A claim so submitted shall be reimbursed using the DRG payment methodology.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.74. DRG Reimbursement: Third Party Liability

DRG payments are subject to reduction based on cost avoidance under Section R9-22-1003 and other rules regarding first- and third-party liability under Article 10 of this Chapter including cost avoidance for claims for ancillary services covered under Part B of Medicare.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.75. DRG Reimbursement: Payment for Administrative Days

- A. Categories of Administrative Days. Administrative days fall into one of two categories, either subsection (A)(1) or (A)(2).
1. Administrative days due to lack of appropriate placement options and not meeting inpatient medical criteria. Administrative days are days in which a member is admitted as an inpatient to an acute care hospital, does not meet the criteria for an acute inpatient stay, but is admitted or not discharged because; (1) an appropriate placement outside the hospital is not available, (2) the member cannot be safely discharged or transferred, or (3) the Administration or the contractor failed to provide for the appropriate placement outside the hospital in a timely manner.
 - a. Administrative days may occur prior to an acute care episode, for example, when a woman with a high-risk pregnancy is admitted to a hospital while awaiting delivery.
 - b. Administrative days may also occur at the end of an acute care episode, for example, when a member is not discharged while awaiting placement in a nursing facility or other sub-acute or post-acute setting.
 - c. Administrative days may also include days in a receiving hospital when the member has been dis-

charged from one acute care hospital for the purpose of receiving sub-acute services at the receiving hospital.

- d. Administrative days do not include days when the member is awaiting appropriate placement or services that are currently available but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays.
 - e. Administrative days include inpatient claims covered by a RBHA or TRBHA that otherwise meet the criteria in subsection (A)(1).
2. Administrative days for claims with the principal diagnosis of behavioral health meeting inpatient medical criteria. Administrative days are days with dates of discharge on or after October 1, 2018, in which a member is admitted as an inpatient to an acute care hospital, meets the criteria for an acute inpatient stay, and the principal diagnosis on the hospital claim is a behavioral health diagnosis. Inpatient claims covered by a RBHA or TRBHA are not considered administrative days under subsection (A)(2) regardless of the principal diagnosis on the hospital claim.
- B. Reimbursement of Administrative Days.
1. Administrative days under subsection (A)(1) are reimbursed at the rate the claim would have paid had the services not been provided in an inpatient hospital setting but had been provided at the appropriate level of care such as the rate paid for stays at a nursing facility.
 2. Administrative days under subsection (A)(2) are reimbursed at the daily rate found on the Inpatient Behavioral Health Capped Fee-For-Service Schedule meeting the criteria of “Service Description – Psychiatric Stay,” regardless of revenue code.
- C. Prior authorization is required for administrative days.
- D. A hospital shall submit a claim for administrative days separate from any claim for reimbursement for the inpatient stay otherwise reimbursable under the DRG payment methodology.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 25 A.A.R. 3111, effective October 1, 2019 (Supp. 19-4).

R9-22-712.76. DRG Reimbursement: Interim Claims

- A. For inpatient stays with a length of stay greater than 29 days, a hospital may submit interim claims for each 30 day period during the inpatient stay.
- B. Hospitals shall be reimbursed for interim claims at a per diem rate of \$500 per day.
- C. Following discharge, the hospital shall void all interim claims. In such circumstances, the hospital shall submit a claim to the payer with whom the member is enrolled on the date of discharge, whether the Administration or a contractor, for the entire inpatient stay for which the final claim shall be reimbursed under the DRG payment methodology. Interim claims will be recouped.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.77. DRG Reimbursement: Admissions and Dis-

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charges on the Same Day

- A. Except as provided for in subsection (B), for any claim for inpatient services with an admission date and discharge date that are the same calendar date, the contractor or the Administration shall process the claim as an outpatient claim and the hospital shall be reimbursed under R9-22-712.10 through R9-22-712.50.
- B. Claims with an admission date and discharge date that are the same calendar date that also indicate that the member expired on the date of discharge shall be reimbursed under the DRG methodology.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.78. DRG Reimbursement: Readmissions

If a member is readmitted without prior authorization to the same hospital that the member was discharged from within 72 hours and the DRG code assigned to the claim for the prior admission has the same first three digits as the DRG code assigned to the claim for the readmission, then payment for the claim for the readmission will be disallowed only if the readmission could have been prevented by the hospital.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.79. DRG Reimbursement: Change of Ownership

The administration shall not change any of the components of the calculation of reimbursement for inpatient services using the DRG methodology based upon a change in the hospital's ownership except to the extent those components would change under the methodology had the hospital not changed ownership (e.g., updating the hospital's cost-to-charge ratio as of September 1 of each year under R9-22-712.68).

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.80. DRG Reimbursement: New Hospitals

- A. DRG base payment for new hospitals. For any hospital that does not have a labor share or wage index published by CMS as described in subsection R9-22-712.62(B) because the hospital was not in operation, the DRG base rate described in subsection R9-22-712.62(B) shall be calculated as the statewide standardized amount after adjusting that amount for the labor-related share and the wage index published by CMS as described in subsection R9-22-712.62(B) that is appropriate to the location of the hospital published by CMS as described in subsection R9-22-712.62(B).
- B. Outlier calculations for new hospitals. For any hospital that does not have an operating cost-to-charge ratio listed in the impact file described in subsection R9-22-712.68(B) because the hospital was not in operation prior to the publication of the impact file, the statewide urban or rural default operating cost-to-charge ratio appropriate to the location of the hospital and the statewide capital cost-to-charge ratio shall be used to determine the unadjusted outlier add-on payment. The statewide urban or rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio shall be based on the ratios published by CMS and updated by the Administration as described in subsection R9-22-712.68(C).

- C. In addition to the requirement of this Section, DRG reimbursement for new hospitals is determined under R9-22-712.60 through R9-22-712.79.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.81. DRG Reimbursement: Updates

In addition to the other updates provided for in Sections R9-22-712.60 through R9-22-712.80, the Administration may update the version of the APR-DRG classification system established by 3M Health Information Systems, adjust the statewide standardized amount in Section R9-22-712.62, the base payments in R9-22-712.63 and R9-22-712.64, the provider policy adjustor in R9-22-712.65, service policy adjustors in R9-22-712.66, and the fixed loss amounts and marginal cost percentages used to calculate the outlier threshold in R9-22-712.68 to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. The Administration shall publish any proposed classification system on the agency's website at least 30 days prior to the effective date, to ensure a sufficient period for public comment, as required by 42 C.F.R. § 447.205. In addition, the public notice shall be available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. The requirements of 42 CFR § 447.205 as of November 2, 2015 are incorporated by reference and do not include any later amendments.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

R9-22-712.90. Reimbursement of Hospital-based Freestanding Emergency Departments

- A. "Hospital-based freestanding emergency department" (hospital-based FSED) means an outpatient treatment center, as defined in R9-10-101, that: (1) provides emergency room services under R9-10-1019, (2) is subject to the requirements of 42 CFR 489.24, and (3) shares an ownership interest with a hospital, regardless of whether the outpatient treatment center operates under a hospital's single group license as described in A.R.S. § 36-422.
- B. A hospital-based FSED shall register with the Administration separately from the hospital with which an ownership interest is shared and shall obtain a separate provider identification number. The Administration shall not charge a separate provider enrollment fee for registration of a hospital-based FSED. The Administration shall accept a hospital's compliance with the provider screening and enrollment requirements of 42 CFR Part 455 as compliance by the hospital-based FSED.
- C. For dates of service on and after March 1, 2017, and except as provided in subsection (D), services provided by a hospital-based FSED for evaluation and management CPT codes 99281 through 99285 shall be reimbursed at the following percentages of the amounts otherwise reimbursable under R9-22-712.20 through R9-22-712.30. All other covered codes shall be reimbursed in accordance with R9-22-712.20 through R9-22-712.30 without a percentage reduction.

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1. 60 percent for a level 1 emergency department visit as indicated by CPT 99281.
 2. 80 percent for a level 2 emergency department visit as indicated by CPT 99282.
 3. 90 percent for a level 3 emergency department visit as indicated by CPT 99283.
 4. 100 percent for a level 4 or 5 emergency department visit as indicated by CPT codes 99284 and 99285.
- D.** A hospital-based FSED located in a city or town in a county with less than 500,000 residents, where the only hospital in the city or town operating an emergency department closed on or after January 1, 2015, shall be reimbursed under R9-22-712.20 through R9-22-712.35 using the adjustment in R9-22-712.35 associated with the nearest hospital with which the freestanding emergency department shares an ownership interest.
- E.** Services provided by an outpatient treatment center that provides emergency room services under R9-10-1019, but does not otherwise meet the criteria in subsection A, shall be reimbursed based on the non-hospital AHCCCS capped fee-for-service schedule under R9-22-710.
- F.** The Administration shall not reimburse a hospital for services provided at a hospital-based FSED if the member is admitted directly from a hospital-based FSED to a hospital with an ownership interest in the hospital-based FSED. As provided in R9-22-712.60(B), payments made for the inpatient stay using the DRG methodology shall be the sole reimbursement.

Historical Note

New Section made by final rulemaking at 23 A.A.R. 22, February 11, 2017 (Supp. 16-4).

R9-22-713. Overpayment and Recovery of Indebtedness

- A.** If a contractor or a subcontracting provider receives an overpayment from the Administration or otherwise becomes indebted to the Administration, the contractor or subcontracting provider shall immediately remit the amount of the indebtedness or overpayment to the Administration for deposit in the AHCCCS fund.
- B.** If the funds described in subsection (A) are not remitted, the Administration may recover the funds paid by the Administration to a contractor or subcontracting provider through:
1. A repayment agreement executed with the Administration;
 2. Withholding or offsetting against current or future payments to be paid to the contractor or subcontracting provider; or
 3. Enforcement of, or collection against, the performance bond, financial reserve, or other financial security under A.R.S. § 36-2903.

Historical Note

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Former Section R9-22-713 repealed, new Section R9-22-713 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714, former Section R9-22-709 renumbered and amended as Section R9-22-713 effective October 1, 1985 (Supp. 85-5). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

R9-22-714. Payments to Providers

- A.** Provider agreement. The Administration or a contractor shall not reimburse a covered service provided to a member unless the provider has signed a provider agreement with the Administration that establishes the terms and conditions of participation and payment under A.R.S. § 36-2904.
- B.** Provider reimbursement. The Administration or a contractor shall reimburse a provider for a service furnished to a member only if:
1. The provider personally furnishes the service to a specific member. For purposes of this Section, services personally furnished by a provider include:
 - a. Services provided by medical residents or dental students in a teaching environment; or
 - b. Services provided by a licensed or certified assistant under the general supervision of a licensed practitioner in accordance with 4 A.A.C. 24, 9 A.A.C. 16, 4 A.A.C. 43, or 4 A.A.C. 45;
 2. The provider verifies that individuals who have provided services described in subsection (B)(1) have not been placed on the List of Excluded Individuals/Entities (LEIE) maintained by the United States Department of Health and Human Services Office of the Inspector General (OIG), located at OIG's web site;
 3. The service contributes directly to the diagnosis or treatment of the member; and
 4. The service ordinarily requires performance by the type of provider seeking reimbursement.
- C.** The Administration or a contractor may make a payment for covered services only:
1. To the provider;
 2. To anyone specified in a reassignment from the provider to a government agency or reassignment by a court order;
 3. To a business agent, if the agent's compensation for the service is:
 - a. Related to the cost of processing the billing;
 - b. Not related on a percentage or other basis to the amount that is billed or collected; and
 - c. Not dependent upon collection of the payment;
 4. To the employer of the provider, if the provider is required as a condition of employment to turn over the provider's fees to the employer;
 5. To the inpatient facility in which the service is provided, if the provider has a contract under which the inpatient facility submits the claim; or
 6. To a foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the foundation, plan or similar organization submits the claim.
- D.** The Administration or a contractor shall not make a payment to or through a factor, either directly or by power of attorney, for a covered service furnished to a member by a provider.
- E.** Reimbursement for a pathology service. Unless otherwise specified in a contract, the Administration or a contractor shall reimburse a pathologist for a pathology service furnished to a member only if the other requirements in this Section are met and the service is:
1. A surgical pathology service;
 2. A specific cytopathology, hematology, or blood banking pathology service that requires performance by a physician and is listed in the capped fee-for-service schedule;
 3. A clinical consultation service that:
 - a. Is requested by the member's attending physician or primary care physician,

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- b. Is related to a test result that is outside the clinically significant normal or expected range in view of the condition of the member,
- c. Results in a written narrative report included in the member's medical record,
- d. Requires the exercise of medical judgment by the consultant pathologist, and
- e. Is listed in the capped fee-for-service schedule; or
- 4. A clinical laboratory interpretative service that:
 - a. Is requested by the member's attending physician or primary care physician,
 - b. Results in a written narrative report included in the member's medical record,
 - c. Requires the exercise of medical judgment by the consultant pathologist, and
 - d. Is listed in the capped fee-for-service schedule.

Historical Note

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule is similar to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714 effective October 1, 1985 (Supp. 85-5). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 9 A.A.R. 3800, effective October 4, 2003 (Supp. 03-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-715. Hospital Rate Negotiations

- A. A contractor that negotiates with hospitals for inpatient or outpatient services shall reimburse hospitals for services rendered on or after March 1, 1993, as described in A.R.S. § 36-2903.01 and this Article, or at the negotiated rate that, in the aggregate, does not exceed reimbursement levels that would have been paid under A.R.S. § 36-2903.01, and this Article. This subsection does not apply to urban hospitals described under R9-22-718. Contractors may engage in rate negotiations with a hospital at any time during the contract period.
- B. The Administration may negotiate or contract with a hospital on behalf of a contractor for discounted hospital rates and may require that the negotiated discounted rates be included in a subcontract between the contractor and hospital.

Historical Note

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). New Section R9-22-715 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act,

effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-716. Repealed**Historical Note**

Adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

R9-22-717. Repealed**Historical Note**

Adopted effective July 30, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3).

Editor's Note: The following Section was originally adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council. The agency was required to submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and was required to hold a public hearing. It has since been amended under the regular rulemaking process.

R9-22-718. Urban Hospital Inpatient Reimbursement Program

- A. Definitions. The following definitions apply to this Section:
 1. "Contractor" has the same meaning as set forth in A.R.S. § 36-2901, and includes all contractors regardless of whether the GSA's served by the contractor includes urban or rural counties.
 2. "Noncontracted Hospital" means an urban hospital, including psychiatric hospitals, which does not have a contract under this Section with a contractor.
 3. "Urban Hospital" means a hospital that is not a rural hospital, as defined in R9-22-712.07, and that is physically located in Maricopa or Pima County.
- B. General Provisions.
 1. This Section applies to an urban hospital who receives payment for inpatient hospital services under A.R.S. §§ 36-2903.01 and 36-2904.
 2. AHCCCS shall operate an inpatient hospital reimbursement program under A.R.S. § 36-2905.01 and this Section.

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3. Residency of the member receiving inpatient AHCCCS covered services is not a factor in determining which hospitals are required to contract with which contractors.
 4. A contractor shall enter into a contract for reimbursement for inpatient AHCCCS covered services with one or more urban hospitals located in the same county as the contractor.
 5. A noncontracted urban hospital shall be reimbursed for inpatient services by a contractor at 95 percent of the amount calculated as defined in A.R.S. § 36-2903.01 and this Article, unless otherwise negotiated by both parties.
- C. Contract Begin Date.** A contract under this Article shall cover inpatient acute care hospital services for members with hospital admissions on and after October 1, 2003.
- D. Outpatient urban hospital services.** Outpatient urban hospital services, including observation days and emergency room treatments that do not result in an admission, shall be reimbursed either through an urban hospital contract negotiated between a contractor and an urban hospital, or the reimbursement rates set forth in A.R.S. § 36-2903.01. Outpatient services in an urban hospital that result in an admission shall be paid as inpatient services in accordance with this Section.
- E. Urban Hospital Contract.**
1. Provisions of an urban hospital contracts. The urban hospital contract shall contain but is not limited to the following provisions:
 - a. Required provisions as described in the Request for Proposals (RFP);
 - b. Dispute settlement procedures. If the AHCCCS Grievance System prescribed in A.R.S. § 36-2903.01(B) and rule is not used, then arbitration shall be used;
 - c. Arbitration procedure. If arbitration is used, the urban hospital contract shall identify:
 - i. The parties' agreement on arbitrating claims arising from the contract,
 - ii. Whether arbitration is nonbinding or binding,
 - iii. Timeliness of arbitration,
 - iv. What contract provisions may be appealed,
 - v. What rules will govern arbitrations,
 - vi. The number of arbitrators that shall be used,
 - vii. How arbitrators shall be selected, and
 - viii. How arbitrators shall be compensated.
 - d. Timeliness of claims submission and payment;
 - e. Prior authorization;
 - f. Concurrent review;
 - g. Electronic submission of claims;
 - h. Claims review criteria;
 - i. Payment of discounts or penalties such as quick-pay and slow-pay provisions;
 - j. Payment of outliers;
 - k. Claim documentation specifications under A.R.S. § 36-2904.
 - l. Treatment and payment of emergency room services; and
 - m. Provisions for rate changes and adjustments.
 2. AHCCCS review and approval of urban hospital contracts:
 - a. AHCCCS may review, approve, or disapprove the hospital contract rates, terms, conditions, and amendments to the contract;
 - b. The AHCCCS evaluation of each urban hospital contract shall include but not be limited to the following areas:
 - i. Availability and accessibility of services to members,
 - ii. Related party interests,
 - iii. Inclusion of required terms pursuant to this Section, and
 - iv. Reasonableness of the rates.
- F. Quick-Pay/Slow-Pay.** A payment made by a contractor to a noncontracted hospital shall be subject to quick-pay discounts and slow-pay penalties under A.R.S. § 36-2904.

Historical Note

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective January 29, 1997; pursuant to Laws 1996, Ch. 288, § 24 (Supp. 97-1). Amended by exempt rulemaking at 10 A.A.R. 500, effective February 1, 2004 (Supp. 04-1). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 24 A.A.R. 1515, effective June 30, 2018 (Supp. 18-2).

R9-22-719. Contractor Performance Measure Outcomes

The Administration may retain a specified percentage of capitation reimbursement to distribute to contractors based on their performance measure outcomes under A.R.S. § 36-2904. The Administration shall notify contractors 60 days prior to a new contract year if this methodology is implemented. The Administration shall specify the details of the reimbursement methodology in contract.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-720. Reinsurance

- A.** Reinsurance is a stop-loss program provided by the Administration to a contractor for partial reimbursement of the cost of covered services for a member with an acute medical condition when the cost of covered services exceeds a pre-determined deductible level amount within a contract year. The Administration self-insures the reinsurance program through a reduction to capitation rates. The reinsurance program also includes a catastrophic reinsurance program for members diagnosed with specific medical conditions.
- B.** The Administration shall specify in contract guidelines for claims submission, processing, payment, and the types of care and services that are provided to a member whose care is covered by reinsurance.
- C.** When the Administration determines that a contractor does not follow the specified guidelines for care or services and the care or services could have been provided at a lower cost according to the guidelines, the Administration shall reimburse the contractor as if the care or services had been provided as specified in the guidelines.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

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R9-22-721. Behavioral Health Inpatient Facilities

“Behavioral health inpatient facility” means a health care institution, other than Arizona State Hospital, that meets the following requirements:

1. Provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:
 - a. Have a limited or reduced ability to meet the individual’s basic physical needs;
 - b. Suffer harm that significantly impairs the individual’s judgment, reason, behavior, or capacity to recognize reality;
 - c. Be a danger to self;
 - d. Be a danger to others;
 - e. Be persistently or acutely disabled as defined in A.R.S. § 36-501; or
 - f. Be gravely disabled; and
2. Is one of the following facility types:
 - a. Psychiatric hospitals;
 - b. Mental health residential treatment centers;
 - c. Secure residential treatment centers with 17 or more beds;
 - d. Non-secure residential treatment centers with 1-16 beds;
 - e. Non-secure residential treatment centers with 17 or more beds;
 - f. Sub-acute facilities with 1-16 beds;
 - g. Sub-acute facilities with 17 or more beds.

Historical Note

New Section made by final rulemaking at 25 A.A.R. 3120, effective October 1, 2019 (Supp. 19-4).

R9-22-722. Reserved

R9-22-723. Reserved

R9-22-724. Reserved

R9-22-725. Reserved

R9-22-726. Reserved

R9-22-727. Reserved

R9-22-728. Reserved

R9-22-729. Reserved

Editor’s Note: Amendments to Section R9-22-730 were filed as a final exempt rulemaking. AHCCCS provided an opportunity for public comment on the amended rules under Laws 2013, 1st Special Session, Ch. 10. A proposed exempt rulemaking was published in the Arizona Administrative Register at 21 A.A.R. 1041 (Supp. 15-3).

Editor’s Note: Amendments to Section R9-22-730 were filed as a final exempt rulemaking. AHCCCS provided an opportunity for public comment on the amended rules under Laws 2013, 1st Special Session, Ch. 10. A proposed exempt rulemaking was published in the Arizona Administrative Register at 21 A.A.R. 491 (Supp. 15-2).

R9-22-730. Hospital Assessment Fund - Hospital Assessment

A. For purposes of this Section, the following terms are defined as provided below unless the context specifically requires another meaning:

1. “2019 Medicare Cost Report” means The Medicare Cost Report for the hospital fiscal year ending in calendar year 2019 as reported in the CMS Healthcare Provider Cost

Reporting Information System (HCRIS) release dated October 9, 2020.

2. “2019 Uniform Accounting Report” means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of December 10, 2020 for the hospital’s fiscal year ending in calendar year 2019.
 3. “Quarter” means the three month period beginning January 1, April 1, July 1, and October 1 of each year.
 4. A “new hospital” means a licensed hospital that did not hold a license from the Arizona Department of Health Services prior to January 2, 2022.
 5. “Outpatient Net Patient Revenues” means an amount, calculated using data in the hospital’s 2019 Uniform Accounting Report, that is equal to the hospital’s 2019 total net patient revenue multiplied by the ratio of the hospital’s 2019 gross outpatient revenue to the hospital’s 2019 total gross patient revenue.
- B.** Beginning January 1, 2014, for each Arizona licensed hospital not excluded under subsection (I) shall be subject to an assessment payable on a quarterly basis. The assessment shall be levied against the legal owner of each hospital as of the first day of the quarter, and except as otherwise required by subsections (D), (E) and (F). For the period beginning October 1, 2022, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital’s 2019 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as “Other Long Term Care Discharges,” multiplied by the following rates appropriate to the hospital’s peer group; and (2) the amount of outpatient net patient revenues multiplied by the following rate appropriate to the hospital’s peer group:
1. \$829.50 per discharge and 1.5314% of outpatient net patient revenues for hospitals located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.
 2. \$829.50 per discharge and 0.6381% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
 3. \$207.50 per discharge and 0.6381% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
 4. \$207.50 per discharge and 0.6381% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2019 Medicare Cost Report.
 5. \$663.50 per discharge and 1.6590% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital’s 2019 Uniform Accounting Report.
 6. \$746.50 per discharge and 1.9142% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with at least 10% but less than 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital’s 2019 Uniform Accounting Report.
 7. \$166.00 per discharge and 0.5105% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children’s.
 8. \$829.50 per discharge and 2.5523% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term not included in another peer group.

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- C. Peer groups for the four quarters beginning October 1 of each year are established based on hospital license type and subtype designated in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website January, 2022.
- D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2019 Medicare Cost Report, are assessed a rate of \$207.50 for each discharge from the psychiatric sub-provider as reported in the 2019 Medicare Cost Report. All discharges other than those reported as discharges from the psychiatric sub-provider are assessed at the rate required by subsection (B).
- E. Notwithstanding subsection (B), rehabilitative discharges from a hospital that reported having a rehabilitative sub-provider in the hospital's 2019 Medicare Cost Report, are assessed a rate of \$0 for each discharge from the rehabilitative sub-provider as reported in the 2019 Medicare Cost Report. All discharges other than those reported as discharges from the rehabilitative sub-provider are assessed at the rate required by subsection (B).
- F. Notwithstanding subsection (B), for any hospital that reported more than 24,000 discharges on the hospital's 2019 Medicare Cost Report, discharges in excess of 24,000 are assessed a rate of \$83.00 for each discharge in excess of 24,000. The initial 24,000 discharges are assessed at the rate required by subsection (B).
- G. Assessment notice. On or before the 15th day of the first month of the quarter or upon CMS approval, whichever is later, the Administration shall send to each hospital a notification that the Hospital Assessment Fund assessment invoice is available to be viewed on a secure website. The invoice shall include the hospital's peer group assignment and the assessment due for the quarter.
- H. Assessment due date. The Hospital Assessment Fund assessment must be received by the Administration no later than:
 1. The 15th day of the second month of the quarter or
 2. In the event CMS approves the assessment after the 15th day of the first month of the quarter, 30 days after notification by the Administration that the assessment invoice is available.
- I. Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's 2019 Medicare Cost Report and Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for January 2, 2022:
 1. Hospitals owned and operated by the state, the United States, or an Indian tribe.
 2. Hospitals designated as type: hospital, subtype: short-term that have a license number beginning "SH".
 3. Hospitals designated as type: hospital, subtype: psychiatric that reported fewer than 2,500 discharges on the 2019 Medicare Cost Report.
 4. Hospitals designated as type: hospital, subtype; rehabilitation.
 5. Hospitals designated as type: med-hospital, subtype: special hospitals.
 6. Hospitals designated as type: hospital, subtype: short-term located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2019 Medicare Cost Report are reimbursed by Medicare.
- 7. Hospitals designated as type: hospital, subtype: short-term that have at least 25 percent Medicare swing beds as percentage of total Medicare days, per the 2019 Medicare Cost Report.
- 8. Hospitals designated as type: hospital, subtype: short-term that are an urban public acute care hospital.
- J. New hospitals. For hospitals that did not file a 2019 Medicare Cost Report because of the date the hospital began operations:
 1. If the hospital was open on the January 2 preceding the October assessment start date, the hospital assessment will begin on October 1 following the date the hospital began operating.
 2. If the hospital began operating between January 3 and June 30, the assessment will begin on October 1 of the following calendar year.
 3. A hospital is not considered a new hospital based on a change in ownership.
 4. The assessment will be based on the discharges reported in the hospital's first Medicare Cost Report and Uniform Accounting Report, which includes 12 months-worth of data, except when any of the following apply:
 - a. If there is not a complete 12 months-worth of data available, the assessment will be based on the annualized number of discharges from the date hospital operations began through December 31 preceding the October assessment start date. The hospital shall self-report the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the Administration no later than January preceding the assessment start date for the new hospitals. "Annualized" means divided by a ratio equal to the number of months of data divided by 12 months.
 - b. If more than 12 months of data is available, the assessment will be based on the most recent 12 months of self-reported data, as of December 31;
 5. For purposes of calculating subpart 4, if a new hospital shares a Medicare Identification Number with an existing hospital, the assessment amount will be based on self-reported data from the new hospital instead of the Medicare Cost Report. The data shall include the number of discharges and all other data requested by the Administration necessary to determine the appropriate assessment.
 6. For hospitals providing self-reported data, described in subpart 4 and 5:
 - a. Psychiatric discharges will be annualized to determine if subsections (B)(4) or (I)(3) apply to the assessment amount.
 - b. Discharges will be annualized to determine if subsection (F) applies to the assessment amount.
- K. Changes of ownership. The parties to a change of ownership shall promptly provide written notice to the Administration of a change of ownership and any agreement regarding the payment of the assessment. The assessed amount will continue at the same amount applied to the prior owner. Assessments are the responsibility of the owner of record as of the first day of the quarter; however, this rule is not intended to prohibit the parties to a change of ownership from entering into an agreement for a new owner to assume the assessment responsibility of the owner of record as of the first day of the prior quarter.

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- L. Hospital closures. Hospitals that close shall pay a proportion of the quarterly assessment equal to that portion of the quarter during which the hospital operated.
- M. Required information for the inpatient assessment. For any hospital that has not filed a 2019 Medicare Cost report, or if the 2019 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the inpatient assessment, the Administration shall use data reported on the 2019 Uniform Accounting Report filed by the hospital in place of the 2019 Medicare Cost report to calculate the assessment. If the 2019 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the inpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2019 Medicare Cost report to calculate the assessment.
- N. Required information for the outpatient assessment. For any hospital that has not filed a 2019 Uniform Accounting Report, or if the 2019 Uniform Accounting Report does not reconcile to 2019 Audited Financial Statements, the Administration shall use the data reported on 2019 Audited Financial Statements to calculate the outpatient assessment. If the 2019 Audited Financial Statements do not include the reliable information sufficient for the Administration to calculate the outpatient assessment, the Administration shall use data reported on the 2019 Medicare Cost report. If the Medicare Cost report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2019 Medicare Cost report to calculate the outpatient assessment.
- O. The Administration will review and update as necessary rates and peer groups periodically to ensure the assessment is sufficient to fund the state match obligation to cover the cost of the populations as specified in A.R.S. § 36-2901.08.
- P. Enforcement. If a hospital does not comply with this Section, the director may suspend or revoke the hospital's provider agreement. If the hospital does not comply within 180 days after the hospital's provider agreement is suspended or revoked, the director shall notify the director of the Department of Health Services who shall suspend or revoke the hospital's license.

Historical Note

New Section R9-22-730 made by exempt rulemaking at 20 A.A.R. 281, effective January 15, 2014 (Supp. 14-1). Amended by exempt rulemaking at 20 A.A.R. 1833, effective July 1, 2014 (Supp. 14-2). Amended by final exempt rulemaking at 21 A.A.R. 637, effective April 15, 2015 (Supp. 15-2). Amended by final exempt rulemaking at 21 A.A.R. 1486, effective July 16, 2015 (Supp. 15-3). Amended by final exempt rulemaking at 22 A.A.R. 2050, effective July 14, 2016 (Supp. 16-4). Amended by final exempt rulemaking at 23 A.A.R. 1945, effective July 1, 2017 (Supp. 17-2). Amended by final exempt rulemaking at 24 A.A.R. 2229, effective July 10, 2018 (Supp. 18-3). Amended by final exempt rulemaking at 25 A.A.R. 1938, effective July 1, 2019 (Supp. 19-3). Amended by final exempt rulemaking at 26 A.A.R. 1702, effective July 1, 2020 (Supp. 20-3). Amended by final exempt rulemaking at 26 A.A.R. 2984, effective October 1, 2020 (Supp. 20-4). Amended by final exempt rulemaking at 27 A.A.R. 2370, effective October 1, 2021 (Supp. 21-3). Amended by final exempt rulemaking at 28 A.A.R. 2213 (September 2, 2022), effective October 1, 2022 (Supp. 22-3).

R9-22-731. Health Care Investment Fund - Hospital Assessment

- A. For purposes of this Section, terms are the same as defined in A.A.C. R9-22-730 as provided below unless the context specifically requires another meaning.
- B. Beginning October 1, 2022, for each Arizona licensed hospital not excluded under subsection (I) shall be subject to an assessment payable on a quarterly basis. The assessment shall be levied against the legal owner of each hospital as of the first day of the quarter, and except as otherwise required by subsections (D), (E) and (F). For the period beginning October 1, 2022, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital's 2019 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as "Other Long Term Care Discharges," multiplied by the following rates appropriate to the hospital's peer group; and (2) the amount of outpatient net patient revenues multiplied by the following rate appropriate to the hospital's peer group:
 1. \$211.50 per discharge and 3.5149% of outpatient net patient revenues for hospitals located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.
 2. \$211.50 per discharge and 1.645% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
 3. \$53.00 per discharge and 1.645% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
 4. \$53.00 per discharge and 1.645% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2019 Medicare Cost Report.
 5. \$169.25 per discharge and 3.8078% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 2019 Uniform Accounting Report.
 6. \$190.50 per discharge and 4.3936% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with at least 10% but less than 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 2019 Uniform Accounting Report.
 7. \$42.50 per discharge and 1.1716% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.
 8. \$211.50 per discharge and 5.8581% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term not included in another peer group.
- C. Peer groups for the four quarters beginning October 1 of each year are established based on hospital license type and subtype designated in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website January 2, 2022.
- D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2019 Medicare Cost Report, are assessed a rate of \$53.00 for each discharge from the psychiatric sub-provider as reported in the 2019 Medicare Cost Report. All discharges other than those reported as discharges from the psychiatric

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- sub-provider are assessed at the rate required by subsection (B).
- E.** Notwithstanding subsection (B), rehabilitative discharges from a hospital that reported having a rehabilitative sub-provider in the hospital's 2019 Medicare Cost Report, are assessed a rate of \$0 for each discharge from the rehabilitative sub-provider as reported in the 2019 Medicare Cost Report. All discharges other than those reported as discharges from the rehabilitative sub-provider are assessed at the rate required by subsection (B).
- F.** Notwithstanding subsection (B), for any hospital that reported more than 24,000 discharges on the hospital's 2019 Medicare Cost Report, discharges in excess of 24,000 are assessed a rate of \$21.25 for each discharge in excess of 24,000. The initial 24,000 discharges are assessed at the rate required by subsection (B).
- G.** Assessment notice. On or before the 10th day of the first month of the quarter or upon CMS approval, whichever is later, the Administration shall send to each hospital a notification that the assessment invoice is available to be viewed on a secure website. The invoice shall include the hospital's peer group assignment and the assessment due for the quarter.
- H.** Assessment due date. The assessment must be received by the Administration no later than the 10th day of the second month of the quarter.
- I.** Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's 2019 Medicare Cost Report and Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for January 2, 2022:
1. Hospitals owned and operated by the state, the United States, or an Indian tribe.
 2. Hospitals designated as type: hospital, subtype: short-term that have a license number beginning "SH".
 3. Hospitals designated as type: hospital, subtype: psychiatric that reported fewer than 2,500 discharges on the 2019 Medicare Cost Report.
 4. Hospitals designated as type: hospital, subtype: rehabilitation.
 5. Hospitals designated as type: med-hospital, subtype: special hospitals.
 6. Hospitals designated as type: hospital, subtype: short-term located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2019 Medicare Cost Report are reimbursed by Medicare.
 7. Hospitals designated as type: hospital, subtype: short-term that have at least 25 percent Medicare swing beds as percentage of total Medicare days, per the 2019 Medicare Cost Report.
 8. Hospitals designated as type: hospital, subtype: short-term that are an urban public acute care hospital.
- J.** New hospitals. For hospitals that did not file a 2019 Medicare Cost Report because of the date the hospital began operations:
1. If the hospital was open on the January 2 preceding the October assessment start date, the hospital assessment will begin on October 1 following the date the hospital began operating.
 2. If the hospital began operating between January 3 and June 30, the assessment will begin on October 1 of the following calendar year.
3. A hospital is not considered a new hospital based on a change in ownership.
 4. The assessment will be based on the discharges reported in the hospital's first Medicare Cost Report and Uniform Accounting Report, which includes 12 months-worth of data, except when any of the following apply:
 - a. If there is not a complete 12 months-worth of data available, the assessment will be based on the annualized number of discharges from the date hospital operations began through December 31 preceding the October assessment start date. The hospital shall self-report the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the Administration no later than January preceding the assessment start date for the new hospitals. "Annualized" means divided by a ratio equal to the number of months of data divided by 12 months.
 - b. If more than 12 months of data is available, the assessment will be based on the most recent 12 months of self-reported data, as of December 31;
 5. For purposes of calculating subpart 4, if a new hospital shares a Medicare Identification Number with an existing hospital, the assessment amount will be based on self-reported data from the new hospital instead of the Medicare Cost Report. The data shall include the number of discharges and all other data requested by the Administration necessary to determine the appropriate assessment.
 6. For hospitals providing self-reported data, described in subpart 4 and 5:
 - a. Psychiatric discharges will be annualized to determine if subsections (B)(4) or (I)(3) apply to the assessment amount.
 - b. Discharges will be annualized to determine if subsection (F) applies to the assessment amount.
 - L.** Changes of ownership. The parties to a change of ownership shall promptly provide written notice to the Administration of a change of ownership and any agreement regarding the payment of the assessment. The assessed amount will continue at the same amount applied to the prior owner. Assessments are the responsibility of the owner of record as of the first day of the quarter; however, this rule is not intended to prohibit the parties to a change of ownership from entering into an agreement for a new owner to assume the assessment responsibility of the owner of record as of the first day of the prior quarter.
 - M.** Hospital closures. Hospitals that close shall pay a proportion of the quarterly assessment equal to that portion of the quarter during which the hospital operated.
 - N.** Required information for the inpatient assessment. For any hospital that has not filed a 2019 Medicare Cost report, or if the 2019 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the inpatient assessment, the Administration shall use data reported on the 2019 Uniform Accounting Report filed by the hospital in place of the 2019 Medicare Cost report to calculate the assessment. If the 2019 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the inpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2019 Medicare Cost report to calculate the assessment.
 - O.** Required information for the outpatient assessment. For any hospital that has not filed a 2019 Uniform Accounting Report,

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or if the 2019 Uniform Accounting Report does not reconcile to 2019 Audited Financial Statements, the Administration shall use the data reported on 2019 Audited Financial Statements to calculate the outpatient assessment. If the 2019 Audited Financial Statements do not include the reliable information sufficient for the Administration to calculate the outpatient assessment, the Administration all use data reported on the 2019 Medicare Cost report. If the Medicare Cost report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2019 Medicare Cost report to calculate the outpatient assessment.

- P. Enforcement.** If a hospital does not comply with this Section, the director may suspend or revoke the hospital's provider agreement. If the hospital does not comply within 180 days after the hospital's provider agreement is suspended or revoked, the director shall notify the director of the Department of Health Services who shall suspend or revoke the hospital's license.

Historical Note

New Section made by final exempt rulemaking at 26 A.A.R. 2984, effective October 1, 2020 (Supp. 20-4). Amended by final rulemaking at 27 A.A.R. 2514 (October 29, 2021), with an immediate effective date of October 6, 2021 (Supp. 21-4). Amended by final exempt rulemaking at 28 A.A.R. 3351 (October 21, 2022), effective October 1, 2022 (Supp. 22-3).

ARTICLE 8. REPEALED

Article 8, consisting of R9-22-801 through R9-22-804 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).

R9-22-801. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-801 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted effective October 29, 1985 (Supp. 85-5). Amended subsections (C), (F), (H), (I), and (K) effective October 1, 1986 (Supp. 86-5). Change of heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (H) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section heading amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-802. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-802 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 29, 1985 (Supp. 85-5). Amended subsections (A), (B), (C) and (D) effective October 14, 1988 (Supp. 88-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-802 repealed, new Section R9-22-802 adopted effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-803. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-803 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-803 repealed, new Section R9-22-803 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-803 renumbered and amended as Section R9-22-804. Adopted effective January 31, 1986 (Supp. 86-1). Amended effective September 29, 1992 (Supp. 92-3). Former Section R9-22-803 repealed, new Section R9-22-803 adopted January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-804. Repealed

Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-804 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Former Section R9-22-804 repealed, former Section R9-22-803 renumbered and amended as Section R9-22-804 effective October 29, 1985 (Supp. 85-5). Amended effective October 14, 1988 (Supp. 88-4). Amended subsections (B) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-804 repealed, new Section R9-22-804 adopted effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

Exhibit A. Repealed

Historical Note

New Exhibit adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Exhibit repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

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R9-22-805. Repealed**Historical Note**

Former Section R9-22-805 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective January 31, 1986 (Supp. 86-1).

New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-904. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-904 renumbered and amended as Section R9-22-903, former Section R9-22-902 renumbered and amended as Section R9-22-904 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-901. Repealed**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-901 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-905. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-905 renumbered without change as Section R9-22-908, former Section R9-22-907 renumbered and amended as Section R9-22-905 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-902. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-902 renumbered and amended as Section R9-22-904, former Section R9-22-903 renumbered and amended as Section R9-22-902 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-902 repealed, new Section R9-22-902 adopted effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-906. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-907. Repealed**Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-907 renumbered and amended as Section R9-22-905, former Section R9-22-908 renumbered and amended as Section R9-22-907 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-908. Repealed**Historical Note****R9-22-903. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-903 renumbered and amended as Section R9-22-902, former Section R9-22-904 renumbered and amended as Section R9-22-903 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-903 repealed, new Section R9-22-903 adopted effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4).

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Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-908 renumbered and amended as Section R9-22-907, former Section R9-22-905 renumbered without change as Section R9-22-908 effective October 1, 1986 (Supp. 86-5). Former R9-22-908 repealed effective May 30, 1989 (Supp. 89-2). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

R9-22-909. Repealed**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES**R9-22-1001. Definitions**

In addition to the definitions in A.R.S. §§ 36-2901, 36-2923 and 9 A.A.C. 22, Article 1, the following definitions apply to this Article:

“Absent parent” means an individual who is absent from the home and is legally responsible for providing financial and/or medical support for a dependent child.

“Cost avoid” means to deny a claim and return the claim to the provider for a determination of the amount of first- or third-party liability.

“First-party liability” means the obligation of any insurance plan or other coverage obtained directly or indirectly by a member that provides benefits directly to the member to pay all or part of the expenses for medical services incurred by AHCCCS or a member.

“Third-party” means a person, entity, or program that is, or may be, liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.

“Third-party liability” means any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a member under a state plan.

Historical Note

Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). Amended subsections (E) through (H) effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E), and (F) effective December 22, 1987 (Supp. 87-4). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

R9-22-1002. General Provisions

AHCCCS is the payor of last resort unless specifically prohibited by applicable state or federal law. AHCCCS is not the payor of last resort when the following entities are the third-party:

1. Indian Health Services (IHS/638), contract health,
2. Title IV-E,
3. Arizona Early Intervention Program (AZEIP),

4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300,
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et seq., and
6. The Arizona Refugee Resettlement Program operated under 45 CFR Part 400, Subpart (G).

Historical Note

Section R9-22-529 adopted effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5). Amended subsections (C) and (D) effective October 1, 1986 (Supp. 86-5). Amended effective December 22, 1987 (Supp. 87-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

R9-22-1003. Cost Avoidance

- A. The Administration’s reimbursement responsibility.
 1. The Administration shall pay no more than the difference between the Capped Fee-For-Service schedule and the amount of the third-party liability, unless Medicare is the third-party.
 2. If Medicare is the third-party that is liable, the Administration shall pay the Medicare copayment, coinsurance, and deductible regardless of the Capped Fee-For-Service Schedule, as described under 9 A.A.C. 29, Article 3.
- B. The Contractor’s reimbursement responsibility.
 1. If the contract between the contractor and the provider does not state otherwise, a contractor shall pay no more than the difference between the contracted rate and the amount of the third-party liability.
 2. If the provider does not have a contract with the contractor, a contractor shall pay no more than the difference between the Capped Fee-For-Service rate and the amount of the third-party liability.
- C. The following parties shall take reasonable measures to identify potentially legally liable first- or third-party sources:
 1. AHCCCS, the Administration, or a contractor;
 2. A provider;
 3. A noncontracting provider; and
 4. A member.
- D. Except as specified under subsection (E), the Administration or a contractor shall cost avoid a claim for AHCCCS covered services under Article 2 if the Administration or a contractor has established the probable existence of a liable party at the time the claim is filed. Establishing liability takes place when the Administration or the contractor receives confirmation that another party is legally responsible for payment of a health care service under Article 2.
- E. The Administration or contractor shall pay the full amount of the claim according to the Capped-Fee-For-Service Schedule or the contracted rate as described under subsection (B), and then seek reimbursement from any liable parties if the claim is for:
 1. Prenatal care for pregnant women,

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2. Preventive pediatric services, including E.P.S.D.T. and administration of vaccines to children under the Vaccines for Children (VFC) program; or
3. Services covered by third-party liability that is derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 3012, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

R9-22-1004. Member Participation

A member shall cooperate in identifying potentially legally liable first- or third-parties and timely assist the Administration and a contractor, provider, or noncontracting provider in pursuing any first- or third-party who may be liable to pay for covered services.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1005. Collections

- A. Parties that notify AHCCCS. A provider or noncontracting provider shall cooperate with AHCCCS by identifying all potential sources of first- or third-party liability and notify AHCCCS of these sources.
- B. Parties that pursue collection or reimbursement. AHCCCS, a provider, or noncontracting provider shall pursue collection or reimbursement from all potential sources of first- or third-party liability.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

R9-22-1006. AHCCCS Monitoring Responsibilities

AHCCCS shall monitor first- or third-party liability payments to a provider or noncontracting provider, which include but are not limited to payments by or for:

1. Private health insurance;
2. Employment-related disability and health insurance;
3. Long-term care insurance;
4. Other federal programs not excluded by statute from recovery;
5. Court ordered or non-court ordered medical support from an absent parent;
6. State worker's compensation;
7. Automobile insurance, including underinsured and uninsured motorists insurance;
8. Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
9. First-party probate estate recovery;
10. Adoption-related payment; or
11. A tortfeasor.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

R9-22-1007. Notification for Perfection, Recording, and**Assignment of AHCCCS Liens**

- A. Hospital requirements. A hospital providing medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall within 30 days after a member's discharge:
 1. Notify AHCCCS via facsimile or mail under R9-22-1008, or
 2. Mail AHCCCS a copy of the lien the hospital proposes to record or has recorded under A.R.S. § 33-932.
- B. Provider and noncontracting provider requirements. A provider or noncontracting provider, other than a hospital, rendering medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall notify AHCCCS via facsimile or mail under R9-22-1008 within 30 days after providing the service.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1008. Notification Information for Liens

- A. Except as provided in subsection (B), a hospital, provider, and noncontracting provider identified in R9-22-1007 shall provide the following information to AHCCCS in writing:
 1. Name of the hospital, provider or noncontracting provider;
 2. Address of the hospital, provider or noncontracting provider;
 3. Name of member;
 4. Member's Social Security Number or AHCCCS identification number;
 5. Address of member;
 6. Date of member's admission or date service is provided;
 7. Amount estimated to be due for care of member;
 8. Date of discharge, if member has been discharged;
 9. Name of county in which injuries were sustained; and
 10. Name and address of all persons, firms, and corporations and their insurance carriers identified by the member or legal representative as being liable for damages.
- B. If the date of discharge is not known at the time the information in subsection (A) is provided, a party identified in subsection (A) shall notify AHCCCS of the date of discharge within 30 days after the member has been discharged.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

R9-22-1009. Notification of Health Insurance Information

A provider or noncontracting provider shall notify AHCCCS, in writing, of the following health insurance information within 10 days of receipt of the health insurance information:

1. Name of member,
2. Member's Social Security Number or AHCCCS identification number,
3. Insurance carrier name,
4. Insurance carrier address,
5. Policy number or insurance holder's Social Security Number,
6. Policy begin and end dates, and
7. Insurance holder's name.

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Historical Note

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS**R9-22-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims; Definitions**

- A. Scope. This Article applies to prohibited acts as described under A.R.S. § 36-2918(A), and submissions of encounters to the Administration. The Administration considers a person who aids and abets a prohibited act affecting any of the AHCCS programs or Health Care Group to be engaging in a prohibited act under A.R.S. § 36-2918(A).
- B. Purpose. This Article describes the circumstances AHCCCS considers and the process that AHCCCS uses to determine the amount of a penalty, assessment, or penalty and assessment as required under A.R.S. § 36-2918. This Article includes the process and time-frames used by a person to request a State Fair Hearing.
- C. Definitions. The following definitions apply to this Article:
 1. "Assessment" means a monetary amount that does not exceed twice the dollar amount claimed by the person for each service.
 2. "Claim" means a request for payment submitted by a person for payment for a service or line item of service, including a submission of an encounter.
 3. "Day" means calendar day unless otherwise specified.
 4. "File" means the date that AHCCCS receives a written acceptance, request for compromise, request for a counter proposal, or a request for a State Fair Hearing as established by a date stamp on the written document or other record of receipt.
 5. "Penalty" means a monetary amount, based on the number of items of service claimed or reported, that does not exceed \$2,000 times the number of line items of service.
 6. "Person" means an individual or entity as described under A.R.S. § 1-215.
 7. "Reason to know" or "had reason to know" means that a person, acts in deliberate ignorance of the truth or falsity of, or with reckless disregard of the truth or falsity of information. No proof of specific intent to defraud is required.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5).
 Amended subsection A. effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective June 9, 1998 (Supp. 98-2).
 Amended by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1102. Determining the Amount of a Penalty and an Assessment

- A. AHCCCS shall determine the amount of a penalty and assessment according to A.R.S. § 36-2918(B) and (C), R9-22-1104, and R9-22-1105.
- B. AHCCCS shall include in the amount of the penalty and assessment the cost incurred by AHCCCS for conducting the following:
 1. An investigation,
 2. Audit, or
 3. Inquiry.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5).
 Amended effective December 13, 1993 (Supp. 93-4).
 Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
 Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1103. Repealed**Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5).
 Amended effective December 13, 1993 (Supp. 93-4).
 Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
 Section repealed by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1104. Mitigating Circumstances

AHCCCS shall consider any of the following to be mitigating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. Nature and circumstances of a claim. The following are mitigating circumstances:
 - a. All the services are of the same type,
 - b. All the dates of services occurred within six months or less,
 - c. The number of claims submitted is less than 25,
 - d. The nature and circumstances do not indicate a pattern of inappropriate claims for the services, and
 - e. The total amount claimed for the services is less than \$1,000.
2. Degree of culpability. The degree of culpability of a person who presents or causes to present a claim is a mitigating circumstance if:
 - a. Each service is the result of an unintentional and unrecognized error in the process that the person followed in presenting or in causing to present the service,
 - b. Corrective steps were taken promptly by the person after the error was discovered, and
 - c. The person had a fraud and abuse control plan that was operating effectively at the time each claim was presented or caused to be presented.
3. Financial condition. The financial condition of a person who presents or causes to present a claim is a mitigating circumstance if the imposition of a penalty, assessment, or penalty and assessment without reduction will render the provider incapable to continue providing services. AHCCCS shall consider the resources available to the person when determining the amount of the penalty, assessment, or penalty and assessment.
4. Other matters as justice may require. AHCCCS shall take into account other circumstances of a mitigating nature, if in the interest of justice, the circumstances require a reduction of the penalty, assessment, or penalty and assessment.

Historical Note

Adopted effective October 1, 1986 (Supp. 86-5).
 Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

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Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1105. Aggravating Circumstances

AHCCCS shall consider any of the following to be aggravating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. Nature and circumstances of each claim. The nature and circumstances of each claim and the circumstances under which the claim is presented or caused to be presented are aggravating circumstances if:
 - a. A person has forged, altered, recreated, or destroyed records;
 - b. The person refuses to provide pertinent documentation to AHCCCS for a claim or refuses to cooperate with investigators;
 - c. The services are of several types;
 - d. All the dates of services did not occur within six months or less;
 - e. The number of claims submitted is greater than 25;
 - f. The nature and circumstances indicate a pattern of inappropriate claims for the services; and
 - g. The total amount claimed for the services is \$5,000 or greater.
2. Degree of culpability. The degree of culpability of a person who presents or causes to present each claim is an aggravating circumstance if:
 - a. The person knows or had reason to know that each service was not provided as claimed,
 - b. The person knows or had reason to know that no payment could be made because the person had been excluded from reimbursement by AHCCCS, or
 - c. The person knows or had reason to know that the payment would violate the terms of an agreement between the person and AHCCCS system.
3. Prior offenses. The prior offenses of a person who presents or causes to present each claim are an aggravating circumstance if:
 - a. At any time before the submittal of the claim the person was held criminally or civilly liable for any act, or
 - b. The person had received an administrative sanction in connection with:
 - i. A Medicaid program,
 - ii. A Medicare program, or
 - iii. Any other public or private program of reimbursement for medical services.
4. Effect on patient care. The adverse effect on patient care that resulted, or could have resulted, from the failure to provide medically necessary care by a person in connection with a claim.
5. Other matters as justice may require. AHCCCS shall take into account other circumstances of an aggravating nature, if in the interest of justice, the circumstances require an increase of the penalty, assessment, or penalty and assessment.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1106. Notice of Intent

If AHCCCS imposes a penalty, assessment, or a penalty and assessment, AHCCCS shall hand deliver or send by certified mail return

receipt requested or Federal Express to the person, a written Notice of Intent to impose a penalty, assessment, or a penalty and assessment. The Notice of Intent shall include:

1. The statutory basis for the penalty, assessment, or the penalty and assessment;
2. Identification of the state or federal regulation and state or federal law that AHCCCS alleges has been violated;
3. The factual basis for AHCCCS' determination that the penalty, assessment, or the penalty and assessment should be imposed;
4. The amount of the penalty, assessment, or penalty and assessment;
5. The process for the person to accept or request a compromise of the penalty, assessment, or penalty and assessment; and
6. The process for requesting a State Fair Hearing.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1107. Reserved**R9-22-1108. Request for a Compromise**

- A. To request a compromise, the person shall file a written request with AHCCCS within 30 days from the date of receipt of the Notice of Intent. The written request for compromise shall contain the person's reasons for the reduction or modification of the penalty, assessment, or penalty and assessment.
- B. Within 30 days from the date of receipt of the request for compromise from the person, AHCCCS shall send a Notice of Compromise Decision that accepts, denies, or offers a counter proposal to the person's request for compromise. If AHCCCS offers a counter proposal the amount of the counter proposal shall represent the penalty, assessment, or penalty and assessment.
 1. If AHCCCS does not withdraw the Notice of Intent under R9-22-1112 or denies the request for compromise the original penalty, assessment, or penalty and assessment is upheld.
 2. To dispute the Compromise Decision, the person shall file a request for a State Fair Hearing under R9-22-1110 within 30 days from the date of receipt of the Notice of Compromise Decision.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1109. Failure to Respond to the Notice of Intent

If a person fails to respond timely to the Notice of Intent, AHCCCS shall uphold the original penalty, assessment, or penalty and assessment.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1110. Request for State Fair Hearing

- A. To request a State Fair Hearing regarding a dispute concerning a penalty, assessment, or penalty and assessment, the person

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shall file a written request for a State Fair Hearing with AHCCCS within 60 days from the date of the receipt of the Notice of Intent under R9-22-1106 or within 30 days from the date of receipt of the Notice of Compromise Decision under R9-22-1108, if applicable.

- B. AHCCCS shall mail a Notice of Hearing under A.R.S. § 41-1092.05 if AHCCCS receives a timely request for a State Fair Hearing from the person.
- C. AHCCCS shall mail a Director's Decision to the person no later than 30 days after the date the Administrative Law Judge sends the decision of the Office of Administrative Hearings (OAH) to AHCCCS.
- D. AHCCCS shall accept a written request for withdrawal of a hearing request if the written request for withdrawal is received from the person before AHCCCS mails a Notice of Hearing under A.R.S. § 41-1092 et seq. If AHCCCS mailed a Notice of Hearing under A.R.S. § 41-1092 et seq., a person may withdraw the hearing request only by sending a written request for withdrawal to OAH.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1111. Issues and Burden of Proof

- A. Preponderance of evidence. In any State Fair Hearing conducted under R9-22-1110, AHCCCS shall prove by a preponderance of the evidence that a person presented or caused to be presented each claim in violation of this Article and any aggravating circumstances under R9-22-1105. A person shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty, assessment, or penalty and assessment.
- B. Statistical sampling.
 - 1. In meeting the burden of proof described in subsection (A), AHCCCS may introduce the results of a statistical sampling study as evidence of the number and amount of claims that were presented or caused to be presented by the person. A statistical sampling study constitutes prima facie evidence of the number and amount of claims if computed by valid statistical methods.
 - 2. The burden of proof shall shift to the person to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once AHCCCS has made a prima facie case as described in subsection (B)(1). AHCCCS shall be given the opportunity to rebut this evidence.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

R9-22-1112. Withdrawal and Continuances

AHCCCS may withdraw the Notice of Intent at any time. Prior to referring a matter to the Office of Administrative Hearings the parties may mutually agree to a continuance.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-22-1201. Definitions

Definitions. The following definitions apply to this Article:

"Adult behavioral health therapeutic home" as defined in 9 A.A.C. 10, Article 1.

"Agency" for the purposes of this Article means a behavioral health facility, a classification of a health care institution, including a mental health treatment agency defined in A.R.S. § 36-501, that is licensed to provide behavioral health services according to A.R.S. Title 36, Chapter 4.

"Assessment" means an analysis of a patient's need for physical health services or behavioral health services to determine which services a health care institution will provide to the patient.

"Behavior management services" means services that assist the member in carrying out daily living tasks and other activities essential for living in the community, including personal care services.

"Behavioral health therapeutic home care services" means interactions that teach the client living, social, and communication skills to maximize the client's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services indicated by the client's treatment plan, as appropriate.

"Behavioral health services" means medical services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's behavioral health issue.

"Behavioral health technician" means an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and

Are provided with clinical oversight by a behavioral health professional.

"Case management" for the purposes of this Article, means services and activities that enhance treatment, compliance, and effectiveness of treatment.

"Certified psychiatric nurse practitioner" means a registered nurse practitioner who meets the psychiatric specialty area requirements under A.A.C. R4-19-505(C).

"Clinical oversight" means as described under 9 A.A.C. 10.

"Cost avoid" means to avoid payment of a third-party liability claim when the probable existence of third-party liability has been established under 42 CFR 433.139(b).

"Court-ordered evaluation" has the same meaning as "evaluation" in A.R.S. § 36-501.

"Court-ordered pre-petition screening" has the same meaning as "pre-petition screening" in A.R.S. § 36-501.

"Court-ordered treatment" means treatment provided according to A.R.S. Title 36, Chapter 5.

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“Crisis services” means immediate and unscheduled behavioral health services provided to a patient to address an acute behavioral health issue affecting the patient.

“Direct supervision” has the same meaning as “supervision” in A.R.S. § 36-401.

“Emergency medical services provider” has the same meaning as in A.R.S. § 36-2201.

“Health care institution” has the same meaning as defined in A.R.S. § 36-401.

“Health care practitioner” means a:

- Physician;
- Physician assistant;
- Nurse practitioner; or
- Other individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. § 32-1901.

“Licensee” means the same as in 9 A.A.C. 10, Article 1.

“Medical practitioner” means a physician, physician assistant, or nurse practitioner.

“Partial care” means a day program of services provided to individual members or groups that is designed to improve the ability of a person to function in a community, and includes basic, therapeutic, and medical day programs.

“Physician assistant” means the same as in A.R.S. § 32-2501 except that when providing a behavioral health service, the physician assistant shall be supervised by an AHCCCS-registered psychiatrist.

“Psychiatrist” means a physician who meets the licensing requirements under A.R.S. § 32-1401 or a doctor of osteopathy who meets the licensing requirements under A.R.S. § 32-1800, and meets the additional requirements of a psychiatrist under A.R.S. § 36-501.

“Psychologist” means a person who meets the licensing requirements under A.R.S. §§ 32-2061 and 36-501.

“Qualified behavioral health service provider” means a behavioral health service provider that meets the requirements of R9-22-1206.

“Respite” means a period of care and supervision of a member to provide rest or relief to a family member or other person caring for the member. Respite provides activities and services to meet the social, emotional, and physical needs of the member during respite.

“TRBHA” or “Tribal Regional Behavioral Health Authority” means a Native American tribe under contract with ADHS/DBHS to coordinate the delivery of behavioral health services to eligible and enrolled members of the federally-recognized tribal nation.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S.

Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R.

179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1202. ADHS, Contractor, Administration and CRS Responsibilities

- A. ADHS responsibilities. ADHS is responsible for payment of behavioral health services provided to members, except as specified under subsection (D). ADHS’ responsibility for payment of behavioral health services includes claims for inpatient hospital services, which may include physical health services, when the principal diagnosis on the hospital claim is a behavioral health diagnosis. Behavioral health diagnoses are identified as “mental disorders” in the latest International Classification of Diseases (ICD) code set as required by AHCCCS claims and encounters.
- B. ADHS/DBHS may contract with a TRBHA for the provision of behavioral health services for American Indian members. American Indian members may receive covered behavioral health services:
 1. From an IHS or tribally operated 638 facility,
 2. From a TRBHA, or
 3. From a RBHA.
- C. Contractor responsibilities. A contractor shall:
 1. Refer a member to a RBHA under the contract terms;
 2. Provide EPSDT developmental and behavioral health screening as specified in R9-22-213;
 3. Coordinate a member’s transition of care and medical records; and
 4. Be responsible for providing covered inpatient hospital services, which may include behavioral health inpatient hospital services, when the principal diagnosis on the hospital claim is not a behavioral health diagnosis.
- D. Administration and CRS responsibilities.
 1. The Administration shall be responsible for payment of behavioral health services provided to an ALTCS FFS or an FES member and for behavioral health services provided by IHS and tribally operated 638 facilities. The Administration is also responsible for payment of behavioral health services provided to these members during prior quarter coverage.
 2. CRS shall be responsible for payment of behavioral health services provided to members enrolled with CRS.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective

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tive October 1, 2001 (Supp. 01-3). Amended to correct typographical errors, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4). Amended by final rulemaking at 21 A.A.R. 1225, effective July 7, 2015 (Supp. 15-3).

R9-22-1203. Eligibility for Covered Services

Title XIX members. A member determined eligible under A.R.S. § 36-2901(6)(a) or (g) except for the failure to meet U.S. citizenship or qualified alien status requirements, shall receive medically necessary covered services under Article 12 and Article 2.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1204. General Service Requirements

- A.** Services. Behavioral health services include mental health, substance abuse, and physical services. Medically necessary services shall be covered and service requirements met as described under Article 2 and Article 5.
- B.** Notification to Administration for American Indians enrolled with a tribal contractor. A provider shall notify the Administration no later than 72 hours after an American Indian member enrolled with a tribal contractor presents to a behavioral health hospital for inpatient emergency behavioral health services.
- C.** Restrictions and limitations. Room and board is not a covered service unless provided in a behavioral health inpatient facility under R9-22-1205.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective January 1, 1996; filed with the Secretary of State December 22, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7

A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1205. Scope and Coverage of Behavioral Health Services

A. Inpatient behavioral health services. The following inpatient services are covered subject to the limitations and exclusions in this Article and Article 2.

1. Covered inpatient behavioral health services include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment, if the service is provided under the direction of a physician in a Medicare-certified:
 - a. General acute care hospital,
 - b. Inpatient psychiatric unit in a general acute care hospital, or
 - c. Behavioral health hospital.
2. Inpatient service limitations:
 - a. Inpatient services, other than emergency services specified in this Section, are not covered unless prior authorization is obtained.
 - b. Inpatient services and room and board are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
 - i. A licensed psychiatrist,
 - ii. A certified psychiatric nurse practitioner,
 - iii. A licensed physician assistant,
 - iv. A licensed psychologist,
 - v. A licensed clinical social worker,
 - vi. A licensed marriage and family therapist,
 - vii. A licensed professional counselor,
 - viii. A licensed independent substance abuse counselor, and
 - ix. A medical practitioner.

B. Behavioral Health Inpatient facility for children. Services provided in a Behavioral Health Inpatient facility for children as defined in 9 A.A.C. 10, Article 3 are covered subject to the limitations and exclusions under this Article.

1. Behavioral Health Inpatient facility for children services are not covered unless provided under the direction of a licensed physician in a licensed Behavioral Health Inpatient facility for children accredited by an AHCCCS-approved accrediting body as specified in contract.
2. Covered Behavioral Health Inpatient facility for children services include room and board and treatment services for behavioral health and substance abuse conditions.
3. Inpatient Behavioral Health Inpatient facility for children service limitations.
 - a. Services are not covered unless prior authorized, except for emergency services as specified in this Section.
 - b. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
 - i. A licensed psychiatrist,
 - ii. A certified psychiatric nurse practitioner,
 - iii. A licensed physician assistant,
 - iv. A licensed psychologist,
 - v. A licensed clinical social worker,

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- vi. A licensed marriage and family therapist,
 - vii. A licensed professional counselor,
 - viii. A licensed independent substance abuse counselor, and
 - ix. A medical practitioner.
4. The following may be billed independently if prescribed by a provider as specified in this Section who is operating within the scope of practice:
- a. Laboratory services, and
 - b. Radiology services.
- C. Covered Inpatient sub-acute agency services.** Services provided in an inpatient sub-acute facility as defined in 9 A.A.C. 10, Article 1 are covered subject to the limitations and exclusions under this Article.
- 1. Inpatient sub-acute facility services are not covered unless provided under the direction of a licensed physician in a licensed inpatient sub-acute facility that is accredited by an AHCCCS-approved accrediting body.
 - 2. Covered Inpatient sub-acute facility services include room and board and treatment services for behavioral health and substance abuse conditions.
 - 3. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
 - a. A licensed psychiatrist,
 - b. A certified psychiatric nurse practitioner,
 - c. A licensed physician assistant,
 - d. A licensed psychologist,
 - e. A licensed clinical social worker,
 - f. A licensed marriage and family therapist,
 - g. A licensed professional counselor,
 - h. A licensed independent substance abuse counselor, and
 - i. A medical practitioner.
 - 4. The following may be billed independently if prescribed by a provider specified in this Section who is operating within the scope of practice:
 - a. Laboratory services, and
 - b. Radiology services.
- D. Behavioral health residential facility services.** Services provided in a licensed behavioral health residential facility as defined in 9 A.A.C. 10, Article 1 are covered subject to the limitations and exclusions under this Article.
- 1. Behavioral health residential facility services are not covered unless provided by a licensed behavioral health residential facility.
 - 2. Covered services include all non-prescription drugs as defined in A.R.S. § 32-1901, non-customized medical supplies, and clinical oversight or direct supervision of the behavioral health residential facility staff, whichever is applicable. Room and board are not covered services.
 - 3. The following licensed and certified providers may bill independently for services:
 - a. A licensed psychiatrist,
 - b. A certified psychiatric nurse practitioner,
 - c. A licensed physician assistant,
 - d. A licensed psychologist,
 - e. A licensed clinical social worker,
 - f. A licensed marriage and family therapist,
 - g. A licensed professional counselor,
 - h. A licensed independent substance abuse counselor, and
- E. Partial care.** Partial care services are covered subject to the limitations and exclusions in this Article.
- 1. Partial care services are not covered unless provided by a licensed and AHCCCS-registered behavioral health agency that provides a regularly scheduled day program of individual member, group, or family activities that are designed to improve the ability of the member to function in the community. Partial care services include basic, therapeutic, and medical day programs.
 - 2. Partial care services. Educational services that are therapeutic and are included in the member's behavioral health treatment plan are included in per diem reimbursement for partial care services.
- F. Outpatient services.** Outpatient services are covered subject to the limitations and exclusions in this Article and Article 2.
- 1. Outpatient services include the following:
 - a. Screening provided by a behavioral health professional or a behavioral health technician as defined in R9-22-1201;
 - b. A behavioral health assessment provided by a behavioral health professional or a behavioral health technician;
 - c. Counseling including individual therapy, group therapy, and family therapy provided by a behavioral health professional or a behavioral health technician;
 - d. Behavior management services as defined in R9-22-1201; and
 - e. Psychosocial rehabilitation services as defined in R9-22-201.
 - 2. Outpatient service limitations.
 - a. The following licensed or certified providers may bill independently for outpatient services:
 - i. A licensed psychiatrist;
 - ii. A certified psychiatric nurse practitioner;
 - iii. A licensed physician assistant as defined in R9-22-1201;
 - iv. A licensed psychologist;
 - v. A licensed clinical social worker;
 - vi. A licensed professional counselor;
 - vii. A licensed marriage and family therapist;
 - viii. A licensed independent substance abuse counselor;
 - ix. A medical practitioner; and
 - x. An outpatient treatment center or substance abuse transitional facility licensed under 9 A.A.C. 10, Article 14, that is an AHCCCS-registered provider.
 - b. A behavioral health practitioner not specified in subsections (F)(2)(a)(i) through (x), who is contracted with or employed by an AHCCCS-registered behavioral health agency shall not bill independently.
- G. Emergency behavioral health services** are covered subject to the limitations and exclusions under this Article. In order to be covered, behavioral health services shall be provided by qualified service providers under R9-22-1206. ADHS/DBHS shall ensure that emergency behavioral health services are available 24 hours per day, seven days per week in each GSA for an emergency behavioral health condition for a non-FES member as defined in R9-22-201.
- H. Other covered behavioral health services.** Other covered behavioral health services include:
- 1. Case management as defined in 9 A.A.C. 10, Article 1;
 - 2. Laboratory and radiology services for behavioral health diagnosis and medication management;

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3. Medication;
 4. Monitoring, administration, and adjustment for psychotropic medication and related medications;
 5. Respite care as described within subsection (J);
 6. Behavioral health therapeutic home care services provided by a RBHA in a professional foster home defined in 6 A.A.C. 5, Article 58 or in an adult behavioral health therapeutic home as defined in 9 A.A.C. 10, Article 1;
 7. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.
- I.** Transportation services. Transportation services are covered under R9-22-211.
- J.** Limited Behavioral Health services. Respite services are limited to no more than 600 hours per benefit year.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by exempt rulemaking at 17 A.A.R. 1870, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1206. Repealed**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Repealed by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1207. General Provisions for Payment

- A.** Claims submissions.
1. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member to the appropriate RBHA.

2. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member to the appropriate RBHA.
 3. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.
 4. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.
 5. A provider of emergency behavioral health services, that are the responsibility of ADHS/DBHS or a contractor, shall submit a claim to the entity responsible for emergency behavioral health services under R9-22-210.01(A).
 6. A provider shall comply with the time-frames and other payment procedures in Article 7 of this Chapter, if applicable, and A.R.S. § 36-2904.
 7. ADHS/DBHS or a contractor, whichever entity is responsible for covering behavioral health services, shall cost avoid any behavioral health service claims if it establishes the existence or probable existence of first-party liability or third-party liability.
- B.** Prior authorization. Payment to a provider for behavioral health services or items requiring prior authorization may be denied if a provider does not obtain prior authorization from a RBHA, ADHS/DBHS, a TRBHA, the Administration or a contractor.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

R9-22-1208. Repealed**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4).

ARTICLE 13. CHILDREN'S REHABILITATIVE SERVICES (CRS)

Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3).

Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Exemption to promulgate rules repealed under Laws 2012, Chapter 299, Section 7 (Supp. 13-3).

Article 13, consisting of Sections R9-22-1301 through R9-22-

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1309, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).

R9-22-1301. Children's Rehabilitative Services (CRS) related Definitions

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

"Active treatment" means there is a current need for treatment of the CRS qualifying condition(s) or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for treatment of any CRS qualifying condition.

"CRS application" means a submitted form with any additional documentation required by the Administration to determine whether an individual is medically eligible for CRS.

"CRS condition" means a list of medical condition(s) in R9-22-1303 and which are referred to as covered conditions in A.R.S. § 36-2912.

"Functionally limiting" means a restriction having a significant effect on an individual's ability to perform an activity of daily living as determined by a provider.

"Medically eligible" means meeting the medical eligibility requirements of R9-22-1303.

"Redetermination" means a decision made by the Administration regarding whether a member continues to meet the requirements in R9-22-1302.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).
Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).
Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2022, effective October 1, 2015 (Supp. 15-3).

R9-22-1302. Children's Rehabilitative Services (CRS) Eligibility Requirements

Beginning October 1, 2013, an AHCCCS member who needs active treatment for one or more of the qualifying medical condition(s) in R9-22-1303 shall be given a CRS Designation. An American Indian member can choose to receive CRS services through an American Indian Health Plan or a contractor. A member enrolled in CMDP shall obtain CRS services through CMDP. The contractor shall provide covered services necessary to treat the condition(s) and other services described within the contract. The effective date of the CRS Designation shall be as specified in contract.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).
Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).
Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final

rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

R9-22-1303. Medical Eligibility

The following lists identify those medical condition(s) that do qualify for CRS services as well as those that do not qualify for CRS services. The list of condition(s) that qualify for a CRS Designation is all inclusive. The list of condition(s) that do not qualify for a CRS Designation is not an all-inclusive list.

1. Cardiovascular System
 - a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. Arrhythmia,
 - ii. Arteriovenous fistula,
 - iii. Cardiomyopathy,
 - iv. Conduction defect,
 - v. Congenital heart defect other than isolated small Ventricular Septal Defects (VSD), Patent Ductus Arteriosus (PDA), Atrial Septal Defects (ASD),
 - vi. Coronary artery and aortic aneurysm,
 - vii. Renal vascular hypertension,
 - viii. Rheumatic heart disease, and
 - ix. Valvular disorder.
 - b. Condition(s) not medically eligible for CRS:
 - i. Arteriovenous fistula that is not expected to cause cardiac failure or threaten loss of function;
 - ii. Benign heart murmur;
 - iii. Branch artery pulmonary stenosis;
 - iv. Essential hypertension;
 - v. Patent foramen ovale (PFO);
 - vi. Peripheral pulmonary stenosis;
 - vii. Postural orthopedic tachycardia; and
 - viii. Premature atrial, nodal or ventricular contractions that are of no hemodynamic significance.
2. Endocrine system:
 - a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. Addison's disease,
 - ii. Adrenogenital syndrome,
 - iii. Cystic fibrosis (including atypical cystic fibrosis),
 - iv. Diabetes insipidus,
 - v. Hyperparathyroidism,
 - vi. Hyperthyroidism,
 - vii. Hypoparathyroidism, and
 - viii. Panhypopituitarism.
 - b. Condition(s) not medically eligible for CRS
 - i. Diabetes mellitus,
 - ii. Hypopituitarism associated with a malignancy and requiring treatment of less than 90 days,
 - iii. Isolated growth hormone deficiency, and
 - iv. Precocious puberty.
3. Genitourinary system medical condition(s):
 - a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. Ambiguous genitalia,
 - ii. Bladder extrophy,
 - iii. Deformity and dysfunction of the genitourinary system secondary to trauma 90 days or more after the trauma occurred,

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- iv. Ectopic ureter,
- v. Hydronephrosis, that is not resolved with antibiotics,
- vi. Polycystic and multicystic kidneys,
- vii. Pyelonephritis when treatment with drugs or biologicals has failed to cure or ameliorate and surgical intervention is required,
- viii. Ureteral stricture, and
- ix. Vesicoureteral reflux, at a grade 3 or higher.
- b. Condition(s) not medically eligible for CRS:
 - i. Enuresis,
 - ii. Hydrocele,
 - iii. Hypospadias,
 - iv. Meatal stenosis,
 - v. Nephritis, infectious or noninfectious,
 - vi. Nephrosis,
 - vii. Phimosis, and
 - viii. Undescended testicle.
- 4. Ear, nose, or throat medical condition(s):
 - a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. Cholesteatoma,
 - ii. Congenital/Craniofacial anomaly that is functionally limiting,
 - iii. Deformity and dysfunction of the ear, nose, or throat secondary to trauma, 90 days or more after the trauma occurred,
 - iv. Mastoiditis that continues 90 days or more after the first diagnosis of the condition,
 - v. Microtia that requires multiple surgical interventions,
 - vi. Neurosensory hearing loss, and
 - vii. Significant conductive hearing loss due to an anomaly in one ear or both ears equal to or greater than a pure tone average of 30 decibels that despite medical treatment, requires a hearing aid.
 - b. Condition(s) not medically eligible for CRS:
 - i. A craniofacial anomaly that is not functionally limiting,
 - ii. Adenoiditis,
 - iii. Cranial or temporal mandibular joint syndrome,
 - iv. Hypertrophic lingual frenum,
 - v. Isolated preauricular tag or pit,
 - vi. Nasal polyp,
 - vii. Obstructive apnea,
 - viii. Perforation of the tympanic membrane,
 - ix. Recurrent otitis media,
 - x. Simple deviated nasal septum,
 - xi. Sinusitis,
 - xii. Tonsillitis, and
 - xiii. Uncontrolled salivation.
- 5. Musculoskeletal system medical condition(s):
 - a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. Achondroplasia,
 - ii. Arthrogryposis (multiple joint contractures),
 - iii. Bone infection that continues 90 days or more after the initial diagnosis,
 - iv. Chondrodysplasia,
 - v. Chondroectodermal dysplasia,
 - vi. Clubfoot,
 - vii. Collagen vascular disease, including but not limited to, ankylosis spondylitis, polymyositis, dermatomyositis, polyarteritis nodosa, psoriatic arthritis, scleroderma, rheumatoid arthritis and lupus,
 - viii. Congenital or developmental cervical spine abnormality,
 - ix. Congenital spinal deformity,
 - x. Diastrophic dysplasia,
 - xi. Enchondromatosis,
 - xii. Femoral anteversion and tibial torsion,
 - xiii. Fibrous dysplasia,
 - xiv. Hip dysplasia,
 - xv. Hypochondroplasia,
 - xvi. Joint infection that continues 90 days or more after the initial diagnosis,
 - xvii. Juvenile rheumatoid arthritis,
 - xviii. Kyphosis (Scheurmann's Kyphosis) 50 degrees or over,
 - xix. Larsen syndrome,
 - xx. Leg length discrepancy of two centimeters or more,
 - xxi. Legg-Calve-Perthes disease,
 - xxii. Limb amputation or limb malformation,
 - xxiii. Metaphyseal and epiphyseal dysplasia,
 - xxiv. Metatarsus adductus,
 - xxv. Muscular dystrophy,
 - xxvi. Orthopedic complications of hemophilia,
 - xxvii. Osgood Schlatter's disease that requires surgical intervention,
 - xxviii. Osteogenesis imperfecta,
 - xxix. Rickets,
 - xxx. Scoliosis when 25 degrees or greater, or when there is a need for bracing or surgery,
 - xxxi. Seronegative spondyloarthropathy such as Reiters, psoriatic arthritis, and ankylosing spondylitis,
 - xxxii. Slipped capital femoral epiphysis,
 - xxxiii. Spinal muscle atrophy,
 - xxxiv. Spondyloepiphyseal dysplasia, and
 - xxxv. Syndactyly.
 - b. Condition(s) not medically eligible for CRS:
 - i. Back pain with no structural abnormality,
 - ii. Benign bone tumor,
 - iii. Bunion,
 - iv. Carpal tunnel syndrome,
 - v. Deformity and dysfunction secondary to trauma or injury,
 - vi. Ehlers Danlos,
 - vii. Flat foot,
 - viii. Fracture,
 - ix. Ganglion cyst,
 - x. Ingrown toenail,
 - xi. Kyphosis under 50 degrees,
 - xii. Leg length discrepancy of less than two centimeters at skeletal maturity,
 - xiii. Polydactyly without bone involvement,
 - xiv. Popliteal cyst,
 - xv. Trigger finger, and
 - xvi. Varus and valgus deformities.
- 6. Gastrointestinal system medical condition(s):
 - a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. Anorectal atresia,

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- ii. Biliary atresia,
 - iii. Cleft lip,
 - iv. Cleft palate,
 - v. Congenital atresia, stenosis, fistula, or rotational abnormalities of the gastrointestinal tract,
 - vi. Deformity and dysfunction of the gastrointestinal system secondary to trauma, 90 days or more after the trauma occurred,
 - vii. Diaphragmatic hernia,
 - viii. Gastroschisis,
 - ix. Hirschsprung's disease,
 - x. Omphalocele, and
 - xi. Tracheoesophageal fistula.
 - b. Condition(s) not medically eligible for CRS:
 - i. Celiac disease,
 - ii. Crohn's disease,
 - iii. Hernia other than a diaphragmatic hernia,
 - iv. Intestinal polyp,
 - v. Malabsorption syndrome, also known as short bowel syndrome,
 - vi. Pyloric stenosis,
 - vii. Ulcer disease, and
 - viii. Ulcerative colitis.
7. Nervous system medical condition(s):
- a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. Benign intracranial tumor,
 - ii. Benign intraspinal tumor,
 - iii. Central nervous system degenerative disease,
 - iv. Central nervous system malformation or structural abnormality,
 - v. Cerebral palsy,
 - vi. Craniosynostosis requiring surgery,
 - vii. Deformity and dysfunction secondary to trauma in an individual that continues 90 days or more after the incident,
 - viii. Hydrocephalus,
 - ix. Muscular dystrophy or other myopathy,
 - x. Myelomeningocele, also known as spina bifida,
 - xi. Myoneural disorder, including but not limited to, amyotrophic Lateral Sclerosis or ALS, myasthenia gravis, Eaton-Lambert syndrome, muscular dystrophy, troyer sclerosis, polymyositis, dermamyositis, progressive bulbar palsy, polio,
 - xii. Neurofibromatosis,
 - xiii. Neuropathy/polyneuropathy, hereditary or idiopathic,
 - xiv. Residual dysfunction that continues 90 days or more after a vascular accident, inflammatory condition, or infection of the central nervous system,
 - xv. Residual dysfunction that continues 90 days or more after near drowning,
 - xvi. Residual dysfunction that continues 90 days or more after the spinal cord injury, and
 - xvii. Uncontrolled seizure disorder, in which there have been more than two seizures with documented compliance of one or more medications.
 - b. Condition(s) not medically eligible for CRS:
- i. Central apnea secondary to prematurity,
 - ii. Febrile seizures,
 - iii. Headaches,
 - iv. Near sudden infant death syndrome,
 - v. Plagiocephaly, and
 - vi. Spina bifida occulta.
8. Ophthalmology:
- a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. Cataracts,
 - ii. Disorder of the iris, ciliary bodies, retina, lens, or cornea,
 - iii. Disorder of the optic nerve,
 - iv. Glaucoma,
 - v. Non-malignant enucleation and post-enucleation reconstruction, and
 - vi. Retinopathy of prematurity.
 - b. Condition(s) not medically eligible for CRS:
 - i. Astigmatism,
 - ii. Ptosis,
 - iii. Simple refraction error, and
 - iv. Strabismus.
9. Respiratory system medical condition(s):
- a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. Anomaly of the larynx, trachea, or bronchi that requires surgery, and
 - ii. Nonmalignant obstructive lesion of the larynx, trachea, or bronchi.
 - b. Condition(s) not medically eligible for CRS:
 - i. Allergies,
 - ii. Asthma,
 - iii. Bronchopulmonary dysplasia,
 - iv. Chronic obstructive pulmonary disease,
 - v. Emphysema, and
 - vi. Respiratory distress syndrome.
10. Dermatological system medical condition(s):
- a. CRS condition(s) that qualify for CRS medical eligibility:
 - i. A burn scar that is functionally limiting,
 - ii. A hemangioma that is functionally limiting that requires laser or surgery,
 - iii. Complicated nevi requiring multiple procedures,
 - iv. Cystic hygroma such as lymphangioma, and
 - v. Malocclusion that is functionally limiting.
 - b. Condition(s) not medically eligible for CRS:
 - i. A deformity that is not functionally limiting,
 - ii. Ectodermal dysplasia,
 - iii. Isolated malocclusion that is not functionally limiting,
 - iv. Pilonidal cyst,
 - v. Port wine stain,
 - vi. Sebaceous cyst,
 - vii. Simple nevi, and
 - viii. Skin tag.
11. Metabolic CRS condition(s) that qualify for CRS medical eligibility:
- a. Amino acid or organic acidopathy,
 - b. Biotinidase deficiency,
 - c. Homocystinuria,
 - d. Inborn error of metabolism,
 - e. Maple syrup urine disease,
 - f. Phenylketonuria, and

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- g. Storage disease.
- 12. Hemoglobinopathies CRS condition(s) that qualify for CRS medical eligibility:
 - a. Sickle cell anemia, and
 - b. Thalassemia.
- 13. Additional medical/behavioral condition(s) which are not medically eligible for CRS:
 - a. Allergies,
 - b. Anorexia nervosa or obesity,
 - c. Attention deficit disorder,
 - d. Autism,
 - e. Cancer,
 - f. Depression or other mental illness,
 - g. Developmental delay,
 - h. Dyslexia or other learning disabilities,
 - i. Failure to thrive,
 - j. Hyperactivity, and
 - k. Immunodeficiency, such as AIDS and HIV.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).
 Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).
 Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2022, effective October 1, 2015 (Supp. 15-3).
 Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

R9-22-1304. Referral and Disposition of CRS Medical Eligibility Determination

- A. To refer an individual for a CRS medical eligibility determination a person shall submit to the Administration the following information:
 - 1. CRS application;
 - 2. Documentation from a specialist who diagnosed the individual, stating the individual's diagnosis;
 - 3. Diagnostic test results that support the individual's diagnosis; and
 - 4. Documentation of the individual's need for specialized treatment of the CRS condition through medical, surgical, or therapy modalities.
- B. The Administration shall notify the CRS applicant, member or authorized representative of the outcome of the determination within 60 days of receipt of information required under subsection (A). The member may appeal the determination under Chapter 34.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).
 Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).
 Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2022, effective October 1, 2015 (Supp. 15-3).

R9-22-1305. CRS Redetermination

- A. Continued eligibility for CRS services shall be redetermined by verifying active treatment status of the CRS qualifying medical condition(s) as follows:
 - 1. The contractor is responsible for notifying the AHCCCS Administration of the date when a member with a CRS Designation is no longer in active treatment for the qualifying condition(s).
 - 2. The Administration may request, at any time, that the contractor submit the medical documentation to the Administration for a CRS medical redetermination within the specified time-frames in contract.
 - 3. The Administration shall notify the member or authorized representative of the outcome of the redetermination.
- B. If the Administration determines that a member is no longer medically eligible for a CRS Designation, the Administration shall provide the member or authorized representative a written notice that informs the member that the Administration is ending the member's CRS Designation. The member may appeal the redetermination under A.A.C. Title 9, Chapter 34.
- C. Upon reaching his or her 21st birthday, the member's CRS Designation will be ended.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).
 Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).
 Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

R9-22-1306. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Repealed by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

R9-22-1307. Covered Services

The Administration will cover medically necessary services as described within Article 2 unless otherwise specified in contract.

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3).
 Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).
 Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3).

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R9-22-1308. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3).
Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

R9-22-1309. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3).
Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR HOUSEHOLDS**R9-22-1401. General Information**

A. Scope. This Article contains eligibility criteria to determine whether a household or individual is eligible for AHCCCS medical coverage. Eligibility criteria described under Article 3 applies to this Article.

B. Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article, Article 3 and Article 15 have the following meanings unless the context explicitly requires another meaning:

“Burial plot” means a space reserved in a cemetery, crypt, vault, or mausoleum for the remains of a deceased person.

“Caretaker relative” means:

A parent of a dependent child with whom the child is living;

When the dependent child does not live with a parent or the parent in the home is incapacitated, another relative of the child by blood, adoption, or marriage in the home who assumes primary responsibility for the child’s care; or

A woman in her third trimester of pregnancy with no other dependent children.

“Cash assistance” means a program administered by the Department that provides assistance to needy families with dependent children under 42 U.S.C. 601 et seq.

“Dependent child” means a child under the age of 18, or if age 18 is a full-time student in secondary school or equivalent vocational or technical training, if reasonably expected to complete such school or training before turning age 19.

“MAGI – based income” means Modified Adjusted Gross Income as defined under 42 CFR 435.603(e).

“Medical expense deduction” or “MED” means the cost of the following expenses if incurred in the United States:

A medical service or supply that would be covered if provided to an AHCCCS member of any age under Articles 2 and 12 of this Chapter;

A medical service or supply that would be covered if provided to an Arizona Long-term Care System member under 9 A.A.C. 28, Articles 2 and 11;

Other necessary medical services provided by a licensed practitioner or physician;

Assistance with daily living if the assistance is documented in an individual plan of care by a nurse, social service worker, registered therapist, or dietitian under the supervision of a physician except when provided by the spouse of an applicant or the parent of a minor child;

Medical services provided in a licensed nursing home or in an alternative HCBS setting under R9-28-101;

Purchasing and maintaining an animal guide or service animal for the assistance of a member of the MED family unit under R9-22-1436; and

Health insurance premiums, deductibles, and coinsurance, if the insured is a member of the MED family unit.

“Monthly income” means the gross countable income received or projected to be received during the month or the monthly equivalent.

“Monthly equivalent” means a monthly countable income amount established by averaging, prorating, or converting a person’s income.

“Spendthrift restriction” means a legal restriction on the use of a resource that prevents a payee or beneficiary from alienating the resource.

“Tax dependent” is described under 42 CFR 435.4.

“Taxpayer” means a person who expects to file a tax return, and does not expect to be claimed as a tax dependent by another person.

“Title IV-D” means Title IV-D of the Social Security Act, 42 U.S.C. 651-669, the statutes establishing the child support enforcement and paternity program.

“Title IV-E” means Title IV-E of the Social Security Act 42 U.S.C. 670-679, the statutes establishing the foster care and adoption assistance programs.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1). Punctuation error corrected with a parenthesis added at the beginning of the definition “Caretaker” (Supp. 20-4).

R9-22-1402. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

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R9-22-1403. Agency Responsible for Determining Eligibility
The Administration or its designee shall determine eligibility under the provisions of this Article. The Administration or its designee shall not discriminate against an applicant or member because of race, color, creed, religion, ancestry, national origin, age, sex, or physical or mental disability.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1404. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1405. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1406. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1407. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 19 A.A.R. 3309,

November 30, 2013 (Supp. 13-4). Section repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; this Section was slated to be codified as repealed in Supp. 14-1. Due to a clerical error the Section wasn't repealed in this Chapter until Supp. 20-4.

R9-22-1408. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1409. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1410. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1411. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1412. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

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Amended by exempt rulemaking at 10 A.A.R. 23, effective December 9, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1413. Time-frames, Reinstatement of an Application

- A. The Administration or its designee shall complete an eligibility determination under R9-22-306(A)(1) unless:
1. The applicant is pregnant. The Administration or its designee shall complete an eligibility determination for a pregnant woman within 20 days after the application date unless additional information is required to determine eligibility; or
 2. The applicant is in a hospital as an inpatient at the time of application. Within seven days of the Administration or its designee's receipt of a signed application the Administration or its designee shall complete an eligibility determination if the Administration or its designee does not need additional information or verification to determine eligibility.
- B. The Administration or its designee shall reopen or reinstate eligibility of an individual who is discontinued for failure to submit the renewal form or necessary information, without requiring a new application, if the individual submits the renewal form or necessary information within 90 days after the date of discontinuance.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1414. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1415. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192,

with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1416. Effective Date of Eligibility

- A. Except as provided in R9-22-303 and subsections (B), (C) and (D), the effective date of eligibility is the first day of the month that the applicant files an application if the applicant is eligible that month, or the first day of the first eligible month following the application month except for:
1. The MED program under R9-22-1439, and
 2. Eligibility for a newborn under R9-22-1429.
- B. The effective date of eligibility for an applicant who moves into Arizona is no sooner than the date Arizona residency is established.
- C. The effective date of eligibility for an inmate applying for medical coverage is the date the applicant no longer meets the definition of an inmate of a public institution.
- D. The effective date of eligibility for a newborn is no sooner than the date of birth.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1417. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1418. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1419. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final

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rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1419.01. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1419.02. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1419.03. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1419.04. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1420. Income Eligibility Criteria

A. Evaluation of income. In determining eligibility, the Administration or its designee shall evaluate the following types of income received by a person identified in subsection (B):

1. Earned income, including in-kind income, before any deductions. For purposes of this Section, in-kind income means room, board, or provision for other needs in exchange for work performed. The person identified in subsection (B) shall ensure that the provider of the in-kind income establishes and verifies the monetary value of the item provided. The provider may be, but is not limited to:
 - a. A landlord who provides all or a portion of rent or utilities in exchange for services;
 - b. A store owner who gives goods such as groceries, clothes, or furniture in exchange for services; or
 - c. An individual who trades goods such as a car, tools, trailer, building material, or gasoline in exchange for services;
2. Self-employment income under R9-22-1424, including gross business receipts minus business expenses; and
3. Unearned income, including deemed income under R9-22-317 from the sponsor of a non-citizen applicant.

B. MAGI income group. The Administration or its designee shall include the following persons in the MAGI income group:

1. When the applicant is a taxpayer include:
 - a. The applicant,
 - b. Everyone the applicant expects to claim as a tax dependent for the current year, and
 - c. The applicant's spouse, when living with the applicant.

2. Except as provided in subsection (B)(3), when the applicant expects to be claimed as a tax dependent for the current year include:

- a. The taxpayer claiming the applicant,
- b. Everyone else the taxpayer expects to claim as a tax dependent,
- c. The taxpayer's spouse when living with the taxpayer, and
- d. The applicant's spouse, when living with the applicant.

3. When any of the following apply, determine the persons whose income is included as described in subsection (4)(a) or (4)(b) based on the applicant's age:

- a. The applicant expects to be claimed as a tax dependent by someone other than a spouse or natural, adopted or step-parent;
- b. The applicant is under age 19, expects to be claimed as a tax dependent by a natural, adopted or step-parent, lives with more than one such parent and the parents do not expect to file a joint tax return; or
- c. The applicant is under age 19 and expects to be claimed as a tax dependent by a non-custodial parent.

4. When the applicant is not a taxpayer, does not expect to be claimed as a tax dependent and is:

- a. Under age 19. Include the income of the applicant and when living with the applicant, the applicant's:
 - i. Spouse;
 - ii. Natural, adopted and step-children;
 - iii. Natural, adopted and step-parents;
 - iv. Natural, adopted and step-siblings; and
- b. Age 19 or older. Include the income of the applicant and when living with the applicant, the applicant's:
 - i. Spouse;
 - ii. Natural, adopted and step-children under age 19.

5. When the applicant is a pregnant woman, the Administration or its designee shall also include the number of expected babies only for the pregnant woman's income group.

6. When the taxpayer cannot reasonably establish that a person is the taxpayer's tax dependent, inclusion of the person in the taxpayer's MAGI income group is determined as provided in subsection (B)(4).

C. A person whose income is counted. The Administration or its designee shall count the MAGI-based income of all members of an applicant's MAGI income group with the following exceptions:

1. The income of an individual who is included in the MAGI income group of his or her natural, adoptive or step parent and is not expected to be required to file a tax return for the year in which eligibility for Medicaid is being determined, is not counted whether or not the individual files a tax return.
2. The income of a tax dependent other than the taxpayer's spouse or biological, adopted or stepchild who is not expected to be required to file a tax return for the year in which eligibility for Medicaid is being determined is not counted when the tax dependent is included in the taxpayer's MAGI income group, whether or not the tax dependent files a tax return.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section

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repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1421. MAGI based Income Eligibility

- A. In determining eligibility, if an individual would otherwise be ineligible under this Article due to excess income, the Administration or its designee shall subtract an amount equivalent to five percentage points of the Federal Poverty Level (FPL) from the household income.
- B. A person is eligible under this Article when:
 - 1. Subject to subsection (A), the monthly household income does not exceed the appropriate FPL;
 - 2. If ineligible under (B)(1), the household income determined in accordance with 26 CFR 1.36B-1(e) is below 100 percent FPL; or
 - 3. For eligibility under R9-22-1437, the person's income during the period defined in R9-22-1437(C) does not exceed the FPL under R9-22-1437(B).
- C. The Administration or its designee shall consider the following factors when determining the income period to use to determine monthly income:
 - 1. Type of income,
 - 2. Frequency of income,
 - 3. If source of income is new or terminated, or
 - 4. Income fluctuation.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1422. Methods for Calculating Monthly Income

- A. Projecting income.
 - 1. Description. Projecting income is a method of determining the amount of income that a person will receive.
 - 2. Calculation. The Administration or its designee shall project income by:
 - a. Converting income to a monthly equivalent,
 - b. Using unconverted income, or
 - c. Prorating income to determine a monthly equivalent.
 - 3. Exclusion. When calculating projected monthly income, the Administration or its designee shall exclude an unusual variation in income under R9-22-1424(E), except for a month in which the variation is anticipated to occur.
- B. Averaged income.
 - 1. Description. Averaging income proportionally distributes the person's income received on a regular basis.
 - 2. Calculation. To average income, the Administration or its designee shall add the amount of the income and divide by the total number of pay periods. If the amount of income received per pay period fluctuates, and the fluctuation is expected to continue, the Administration or its designee shall:
 - a. Use the averaged weekly or bi-weekly amounts to convert weekly or bi-weekly income to a monthly equivalent;
 - b. Use the averaged monthly or semi-monthly amounts to project monthly income; and
 - c. Use the averaged hours worked and multiply the average by the current rate of pay. If there is a change in the rate of pay, use the new rate of pay when calculating projected income under subsection (A).

C. Prorated income.

- 1. Description. Prorated income evenly distributes a person's income over the period the income is intended to cover to calculate a monthly equivalent.
- 2. Calculation. To prorate income, the Administration or its designee shall divide the total amount of the person's income received during the period by the number of months that the income is intended to cover.

D. Converted income.

- 1. Description. Converted income is income received weekly or biweekly that is changed to a monthly equivalent.
- 2. Calculation.
 - a. The Administration or its designee shall average the weekly or bi-weekly income amounts before converting to the monthly equivalent if the person's past income fluctuates and the fluctuation is expected to recur.
 - b. To convert income paid weekly to a monthly equivalent, the Administration or its designee shall multiply the weekly average by 4.3 weeks.
 - c. To convert income paid bi-weekly to a monthly equivalent, the Administration or its designee shall multiply the bi-weekly average by 2.15 weeks.

E. Unconverted income.

- 1. Description. Unconverted income is the actual amount of income received or projected to be received during a month.
- 2. Calculation. The Administration or its designee shall sum the actual amount of income received or projected to be received during a month.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1423. Calculations and Use of Methods Listed in R9-22-1422 Based on Frequency of Income

- A. Monthly income. If otherwise countable income is received monthly or in a lump sum, the Administration or its designee shall use the unconverted method for calculating monthly income.
 - 1. Lump sum means a nonrecurring payment that serves as a complete payment.
 - 2. Lump sum payments include but are not limited to: rebates or credits; inheritances; insurance settlements; and payments for prior months from such sources as Social Security, Railroad Retirement, or other benefits.

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3. A lump sum payment may include a portion intended for the current month.
- B.** Weekly income. If income is received weekly, the Administration or its designee shall convert the income to a monthly equivalent under R9-22-1422(D).
- C.** Bi-weekly income. If income is received bi-weekly, the Administration or its designee shall convert the income to a monthly equivalent under R9-22-1422(D).
- D.** Semi-monthly or daily income. If income is received semi-monthly or daily, the Administration or its designee shall use the unconverted method for calculating monthly income under R9-22-1422(E).
- E.** Bimonthly, quarterly, semi-annual, or annual income. If income is received bimonthly, quarterly, semi-annually, or annually, the Administration or its designee shall prorate the income received or projected to be received under R9-22-1422(C).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1424. Use of Methods Listed in R9-22-1423 Based on Type of Income

- A.** New income.
 1. Description. New income is income received from a new source during the first calendar month that the income is received from the source.
 2. Calculating monthly income.
 - a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
 - b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.
- B.** Terminated income.
 1. Terminated income is income received during the last calendar month when no more income is expected to be received from that source.
 2. Calculating monthly income.
 - a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
 - b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.
- C.** Break in income.
 1. Description. A break in income is a break in established frequency of income of one calendar month or more.
 2. Calculating monthly income.
 - a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
- D.** Contract or regular seasonal income.
 1. Descriptions.
 - a. Contract income is income a person earns under a contract that specifies a length of time the contract covers, the amount of income to be paid, and the frequency of payment.
 - b. Regular seasonal income is income that fluctuates based on season or is only received during a certain season, and can reasonably be anticipated based on history or other verification.
 2. Calculating monthly income.
 - a. When the contract or regular seasonal income will not fluctuate over the 12-month period beginning with the month the application or renewal is submitted, the Administration or its designee shall use the appropriate income calculation method in R9-22-1423 for the frequency of receipt.
 - b. When the contract or regular seasonal income is anticipated to fluctuate over the 12-month period beginning with the month the application or renewal is submitted, the Administration or its designee shall calculate the monthly income as follows:
 - i. For a one-time contract that ends between the month the application or renewal is submitted and the end of the calendar year, divide the income that will be received from the application or renewal month through the end of the calendar year by the number of months in that period to get a monthly equivalent;
 - ii. For contracts that extend into the next calendar year, contracts that are anticipated to be renewed and regular seasonal income, the Administration or its designee shall divide the income that will be received in the 12-month period beginning with the application or renewal month by 12 to get the monthly equivalent.
- E.** Unusual variation in the amount of income.
 1. Description. Unusual variation is an amount of income that is different from the established amount received and is not projected to continue or recur.
 2. Calculating monthly income.
 - a. When calculating income for the month in which an unusual variation in income occurs, the Administration or its designee shall include the unusual variation in the income calculation.
 - b. When an unusual variation in income occurs during the month, the Administration or its designee shall use the converted method for calculating monthly income if income is received weekly or bi-weekly.
 - c. When projecting income for the months following the month in which the unusual variation occurs, the Administration or its designee shall exclude the unusual variation in income from the income calculation.
- F.** Self-employment income.
 1. Description. Self-employment income is income a person earns from the person's own trade or business less allowable expenses.

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2. Calculating monthly income. The Administration or its designee shall prorate the income under R9-22-1422.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1425. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1426. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1427. Eligibility Under MAGI

- A. Caretaker Relatives. An individual is eligible for AHCCCS medical coverage as a Caretaker Relative when the individual meets the following requirements:
 1. Is a caretaker relative as defined in R9-22-1401.
 2. The total countable income under R9-22-1420(B) does not exceed 106 percent of the FPL for the number of people in the MAGI income group.
- B. Continued medical coverage.
 1. A caretaker relative eligible under subsection (A) and all dependent children eligible under subsection (D) in the caretaker relative's MAGI income group are entitled to continued AHCCCS coverage for up to 12 months if eligible under subsection (B)(1)(c)(i) and up to four months if eligible under subsection (B)(1)(c)(ii) if the MAGI income group's income exceeds the limit for the income group's size and the following conditions are met:
 - a. The caretaker relative still lives with a dependent child;
 - b. A caretaker relative in the income group received AHCCCS medical coverage under this Section for three calendar months out of the most recent six months; and
 - c. The loss of AHCCCS coverage under this Section is due to:
 - i. Increased earned income of a caretaker relative, or

- ii. Increased spousal support.

2. An applicant may be added to the continued medical coverage under subsection (B)(1), if the applicant did not reside in the household at the time continued medical coverage under this Section was determined and the applicant is:
 - a. The spouse or dependent child of a caretaker relative receiving continued medical coverage, or
 - b. The parent of a dependent child who is receiving continued medical coverage.
- C. Pregnant Women. A pregnant woman is eligible for AHCCCS medical coverage when the total countable income under R9-22-1420(B) does not exceed 156 percent of the FPL for the number of people in the MAGI income group. A pregnant woman who applies for AHCCCS medical coverage during the pregnancy or postpartum period and is determined eligible, remains eligible throughout the postpartum period. The postpartum period begins the day the pregnancy terminates and ends the last day of the month in which the 60th day following pregnancy termination occurs.
- D. Children. A child less than 19 years of age is eligible for AHCCCS medical coverage when the total countable income under R9-22-1420(B) does not exceed the following percentage of the FPL for the number of people in the MAGI income group:
 1. 147 percent for a child under one year of age,
 2. 141 percent for a child age one through five years of age, or
 3. 133 percent for all other persons.
- E. Adults. An individual is eligible for AHCCCS medical coverage when the individual meets the following eligibility requirements:
 1. Is 19 years of age or older but less than 65 years of age;
 2. Is not pregnant;
 3. Is not eligible for AHCCCS Medical Coverage under any other coverage group listed in 42 U.S.C. 1396a(a)(10)(A)(i);
 4. Is not entitled to or enrolled for Medicare benefits under Part A or Part B;
 5. The total countable income under R9-22-1420(B) does not exceed 133 percent of the FPL for the number of people in the MAGI income group; and
 6. When the individual is a caretaker relative, but has income exceeding the limit in subsection (A)(2), each child under age 19 living with the individual is receiving AHCCCS medical coverage or KidsCare, or is enrolled in minimum essential coverage as defined in 42 CFR 435.4.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Section R9-22-1427 repealed; new Section R9-22-1427 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1428. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking

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at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1429. Eligibility for a Newborn

A child born to a mother eligible for and receiving medical coverage under this Article, Article 15 of the Chapter, or 9 A.A.C. 28, is automatically eligible for AHCCCS medical coverage for a period not to exceed 12 months. Automatic eligibility begins on the child's date of birth and ends with the last day of the month in which the child turns age one.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1430. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1431. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 2633, effective July 10, 2007 (Supp. 07-3). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1). Repealed by final rulemaking at 21 A.A.R. 1241, effective September 5, 2015 (Supp. 15-3).

R9-22-1432. Young Adult Transitional Insurance

An individual is eligible for AHCCCS medical coverage when the individual meets all of the following eligibility requirements:

1. Is 18 through 25 years of age;
2. Was in the custody of the Department of Economic Security under A.R.S. Title 8, Chapter 5 or Chapter 10 on the individual's 18th birthday;
3. Was eligible for and receiving AHCCCS Medical Coverage on the individual's 18th birthday; and
4. Is not eligible for AHCCCS Medical Coverage under 42 U.S.C. 1396a(a)(10)(A)(i)(I) - (VII).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1433. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1434. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4).

R9-22-1435. Eligibility for a Person With Medical Expenses Whose Income is Over 100 Percent FPL

An applicant who is not eligible for AHCCCS medical coverage due to excess income may become AHCCCS eligible by deducting medical expenses from the applicant's income. This coverage is called Medical Expense Deduction (MED).

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1436. MED Family Unit

- A. For the purpose of this Section, a child is an unmarried person under age 18.
- B. The Department shall consider each of the following to be a family when living together:
 1. A parent and the parent's children;
 2. A married couple without children;
 3. A married couple and the children of either or both spouses;
 4. Unmarried parents who live with at least one child in common, and the parents' other children, whether in common or not; and
 5. A person without children.
- C. If an applicant is pregnant, the family unit includes the number of unborn children.

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- D. A child of the children included in subsections (B)(1), (B)(3), or (B)(4) is considered part of the family unit when living together.
- E. The Department shall not include a SSI-cash recipient in the MED family unit even if the SSI-cash recipient is a parent, spouse, or child.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1437. MED Income Eligibility Requirements

- A. Income exclusions. The exclusions in R9-22-1420(C) apply to the MED family unit.
- B. Income standard.
 - 1. The Department shall divide the annual FPL for the MED family unit that is in effect during each month of the income period by 12 to determine the monthly FPL.
 - 2. The Department shall add the monthly FPLs for the income period and multiply the resulting amount by 40 percent.
 - 3. Changes to the annual FPL are implemented in April of each year.
- C. Income period. The income period is the month of application and the next two months. The Department shall add together the three months' income to establish the MED family unit's income amount.
- D. Medical expense deduction period. The medical expense deduction period is a three-month period consisting of:
 - 1. For a new application, the month before the application month, the month of application, and month following the application month; or
 - 2. For a MED eligibility review, the last month of the prior MED eligibility period and the following two months.
- E. The Department shall calculate the amount of countable monthly income as follows:
 - 1. Subtract a \$90 cost of employment allowance from the gross amount of earned income for each person whose earned income is counted;
 - 2. Disregard from the remaining earned income an amount billed by the provider for the care of each dependent child under age 18 or incapacitated adult member of the MED family unit if the care is for the purpose of allowing the person to work. If more than one person in the household is responsible for and billed for the care of a dependent child, the disregard may be split between the wage earners if splitting the disregard is to the benefit of the family, but shall not exceed the maximum disregards as follows:
 - a. A maximum of \$200 for a child under age two and \$175 for other dependents for a wage-earner employed full-time (86 or more hours per month); and
 - b. A maximum of \$100 for a child under age two, and \$88 for other dependents for a wage earner employed part-time (less than 86 hours a month);
 - 3. Add the remaining earned income for each MED family member to the unearned income of all MED family members;
 - 4. Compare the MED family's unit countable income amount to the income standard in subsection (B). The difference is the amount of medical expenses the family

shall incur during the medical expense deduction period to become eligible;

- 5. Subtract allowable medical expense deductions that were incurred by:
 - a. A member of the MED family unit;
 - b. A deceased spouse or minor child of a MED family unit if this person would have been a member of the MED unit during the MED expense deduction period;
 - c. A person who was a minor child of a MED family unit member when the expense was incurred but who is no longer a minor child; or
 - d. A minor child, including a child who is a runaway, who left home before the date of application to live with someone other than a parent; and
- 6. Compare the net MED family income to the income standard listed in subsection (B).
- F. The family is eligible if the net income in subsection (E)(6) does not exceed the income standard in subsection (B).

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1438. MED Resource Eligibility Requirements

- A. Including countable resources. The Department shall include the resources not excluded that belong to and are available to members of the family of a qualified alien under A.R.S. § 36-2903.03 and the sponsor and sponsor's spouse of a person who is a qualified alien.
- B. Ownership and availability. The Department shall evaluate the ownership of resources to determine the availability of resources to a person listed in subsection (A).
 - 1. Jointly owned resources with ownership records containing the words "and" or "and/or" between the owners' names are available to each owner except if one of the owners refuses to sell. A consent to sale is not required if all owners are members of the MED family unit.
 - 2. Jointly owned resources with ownership records containing the word "or" between the owners' names are presumed to be available in full to each owner. The applicant or member may rebut the presumption by providing clear and convincing evidence of intent to establish a different type of ownership. If the presumption is rebutted, the resource is available to the owners:
 - a. Consistent with the intent of the owners, or
 - b. Based on each owner's proportionate net contribution if there is not clear and convincing evidence of a different allocation.
 - 3. The Department shall establish availability of a trust under 42 U.S.C. 1396p(d)(4)(A) or (C).
- C. Unavailability. The Department shall consider the following resources unavailable:
 - 1. Property subject to spendthrift restriction, such as:
 - a. Accounts established by the SSA, Veteran's Administration, or similar sources that mandate that the funds in the account be used for the benefit of a person not residing with the MED family unit; or
 - b. Trusts established by a will or funded solely by the income and resources of someone other than a member of the MED family unit.
 - 2. A resource being disputed in a divorce proceeding or probate matter;
 - 3. Real property located on a Native American reservation;

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4. A resource held by a conservator to the extent court-imposed restrictions make the resource unavailable to the applicant, member, or member of the family unit for:
 - a. Medical care,
 - b. Food,
 - c. Clothing, or
 - d. Shelter.
- D. Resource exclusion. The Department shall exclude the following resources from the calculation of resources under subsection (E):
 1. One burial plot for each person listed in R9-22-1436;
 2. Household furnishings and personal items that are necessary for day-to-day living;
 3. Up to \$1500 of the value of one prepaid funeral plan for each person listed in R9-22-1436 that specifically covers only funeral-related expenses as evidenced by a written contract;
 4. The value of one motor vehicle regularly used for transportation. If the MED family unit owns more than one vehicle, the exclusion is applied to the vehicle with the highest equity value;
 5. The value of a vehicle used to earn income and not used simply for transportation to and from employment;
 6. The value of a vehicle in which a SSI-cash recipient has an ownership interest; and
 7. The value of any vehicle used for medical treatment, employment, or transportation of a SSI-cash disabled child, and that is excluded by SSI for that reason.
 8. Funds set aside in an Individual Development Account under 6 A.A.C. 12, Article 4; and
 9. Any other resource specifically excluded by federal law.
- E. Calculation of resources. The Department shall determine the value of all household resources as follows:
 1. Calculate the total amount of countable liquid resources;
 2. Calculate the equity value of each countable non-liquid resource. The Department shall determine the equity value of a countable non-liquid resource by subtracting the amount of valid encumbrances on that resource from:
 - a. The market value of real property if there is no assessor's evaluation of the property,
 - b. The market value of real property if the assessor's value of the real property does not include the value of permanent structures on that property,
 - c. The assessor's full cash value if subsections (E)(2)(a) and (E)(2)(b) do not apply, and
 - d. The market value of a non-liquid resource that is not real property;
 3. Not assign an equity value to a resource that is less than zero; and
 4. Determine the MED family unit's resources by adding the totals determined in subsections (1) and (2).
- F. Resource standard to be eligible for MED. A person is not eligible for MED if the resources determined in subsection (E) exceed \$100,000 or if more than \$5,000 are liquid resources.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1439. MED Effective Date of Eligibility

- A. A MED family unit is eligible on the day the income and resource eligibility requirements are met but no earlier than the first day of the month of application. If the family unit meets the income requirements in the application month but does not meet the resource limit until the following month, the family

unit's effective date of eligibility is the first day of the month following the month of application.

- B. The Department shall adjust the effective date of eligibility under subsection (A) to an earlier date if:
 1. A member presents verification of additional allowable medical expenses incurred on an earlier date during the medical expense deduction period that allow the member to meet the income requirements, and
 2. The member presents the verification within 60 days of approval of eligibility under this Section.
- C. The Department shall not adjust an effective date of eligibility more than one time per application.
- D. The Department shall adjust the effective date no later than 30 days after the end of the 60-day period under subsection (B)(2).
- E. The Department shall deny an application and provide the applicant a denial notice when the applicant does not meet the MED requirements under this Article during the month of application or the month following the month of application.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1440. MED Eligibility Period

The Department shall approve eligibility for six months. Changes in circumstances do not affect eligibility for the first three months.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1441. Eligibility Appeals

- A. Adverse actions. An applicant or member may appeal by requesting a hearing from the Department concerning any of the following adverse actions:
 1. Complete or partial denial of eligibility under R9-22-1413;
 2. Suspension, termination, or reduction of AHCCCS medical coverage under R9-22-1415;
 3. Delay in the eligibility determination beyond the timeframes under this Article;
 4. The imposition of or increase in a premium or copayment; or
 5. The effective date of eligibility.
- B. Notice of Adverse Action. The Department shall personally deliver or send, by regular mail, a Notice of Adverse Action to the person affected by the action. For the purpose of this Section, the date of the Notice of Adverse Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.
- C. Automatic change and hearing rights.
 1. An applicant or a member is not entitled to a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
 2. An applicant or a member is entitled to a hearing if a federal or state law requires an automatic change and the applicant or member timely files an appeal that alleges a misapplication of the facts to the law.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1442. Cessation of MED Coverage

The Department shall not approve any individual or family who has applied on or after May 1, 2011 as eligible for MED coverage. With

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respect to any applications that are pending as of May 1, 2011, the Department shall not approve any individual or family as eligible for MED coverage who has not met all eligibility requirements prior to May 1, 2011.

Historical Note

New Section made by exempt rulemaking at 17 A.A.R. 1028, effective May 1, 2011 (Supp. 11-2).

R9-22-1443. Repealed**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 1345, effective July 8, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 2624, effective July 8, 2011 (Supp. 11-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED**R9-22-1501. General Information**

A. General. The Administration shall determine eligibility for AHCCCS medical coverage for the following applicants or members using the eligibility criteria and requirements in this Article and Article 3:

1. A person who is aged, blind, or disabled and does not receive SSI cash; and
2. A person terminated from the SSI cash program under R9-22-1505.

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

“Aged” means a person who is 65 years of age or older as specified in 42 U.S.C. 1382c(a)(1)(A).

“Blind” means a person who has been determined blind by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2) and 42 CFR 435.530 as of October 1, 2012, which are incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

“Disabled” means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E) and 42 CFR 435.540 as of October 1, 2012, which are incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

C. Eligibility effective date.

1. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the period described under R9-22-303.
2. The effective date of eligibility for an applicant who moves into Arizona is no sooner than the date Arizona residency is established.
3. The effective date of eligibility for an inmate applying for medical coverage is the date the applicant no longer meets the definition of an inmate of a public institution.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 23, effective December 9, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). Section amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; amendments to this Section were slated to be codified in Supp. 14-1 but due to a clerical error, were not published. The amendments to this Section were published in Supp. 20-4 and no additional amendments have been made to this Section since January 7, 2014 (Supp. 20-4).

R9-22-1502. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1503. Financial Eligibility Criteria

A. General income eligibility. Except as provided under subsection (B) of this rule, the Administration or its designee shall count the identified income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K.

B. Exceptions.

1. In-kind support and maintenance under 42 U.S.C. 1382a(a)(2)(A) is excluded.
2. For a person living with a spouse, the Administration or its designee calculates net income for an eligible couple under 20 CFR 416.1160 as of April 1, 2013, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments, even if the spouse is not eligible for or applying for SSI or coverage under this Article.
3. In determining the net income of a married couple living with a child or the net income of a person who is not living with a spouse but living with a child, a child allocation is allowed as a deduction from the combined net income of the couple for each child regardless of whether the child is ineligible or eligible. For the purposes of this Section, a child means a person who is unmarried, natural or adopted, and under age 18 or under age 22 if a full-time student. Each child's allocation deduction is reduced by that child's income, including public income maintenance payments, using the methodology under 20 CFR 416.1163(b)(1) and (2) as of April 1, 2013, which is incorporated by reference and on file with the Adminis-

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tration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

4. In determining the income deemed available to an applicant who is a child from an ineligible parent or parents, an allocation for each eligible or ineligible child of the parent is allowed as a deduction from the parent's income under 20 CFR 416.1165(b). The child's allocation is reduced by that child's income, including public income maintenance payments.
5. In determining the income of a person who receives an annual Title II Cost of Living Allowance (COLA) increase, the COLA amount is disregarded from January until the Administration applies the effective income limits under R9-22-1504 based on the FPL for the calendar year.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1504. Eligibility For A Person Who is Aged, Blind, or Disabled

- A. To be eligible for AHCCCS medical coverage, an applicant shall meet the conditions of eligibility and requirements in this Article and:
 1. Meet one of the income tests described in subsection (B) or (C), or
 2. The special requirements in R9-22-1505.
- B. The Administration shall determine whether the applicant's countable income, as described in R9-22-1503, is less than or equal to 100 percent of the SSI FBR, as adjusted annually.
- C. The Administration shall determine whether the applicant's countable income, as described in R9-22-1503, without deducting the amount from earned income under 42 U.S.C. 1382a(b)(4)(B)(iii), is less than or equal to 100 percent FPL as adjusted annually.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

R9-22-1505. Eligibility for Special Groups

- A. The following are considered special groups:
 1. A person meeting the requirements in A.R.S. § 36-2903.03 who:
 - a. Is aged, blind, or disabled under 42 CFR 435.520, 42 CFR 435.530, or 42 CFR 435.540 as of October 1, 2012, which are incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

- b. Received SSI cash or AHCCCS medical coverage under this subsection, or subsections (A)(2), (A)(3), or (A)(4) on or before August 21, 1996;
 - c. Was residing in the United States under color of law on or before August 21, 1996; and
 - d. Meets the requirements under this Article;
2. A disabled child (DC) under 42 U.S.C. 1396a(a)(10)(A)(i)(II). A disabled child is a child who:
 - a. Was receiving SSI cash benefits as a disabled child on August 22, 1996;
 - b. Lost SSI cash benefits effective July 1, 1997, or later, due to a disability determination under Section 211(d) of Subtitle B of P.L. 104-193;
 - c. Continues to meet the disability requirements for a child that were in effect on August 21, 1996; and
 - d. Meets the requirements under this Article;
3. A disabled adult child (DAC), under 42 U.S.C. 1383c(c) who:
 - a. Was determined disabled by the Social Security Administration before attaining the age of 22 years,
 - b. Became entitled to or received an increase in child's insurance benefits under Title II of the Act on the basis of blindness or disability,
 - c. Was terminated from SSI cash benefits due to entitlement to or an increase in income under Title II of the Act,
 - d. Meets the requirements under this Article, and
 - e. Is 18 years of age or older;
4. A disabled widow or widower (DWW) under 42 U.S.C. 1383c(b) and (d) who:
 - a. Is blind or disabled,
 - b. Is ineligible for Medicare Part A benefits,
 - c. Received SSI cash benefits the month before Title II of the Act benefit payments began,
 - d. Meets the requirements under this Article;
 - e. Is at least 50 years of age but under age 65; and
 - f. Is unmarried.
5. Under 42 CFR 435.135, a person who:
 - a. Is aged, blind, or disabled;
 - b. Receives benefits under Title II of the Act;
 - c. Received SSI cash benefits in the past;
 - d. Received SSI cash benefits and Title II of the Social Security Act benefits concurrently for at least one month anytime after April 1977;
 - e. Became ineligible for SSI cash benefits while receiving SSI and benefits under Title II of the Act concurrently; and
 - f. Meets the requirements under this Article.
- B. Income for special groups.
 1. Except as provided in subsection (B)(2), income eligibility is determined using the income criteria in R9-22-1503.
 2. Exceptions to income for special groups.
 - a. For a person in the DAC coverage group under subsection (A)(3), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(c).
 - b. For a person in the DWW coverage group, under subsection (A)(4), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(b) and (d).
 - c. For an applicant or member in the coverage group under subsection (A)(5), the portion of the appli-

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cant's or member's Title II of the Social Security Act benefits attributed to cost-of-living adjustments received by the applicant since the effective date of SSI ineligibility is disregarded in determining income eligibility under 42 CFR 435.135.

- C. 100 percent FBR. As a condition of eligibility for all special groups, countable income shall be equal to or less than 100 percent of the SSI FBR, as adjusted annually.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

R9-22-1506. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1507. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1508. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

ARTICLE 16. HOSPITAL PRESUMPTIVE ELIGIBILITY**R9-22-1601. General Eligibility Requirements**

- A. Notwithstanding Article 3, a qualified hospital may determine Hospital Presumptive Eligibility (HPE), on the basis of preliminary information, that an individual is eligible for AHCCCS medical coverage during the presumptive eligibility period described in this section, if the individual is a United States citizen or eligible qualified alien, and the individual is:
1. Pregnant with gross household income that does not exceed 156% of the FPL;
 2. An adult who meets the requirements of R9-22-1427(E);
 3. A caretaker relative as defined in R9-22-1401(B) with gross household income that does not exceed 106% of the FPL;
 4. Under age 19 with gross household income that does not exceed the limit set in R9-22-1427(D) for the child's age;
 5. A woman screened for breast or cervical cancer by an Arizona program of the National Breast and Cervical Cancer Early Detection Program who meets the requirements of R9-22-2003(A); or
 6. A former foster care child who meets the requirements of R9-22-1432.
- B. Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article

have the following meanings unless the context explicitly requires another meaning: "Qualified hospital" means a hospital that has signed an agreement with the Administration to process HPE applications and has not been disqualified.

C. Application Process:

1. Right to apply. A person may apply for presumptive eligibility for AHCCCS medical coverage by submitting an Administration-approved application to the qualified hospital.
2. Application. To initiate the application process, the qualified hospital will accept an application from the applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in section 36B(d)(1) of the Internal Revenue Service (IRS) Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant by submitting a written or online application under 42 CFR 435.907.

- D. To establish presumptive eligibility, an applicant must complete and submit an AHCCCS-approved presumptive eligibility application signed under penalty of perjury to a qualified hospital. The applicant must attest to the name(s), relationship(s), and income of all persons in the household. In addition, the applicant must provide and attest to the following information regarding each household member on whose behalf AHCCCS medical coverage is sought:

1. The individual's date of birth;
2. Whether the individual is pregnant;
3. Whether the individual has been determined eligible for Breast and Cervical Cancer Treatment Program, described under Article 20;
4. Whether the individual is a former foster child, described under R9-22-1432;
5. The U.S. citizenship status or eligible qualified alien status under A.R.S. 36-2903.03 of the individual; and
6. The individual's permanent and mailing addresses;
7. The individual's Arizona residency status; and
8. Whether the individual has Medicare coverage.

- E. Presumptive eligibility begins on the date the hospital determines an individual's presumptive eligibility and ends with the earlier of:

1. In the case of an individual on whose behalf an application has been submitted to AHCCCS or its designee under Article 3, the day on which AHCCCS or its designee makes a determination on that application; or
2. In the case of an individual on whose behalf an application has not been submitted to AHCCCS or its designee under Article 3, on the last day of the following month in which the determination of presumptive eligibility was made by the qualified hospital.

- F. An individual may not be determined presumptively eligible more often than once every two years.

G. Coverage and reimbursement of services.

1. The Administration shall provide coverage of medically necessary services described under Article 2 to persons determined eligible for HPE on a fee-for-service basis.
2. Providers shall submit claims for services provided to persons determined eligible for HPE to the Administration as described under Article 7.

- H. A member may withdraw from HPE coverage by notifying the Administration or its designee.

- I. Upon determining an individual presumptively eligible, the qualified hospital shall:

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1. Notify the applicant at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of the determination for each individual on whose behalf presumptive eligibility was requested and the effective date of the presumptive eligibility;
2. Provide the applicant with a regular AHCCCS-approved application form and inform the applicant that the applicant may file an application for Medicaid with the Administration or its designee;
3. Notify AHCCCS of the presumptive eligibility determination;
4. Notify the applicant at the time the determination is made that presumptive eligibility ends with the earlier of:
 - a. In the case of an individual on whose behalf an application has been submitted to AHCCCS or its designee under Article 3, the day on which AHCCCS or its designee makes a determination on that application; or
 - b. In the case of an individual on whose behalf an application has not been submitted to AHCCCS or its designee under Article 3, on the last day of the following month in which the determination of presumptive eligibility was made by the qualified hospital.

J. A determination by a qualified hospital that an individual is not presumptively eligible is not appealable under Chapter 34. If a qualified hospital denies an individual presumptive eligibility, the individual may apply for coverage by submitting an application to the Administration or its designee.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4). New Section made by final rulemaking at 20 A.A.R. 3436, effective January 1, 2015 (Supp. 14-4).

R9-22-1602. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1603. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1604. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R.

294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1605. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1606. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1607. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1608. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1609. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section

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expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1610. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1611. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1612. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1613. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1614. Expired**Historical Note**

New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1615. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1616. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1617. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1618. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1619. Expired**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

R9-22-1620. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1621. Reserved**R9-22-1622. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1623. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

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R9-22-1624. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1625. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1626. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1627. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1628. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1629. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1630. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1631. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1632. Reserved**R9-22-1633. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section

repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1634. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

R9-22-1635. Reserved**R9-22-1636. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

ARTICLE 17. ENROLLMENT**R9-22-1701. Enrollment-Related Definitions**

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

“Annual enrollment choice” means the annual opportunity for a person to change contractors.

“Auto-assignment algorithm” or “Algorithm” means a formula used by the Administration to assign to a contractor a member who did not make a timely choice under R9-22-1702.

“CMDP” means Comprehensive Medical and Dental Program.

“Disenrollment” means the discontinuance of a person’s entitlement to receive covered services from a contractor of record.

“Enrollment” means the process by which an eligible person becomes a member of a contractor’s plan.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

Amended to correct a typographical error, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1702. Enrollment of a Member with an AHCCCS Contractor

A. General enrollment requirements. The Administration shall enroll a member with a contractor as described in this Section, unless the member has pre-selected a contractor on the application:

1. Except as provided in subsections (A)(3), (A)(5), and (C), a member who is determined to be eligible under this Chapter and resides in an area served by more than one contractor, may choose an available contractor serving the member’s GSA within 30 days from the date of notice

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of enrollment. A Native American member may select IHS or another available contractor.

2. If the member does not make a choice under subsection (A)(1), the Administration shall immediately auto-assign the member to:
 - a. IHS if the member is a Native American living on a reservation,
 - b. A contractor based on family continuity, or
 - c. A contractor by using the auto-assignment algorithm.
3. If the member's period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days, the Administration shall enroll the member with the member's most recent contractor of record, if available, except if:
 - a. The member no longer resides in the contractor's GSA;
 - b. The contractor's contract is suspended or terminated;
 - c. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child;
 - d. The member chooses another contractor or chooses IHS, if available to the member, during the annual enrollment choice period; or
 - e. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.
4. When the member's disenrollment period is more than 90 days, the member may select a contractor as described in subsection (A)(1).
5. The Administration shall not enroll a member with a contractor if a member:
 - a. Is eligible for the FESP under R9-22-1419;
 - b. Is eligible for less than 30 days from the date the Administration receives notification of a member's eligibility, except for a member who is enrolled with CMDP or IHS;
 - c. Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with CMDP or IHS; or
 - d. Resides in an area not served by a contractor.
- B. Fee-for-service coverage.** A member not enrolled with a contractor under subsection (A)(5) shall obtain covered medical services from an AHCCCS-registered provider on a fee-for-service basis under Article 7.
- C. Foster care child.** The Administration shall enroll a member with CMDP if the member is a foster care child under A.R.S. § 8-512.
- D. Family Planning Services Extension Program.** A member eligible for the Family Planning Services Extension Program under R9-22-1431, shall remain enrolled with the member's contractor of record or IHS.
- E. Contractor or IHS enrollment change for a member.**
 1. The Administration shall change a member's enrollment if the member requests a change to an available contractor or IHS during an annual enrollment period. A Native American may change from an available contractor to IHS or from IHS to an available contractor at any time.
 2. The Administration shall approve a change in enrollment for any member if the change is a result of the final outcome of a grievance under 9 A.A.C. 34.
 3. A member may choose a different contractor if the member moves into a GSA not served by the current contrac-

tor or if the contractor is no longer available. If the member does not select a contractor, the Administration shall auto-assign the member as provided in subsection (A)(2).

4. The Administration shall provide the member 60-day advance notice of the member's option to change plans by the member's annual enrollment date.
5. A member may disenroll from a plan if:
 - a. The member moves out of the GSA;
 - b. The plan does not, because of moral or religious objections, cover the service a member seeks; or
 - c. The member needs related services to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.
6. For exceptions to this Article, the Administration shall approve a change for an enrolled member as determined by the Director.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1703. Effective Date of Enrollment with a Contractor

- A.** Effective date of enrollment. A member's date of enrollment is the date enrollment action is taken by the Administration. However, if a plan change occurs for an annual enrollment choice, the effective date is the month of the member's enrollment anniversary date.
- B.** Financial liability of the contractor. The contractor shall be financially liable for an enrolled member's care as specified in contract.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1704. Newborn Enrollment

- A. General.**
 1. The Administration shall enroll a newborn child of an eligible mother with an available contractor or IHS, based on the mother's enrollment.
 2. The Administration shall auto-assign a newborn child of an eligible mother who is not enrolled with a contractor or IHS or who is enrolled with CMDP. When a mother enrolled in CMDP has a newborn and the newborn is surrendered to Administration on Children, Youth and Families (ACYF), the newborn is then enrolled with CMDP.
 3. The Administration shall notify the mother of the right to choose a different contractor for her newborn child. The mother may make her choice within 30 days from the date of notice of enrollment.
- B.** Financial liability for newborns. The contractor shall be financially liable for the medical care of a newborn as specified in contract.

Historical Note

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New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct a typographical error, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

R9-22-1705. Guaranteed Enrollment Period

- A.** General. Except for members enrolled with IHS or CMDP, the Administration shall provide a guaranteed enrollment period for a one-time period that begins on the effective date of the member's initial enrollment with a contractor and ends on the last day of the fifth full calendar month after the date of the member's initial enrollment.
- B.** Exceptions to guaranteed period. The Administration shall not grant a guaranteed enrollment period or shall terminate a guaranteed enrollment period as provided in subsection (C), if the member:
 1. Did not meet the conditions of eligibility when initially enrolled with the contractor;
 2. Except as provided in 9 A.A.C. 22, Article 12, is an inmate of a public institution as defined in 42 CFR 435.1010;
 3. Dies;
 4. Moves out-of-state;
 5. Voluntarily withdraws from the AHCCCS program;
 6. Is adopted; or
 7. Has whereabouts that are unknown.
- C.** Disenrollment effective date. The Administration shall terminate any guaranteed enrollment period to which the member is not entitled effective on:
 1. The date the member is admitted to a public institution under subsection (B);
 2. The member's date of death;
 3. The last day of the month in which the Administration receives notification that a member moved out-of-state;
 4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program;
 5. The last day of the month in which the Administration receives notification that a member's adoption proceedings are finalized; or
 6. The last day of the month in which the Administration receives notification that a member's whereabouts are unknown.
- D.** Retroactive adjustments. The Administration shall adjust the member's eligibility and enrollment retroactively under subsection (C).

Historical Note

New Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

ARTICLE 18. RESERVED**ARTICLE 19. FREEDOM TO WORK**

Article 19, consisting of Sections R9-22-1901 through R9-22-1922, made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1901. General Freedom to Work Requirements

Under 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI), the Administration shall determine eligibility for AHCCCS medical services, under Article 2 of this Chapter, using the eligibility criteria and requirements under this Article for an applicant or member who is:

1. At least 16 years of age, but less than 65 years of age,
2. Employed, and
3. Not income eligible under A.R.S. § 36-2901(6)(a).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1902. General Administration Requirements

The Administration shall comply with the confidentiality rule under R9-22-512(C).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1903. Application for Coverage

- A.** A person may apply by submitting an application to an Administration office.
- B.** The application date is the date the application is received at an Administration office or outstation location approved by the Director as described under R9-22-1406(A).
- C.** The provisions in R9-22-1406(B) and (D) apply to this Section.
- D.** The applicant or representative who files the application may withdraw the application for coverage either orally or in writing. An applicant withdrawing an application shall receive a denial notice under R9-22-1904.
- E.** Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 45 days.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1904. Notice of Approval or Denial

The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the action, and:

1. If approved, the notice shall contain:
 - a. The effective date of eligibility,
 - b. The amount the person shall pay, and
 - c. An explanation of the person's hearing rights specified in 9 A.A.C. 34.
2. If denied, R9-22-1501(G)(3) applies.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1905. Reporting and Verifying Changes

An applicant or member shall report and verify changes, as described under R9-22-1501(H), to the Administration.

Historical Note

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New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1906. Actions that Result from a Redetermination or Change

The processing of a redetermination or change shall result in one of the following actions:

1. No change in eligibility or premium,
2. Discontinuance of eligibility if a condition of eligibility is no longer met,
3. A change in premium amount, or
4. A change in the coverage group under which a person receives AHCCCS medical coverage.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1907. Notice of Adverse Action Requirements

- A. The requirements under R9-22-1501(K)(1) apply.
- B. Advance notice of a change in eligibility or premium amount. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (C), advance notice shall be issued whenever an adverse action is taken to discontinue eligibility, or increase the premium amount.
- C. Exceptions from advance notice. A notice shall be issued to the member to discontinue eligibility no later than the effective date of action if:
 1. A member provides a clearly written statement, signed by that member, that services are no longer wanted.
 2. A member provides information that requires termination of eligibility or reduction of services, indicates that the member understands that this must be the result of supplying that information, and the member signs a written statement waiving advance notice;
 3. A member cannot be located and mail sent to the member's last known address has been returned as undeliverable subject to reinstatement of discontinued services under 42 CFR 431.231(d);
 4. A member has been admitted to a public institution where a person is ineligible for coverage;
 5. A member has been approved for Medicaid in another state; or
 6. The Administration receives information confirming the death of a member.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1908. Request for Hearing

An applicant or member may request a hearing under 9 A.A.C. 34.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1909. Conditions of Eligibility

An applicant or member shall meet the following conditions to qualify for the Freedom to Work program:

1. Furnish a valid Social Security Number (SSN);
2. Be a resident of Arizona;
3. Be a citizen of the United States, or meet requirements for a qualified alien under A.R.S. § 36-2903.03(B);
4. Be at least 16 years of age, but less than 65 years of age;
5. Have countable income that does not exceed 250 percent of FPL. The Administration shall count the income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K with the following exceptions:
 - a. The unearned income of the applicant or member shall be disregarded,
 - b. The income of a spouse or other family member shall be disregarded, and
 - c. The deduction for a minor child shall not apply;
6. Comply with the member responsibility provisions under R9-22-1502(D) and (F).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Section repealed; new Section made by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1910. Prior Quarter Eligibility

A person may be made eligible during a prior quarter period when applying for the Freedom to Work program, as described under Article 3.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). New Section made by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

R9-22-1911. Repealed

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1912. Repealed

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1913. Premium Requirements

- A. As a condition of eligibility, an applicant or member shall:
 1. Pay the premium required under subsection (B).
 2. Not have any unpaid premiums for more than one month's premium amount.
- B. The Administration shall process premiums under 9 A.A.C. 31, Article 14 with the following exceptions:
 1. A member who has countable income:
 - a. Under \$500, the monthly premium payment shall be \$0.
 - b. Over \$500 but not greater than \$750, the monthly premium payment shall be \$10.
 2. The premium for a member shall be increased by \$5 for each \$250 increase in countable income above \$750.

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Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1914. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1915. Institutionalized Person

A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution if federal financial participation (FFP) is not available, or
2. Age 21 through age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except when allowed under the Administration's Section 1115 IMD waiver or allowed under a managed care contract approved by CMS.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1916. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1917. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1918. Additional Eligibility Criteria for the Basic Coverage Group

An applicant or member shall meet the following eligibility criteria:

1. Disabled. As a condition of eligibility, an applicant or member shall be disabled. Disabled means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E), except employment activity, earnings, and substantial gainful activity shall not be considered in determining whether the individual meets the definition of disability.
2. Employed. As a condition of eligibility, an applicant or member shall be employed. Employed means that an applicant or member is paid for working and Social Security or Medicare taxes are paid on the applicant or member's work.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1919. Additional Eligibility Criteria for the Medi-**cally Improved Group**

As a condition of eligibility for the Medically Improved Group, a member shall:

1. Be employed. Under this Section, employed means an individual who:
 - a. Earns at least the minimum wage and works at least 40 hours per month, or
 - b. Has gross monthly earnings at least equal to those earned by an individual who is earning the minimum wage working 40 hours per month.
2. Cease to be eligible for medical coverage under R9-22-1918 or a similar Basic Coverage Group program administered by another state because the member, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be disabled; and
3. Continues to have a severe medically determinable impairment, as determined under Social Security Act section 1902(a)(10)(A)(ii)(XVI).

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1920. Repealed**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

R9-22-1921. Enrollment

The Administration shall enroll members under Article 17 of this Chapter. If a member has not paid a required premium, the Administration shall not grant a guaranteed enrollment period.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

R9-22-1922. Redetermination of Eligibility

- A. Redetermination. Except as provided in subsection (B), the Administration shall complete a redetermination of eligibility at least once a year.
- B. Change in circumstance. The Administration may complete a redetermination of eligibility if there is a change in the member's circumstances, including a change in disability or employment that may affect eligibility.
- C. Medical Improvement. If a member is no longer disabled under R9-22-1918, the Administration shall determine if the member is eligible under other coverage groups including the medically improved group.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

ARTICLE 20. BREAST AND CERVICAL CANCER TREATMENT PROGRAM**R9-22-2001. Breast and Cervical Cancer Treatment Program Related Definitions**

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

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“AZ-NBCCEDP” means the Arizona programs of the National Breast and Cervical Cancer Early Detection Program. AZ-NBCCEDP provides breast and cervical cancer screening and diagnosis in Arizona.

“Cryotherapy” means the destruction of abnormal tissue using an extremely cold temperature.

“LEEP” means the loop electrosurgical excision procedure that passes an electric current through a thin wire loop.

“Peer-reviewed study” means that, prior to publication, a medical study has been subjected to the review of medical experts who:

- Have expertise in the subject matter of the study,
- Evaluate the science and methodology of the study,
- Are selected by the editorial staff of the publication, and
- Review the study without knowledge of the identity or qualifications of the author.

“WWHP” means the Well Women Healthcheck Program administered by the Arizona Department of Health Services. The WWHP is one of the programs within AZ-NBCCEDP that provides breast and cervical cancer screening and diagnosis.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2002. General Requirements

- A. Confidentiality. The Administration shall maintain the confidentiality of a woman’s records and shall not disclose a woman’s financial, medical, or other confidential information except as allowed under R9-22-512.
- B. Covered services. A woman who is eligible under this Article receives all medically necessary services under Articles 2 and 12 of this Chapter.
- C. Choice of health plan. A woman who is eligible under this Article shall be enrolled with a contractor under Article 17 of this Chapter.
- D. A Native American woman who receives services through Indian Health Service (IHS) or through a tribal health program qualifies for services provided under this Article if all eligibility requirements are met.
- E. A woman qualified under this Article shall pay co-pays as described in R9-22-711.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2003. Eligibility Criteria

- A. General. To be eligible under this Article, a woman shall meet the requirements of this Article and:
 1. Be screened for breast and cervical cancer through AZ-NBCCEDP;
 2. Be less than 65 years of age;
 3. Be ineligible for Title XIX under Articles 14 and 15 in this Chapter;
 4. Receive a positive screen under subsection (A)(1), a confirmed diagnosis through AZ-NBCCEDP, and need treatment for breast cancer or cervical cancer, including a pre-cancerous cervical lesion, as specified in R9-22-2004;

5. Not be covered under creditable coverage as specified in Section 2701(c) of the Public Health Services Act, 42 U.S.C. 300gg(c). For purposes of this Article, IHS or Tribal health coverage is not considered creditable coverage as specified in 42 U.S.C. 1396a(a)(10)(A)(ii), as amended by the Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2002; and
6. Meet the requirements under R9-22-1417 and R9-22-1418.

- B. Ineligible woman. A woman is ineligible under this Article if the woman:
 1. Is an inmate of a public institution and federal financial participation (FFP) is not available,
 2. Is at least age 21 but less than age 65 and resides in an Institution for Mental Disease (IMD) as defined in R9-22-112, except if allowed under the Administration’s Section 1115 waiver, or
 3. No longer meets an eligibility requirement under this Article.
- C. Metastasized cancer. The AHCCCS Chief Medical Officer may continue a woman’s eligibility under this Article if a metastasized cancer is found in another part of the woman’s body and that metastasized cancer is a known or a presumed complication of the breast or cervical cancer as determined by the treating physician.
- D. Reoccurrence of cancer. A woman shall have eligibility reestablished after eligibility under this Article ends if the woman is screened under the AZ-NBCCEDP program and additional breast cancer or cervical cancer, including a pre-cancerous cervical lesion, is found.
- E. Ineligible male. A male is precluded from receiving screening and diagnostic services under the AZ-NBCCEDP program and is ineligible under this Article.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2004. Treatment

- A. Breast cancer. Coverage for treatment for breast cancer under this Article shall conclude on the last provider visit for the specific treatment of the cancer or at the end of hormonal therapy for the cancer, whichever is later. For purposes of this subsection treatment means:
 1. Lumpectomy or surgical removal of breast cancer;
 2. Chemotherapy;
 3. Radiation therapy; and
 4. A treatment for breast cancer that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.
- B. Pre-cancerous cervical lesion. Coverage for treatment for a pre-cancerous cervical lesion under this Article, including moderate or severe cervical dysplasia or carcinoma in situ, shall conclude on the last provider visit for specific treatment for the pre-cancerous lesion. For purposes of this subsection treatment means:
 1. Conization;
 2. LEEP;
 3. Cryotherapy; and
 4. A treatment for pre-cancerous cervical lesion that, as determined by the AHCCCS Chief Medical Officer, is

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considered the standard of care as supported by a peer-reviewed study published in a medical journal.

- C. Cervical cancer. Coverage for treatment for cervical cancer under this Article shall conclude on the last provider visit for the specific treatment for the cancer. For purposes of this subsection treatment means:
1. Surgery;
 2. Radiation therapy;
 3. Chemotherapy; and
 4. A treatment for cervical cancer that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2005. Application Process

- A. Application. A woman may apply for eligibility under this Article by submitting a complete application as specified in R9-22-1406.
- B. Submitting the application. The woman may complete and submit an application at the time of the AZ-NBCCEDP screening. The AZ-NBCCEDP staff may mail or fax the application directly to the Administration.
- C. Date of application. The date of the application is the date of the diagnostic procedure that results in a positive diagnosis for breast cancer or cervical cancer, including a pre-cancerous cervical lesion.
- D. Responsibility of a woman who is applying or who is a member. A woman who is applying or who is a member shall:
1. Provide medical insurance information, including any changes in medical insurance; and
 2. Inform the Administration about a change in address, residence, and alienage status.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2006. Approval, Denial, or Discontinuance of Eligibility

- A. Eligibility determination. The Administration shall determine eligibility under this Article and send the notice under subsection (B) or (C) within seven days of receiving a complete application.
- B. Approval. If a woman meets all the eligibility requirements in this Article, the Administration shall provide the woman with an approval notice. The approval notice shall contain:
1. The name of the eligible woman, and
 2. The effective date of eligibility.
- C. Denial. If the Administration denies eligibility, the Administration shall provide the woman with a denial notice. The denial notice shall contain:
1. The name of the ineligible woman,
 2. The specific reason why the woman is ineligible,
 3. The legal citations supporting the reason for the denial,
 4. The location where the woman can review the legal citations, and
 5. Information regarding the woman's appeal and request for hearing rights.

D. Discontinuance.

1. Except as specified in subsection (D)(2), if a woman no longer meets an eligibility requirement under this Article, the Administration shall provide the woman a Notice of Action no later than 10 days before the effective date of the discontinuance.
2. The Administration may mail the Notice of Action no later than the effective date of the discontinuance if the Administration:
 - a. Receives a written statement from the woman voluntarily withdrawing from AHCCCS,
 - b. Receives information confirming the death of the woman,
 - c. Receives returned mail with no forwarding address from the post office and the woman's whereabouts are unknown, or
 - d. Receives information confirming that the woman has been approved for Title XIX services outside the state of Arizona.
3. The Notice of Action shall contain the:
 - a. Name of the ineligible woman,
 - b. Effective date of the discontinuance,
 - c. Specific reason why the woman is discontinued,
 - d. Legal citations supporting the reason for the discontinuance,
 - e. Location where the woman can review the legal citations, and
 - f. Information regarding the woman's appeal and request for hearing rights.

- E. Request for hearing. A woman who is denied, or discontinued for the Breast and Cervical Cancer Treatment Program may request a hearing under Chapter 34.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

R9-22-2007. Effective and End Date of Eligibility

- A. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the period described under R9-22-303.
- B. The end date of eligibility:
1. For breast cancer, is 12 months after the last provider visit for a treatment specified in R9-22-2004 for the cancer or at the end of hormonal therapy for the cancer, whichever is later.
 2. For pre-cancerous cervical lesion, is four months after the last provider visit for a treatment specified in R9-22-2004 for the pre-cancerous lesion.
 3. For cervical cancer, is 12 months after the last provider visit for a treatment specified in R9-22-2004 for the cancer.

Historical Note

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4). Section amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

R9-22-2008. Redetermination of Eligibility

- A. Redetermination. Except as provided in subsection (B), the Administration shall redetermine eligibility at least once a

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

year. If a woman continues to meet the requirements of eligibility for the Breast and Cervical Cancer Treatment Program under this Article, the Administration shall notify the woman of continued eligibility. A woman is not required to be screened for breast and cervical cancer through AZ-NBC-CEDP at redetermination.

- B.** Change in circumstance. The Administration shall complete a redetermination of eligibility if there is a change in the woman's circumstances that may affect eligibility, including a change in treatment.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

ARTICLE 21. TRAUMA AND EMERGENCY SERVICES FUND

Article 21, consisting of Sections R9-22-2101 through R9-22-2103, made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).

R9-22-2101. General Provisions

- A.** A.R.S. § 36-2903.07 establishes the Administration as the authority to administer the Trauma and Emergency Services Fund.
- B.** The Administration shall distribute 90% of monies from the trauma and emergency services fund to a level I trauma center, as defined in subsection (F) of this Section, for unrecovered trauma center readiness costs as defined in subsection (F) of this Section. Reimbursement is limited to no more than the amount of unrecovered trauma center readiness costs as determined in subsections (D) and (E) of this Section. Unexpended funds may be used to reimburse unrecovered emergency room costs under subsection (C) of this Section.
- C.** The Administration shall distribute 10% of monies from the trauma and emergency services fund, for unrecovered emergency services costs, to a hospital having an emergency department, using criteria under R9-22-2103. Reimbursement is limited to no more than the amount of unrecovered emergency services costs as determined in R9-22-2103. The Administration may distribute more than 10% of the monies for unrecovered emergency room costs when there are unexpended monies under subsection (B) of this Section.
- D.** The Administration shall distribute a reporting tool and guidelines to level I trauma centers to determine, on an annual basis, the unrecovered trauma center readiness costs for level I trauma centers as defined in subsection (F) of this Section. The reporting time-frame is July 1 of the prior year through June 30 of the reporting year. A level I trauma center shall submit the requested data and a copy of the most recently completed uniform accounting report under A.R.S. § 36-125.04 to the Administration no later than October 31 of each reporting year.
- E.** When a level I trauma center closes in a county where there are one or more level I trauma center(s) remaining in operation, the following shall occur:
1. The closing level I trauma center shall submit the requested data under subsection (D) of this Section for the months of the reporting time-frame in which it met the definition of a level I trauma center, and
 2. The data under subsection (D) of this Section, which is submitted by the closing level I trauma center, shall be added to the remaining level I trauma center(s) in that county for the current reporting time-frame only.

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

1. "Level I trauma center" means any acute care hospital designated by the Arizona Department of Health Services as a level I trauma center, a provisional level I trauma center, a pediatric level I trauma center or an initial level I trauma center.
2. "Unrecovered trauma center readiness costs" means losses incurred treating trauma patients:
 - a. Determined in accordance with Generally Accepted Accounting Principles,
 - b. Based on both clinical and professional costs incurred by a level I trauma center necessary for the provision of level I trauma care, and
 - c. Based on administrative and overhead costs directly associated with providing level I trauma care.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

R9-22-2102. Distribution of Trauma and Emergency Services Fund: Level I Trauma Centers

- A.** On or after November 1, 2003, the Administration shall distribute monies, under R9-22-2101(B), to level I trauma centers using monies available in the trauma and emergency services fund at the time of payment. The Administration shall take into consideration the proportion of those hospitals' trauma case volume. The Administration shall:
1. Recalculate the November 2003 payments in July 2004 using the formula in subsection (B) of this Section;
 2. Recoup November 2003 overpayments by reducing the July 2004 distributions under subsection (C) as appropriate; and
 3. Redistribute recouped funds, with the July 2004 payment, to level I trauma centers underpaid in November 2003.
- B.** On or after January 31 of each year, the Administration shall distribute monies, under R9-22-2101(B), to level I trauma centers using monies available in the trauma and emergency services fund at the time of payment. The Administration shall determine each hospital's unrecovered trauma center readiness costs for the current fiscal year using data from the most recent reporting year as provided under R9-22-2101(D) and (E). The proportion of each hospital's share of the fund for unrecovered trauma center readiness costs is determined after considering:
1. The professional, clinical, administrative, and overhead costs directly associated with providing level I trauma care, and
 2. The volume and acuity of trauma care provided by each hospital.
- C.** On or after July 31 of each year, the Administration shall distribute monies to level I trauma centers using monies, under R9-22-2101(B), available in the trauma and emergency services fund at the time of payment according to the proportions calculated and used for the January payments in the same year, under subsection (B) of this Section.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).

R9-22-2103. Distribution of Trauma and Emergency Ser-

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vices Fund: Emergency Services

On or after June 30 of each year, the Administration shall distribute monies available in the trauma and emergency services fund at the time of payment as follows:

1. As allocated under R9-22-2101(C),
2. To hospitals that had an emergency department from July 1 through June 30 of the prior year, and
3. On a pro rata share of each hospital's cost of uncompensated emergency care as a percentage of the total statewide cost of uncompensated emergency care provided by hospitals under subsection (2) as reported in the uniform accounting reports to the Arizona Department of Health Services under A.R.S. § 36-125.04.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by exempt rulemaking at 18 A.A.R. 1748, effective July 1, 2012 (Supp. 12-2).

R9-22-2104. Additional Trauma and Emergency Services Payments under the Section 1115 Waiver

- A. Notwithstanding R9-22-2101(D), for the reporting years ending June 30, 2011 and June 30, 2012, the Administration shall distribute an amount equal to the balance of the Trauma and Emergency Services fund in the following manner:
 1. Ninety percent of the amount shall be distributed to Level I trauma centers based upon each center's pro rata share of each center's acuity-adjusted volume as a percentage of the total acuity-adjusted volume for all centers in the state. The acuity-adjusted volume is calculated by multiplying the Injury Severity Score employed by trauma.org by the number of trauma cases at that level treated at the center during the reporting year. Hospitals shall report trauma scores and case volume on a worksheet prescribed by the Administration.
 2. Ten percent of the amount shall be distributed proportionately to hospitals that had an emergency department from July 1 through June 30 of the reporting year based the pro rata share of each hospital's cost of emergency care as a percentage of the total statewide cost of emergency care provided by hospitals as reported on the Worksheet B, column 27, line 61 of the hospital's most current Medi-

care Cost Report as of January 31 following the end of each reporting year.

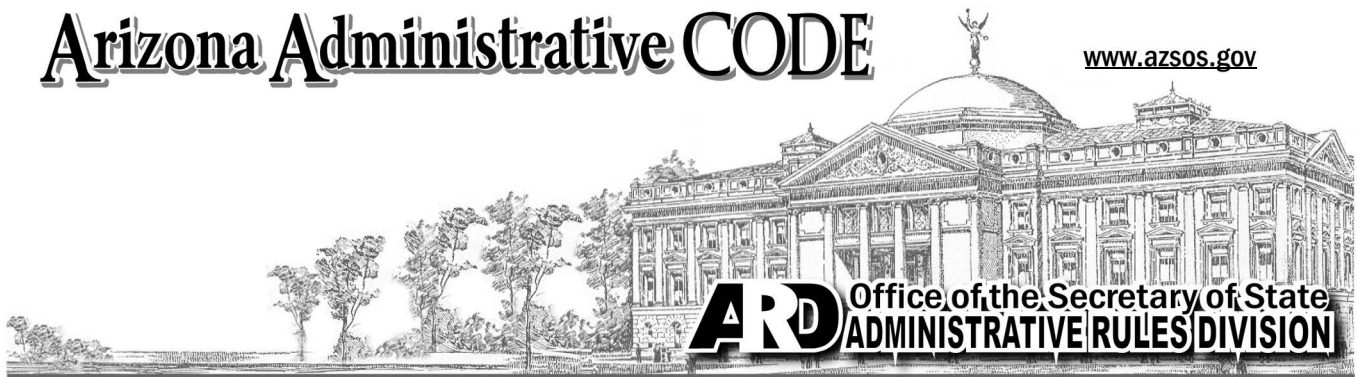
- B. For the reporting years ending June 30, 2011 and June 30, 2012, the Administration shall distribute an amount equal to the federal financial participation made available under the section 1115 waiver for the purpose of making payments for unrecovered trauma and emergency services as follows:
 1. Thirty percent of such funds to a Level I trauma center, in amounts calculated in the same manner as described in subsection (A)(1) of this Section, for any unrecovered trauma center readiness costs not reimbursed under subsection (A) of this Section;
 2. Thirty percent of such funds to a hospital having an emergency department from July 1 through June 30 of the reporting year, in amounts calculated in the same manner as described in subsection (A)(2) of this Section, for any unrecovered emergency services costs not reimbursed under subsection (A) of this Section; and
 3. Forty percent of such funds to rural hospitals, as defined in R9-22-718 that are not Level 1 trauma centers as defined in R9-22-2101(F), having an emergency department from July 1 through June 30 of the reporting year, in amounts calculated in the same manner as described in subsection (A)(2) of this Section, for any unrecovered emergency services costs not reimbursed under subsections (A) and (B)(2) of this Section.
- C. For the reporting years ending June 30, 2011 and June 30, 2012, payments made under this Article shall not be made in an amount that results in aggregate payments to the hospital by the Administration and contractors exceeding of the upper payment limit for the hospital services as calculated in accordance with 42 CFR 447.
- D. For the reporting years ending June 30, 2011 and June 30, 2012, to ensure compliance with subsection (C), payments under this Article shall be reconciled to the federal fiscal year that is two years subsequent to the payment.
- E. Any payments that are determined under subsection (D) to exceed the limit in subsection (C) shall be distributed as described in this Article to hospitals that have not received payments in excess of the limit in subsection (C).

Historical Note

New Section made by exempt rulemaking at 18 A.A.R. 1748, effective July 1, 2012 (Supp. 12-2).

Arizona Administrative CODE

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9 A.A.C. 25

Supp. 23-1

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of
January 1, 2023 through March 31, 2023

[R9-25-1303.01. Expired](#) [99](#)

Questions about these rules? Contact:

Department: Arizona Department of Health Services
Bureau of Emergency Medical Services and
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The release of this Chapter in Supp. 23-1 replaces Supp. 22-4, 1-116 pages.

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, www.azsos.gov under Services-> Legislative Filings.

EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.

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Administrative Rules Division

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TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

Authority: A.R.S. §§ 36-136(F) and 36-2209(A) et seq.

Supp. 23-1

Editor's Note: Article 5 consisting of Sections R9-25-501 through R9-25-508 were recodified from Sections in Article 8 effective September 21, 2004 (Supp. 04-3). The Sections recodified from Article 8 were originally made or amended under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6).

Editor's Note: The Office of the Secretary of State publishes all Chapters on white paper.

Editor's Note: This Chapter contains rules which were adopted, amended, and repealed under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 36-2205(C). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper.

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Article 5, consisting of R9-25-501 through R9-25-508, recodified from Article 8 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).

Article 5 repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

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Article 6, consisting of new Sections R9-25-601 and R9-25-602 made by exempt rulemaking effective April 5, 2013 (Supp. 13-1).

Article 6 repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

Article 6, consisting of Sections R9-25-601 through R9-25-616 and Exhibits L through O and Q through S, adopted effective October 15, 1996 (Supp. 96-4).

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Article 8, consisting of R9-25-801, R9-25-802, Exhibits 1 through 4, and R9-25-803 Exhibit 1, recodified from A.A.C. R9-13-1501, R9-13-1502, Exhibits 1 through 4, and R9-13-1503 Exhibit 1; originally filed under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 98-1).

Article 8, consisting of Section R9-25-805 and Exhibits 1 through 3, adopted effective May 19, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2).

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ARTICLE 1. GENERAL

R9-25-101. Definitions (Authorized by A.R.S. §§ 36-2201, 36-2202, 36-2204, and 36-2205)

In addition to the definitions in A.R.S. § 36-2201, the following definitions apply in this Chapter, unless otherwise specified:

1. "Administer" or "administration" means to directly apply or the direct application of an agent to the body of a patient by injection, inhalation, ingestion, or any other means and includes adjusting the administration rate of an agent.
2. "AEMT" has the same meaning as "advanced emergency medical technician" in A.R.S. § 36-2201.
3. "Agent" means a chemical or biological substance that is administered to a patient to treat or prevent a medical condition.
4. "ALS" has the same meaning as "advanced life support" in A.R.S. § 36-2201.
5. "ALS base hospital" has the same meaning as "advanced life support base hospital" in A.R.S. § 36-2201.
6. "Applicant" means a person requesting certification, licensure, approval, or designation from the Department under this Chapter.
7. "Chain of custody" means the transfer of physical control of and accountability for an item from one individual to another individual, documented to indicate the:
 - a. Date and time of the transfer,
 - b. Integrity of the item transferred, and
 - c. Signatures of the individual relinquishing and the individual accepting physical control of and accountability for the item.
8. "Chief administrative officer" means:
 - a. For a hospital, the same as in A.A.C. R9-10-101; and
 - b. For a training program, an individual assigned to act on behalf of the training program by the body organized to govern and manage the training program.
9. "Clinical training" means experience and instruction in providing direct patient care in a health care institution.
10. "Controlled substance" has the same meaning as in A.R.S. § 32-1901.
11. "Course" means didactic instruction and, if applicable, hands-on practical skills training, clinical training, or field training provided by a training program to prepare an individual to become or remain an EMCT.
12. "Course session" means an offering of a course, during a period of time designated by a training program certificate holder, for a specific group of students.
13. "Current" means up-to-date and extending to the present time.
14. "Day" means a calendar day.
15. "Document" or "documentation" means signed and dated information in written, photographic, electronic, or other permanent form.
16. "Drug" has the same meaning as in A.R.S. § 32-1901.
17. "Electronic signature" has the same meaning as in A.R.S. § 44-7002.
18. "EMCT" has the same meaning as "emergency medical care technician" in A.R.S. § 36-2201.
19. "EMT" has the same meaning as "emergency medical technician" in A.R.S. § 36-2201.
20. "EMT-I(99)" means an individual, other than a Paramedic, who:
 - a. Was certified as an EMCT by the Department before January 28, 2013 to perform ALS, and
 - b. Has continuously maintained the certification.
21. "EMS" has the same meaning as "emergency medical services" subsections (17)(a) through (d) in A.R.S. § 36-2201.
22. "Field training" means emergency medical services experience and training outside of a health care institution or a training program facility.
23. "General hospital" has the same meaning as in A.A.C. R9-10-101.
24. "Health care institution" has the same meaning as in A.R.S. § 36-401.
25. "Hospital" has the same meaning as in A.A.C. R9-10-101.
26. "In use" means in the immediate physical possession of an EMCT and readily accessible for potential imminent administration to a patient.
27. "Infusion pump" means a device approved by the U.S. Food and Drug Administration that, when operated mechanically, electrically, or osmotically, releases a measured amount of an agent into a patient's circulatory system in a specific period of time.
28. "Interfacility transport" means an ambulance transport of a patient from one health care institution to another health care institution.
29. "IV" means intravenous.
30. "Locked" means secured with a key, including a magnetic, electronic, or remote key, or combination so that opening is not possible except by using the key or entering the combination.
31. "Medical direction" means administrative medical direction or on-line medical direction.
32. "Medical record" has the same meaning as in A.R.S. § 36-2201.
33. "Minor" means an individual younger than 18 years of age who is not emancipated.
34. "Monitor" means to observe the administration rate of an agent and the patient's response to the agent and may include discontinuing administration of the agent.
35. "On-line medical direction" means emergency medical services guidance or information provided to an EMCT by a physician through two-way voice communication.
36. "Patient" means an individual who is sick, injured, or wounded and who requires medical monitoring, medical treatment, or transport.
37. "Pediatric" means pertaining to a child.
38. "Person" has the same meaning as in A.R.S. § 1-215 and includes governmental agencies.
39. "Physician assistant" has the same meaning as in A.R.S. § 32-2501.
40. "Practical nurse" has the same meaning as in A.R.S. § 32-1601.
41. "Practicing emergency medicine" means acting as an emergency medicine physician in a hospital emergency department.
42. "Prehospital incident history report" has the same meaning as in A.R.S. § 36-2220.
43. "Refresher challenge examination" means a test given to an individual to assess the individual's knowledge, skills, and competencies compared with the national education standards established for the applicable EMCT classification level.
44. "Refresher course" means a course intended to reinforce and update the knowledge, skills, and competencies of an individual who has previously met the national educational standards for a specific level of EMS personnel.
45. "Registered nurse" has the same meaning as in A.R.S. § 32-1601.
46. "Registered nurse practitioner" has the same meaning as in A.R.S. § 32-1601.
47. "Scene" means the location of the patient to be transported or the closest point to the patient at which an ambulance can arrive.
48. "Special hospital" has the same meaning as in A.A.C. R9-10-101.
49. "STR skill" means "Specialty Training Requirement skill," a medical treatment, procedure, or technique or administration of a medication for which an EMCT needs

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specific training beyond the training required in 9 A.A.C. 25, Article 4 in order to perform or administer.

50. "Transfer of care" means to relinquish to the control of another person the ongoing medical treatment of a patient.
51. "Transport agent" means an agent that an EMCT at a specified level of certification is authorized to administer only during interfacility transport of a patient for whom the agent's administration was started at the sending health care institution.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4).
Amended by exempt rulemaking at 7 A.A.R. 4888, effective November 1, 2001 (Supp. 01-4). Amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-102. Individuals to Act for a Person Regulated Under This Chapter (Authorized by A.R.S. § 36-2202)

When a person regulated under this Chapter is required by this Chapter to provide information on or sign an application form or other document, the following individual shall satisfy the requirement on behalf of the person regulated under this Chapter:

1. If the person regulated under this Chapter is an individual, the individual; or
2. If the person regulated under this Chapter is a business organization, political subdivision, government agency, or tribal government, the individual who the business organization, political subdivision, government agency, or tribal government has designated to act on behalf of the business organization, political subdivision, government agency, or tribal government and who:
 - a. Is a U.S. citizen or legal resident, and
 - b. Has an Arizona address.

Historical Note

New Section made by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

ARTICLE 2. MEDICAL DIRECTION; ALS BASE HOSPITAL CERTIFICATION**R9-25-201. Administrative Medical Direction (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (A)(4), 36-2204(5), (6), and (7), 36-2204.01, and 36-2205(A) and (D))**

A. An emergency medical services provider or ambulance service shall:

1. Except as specified in subsection (B) or (C), designate a physician as administrative medical director who meets one of the following:
 - a. Has emergency medicine certification issued by a member board of the American Board of Medical Specialties;
 - b. Has emergency medical services certification issued by the American Board of Emergency Medicine;
 - c. Has emergency medicine certification issued by the American Osteopathic Board of Emergency Medicine;
 - d. Has emergency medicine certification issued by the American Board of Physician Specialties;
 - e. Has completed an emergency medicine residency training program accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association; or
 - f. Is an emergency medicine physician in an emergency department located in Arizona and has current certification in:

- i. Advanced emergency cardiac life support that includes didactic instruction and a practical skills test, consistent with training recognized by the American Heart Association;
- ii. Advanced emergency trauma life support that includes didactic instruction and a practical skills test, consistent with training recognized by the American College of Surgeons; and
- iii. Pediatric advanced emergency life support that includes didactic instruction and a practical skills test, consistent with training recognized by the American Heart Association;

2. If the emergency medical services provider or ambulance service designates a physician as administrative medical director according to subsection (A)(1), notify the Department in writing:

- a. Of the identity and qualifications of the designated physician within 10 days after designating the physician as administrative medical director; and
- b. Within 10 days after learning that a physician designated as administrative medical director is no longer qualified to be an administrative medical director; and

3. Maintain for Department review:

- a. A copy of the policies, procedures, protocols, and documentation required in subsection (E); and
- b. Either:
 - i. The name, e-mail address, telephone number, and qualifications of the physician providing administrative medical direction on behalf of the emergency medical services provider or ambulance service; or
 - ii. If the emergency medical services provider or ambulance service provides administrative medical direction through an ALS base hospital or a centralized medical direction communications center, a copy of a written agreement with the ALS base hospital or centralized medical direction communications center documenting that the administrative medical director is qualified under subsection (A)(1).

B. Except as provided in R9-25-502(A)(3), if an emergency medical services provider or ambulance service provides only BLS, the emergency medical services provider or ambulance service is not required to have an administrative medical director.

C. If an emergency medical services provider or ambulance service provides administrative medical direction through an ALS base hospital or a centralized medical direction communications center, the emergency medical services provider or ambulance service shall ensure that the ALS base hospital or centralized medical direction communications center designates a physician as administrative medical director who meets one of the requirements in subsections (A)(1)(a) through (f).

D. An emergency medical services provider or ambulance service may provide administrative medical direction through an ALS base hospital certified according to R9-25-203(C), if the emergency medical services provider or ambulance service:

1. Uses the ALS base hospital for administrative medical direction only for patients who are children, and
2. Has a written agreement for the provision of administrative medical direction with an ALS base hospital that meets the requirements in R9-25-203(B)(1) or a centralized medical direction communications center.

E. An emergency medical services provider or an ambulance service shall ensure that:

1. An EMCT receives administrative medical direction as required by A.R.S. Title 36, Chapter 21.1 and this Chapter;
2. Protocols are established, documented, and implemented by an administrative medical director, consistent with

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A.R.S. Title 36, Chapter 21.1 and this Chapter, that include:

- a. A communication protocol for:
 - i. How and from what sources an EMCT requests and receives on-line medical direction,
 - ii. When and how an EMCT notifies a health care institution of the EMCT's intent to transport a patient to the health care institution, and
 - iii. What procedures an EMCT follows in the event of a communications equipment failure;
 - b. A triage protocol for:
 - i. How an EMCT assesses and prioritizes the medical condition of a patient,
 - ii. How an EMCT selects a health care institution to which a patient may be transported,
 - iii. How a patient is transported to the health care institution, and
 - iv. When on-line medical direction is required;
 - c. A treatment protocol for:
 - i. How an EMCT performs a medical treatment on a patient or administers an agent to a patient, and
 - ii. When on-line medical direction is required while an EMCT is providing treatment; and
 - d. A protocol for the transfer of information to the emergency receiving facility for:
 - i. What information is required to be communicated to emergency receiving facility staff concurrent with the transfer of care and by what method, including the condition of the patient, the treatment provided to the patient, and the patient's response to the treatment;
 - ii. What information is required to be documented on a prehospital incident history report; and
 - iii. The time-frame, which is associated with the transfer of care, for completion and submission of a prehospital incident history report;
3. Policies and procedures are established, documented, and implemented by an administrative medical director, consistent with A.R.S. Title 36, Chapter 21.1 and this Chapter, that:
- a. Are consistent with an EMCT's scope of practice, as specified in Table 5.1;
 - b. Cover:
 - i. Medical recordkeeping;
 - ii. Medical reporting, including to whom and by what method medical reporting is accomplished;
 - iii. Completion and submission of prehospital incident history reports;
 - iv. Obtaining, storing, transferring, and disposing of agents to which an EMCT has access including methods to:
 - (1) Identify individuals authorized by the administrative medical director to have access to agents,
 - (2) Maintain chain of custody for controlled substances, and
 - (3) Minimize potential degradation of agents due to temperature extremes;
 - v. Administration, monitoring, or assisting in patient self-administration of an agent;
 - vi. Monitoring and evaluating an EMCT's compliance with treatment protocols, triage protocols, and communications protocols specified in subsection (E)(2);
 - vii. Monitoring and evaluating an EMCT's compliance with medical recordkeeping, medical reporting, and prehospital incident history report requirements;
 - viii. Monitoring and evaluating an EMCT's compliance with policies and procedures for agents to which the EMCT has access;
 - ix. Monitoring and evaluating an EMCT's competency in performing skills authorized for the EMCT by the EMCT's administrative medical director and within the EMCT's scope of practice, as specified in Table 5.1;
 - x. Ongoing education, training, or remediation necessary to maintain or enhance an EMCT's competency in performing skills within the EMCT's scope of practice, as specified in Table 5.1;
 - xi. The process by which administrative medical direction is withdrawn from an EMCT; and
 - xii. The process for reinstating an EMCT's administrative medical direction; and
 - c. Include a quality assurance process to evaluate the effectiveness of the administrative medical direction provided to EMCTs;
4. Protocols in subsection (E)(2) and policies and procedures in subsection (E)(3) are reviewed annually by the administrative medical director and updated as necessary;
5. Requirements in A.R.S. Title 36, Chapter 21.1 and this Chapter are reviewed annually by the administrative medical director; and
6. The Department is notified in writing no later than ten days after the date:
- a. Administrative medical direction is withdrawn from an EMCT; or
 - b. An EMCT's administrative medical direction is reinstated.
- F. An administrative medical director for an emergency medical services provider or ambulance service shall ensure that:
1. An EMCT for whom the administrative medical director provides administrative medical direction:
 - a. Has access to at least the minimum supply of agents required for the highest level of service to be provided by the EMCT, consistent with requirements in Article 5 of this Chapter;
 - b. Administers, monitors, or assists in patient self-administration of an agent according to the requirements in policies and procedures; and
 - c. Has access to a copy of the policies and procedures required in subsection (F)(2) while on duty for the emergency medical services provider or ambulance service;
 2. Policies and procedures for agents to which an EMCT has access:
 - a. Specify that an agent is obtained only from a person:
 - i. Authorized by law to prescribe the agent, or
 - ii. Licensed under A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23 to dispense or distribute the agent;
 - b. Cover chain of custody and transfer procedures for each supply of agents, requiring an EMCT for whom the administrative medical director provides administrative medical direction to:
 - i. Document the name and the EMCT certification number or employee identification number of each individual who takes physical control of the supply of agents;
 - ii. Document the time and date that each individual takes physical control of the supply of agents;
 - iii. Inspect the supply of agents for expired agents, deteriorated agents, damaged or altered agent containers or labels, and depleted, visibly adulterated, or missing agents upon taking physical control of the supply of agents;

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- iv. Document any of the conditions in subsection (F)(2)(b)(iii);
 - v. Notify the administrative medical director of a depleted, visibly adulterated, or missing controlled substance;
 - vi. Obtain a replacement for each affected agent in subsection (F)(2)(b)(iii) for which the minimum supply is not present; and
 - vii. Record each administration of an agent on a prehospital incident history report;
 - c. Cover mechanisms for controlling inventory of agents and preventing diversion of controlled substances; and
 - d. Include that an agent is kept inaccessible to all individuals who are not authorized access to the agent by policies and procedures required under subsection (E)(3)(b)(iv)(1) and, when not being administered, is:
 - i. Secured in a dry, clean, washable receptacle;
 - ii. While on a motor vehicle or aircraft registered to the emergency medical services provider or ambulance service, secured in a manner that restricts movement of the agent and the receptacle specified in subsection (F)(2)(d)(i); and
 - iii. If a controlled substance, in a hard-shelled container that is difficult to breach without the use of a power cutting tool and:
 - (1) Locked inside a motor vehicle or aircraft registered to the emergency medical services provider or ambulance service,
 - (2) Otherwise locked and secured in such a manner as to deter misappropriation, or
 - (3) On the person of an EMCT authorized access to the agent;
 - 3. The Department is notified in writing within 10 days after the administrative medical director receives notice, as required subsection (F)(2)(b)(v), that any quantity of a controlled substance is depleted, visibly adulterated, or missing; and
 - 4. Except when the emergency medical services provider or ambulance service obtains all agents from an ALS base hospital pharmacy, which retains ownership of the agents, agents to which an EMCT has access are obtained, stored, transferred, and disposed of according to policies and procedures; A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; 4 A.A.C. 23; and requirements of the U.S. Drug Enforcement Administration.
 - G. An administrative medical director may delegate responsibilities to an individual as necessary to fulfill the requirements in this Section, if the individual is:
 - 1. Another physician,
 - 2. A physician assistant,
 - 3. A registered nurse practitioner,
 - 4. A registered nurse,
 - 5. A Paramedic, or
 - 6. An EMT-I(99).
- Historical Note**
- Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-201 renumbered to R9-25-207; new R9-25-201 made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section R9-25-201 renumbered from R9-25-202 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 953, effective July 1, 2019 (Supp. 19-2).
- R9-25-202. On-line Medical Direction (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (A)(4), 36-2204(5), (6), and (7), 36-2204.01, and 36-2205(A) and (D))**
- A. In this Section, "physician" means an individual licensed:
 - 1. According to A.R.S. Title 32, Chapter 13 or 17; or
 - 2. When working in a health care institution operating under federal or tribal law as an administrative unit of the U.S. government or a sovereign tribal nation, by a similar licensing board in another state.
 - B. An emergency medical services provider or ambulance service shall:
 - 1. Except as provided in R9-25-203(C)(3), ensure that a physician provides on-line medical direction to EMCTs on behalf of the emergency medical services provider or ambulance service only if the physician meets one of the following:
 - a. Has emergency medicine certification issued by a member board of the American Board of Medical Specialties;
 - b. Has emergency medical services certification issued by the American Board of Emergency Medicine;
 - c. Has emergency medicine certification issued by the American Osteopathic Board of Emergency Medicine;
 - d. Has emergency medicine certification issued by the American Board of Physician Specialties;
 - e. Has completed an emergency medicine residency training program accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association; or
 - f. Is an emergency medicine physician in an emergency department located in Arizona and has current certification that meets the requirements in R9-25-201(A)(1)(f)(i) through (iii);
 - 2. For each physician providing on-line medical direction on behalf of the emergency medical services provider or ambulance service, maintain for Department review either:
 - a. The name, e-mail address, telephone number, and qualifications of the physician providing on-line medical direction on behalf of the emergency medical services provider or ambulance service; or
 - b. If the emergency medical services provider or ambulance service provides on-line medical direction through an ALS base hospital or a centralized medical direction communications center, a copy of a written agreement with the ALS base hospital or centralized medical direction communications center documenting that the physician providing on-line medical direction is qualified under subsection (B)(1);
 - 3. Ensure that the on-line medical direction provided to an EMCT on behalf of the emergency medical services provider or ambulance service is consistent with:
 - a. The EMCT's scope of practice, as specified in Table 5.1; and
 - b. Communication protocols, triage protocols, treatment protocols, and protocols for prehospital incident history reports, specified in R9-25-201(E)(2); and
 - 4. Ensures that a physician providing on-line medical direction on behalf of the emergency medical services provider or ambulance service relays on-line medical direction only through one of the following individuals, under the supervision of the physician and consistent with the individual's scope of practice:
 - a. Another physician,
 - b. A physician assistant,
 - c. A registered nurse practitioner,
 - d. A registered nurse,
 - e. A Paramedic, or
 - f. An EMT-I(99).

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- C. An emergency medical services provider or ambulance service may provide on-line medical direction through an ALS base hospital certified according to R9-25-203(C), if the emergency medical services provider or ambulance service:
1. Uses the ALS base hospital for on-line medical direction only for patients who are children, and
 2. Has an additional written agreement for the provision of on-line medical direction with an ALS base hospital that meets the requirements in R9-25-203(B)(1) or a centralized medical direction communications center.
- D. An emergency medical services provider or ambulance service shall ensure that the emergency medical services provider or ambulance service, or an ALS base hospital or a centralized medical direction communications center providing on-line medical direction on behalf of the emergency medical services provider or ambulance service, has:
1. Operational and accessible communication equipment that will allow on-line medical direction to be given to an EMCT;
 2. A written plan for alternative communications with an EMCT in the event of a disaster, communication equipment breakdown or repair, power outage, or malfunction; and
 3. A physician qualified under subsection (B)(1) available to give on-line medical direction to an EMCT 24 hours a day, seven days a week.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-202 renumbered to R9-25-208; new R9-25-202 made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-202 renumbered to Section R9-25-201; new Section R9-25-202 renumbered from R9-25-203 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 953, effective July 1, 2019 (Supp. 19-2).

Exhibit A. Repealed**Historical Note**

Exhibit A adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-203. ALS Base Hospital General Requirements (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (A)(4), and 36-2204(5), (6), and (7))

- A. A person shall not operate as an ALS base hospital without certification from the Department.
- B. The Department shall certify an ALS base hospital if the applicant:
1. Is:
 - a. Licensed as a general hospital under 9 A.A.C. 10, Article 2; or
 - b. A facility operated as a hospital in this state by the United States federal government or by a sovereign tribal nation;
 2. Maintains at least one current written agreement described in A.R.S. § 36-2201(4);
 3. Has not been decertified as an ALS base hospital by the Department within five years before submitting the application;
 4. Submits an application that is complete and compliant with the requirements in this Article; and
 5. Has not knowingly provided false information on or with an application required by this Article.
- C. The Department may certify as an ALS base hospital a special hospital, which is licensed under 9 A.A.C. 10, Article 2 and provides surgical services and emergency services only to children, if the applicant:

1. Meets the requirements in subsection (B)(2) through (5);
 2. Provides administrative medical direction or on-line medical direction only for patients who are children; and
 3. Ensures that:
 - a. Administrative medical direction is provided by a physician who meets the requirements in R9-25-201(A)(1); and
 - b. On-line medical direction is provided by a physician who meets one of the following:
 - i. Meets the requirements in R9-25-202(B)(1),
 - ii. Has board certification in pediatric emergency medicine from either the American Board of Pediatrics or the American Board of Emergency Medicine, or
 - iii. Is board eligible in pediatric emergency medicine.
- D. An ALS base hospital certificate is valid only for the name and address listed by the Department on the certificate.
- E. At least every 36 months after certification, the Department shall assess an ALS base hospital to determine ongoing compliance with the requirements of this Article.
- F. The Department may inspect an ALS base hospital according to A.R.S. § 41-1009:
1. As part of the substantive review time-frame required in A.R.S. §§ 41-1072 through 41-1079; or
 2. As necessary to determine compliance with the requirements of this Article.
- G. If the Department determines that an ALS base hospital is not in compliance with the requirements in this Article, the Department may:
1. Take an enforcement action as described in R9-25-207; or
 2. Require that an ALS base hospital submit to the Department, within 15 days after written notice from the Department, a corrective action plan to address issues of compliance that do not directly affect the health or safety of a patient that:
 - a. Describes how each identified instance of non-compliance will be corrected and reoccurrence prevented, and
 - b. Includes a date for correcting each instance of non-compliance that is appropriate to the actions necessary to correct the instance of non-compliance.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-203 renumbered to Section R9-25-202; new Section R9-25-203 renumbered from R9-25-207 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 953, effective July 1, 2019 (Supp. 19-2).

R9-25-204. Application Requirements for ALS Base Hospital Certification (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (A)(4), and 36-2204(5))

- A. An applicant for ALS base hospital certification shall submit to the Department an application, including:
1. The following information in a Department-provided format:
 - a. The applicant's name, address, and telephone number;
 - b. The name, email address, and telephone number of the applicant's chief administrative officer;
 - c. The name, email address, and telephone number of the applicant's chief administrative officer's designee if the chief administrative officer will not be the liaison between the ALS base hospital and the Department;

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- d. Whether the applicant is applying for certification of a:
 - i. General hospital licensed under 9 A.A.C. 10, Article 2;
 - ii. Special hospital licensed under 9 A.A.C. 10, Article 2, that provides surgical services and emergency services only to children; or
 - iii. Facility operating as a federal or tribal hospital;
 - e. The name of each emergency medical services provider or ambulance service for which the applicant has a proposed written agreement described in A.R.S. § 36-2201(4) to provide administrative medical direction or on-line medical direction;
 - f. The name, address, email address, and telephone number of each administrative medical director;
 - g. The name of each physician providing on-line medical direction;
 - h. Attestation that the applicant meets the requirements in R9-25-202(D);
 - i. Attestation that the applicant will comply with all requirements in A.R.S. Title 36, Chapter 21.1 and this Chapter;
 - j. Attestation that all information required as part of the application has been submitted and is true and accurate; and
 - k. The signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative and date of signature or electronic signature;
- 2. A copy of the applicant's current hospital license issued under 9 A.A.C. 10, Article 2, if applicable; and
 - 3. A copy of each executed written agreement described in A.R.S. § 36-2201(4), including all attachments and exhibits.
- B.** The Department shall approve or deny an application under this Section according to Article 12 of this Chapter.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-204 renumbered to R9-25-209; new R9-25-204 made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section R9-25-204 repealed; new Section R9-25-204 renumbered from R9-25-208 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 953, effective July 1, 2019 (Supp. 19-2).

R9-25-205. Changes Affecting an ALS Base Hospital Certificate (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (A)(4), and 36-2204(5) and (6))

- A.** No later than 30 days after the date of a change in the name listed on the ALS base hospital certificate, an ALS base hospital certificate holder shall notify the Department of the change, in a Department-provided format, including:
- 1. The current name of the ALS base hospital;
 - 2. The ALS base hospital's certificate number;
 - 3. The new name and the effective date of the name change;
 - 4. Documentation supporting the name change;
 - 5. Documentation of compliance with the requirements in A.A.C. R9-10-109(A), if applicable;
 - 6. Attestation that all information submitted to the Department is true and correct; and
 - 7. The signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative and date of signature or electronic signature.
- B.** No later than 48 hours after changing the information provided according to R9-25-204(A)(1)(e) by terminating, adding, or amending a written agreement required in R9-25-203(B)(2),

an ALS base hospital certificate holder shall notify the Department of the change, including:

- 1. The following information in a Department-provided format:
 - a. The name of the ALS base hospital;
 - b. The ALS base hospital's certificate number; and
 - c. As applicable, the name of the emergency medical services provider or ambulance service for which the ALS base hospital:
 - i. Has a newly executed or amended written agreement described in A.R.S. § 36-2201(4), or
 - ii. Is no longer providing administrative medical direction or on-line medical direction under a written agreement described in A.R.S. § 36-2201(4); and
 - 2. If applicable, a copy of the newly executed or amended written agreement described in A.R.S. § 36-2201(4), including all attachments and exhibits.
- C.** No later than 10 days after the date of a change in an administrative medical director provided according to R9-25-204(A)(1)(f), an ALS base hospital certificate holder shall notify the Department of the change, in a Department-provided format, including:
- 1. The name of the ALS base hospital,
 - 2. The ALS base hospital's certificate number,
 - 3. The name of the new administrative medical director and the effective date of the change,
 - 4. Attestation that the new administrative medical director meets the requirements in R9-25-201(A)(1),
 - 5. Attestation that all information submitted to the Department is true and correct, and
 - 6. The signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative and date of signature or electronic signature.
- D.** No later than 30 days after the date of a change in the address listed on an ALS base hospital certificate or a change in ownership, as defined in A.A.C. R9-10-101, an ALS base hospital certificate holder shall submit to the Department an application required in R9-25-204(A).

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 13 A.A.R. 3014, effective October 6, 2007 (Supp. 07-3). Section R9-25-205 repealed; new Section R9-25-205 renumbered from R9-25-209 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 953, effective July 1, 2019 (Supp. 19-2).

R9-25-206. ALS Base Hospital Authority and Responsibilities (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (A)(4), 36-2204(5) and (6), 36-2208(A), and 36-2209(A)(2))

- A.** An ALS base hospital certificate holder shall:
- 1. Have the capability of providing both administrative medical direction and on-line medical direction;
 - 2. Provide administrative medical direction and on-line medical direction to an EMCT according to:
 - a. A written agreement described in A.R.S. § 36-2201(4);
 - b. The requirements in R9-25-201 for administrative medical direction; and
 - c. The requirements in R9-25-202 for on-line medical direction;
 - 3. Ensure that personnel are available to provide administrative medical direction and on-line medical direction; and
 - 4. Establish, document, and implement policies and procedures, consistent with A.R.S. Title 36, Chapter 21.1 and

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this Chapter, that include a quality assurance process to evaluate the effectiveness of the on-line medical direction provided to EMCTs.

- B.** An ALS base hospital certificate holder shall notify in writing:
1. The Department no later than 24 hours after:
 - a. Ceasing to meet a requirement in R9-25-203(B)(1) or (2); or
 - b. For a special hospital, ceasing to be licensed under 9 A.A.C. 10, Article 2, as a special hospital or to meet the requirement in R9-25-203(B)(2); and
 2. Each emergency medical services provider or ambulance service with which the ALS base hospital has a current written agreement to provide administrative medical direction or on-line medical direction no later than seven days before ceasing to provide administrative medical direction or on-line medical direction or as specified in the written agreement, whichever is earlier.
- C.** An ALS base hospital may act as a training program without training program certification from the Department, if the ALS base hospital:
1. Is eligible for training program certification as provided in R9-25-301(C); and
 2. Complies with the requirements in R9-25-301(D), R9-25-302, R9-25-303(B), (C), and (F), and R9-25-304 through R9-25-306.
- D.** If an ALS base hospital's pharmacy provides all of the agents for an emergency medical services provider or ambulance service, and the ALS base hospital owns the agents provided, the ALS base hospital's certificate holder shall ensure that:
1. Except as stated in subsections (D)(2) and (3), the policies and procedures for agents to which an EMCT has access that are established by the administrative medical director for the emergency medical services provider or ambulance service comply with requirements in R9-25-201(F)(2);
 2. The emergency medical services provider or ambulance service requires an EMCT for the emergency medical services provider or ambulance service to notify the pharmacist in charge of the hospital pharmacy of a missing, visibly adulterated, or depleted controlled substance; and
 3. The pharmacist in charge of the hospital pharmacy notifies the Department, as specified in R9-25-201(F)(3), of a missing, visibly adulterated, or depleted controlled substance.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Amended effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4). Amended by exempt rulemaking at 7 A.A.R. 4888, effective November 1, 2001 (Supp. 01-4). Former R9-25-206 renumbered to R9-25-210; new R9-25-206 made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-206 repealed; new Section R9-25-206 renumbered from R9-25-210 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 953, effective July 1, 2019 (Supp. 19-2).

The following Exhibit was repealed under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 36-2205(C). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit this change to the Secretary of State's Office for publication in the Arizona Administrative Register as proposed rules; the Department did not submit the change to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings on

the repealing of this Exhibit (Supp. 98-4).

Exhibit B. Repealed**Historical Note**

Exhibit B adopted effective October 15, 1996 (Supp. 96-4). Repealed effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4).

R9-25-207. ALS Base Hospital Enforcement Actions (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (A)(4), and 36-2204(7))

- A.** Except as provided in subsection (C), the Department may take an action listed in subsection (B) against an ALS base hospital certificate holder who:
1. Does not meet the certification requirements:
 - a. In R9-25-203(B)(1) or (2); or
 - b. For a special hospital, in R9-25-203(B)(2) and being licensed under 9 A.A.C. 10, Article 2, as a special hospital;
 2. Violates the requirements in A.R.S. Title 36, Chapter 21.1 or 9 A.A.C. 25;
 3. Does not submit a corrective action plan, as provided in R9-25-203(G)(2), that is acceptable to the Department;
 4. Does not complete a corrective action plan submitted according to R9-25-203(G)(2); or
 5. Knowingly or negligently provides false documentation or information to the Department.
- B.** The Department may take the following action against an ALS base hospital certificate holder:
1. After notice is provided according to A.R.S. Title 41, Chapter 6, Article 10, issue a letter of censure,
 2. After notice is provided according to A.R.S. Title 41, Chapter 6, Article 10, issue an order of probation,
 3. After notice and an opportunity to be heard is provided according to A.R.S. Title 41, Chapter 6, Article 10, suspend the ALS base hospital certificate, or
 4. After notice and an opportunity to be heard is provided according to A.R.S. Title 41, Chapter 6, Article 10, decertify the ALS base hospital.
- C.** An ALS base hospital operated as a hospital in this state by the United States federal government or by a sovereign tribal nation is under federal or tribal government jurisdiction.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-207 repealed; new R9-25-207 renumbered from R9-25-201 and amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-207 renumbered to Section R9-25-203; new Section R9-25-207 renumbered from Section R9-25-211 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 953, effective July 1, 2019 (Supp. 19-2).

R9-25-208. Renumbered**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-208 repealed; new R9-25-208 renumbered from R9-25-202 and amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-208 renumbered to Section R9-25-204 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-209. Renumbered

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Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-209 repealed; new R9-25-209 renumbered from R9-25-204 and amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-209 renumbered to Section R9-25-205 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-210. Renumbered**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-210 repealed; new R9-25-210 renumbered from R9-25-206 and amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section R9-25-210 renumbered to Section R9-25-206 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-211. Renumbered**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-211 repealed; new R9-25-211 renumbered from R9-25-213 and amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-211 renumbered to Section R9-25-207 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-212. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-213. Renumbered**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section renumbered to R9-25-211 by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

ARTICLE 3. TRAINING PROGRAMS**R9-25-301. Application for Certification (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))**

- A. To apply for certification as a training program, an applicant shall submit an application to the Department, in a Department-provided format, including:
1. The applicant's name, address, and telephone number;
 2. The name, telephone number, and e-mail address of the applicant's chief administrative officer;
 3. The name of each course the applicant plans to provide;
 4. Attestation that the applicant has the equipment and facilities that meet the requirements established according to A.R.S. § 36-2204 and available through the Department at www.azdhs.gov/ems-regulatory-references for the courses specified in subsection (A)(3);
 5. The name, telephone number, and e-mail address of the training program medical director;
 6. The name, telephone number, and e-mail address of the training program director;
 7. Attestation that the applicant will comply with all requirements in A.R.S. Title 36, Chapter 21.1 and 9 A.A.C. 25;

8. Attestation that all information required as part of the application has been submitted and is true and accurate; and
 9. The signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative and date of signature or electronic signature.
- B. An applicant may submit to the Department a copy of an accreditation report if the applicant is currently accredited by a national accrediting organization.
- C. The Department shall certify a training program if the applicant:
1. Has not operated a training program that has been decertified by the Department within five years before submitting the application,
 2. Submits an application that is complete and compliant with requirements in this Article, and
 3. Has not knowingly provided false information on or with an application required by this Article.
- D. The Department:
1. Shall assess a training program at least once every 24 months after certification to determine ongoing compliance with the requirements of this Article; and
 2. May inspect a training program according to A.R.S. § 41-1009:
 - a. As part of the substantive review time-frame required in A.R.S. §§ 41-1072 through 41-1079, or
 - b. As necessary to determine compliance with the requirements of this Article.
- E. The Department shall approve or deny an application under this Article according to Article 12 of this Chapter.
- F. A training program certificate is valid only for the name of the training program certificate holder and the courses listed by the Department on the certificate and may not be transferred to another person.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1). Amended by final expedited rulemaking at 24 A.A.R. 3487, with an immediate effective date of December 4, 2018 (Supp. 18-4).

R9-25-302. Administration (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))

- A. A training program certificate holder shall ensure that a training program medical director:
1. Is a physician or exempt from physician licensing requirements under A.R.S. §§ 32-1421(A)(7) or 32-1821(3);
 2. Meets one of the following:
 - a. Has emergency medicine certification issued by a member board of the American Board of Medical Specialties,
 - b. Has emergency medical services certification issued by the American Board of Emergency Medicine,
 - c. Has completed an emergency medicine residency training program accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association, or

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- d. Is an emergency medicine physician in an emergency department located in Arizona and has current certification that meets the requirements in R9-25-201(A)(1)(d)(i) through (iii); and
3. Before the start date of a course session, reviews the course content outline and final examinations to ensure consistency with the national educational standards for the applicable EMCT classification level.
- B.** A training program certificate holder shall ensure that a training program director:
 1. Is one of the following:
 - a. A physician with at least two years of experience providing emergency medical services as a physician;
 - b. A doctor of allopathic medicine or osteopathic medicine licensed in another state or jurisdiction with at least two years of experience providing emergency medical services as a doctor of allopathic medicine or osteopathic medicine;
 - c. An individual who meets the definition of registered nurse in A.R.S. § 32-1601 with at least two years of experience providing emergency medical services as a registered nurse;
 - d. A physician assistant with at least two years of experience providing emergency medical services as a physician assistant; or
 - e. An EMCT with at least two years of experience at that classification of EMCT, only for courses to prepare an individual for certification or recertification at the same or lower level of EMCT;
 2. Has completed 24 hours of training related to instructional methodology including:
 - a. Organizing and preparing materials for didactic instruction, clinical training, field training, and skills practice;
 - b. Preparing and administering tests and practical examinations;
 - c. Using equipment and supplies;
 - d. Measuring student performance;
 - e. Evaluating student performance;
 - f. Providing corrective feedback; and
 - g. Evaluating course effectiveness;
 3. Supervises the day-to-day operation of the courses offered by the training program;
 4. Supervises and evaluates the lead instructor for a course session;
 5. Monitors the training provided by all preceptors providing clinical training or field training; and
 6. Does not participate as a student in a course session, take a refresher challenge examination, or receive a certificate of completion for a course given by the training program.
- C.** A training program certificate holder shall:
 1. Maintain with an insurance company authorized to transact business in this state:
 - a. A minimum single claim professional liability insurance coverage of \$500,000, and
 - b. A minimum single claim general liability insurance coverage of \$500,000 for the operation of the training program; or
 2. Be self-insured for the amounts in subsection (C)(1).
- D.** A training program certificate holder shall ensure that policies and procedures are:
 1. Established, documented, and implemented covering:
 - a. Student enrollment, including verification that a student has proficiency in reading at the 9th grade level and meets all course admission requirements;
 - b. Maintenance of student records and medical records, including compliance with all applicable state and federal laws governing confidentiality, privacy, and security; and
 - c. For each course offered:
 - i. Student attendance requirements, including leave, absences, make-up work, tardiness, and causes for suspending or expelling a student for unsatisfactory attendance;
 - ii. Grading criteria, including the minimum grade average considered satisfactory for continued enrollment and standards for suspending or expelling a student for unsatisfactory grades;
 - iii. Administration of final examinations; and
 - iv. Student conduct, including causes for suspending or expelling a student for unsatisfactory conduct;
 2. Reviewed annually and updated as necessary; and
 3. Maintained on the premises and provided to the Department at the Department's request.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-303. Changes Affecting a Training Program Certificate (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))

- A.** No later than 10 days after a change in the name, address, or e-mail address of the training program certificate holder listed on a training program certificate, the training program certificate holder shall notify the Department of the change, in a Department-provided format, including:
 1. The current name, address, and e-mail address of the training program certificate holder;
 2. The certificate number for the training program;
 3. The new name, new address, or new e-mail address and the date of the name, address, or e-mail address change;
 4. If applicable, attestation that the training program certificate holder has insurance required in R9-25-302(C) that is valid for the new name or new address;
 5. Attestation that all information submitted to the Department is true and correct; and
 6. The signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative and date of signature or electronic signature.
- B.** No later than 10 days after a change in the training program medical director or training program director, a training program certificate holder shall notify the Department, in a Department-provided format, including:
 1. The name and address of the training program certificate holder;
 2. The certificate number for the training program;
 3. The name, telephone number, and e-mail address of the new training program medical director or training program director and the date of the change; and
 4. The signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative and date of signature or electronic signature.
- C.** A training program certificate holder that intends to add a course shall submit to the Department a request for approval, in a Department-provided format, including:
 1. The name and address of the training program certificate holder;
 2. The certificate number for the training program;
 3. The name, telephone number, and e-mail address of the applicant's chief administrative officer;

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4. The name of each course the training program certificate holder plans to add;
 5. Attestation that the training program certificate holder has the equipment and facilities that meet the requirements established according to A.R.S. § 36-2204 and available through the Department at www.azdhs.gov/ems-regulatory-references for the courses specified in subsection (C)(4);
 6. Attestation that all information required as part of the request is true and accurate; and
 7. The signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative and date of signature or electronic signature.
- D.** For notification made under subsection (A) of a change in the name or address of a certificate holder, the Department shall issue an amended certificate to the training program certificate holder that incorporates the new name or address but retains the date on the current certificate.
- E.** The Department shall approve or deny a request for the addition of a course in subsection (C) according to Article 12 of this Chapter.
- F.** A training program certificate holder shall not conduct a course until an amended certificate is issued by the Department.
- Historical Note**
- Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 3487, with an immediate effective date of December 4, 2018 (Supp. 18-4).
- R9-25-304. Course and Examination Requirements (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1), (2), and (3))**
- A.** For each course provided, a training program director shall ensure that:
1. The required equipment and facilities established for the course are available for use;
 2. The following are prepared and provided to course applicants before the start date of a course session:
 - a. A description of requirements for admission, course content, course hours, course fees, and course completion, including whether the course prepares a student for:
 - i. A national certification organization examination for the specific EMCT classification level,
 - ii. A statewide standardized certification test under the state certification process, or
 - iii. Recertification at a specific EMCT classification level;
 - b. A list of books, equipment, and supplies that a student is required to purchase for the course;
 - c. Notification of eligibility for the course as specified in R9-25-305(B), (D)(1) and (2), or (F)(1) and (2), as applicable;
 - d. Notification of any specific requirements for a student to begin any component of the course, including, as applicable:
 - i. Prerequisite knowledge, skill, and abilities;
 - ii. Physical examinations;
 - iii. Immunizations;
 - iv. Documentation of freedom from infectious tuberculosis;
 - v. Drug screening; and
 - vi. The ability to perform certain physical activities; and
 - e. The policies for the course on student attendance, grading, student conduct, and administration of final examinations, required in R9-25-302(D)(1)(c)(i) through (iv);
- 3.** Information is provided to assist a student to:
- a. Register for and take an applicable national certification organization examination;
 - b. Complete application forms for registration in a national certification organization; and
 - c. Complete application forms for certification under 9 A.A.C. 25, Article 4;
- 4.** A lead instructor is assigned to each course session who:
- a. Is one of the following:
 - i. A physician with at least two years of experience providing emergency medical services;
 - ii. A doctor of allopathic medicine or osteopathic medicine licensed in another state or jurisdiction with at least two years of experience providing emergency medical services;
 - iii. An individual who meets the definition of registered nurse in A.R.S. § 32-1601 with at least two years of experience providing emergency medical services;
 - iv. A physician assistant with at least two years of experience providing emergency medical services; or
 - v. An EMCT with at least two years of experience at that classification of EMCT, only for courses to prepare an individual for certification or recertification at the same or lower EMCT classification level;
 - b. Has completed training related to instructional methodology specified in R9-25-302(B)(2);
 - c. Except as provided in subsection (A)(4)(d), is available for student-instructor interaction during all course hours established for the course session; and
 - d. Designates an individual who meets the requirements in subsections (A)(4)(a) and (b) to be present and act as the lead instructor when the lead instructor is not present; and
- 5.** Clinical training and field training are provided:
- a. Under the supervision of a preceptor who has at least two years of experience providing emergency medical services and is one of the following:
 - i. An individual licensed in this or another state or jurisdiction as a doctor of allopathic medicine or osteopathic medicine;
 - ii. An individual licensed in this or another state or jurisdiction as a registered nurse;
 - iii. An individual licensed in this or another state or jurisdiction as a physician assistant; or
 - iv. An EMCT, only for courses to prepare an individual for certification or recertification at the same or lower EMCT classification level;
 - b. Consistent with the clinical training and field training requirements established for the course; and
 - c. If clinical training or field training are provided by a person other than the training program certificate holder, under a written agreement with the person providing the clinical training or field training that includes a termination clause that provides sufficient time for a student to complete the training upon termination of the written agreement.
- B.** A training program director may combine the students from more than one course session for didactic instruction.
- C.** For a final examination or refresher challenge examination for each course offered, a training program director shall ensure that:

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1. The final examination or refresher challenge examination for the course is completed onsite at the training program or at a facility used for course instruction;
 2. Except as provided in subsection (D), the final examination or refresher challenge examination for a course includes a:
 - a. Written test:
 - i. With one absolutely correct answer, two incorrect answers, and one distractor, none of which is "all of the above" or "none of the above";
 - ii. With 150 multiple-choice questions for the:
 - (1) Final examination for a refresher course, or
 - (2) Refresher challenge examination for a course;
 - iii. That covers the learning objectives of the course with representation from all topics covered by the course; and
 - iv. That requires a passing score of 75% or higher in no more than three attempts for a final examination and no more than one attempt for a refresher challenge examination; and
 - b. Comprehensive practical skills test:
 - i. Evaluating the student's technical proficiency in skills consistent with the national education standards for the applicable EMCT classification level, and
 - ii. Reflecting the skills necessary to pass a national certification organization examination at the applicable EMCT classification level;
 3. The identity of each student taking the final examination or refresher challenge examination is verified;
 4. A student does not receive verbal or written assistance from any other individual or use notes, books, or documents of any kind as an aid in taking the examination;
 5. A student who violates subsection (C)(4) is not permitted to complete the examination or to receive a certificate of completion for the course or refresher challenge examination; and
 6. An instructor who allows a student to violate subsection (C)(4) or assists a student in violating subsection (C)(4) is no longer permitted to serve as an instructor.
- D.** A training program director shall ensure that a standardized certification test for a student under the state certification process includes:
1. A written test that meets the requirements in subsection (C)(2)(a); and
 2. Either:
 - a. A comprehensive practical skills test that meets the requirements in subsection (C)(2)(b), or
 - b. An attestation of practical skills proficiency on a Department-provided form.
- E.** A training program director shall ensure that:
1. A student is allowed no longer than six months after the date of the last day of classroom instruction for a course session to complete all course requirements,
 2. There is a maximum ratio of four students to one preceptor for the clinical training portion of a course, and
 3. There is a maximum ratio of one student to one preceptor for the field training portion of a course.
- F.** A training program director shall:
1. For a student who completes a course, issue a certificate of completion containing:
 - a. Identification of the training program,
 - b. Identification of the course completed,
 - c. The name of the student who completed the course,
 - d. The date the student completed all course requirements,
 - e. Attestation that the student has met all course requirements, and
 - f. The signature or electronic signature of the training program director and the date of signature or electronic signature; and
2. For an individual who passes a refresher challenge examination, issue a certificate of completion containing:
- a. Identification of the training program,
 - b. Identification of the refresher challenge examination administered,
 - c. The name of the individual who passed the refresher challenge examination,
 - d. The date or dates the individual took the refresher challenge examination,
 - e. Attestation that the individual has passed the refresher challenge examination, and
 - f. The signature or electronic signature of the training program director and the date of signature or electronic signature.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-305. Supplemental Requirements for Specific Courses (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))

- A.** Except as specified in subsection (B), a training program certificate holder shall ensure that a certification course offered by the training program:
1. Covers knowledge, skills, and competencies comparable to the national education standards established for a specific EMCT classification level;
 2. Prepares a student for:
 - a. A national certification organization examination for the specific EMCT classification level, or
 - b. A standardized certification test under the state certification process;
 3. Has no more than 24 students enrolled in each session of the course; and
 4. Has a minimum course length of:
 - a. For an EMT certification course, 130 hours;
 - b. For an AEMT certification course, 244 hours, including:
 - i. A minimum of 100 contact hours of didactic instruction and practical skills training, and
 - ii. A minimum of 144 contact hours of clinical training and field training; and
 - c. For a Paramedic certification course, 1000 hours, including:
 - i. A minimum of 500 contact hours of didactic instruction and practical skills training, and
 - ii. A minimum of 500 contact hours of clinical training and field training.
- B.** A training program director shall ensure that, for an AEMT certification course or a Paramedic certification course, a student has one of the following:
1. Current certification from the Department as an EMT or higher EMCT classification level,
 2. Documentation of completion of prior training in an EMT course or a course for a higher EMCT classification level provided by a training program certified by the Department or an equivalent training program, or
 3. Documentation of current registration in a national certification organization at the EMT classification level or higher EMCT classification level.

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- C. A training program director shall ensure that for a course to prepare an EMT-I(99) for Paramedic certification:
1. A student has current certification from the Department as an EMT-I(99);
 2. The course covers the knowledge, skills, and competencies established according to A.R.S. § 36-2204 and available through the Department at www.azdhs.gov/ems-regulatory-references;
 3. The minimum course length is 600 hours, including:
 - a. A minimum of 220 contact hours of didactic instruction and practical skills training; and
 - b. A minimum of 380 contact hours of clinical training and field training; and
 4. A minimum of 60 contact hours of training in anatomy and physiology are completed by the student:
 - a. As a prerequisite to the course,
 - b. As preliminary instruction completed at the beginning of the course session before the didactic instruction required in subsection (C)(3)(a) begins, or
 - c. Through integration of the anatomy and physiology material with the units of instruction required in subsection (C)(3).
- D. A training program director shall ensure that for an EMT refresher course:
1. A student has one of the following:
 - a. Current certification from the Department as an EMT or higher EMCT classification level,
 - b. Documentation of completion of prior training in an EMT course or a course for a higher EMCT classification level provided by a training program certified by the Department or an equivalent training program,
 - c. Documentation of current registration in a national certification organization at the EMT classification level or higher EMCT classification level, or
 - d. Documentation from a national certification organization requiring the student to complete the EMT refresher course to be eligible to apply for registration in the national certification organization;
 2. A student has documentation of current certification in adult, pediatric, and infant cardiopulmonary resuscitation through instruction consistent with American Heart Association recommendations for emergency cardiovascular care by EMCTs;
 3. The EMT refresher course cover the knowledge, skills, and competencies in the national education standards established at the EMT classification level;
 4. No more than 32 students are enrolled in each session of the course; and
 5. The minimum course length is 24 contact hours.
- E. A training program authorized to provide an EMT refresher course may administer a refresher challenge examination covering materials included in the EMT refresher course to an individual eligible for admission into the EMT refresher course.
- F. A training program director shall ensure that for an ALS refresher course:
1. A student has one of the following:
 - a. Current certification from the Department as an AEMT, EMT-I(99), or Paramedic;
 - b. Documentation of completion of a prior training course, at the AEMT classification level or higher, provided by a training program certified by the Department or an equivalent training program;
 - c. Documentation of current registration in a national certification organization at the AEMT or Paramedic classification level; or
 - d. Documentation from a national certification organization requiring the student to complete the ALS refresher course to be eligible to apply for registration in the national certification organization;
 2. A student has documentation of current certification in:
 - a. Adult, pediatric, and infant cardiopulmonary resuscitation through instruction consistent with American Heart Association recommendations for emergency cardiovascular care by EMCTs, and
 - b. For a student who has current certification as an EMT-I(99) or higher level of EMCT classification, advanced emergency cardiac life support;
 3. The ALS refresher course covers:
 - a. For a student who has current certification as an AEMT or documentation of completion of prior training at an AEMT classification level, the knowledge, skills, and competencies in the national education standards established for an AEMT;
 - b. For a student who has current certification as an EMT-I(99), the knowledge, skills, and competencies established according to A.R.S. § 36-2204 for an EMT-I(99) as of the effective date of this Section and available through the Department at www.azdhs.gov/ems-regulatory-references; and
 - c. For a student who has current certification as a Paramedic or documentation of completion of prior training at a Paramedic classification level, the knowledge, skills, and competencies in the national education standards established for a Paramedic;
 4. No more than 32 students are enrolled in each session of the course; and
 5. The minimum course length is 48 contact hours.
- G. A training program authorized to provide an ALS refresher course may administer a refresher challenge examination covering materials included in the ALS refresher course to an individual eligible for admission into the ALS refresher course.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 3014, effective October 6, 2007 (Supp. 07-3). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1). Amended by final expedited rulemaking at 24 A.A.R. 3487, with an immediate effective date of December 4, 2018 (Supp. 18-4).

Exhibit F. Repealed**Historical Note**

Exhibit F adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-306. Training Program Notification and Recordkeeping (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))

- A. At least 10 days before the start date of a course session, a training program certificate holder shall submit to the Department the following information in a Department-provided format:
1. Identification of the training program;
 2. Identification of the course;
 3. The name of the training program medical director;

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4. The name of the training program director;
 5. The name of the course session's lead instructor;
 6. The course session start date and end date;
 7. The physical location at which didactic training and practical skills training will be provided;
 8. The days of the week and times of each day during which didactic training and practical skills training will be provided;
 9. The number of clock hours of didactic training and practical skills training;
 10. If applicable, the number of hours of clinical training and field training included in the course session;
 11. The date, start time, and location of the final examination for the course;
 12. Attestation that the lead instructor is qualified under R9-25-304(A)(4)(a); and
 13. The name and signature of the chief administrative officer or program director and the date signed.
- B.** The Department shall review the information submitted according to subsection (A) and, within five days after receiving the information:
1. Approve a course session, issue an identifying number to the course session, and notify the training program certificate holder of the approval and identifying number; or
 2. Disapprove a course session that does not comply with requirements in this Article and notify the training program certificate holder of the disapproval.
- C.** A training program certificate holder shall ensure that:
1. No later than 10 days after the date a student completes all course requirements, the training program director submits to the Department the following information in a Department-provided format:
 - a. Identification of the training program;
 - b. The name of the training program director;
 - c. Identification of the course and the start date and end date of the course session completed by the student;
 - d. The name, date of birth, and mailing address of the student who completed the course;
 - e. The date the student completed all course requirements;
 - f. The score the student received on the final examination;
 - g. Attestation that the student has met all course requirements;
 - h. Attestation that all information submitted is true and accurate; and
 - i. The signature of the training program director and the date signed; and
 2. No later than 10 days after the date an individual passes a refresher challenge examination administered by the training program, the training program director submits to the Department the following information in a Department-provided format:
 - a. Identification of the training program;
 - b. Identification of the:
 - i. Refresher challenge examination administered, and
 - ii. Course for which the refresher challenge examination substitutes;
 - c. The name of the training program medical director;
 - d. The name of the training program director;
 - e. The name, date of birth, and mailing address of the individual who passed the refresher challenge examination;
 - f. The date and location at which the refresher challenge examination was administered;
 - g. The score the individual received on the refresher challenge examination;
 - h. Attestation that the individual:
 - i. Met the requirements for taking the refresher challenge examination, and
 - ii. Passed the refresher challenge examination;
 - i. Attestation that all information submitted is true and accurate; and
 - j. The name and signature of the training program director and the date signed.
- D.** A training program certificate holder shall ensure that:
1. A record is established for each student enrolled in a course session, including:
 - a. The student's name and date of birth;
 - b. A copy of the student's enrollment agreement or contract;
 - c. Identification of the course in which the student is enrolled;
 - d. The start date and end date for the course session;
 - e. Documentation supporting the student's eligibility to enroll in the course;
 - f. Documentation that the student meets prerequisites for the course, established as specified in R9-25-304(A)(2)(d)(i);
 - g. The student's attendance records;
 - h. The student's clinical training records, if applicable;
 - i. The student's field training records, if applicable;
 - j. The student's grades;
 - k. Documentation of the final examination for the course, including:
 - i. A copy of each scored written test attempted or completed by the student, and
 - ii. All forms used as part of the comprehensive practical skills test attempted or completed by the student; and
 - l. A copy of the student's certificate of completion required in R9-25-304(F)(1);
 2. A student record required in subsection (D)(1) is maintained for at least three years after the end date of a student's course session and provided to the Department at the Department's request;
 3. A record is established for each individual to whom a refresher challenge examination is administered, including:
 - a. The individual's name and date of birth;
 - b. Identification of the refresher challenge examination administered to the individual;
 - c. Documentation supporting the individual's eligibility for a refresher challenge examination;
 - d. The date the refresher challenge examination was administered;
 - e. Documentation of the refresher challenge examination, including:
 - i. A copy of the scored written test attempted or completed by the individual, and
 - ii. All forms used as part of the comprehensive practical skills test attempted or completed by the individual; and
 - f. A copy of the individual's certificate of completion required in R9-25-304(F)(2); and
 4. A record required in subsection (D)(3) is maintained for at least three years after the date the refresher challenge examination was administered and provided to the Department at the Department's request.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 11 A.A.R. 553, effective March 5, 2005 (Supp. 05-1). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 3014, effective October 6, 2007 (Supp. 07-3). R9-25-306 repealed; new Section R9-25-306 renumbered from R9-25-316 and amended by exempt rulemaking at 19 A.A.R.

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282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1).

R9-25-307. Training Program Enforcement Actions (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))

- A.** The Department may take an action listed in subsection (B) against a training program certificate holder who:
1. Violates the requirements in A.R.S. Title 36, Chapter 21.1 or 9 A.A.C. 25; or
 2. Knowingly or negligently provides false documentation or information to the Department.
- B.** The Department may take the following action against a training program certificate holder:
1. After notice is provided according to A.R.S. Title 41, Chapter 6, Article 10, issue:
 - a. A letter of censure, or
 - b. An order of probation; or
 2. After notice and opportunity to be heard is provided according to A.R.S. Title 41, Chapter 6, Article 10:
 - a. Suspend the training program certificate, or
 - b. Decertify the training program.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 3014, effective October 6, 2007 (Supp. 07-3). Section expired under A.R.S. 41-1056(E) at 18 A.A.R. 2153, effective June 30, 2012 (Supp. 12-3). New Section R9-25-307 renumbered from R9-25-317 and amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

Exhibit H. Repealed

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-308. Repealed

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 3014, effective October 6, 2007 (Supp. 07-3). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

R9-25-309. Repealed

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 11 A.A.R. 553, effective March 5, 2005 (Supp. 05-1). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 3014,

effective October 6, 2007 (Supp. 07-3). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

R9-25-310. Repealed

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

R9-25-311. Repealed

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

Exhibit D. Repealed

Historical Note

Exhibit D adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

Exhibit C. Repealed

Historical Note

Exhibit C adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

Exhibit E. Repealed

Historical Note

Exhibit E adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-312. Repealed

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

R9-25-313. Repealed

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

R9-25-314. Repealed

Historical Note

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007

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(Supp. 06-4). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

R9-25-315. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

R9-25-316. Renumbered**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). R9-25-316 renumbered to R9-25-306 by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

R9-25-317. Renumbered**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). R9-25-317 renumbered to R9-25-307 by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

R9-25-318. Repealed**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

Exhibit A. Repealed**Historical Note**

New Exhibit made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Exhibit A repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

Exhibit B. Expired**Historical Note**

New Exhibit made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Exhibit B expired under A.R.S. 41-1056(E) at 18 A.A.R. 2153, effective June 30, 2012 (Supp. 12-3).

Exhibit C. Repealed**Historical Note**

New Exhibit made by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 3014, effective October 6, 2007 (Supp. 07-3). Exhibit C repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

ARTICLE 4. EMCT CERTIFICATION

Article 4 repealed; new Article 4 made by final rulemaking at

9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-401. EMCT General Requirements (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), (A)(6), and (H) and 36-2204(1), (6), and (7))

- A. Except as provided in R9-25-404(E) and R9-25-405, an individual shall not act as an EMCT unless the individual has current certification or recertification from the Department.
- B. An EMCT shall act as an EMCT only:
 1. As authorized under the EMCT's scope of practice as specified in Article 5 of this Chapter; and
 2. For an EMCT required to have medical direction according to A.R.S. Title 36, Chapter 21.1 and R9-25-502, as authorized by the EMCT's administrative medical director under:
 - a. Treatment protocols, triage protocols, and communication protocols approved by the EMCT's administrative medical director as specified in R9-25-201(E)(2); and
 - b. Medical recordkeeping, medical reporting, and pre-hospital incident history report requirements approved by the EMCT's administrative medical director as specified in R9-25-201(E)(3)(b).
- C. Except as provided in A.R.S. § 36-2211, the Department shall certify or re-certify an individual as an EMCT for a period of two years.
- D. An individual whose EMCT certificate is expired shall not apply for recertification, except as provided in R9-25-404(A).
- E. The Department shall comply with the confidentiality requirements in A.R.S. §§ 36-2220(E) and 36-2245(M).

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 13 A.A.R. 1713, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1).

R9-25-402. EMCT Certification and Recertification Requirements (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), (A)(6), and (H) and 36-2204(1), (6), and (7))

- A. The Department shall not certify an EMCT if the applicant:
 1. Is currently:
 - a. Incarcerated for a criminal conviction;
 - b. On parole for a criminal conviction;
 - c. On supervised release for a criminal conviction; or
 - d. On probation for a criminal conviction;
 2. Within 10 years before the date of filing an application for certification required by this Article, has been convicted of any of the following crimes, or any similarly defined crimes in this state or in any other state or jurisdiction, unless the conviction has been absolutely discharged, expunged, or vacated:
 - a. 1st or 2nd degree murder;
 - b. Attempted 1st or 2nd degree murder;
 - c. Sexual assault;
 - d. Attempted sexual assault;
 - e. Sexual abuse of a minor;
 - f. Attempted sexual abuse of a minor;
 - g. Sexual exploitation of a minor;
 - h. Attempted sexual exploitation of a minor;
 - i. Commercial sexual exploitation of a minor;
 - j. Attempted commercial sexual exploitation of a minor;
 - k. Molestation of a child;
 - l. Attempted molestation of a child; or

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- m. A dangerous crime against children as defined in A.R.S. § 13-705;
- 3. Within five years before the date of filing an application for certification required by this Article, has been convicted of a misdemeanor involving moral turpitude or a felony in this state or any other state or jurisdiction, other than a misdemeanor involving moral turpitude or a felony listed in subsection (A)(2), unless the conviction has been absolutely discharged, expunged, or vacated;
- 4. Within five years before the date of filing an application for certification required by this Article, has had EMCT certification or recertification revoked in this state or certification, recertification, or licensure at an EMCT classification level revoked in any other state or jurisdiction; or
- 5. Knowingly provides false information in connection with an application required by this Article.
- B. The Department shall not re-certify an EMCT, if:
 - 1. While certified, the applicant has been convicted of a crime listed in subsection (A)(2), or any similarly defined crimes in this state or in any other state or jurisdiction, unless the conviction has been absolutely discharged, expunged, or vacated; or
 - 2. The applicant knowingly provides false information in connection with an application required by this Article.
- C. The Department shall make probation a condition of EMCT certification if, within two years before the date of filing an application under R9-25-403, an applicant has been convicted of a misdemeanor in this state or in any other state or jurisdiction, involving:
 - 1. Possession, use, administration, acquisition, sale, manufacture, or transportation of an intoxicating liquor, dangerous drug, or narcotic drug, as defined in A.R.S. § 13-3401, unless the conviction has been absolutely discharged, expunged, or vacated; or
 - 2. Driving or being in physical control of a vehicle while under the influence of an intoxicating liquor, a dangerous drug, or a narcotic drug, as defined in A.R.S. § 13-3401, unless the conviction has been absolutely discharged, expunged, or vacated.
- D. Except as provided in subsection (E), the Department shall make probation a condition of EMCT recertification if an applicant:
 - 1. Is currently:
 - a. Incarcerated for a criminal conviction,
 - b. On parole for a criminal conviction,
 - c. On supervised release for a criminal conviction, or
 - d. On probation for a criminal conviction; or
 - 2. Within five years before the date of filing an application under R9-25-404, has been convicted of a misdemeanor involving moral turpitude or a felony in this state or any other state or jurisdiction, other than those listed in subsection (A)(2), unless the conviction has been absolutely discharged, expunged, or vacated.
- E. As specified in R9-25-409, the Department may make probation a condition of EMCT recertification if an applicant, within two years before the date of filing an application under R9-25-404, has been convicted of a misdemeanor in this state or in any other state or jurisdiction, involving:
 - 1. Possession, use, administration, acquisition, sale, manufacture, or transportation of an intoxicating liquor, dangerous drug, or narcotic drug, as defined in A.R.S. § 13-3401, unless the conviction has been absolutely discharged, expunged, or vacated; or
 - 2. Driving or being in physical control of a vehicle while under the influence of an intoxicating liquor, a dangerous drug, or a narcotic drug, as defined in A.R.S. § 13-3401, unless the conviction has been absolutely discharged, expunged, or vacated.
- F. If the Department makes probation a condition of EMCT certification or recertification, the Department shall fix the period and terms of probation that will:

- 1. Protect the public health and safety, and
- 2. Rehabilitate and educate the applicant.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1).

R9-25-403. Application Requirements for EMCT Certification (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), and (H) and 36-2204(1) and (6))

- A. An individual may apply for initial EMCT certification if:
 - 1. The individual is at least 18 years of age;
 - 2. The individual complies with the requirements in A.R.S. § 41-1080;
 - 3. The individual is not ineligible under R9-25-402; and
 - 4. One of the following applies to the individual:
 - a. The individual has not previously applied for certification from the Department or has withdrawn an application for certification;
 - b. An application for certification submitted by the individual was denied by the Department two or more years before the present date;
 - c. Except as provided in R9-25-404(A)(2) or (3), the individual's certification as an EMCT is expired;
 - d. The individual's certification as an EMCT was revoked by the Department five or more years before the present date; or
 - e. The individual has current certification as an EMCT and is applying for certification at a different classification level of EMCT.
- B. An applicant for initial EMCT certification shall submit to the Department an application in a Department-provided format, including:
 - 1. A form containing:
 - a. The applicant's name, address, telephone number, email address, date of birth, gender, and Social Security number;
 - b. The level of EMCT certification being requested;
 - c. Responses to questions addressing the applicant's criminal history according to R9-25-402(A)(1) through (3) and (C);
 - d. Whether the applicant has within the five years before the date of the application had:
 - i. EMCT certification or recertification revoked in Arizona; or
 - ii. Certification, recertification, or licensure at an EMCT classification level revoked in another state or jurisdiction;
 - e. Attestation that all information required as part of the application has been submitted and is true and accurate; and
 - f. The applicant's signature or electronic signature and date of signature;
 - 2. For each affirmative response to a question addressing the applicant's criminal history required in subsection (B)(1)(c), a detailed explanation on a Department-provided form and supporting documentation;
 - 3. For each affirmative response to subsection (B)(1)(d), a detailed explanation on a Department-provided form and supporting documentation;
 - 4. If applicable, a copy of certification, recertification, or licensure at an EMCT classification level issued to the applicant in another state or jurisdiction;
 - 5. A copy of one of the following for the applicant:
 - a. U.S. passport, current or expired;
 - b. Birth certificate;

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- c. Naturalization documents; or
 - d. Documentation of legal resident alien status; and
 - 6. One of the following:
 - a. Either:
 - i. A certificate of completion showing that within two years before the date of the application, the applicant completed statewide standardized training; and
 - ii. A statewide standardized certification test; or
 - b. Documentation of current registration in a national certification organization at the applicable or higher level of EMCT classification.
 - B. The Department shall approve or deny an application for initial EMCT certification according to Article 12 of this Chapter.
 - C. If the Department denies an application for initial EMCT certification, the applicant may request a hearing according to A.R.S. Title 41, Chapter 6, Article 10.
- Historical Note**
- Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-403 repealed; new Section R9-25-403 renumbered from Section R9-25-404 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1).
- R9-25-404. Application Requirements for EMCT Recertification (Authorized by A.R.S. §§ 36-2202(A)(2), (3), (4), and (6), (B), and (H) and 36-2204(1), (4), and (6))**
- A. An individual may apply for recertification at the same level of EMCT certification held or at a lower level of EMCT certification:
 - 1. Within 90 days before the expiration date of the individual's current EMCT certification;
 - 2. Within the 30-day period after the expiration date of the individual's EMCT certification, as provided in subsection (E); or
 - 3. Within the extension time period granted under R9-25-405.
 - B. To apply for recertification, an applicant shall submit to the Department an application, in a Department-provided format, including:
 - 1. A form containing:
 - a. The applicant's name, address, telephone number, email address, date of birth, and Social Security number;
 - b. The applicant's current certification number;
 - c. Responses to questions addressing the applicant's criminal history according to R9-25-402(B), (D), and (E);
 - d. Whether the applicant has within the five years before the date of the application had:
 - i. EMCT certification or recertification revoked in Arizona; or
 - ii. Certification, recertification, or licensure at an EMCT classification level revoked in another state or jurisdiction;
 - e. An indication of the level of EMCT certification held currently or within the past 30 days and of the level of EMCT certification for which recertification is requested;
 - f. Attestation that all information required as part of the application has been submitted and is true and accurate; and
 - g. The applicant's signature or electronic signature and date of signature;
 - 2. For each affirmative response to a question addressing the applicant's criminal history required in subsection (B)(1)(c), a detailed explanation on a Department-provided form and supporting documentation;
 - 3. For an affirmative response to subsection (B)(1)(d), a detailed explanation on a Department-provided form; and
 - 4. For an application submitted within 30 days after the expiration date of EMCT certification, a nonrefundable certification extension fee of \$150.
 - C. In addition to the application in subsection (B), an applicant for EMCT recertification shall submit one of the following to the Department:
 - 1. A certificate of course completion issued by the training program director under R9-25-304(F) showing that within two years before the date of the application, the applicant completed either the applicable refresher course or applicable refresher challenge examination;
 - 2. Documentation of current registration in a national certification organization at the applicable or higher level of EMCT classification; or
 - 3. Attestation on a Department-provided form that the applicant:
 - a. Has documentation of current certification in adult, pediatric, and infant cardiopulmonary resuscitation through instruction consistent with American Heart Association recommendations for emergency cardiovascular care by EMCTs;
 - b. For EMT-I(99) recertification or Paramedic recertification, has documentation of current certification in advanced emergency cardiac life support;
 - c. Has documentation of having completed within the previous two years the following number of hours of continuing education in topics that are consistent with the content of the applicable refresher course:
 - i. For EMT recertification, a minimum of 24 hours;
 - ii. For AEMT recertification, EMT-I(99) recertification, or Paramedic recertification, a minimum of 48 hours; and
 - iii. Included in the hours required in subsections (C)(3)(c)(i) or (ii), as applicable, a minimum of 5 hours in pediatric emergency care; and
 - d. For EMT recertification, has functioned in the capacity of an EMT for at least 240 hours during the previous two years.
 - D. An applicant who submits an attestation under subsection (C)(3) shall maintain the applicable documentation for at least three years after the date of the application.
 - E. If an individual submits an application for recertification, with a certification extension fee, within 30 days after the expiration date of the individual's EMCT certification, the individual:
 - 1. Was authorized to act as an EMCT during the period between the expiration date of the individual's EMCT certification and the date the application was submitted, and
 - 2. Is authorized to act as an EMCT until the Department makes a final determination on the individual's application for recertification.
 - F. If an individual does not submit an application for recertification before the expiration date of the individual's EMCT certification or, with a certification extension fee, within 30 days after the expiration date of the individual's EMCT certification, the individual:
 - 1. Is not an EMCT,
 - 2. Was not authorized to act as an EMCT during the 30-day period after the expiration date of the individual's EMCT certification, and
 - 3. May submit an application to the Department for initial EMCT certification according to R9-25-403.

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- G. The Department shall approve or deny an application for recertification according to Article 12 of this Chapter.
- H. If the Department denies an application for recertification, the applicant may request a hearing according to A.R.S. Title 41, Chapter 6, Article 10.
- I. The Department may deny, based on failure to meet the standards for recertification in A.R.S. Title 36, Chapter 21.1 and this Article, an application submitted with a certification extension fee.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section R9-25-404 renumbered to R9-25-403; new Section R9-25-404 renumbered from Section R9-25-406 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-405. Extension to File an Application for EMCT Recertification (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), (A)(6), and (H) and 36-2204(1), (4), (5), and (7))

- A. Before the expiration of a current certificate, an EMCT who is unable to meet the recertification requirements in R9-25-404 because of personal or family illness, military service, or authorized federal or state emergency response deployment may apply to the Department in writing for an extension of time to file for recertification by submitting:
 - 1. The following information in a Department-provided format:
 - a. The EMCT's name, address, telephone number, and email address;
 - b. The EMCT's current certification number;
 - c. The reason for requesting the extension; and
 - d. The EMCT's signature or electronic signature and date of signature; and
 - 2. For an exemption based on military service or authorized federal or state emergency response deployment, a copy of the EMCT's military orders or documentation of authorized federal or state emergency response deployment.
- B. The Department may grant an extension of time to file for recertification:
 - 1. For personal or family illness, for no more than 180 days; or
 - 2. For each military service or authorized federal or state emergency response deployment, for the term of service or deployment plus 180 days.
- C. An individual applying for or granted an extension of time to file for recertification:
 - 1. Remains certified according to A.R.S. § 41-1092.11 during the extension period, and
 - 2. Shall submit an application for recertification according to R9-25-404.
- D. An individual who does not meet the recertification requirements in R9-25-404 within the extension period or has the application for recertification denied by the Department:
 - 1. Is not an EMCT, and
 - 2. May submit an application to the Department for initial EMCT certification according to R9-25-403.
- E. The Department shall approve or deny a request for an extension to file for EMCT recertification according to Article 12 of this Chapter.
- F. If the Department denies a request for an extension to file for EMCT recertification, the applicant may request a hearing according to A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-405 repealed; new Section R9-25-405 renumbered from Section R9-25-407 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1).

R9-25-406. Requirements for Downgrading of Certification (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), and (H) and 36-2204(1) and (6))

An individual who holds current EMCT certification at a classification level higher than EMT and who is not under investigation according to A.R.S. § 36-2211 may apply for:

- 1. Continued certification at a lower EMCT classification level for the remainder of the certification period by submitting to the Department:
 - a. A written request containing:
 - i. The EMCT's name, address, email address, telephone number, date of birth, and Social Security number;
 - ii. The lower EMCT classification level requested;
 - iii. Attestation that the applicant has not committed an act or engaged in conduct that would warrant revocation of a certificate under A.R.S. § 36-2211;
 - iv. Attestation that all information submitted is true and accurate; and
 - v. The applicant's signature or electronic signature and date of signature; and
 - b. Either:
 - i. A written statement from the EMCT's administrative medical director attesting that the EMCT is able to perform at the lower EMCT classification level requested; or
 - ii. If applying for continued certification as an EMT, an Arizona EMT refresher certificate of completion or an Arizona EMT refresher challenge examination certificate of completion signed by the training program director designated for the Arizona EMT refresher course; or
- 2. Recertification at a lower EMCT classification level according to R9-25-404.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 1713, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Section R9-25-406 renumbered to Section R9-25-404; new Section R9-25-406 renumbered from Section R9-25-408 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1).

R9-25-407. Notification Requirements (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), and (A)(4), 36-2204(1) and (6), and 36-2211)

- A. No later than 30 days after the date an EMCT's name legally changes, the EMCT shall submit to the Department:

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1. A completed form provided by the Department containing:
 - a. The name under which the EMCT is currently certified by the Department;
 - b. The EMCT's address, telephone number, and Social Security number; and
 - c. The EMCT's new name; and
 2. Documentation showing that the name has been legally changed.
- B.** No later than 30 days after the date an EMCT's address or email address changes, the EMCT shall submit to the Department a completed form provided by the Department containing:
1. The EMCT's name, telephone number, and Social Security number; and
 2. The EMCT's new address or email address.
- C.** An EMCT shall notify the Department in writing no later than 10 days after the date the EMCT:
1. Is incarcerated or is placed on parole, supervised release, or probation for any criminal conviction;
 2. Is convicted of:
 - a. A crime specified in R9-25-402(A)(2),
 - b. A misdemeanor involving moral turpitude,
 - c. A felony in this state or any other state or jurisdiction, or
 - d. A misdemeanor specified in R9-25-402(E);
 3. Has registration revoked or suspended by a national certification organization; or
 4. Has certification, recertification, or licensure at an EMCT classification level revoked or suspended in another state or jurisdiction.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-407 renumbered to Section R9-25-405; new Section R9-25-407 renumbered from Section R9-25-409 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1).

R9-25-408. Unprofessional Conduct; Physical or Mental Incompetence; Gross Incompetence; Gross Negligence (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), (A)(6), and (H), 36-2204(1), (6), and (7), and 36-2211)

- A.** For purposes of A.R.S. § 36-2211(A)(1), unprofessional conduct is an act or omission made by an EMCT that is contrary to the recognized standards or ethics of the Emergency Medical Technician profession or that may constitute a danger to the health, welfare, or safety of a patient or the public, including:
1. Impersonating an EMCT of a higher level of certification or impersonating a health professional as defined in A.R.S. § 32-3201;
 2. Permitting or allowing another individual to use the EMCT's certification for any purpose;
 3. Aiding or abetting an individual who is not certified according to this Chapter in acting as an EMCT or in representing that the individual is certified as an EMCT;
 4. Engaging in or soliciting sexual relationships, whether consensual or non-consensual, with a patient while acting as an EMCT;
 5. Physically or verbally harassing, abusing, threatening, or intimidating a patient or another individual while acting as an EMCT;
 6. Making false or materially incorrect entries in a medical record or willful destruction of a medical record;
 7. Failing or refusing to maintain adequate records on a patient;

8. Soliciting or obtaining monies or goods from a patient by fraud, deceit, or misrepresentation;
 9. Aiding or abetting an individual in fraud, deceit, or misrepresentation in meeting or attempting to meet the application requirements for EMCT certification or EMCT recertification contained in this Article, including the requirements established for:
 - a. Completing and passing a course provided by a training program; and
 - b. The national certification organization examination process and national certification organization registration process;
 10. Providing false information or making fraudulent or untrue statements to the Department or about the Department during an investigation conducted by the Department;
 11. Being incarcerated or being placed on parole, supervised release, or probation for any criminal conviction;
 12. Being convicted of a misdemeanor identified in R9-25-402(E), which has not been absolutely discharged, expunged, or vacated;
 13. Having national certification organization registration revoked or suspended by the national certification organization for material noncompliance with national certification organization rules or standards; and
 14. Having certification, recertification, or licensure at an EMCT classification level revoked or suspended in another state or jurisdiction.
- B.** Under A.R.S. § 36-2211, physical or mental incompetence of an EMCT is the EMCT's lack of physical or mental ability to provide emergency medical services as required under this Chapter.
- C.** Under A.R.S. § 36-2211 gross incompetence or gross negligence is an EMCT's willful act or willful omission of an act that is made in disregard of an individual's life, health, or safety and that may cause death or injury.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section R9-25-408 renumbered to Section R9-25-406; new Section R9-25-408 renumbered from Section R9-25-410 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1).

R9-25-409. Enforcement Actions (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), (A)(6), and (H), 36-2204(1), (6), and (7), and 36-2211)

- A.** If the Department determines that an applicant or EMCT is not in substantial compliance with applicable laws and rules, under A.R.S. §§ 36-2204 or 36-2211, the Department may:
1. Take the following action against an applicant or EMCT:
 - a. After notice is provided according to A.R.S. § 36-2211 and, if applicable, A.R.S. Title 41, Chapter 6, Article 10, issue:
 - i. A decree of censure to the EMCT, or
 - ii. An order of probation to the EMCT; or
 - b. After notice and opportunity to be heard is provided according to A.R.S. Title 41, Chapter 6, Article 10:
 - i. Deny an application,
 - ii. Suspend the EMCT's certificate, or
 - iii. Revoke the EMCT's certificate; and
 2. Assess civil penalties against the EMCT.
- B.** In determining which action in subsection (A) is appropriate, the Department shall consider:
1. Prior disciplinary actions;

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2. The time interval since a prior disciplinary action, if applicable;
3. The applicant's or EMCT's motive;
4. The applicant's or EMCT's pattern of conduct;
5. The number of offenses;
6. Whether the applicant or EMCT failed to comply with instructions from the Department;
7. Whether interim rehabilitation efforts were made by the applicant or EMCT;
8. Whether the applicant or EMCT refused to acknowledge the wrongful nature of the misconduct;
9. Whether the applicant or EMCT made timely and good-faith efforts to rectify the consequences of the misconduct;
10. The submission of false evidence, false statements, or other deceptive practices during an investigation or disciplinary process;
11. The vulnerability of a patient or other victim of the applicant's or EMCT's conduct, if applicable; and
12. How much control the applicant or EMCT had over the processes or situation leading to the misconduct.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-409 renumbered to Section R9-25-407; new Section R9-25-409 renumbered from Section R9-25-411 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1).

R9-25-410. Renumbered**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-410 renumbered to Section R9-25-408 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-411. Renumbered**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-411 renumbered to Section R9-25-409 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

Exhibit I. Repealed**Historical Note**

Exhibit I adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

Exhibit J. Repealed**Historical Note**

Exhibit J adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

Exhibit K. Repealed**Historical Note**

Exhibit K adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-412. Expired**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section expired under A.R.S. 41-1056(E) at 18 A.A.R. 2153, effective June 30, 2012 (Supp. 12-3).

ARTICLE 5. MEDICAL DIRECTION PROTOCOLS FOR EMERGENCY MEDICAL CARE TECHNICIANS

Article 5, consisting of R9-25-501 through R9-25-508, recodified from Article 8 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).

Article 5 repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-501. Definitions

In addition to the definitions in A.R.S. § 36-2201 and R9-25-101, the following definitions apply in this Article, unless otherwise specified:

1. "ALS skill" means a medical treatment, procedure, or technique or administration of a medication that is indicated by a check mark in Table 5.1 under AEMT, EMT-I(99), or Paramedic, but not under EMT.
2. "Immunizing agent" means an immunobiologic recommended by the Advisory Committee on Immunization Practices of the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-501 recodified from R9-25-801 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Amended by exempt rulemaking at 14 A.A.R. 3491, effective August 14, 2008 (Supp. 08-3). Section R9-25-501 repealed; new Section R9-25-501 made by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-502. Scope of Practice for EMCTs

- A.** An EMCT shall perform a medical treatment, procedure, or technique or administer a medication only:
1. If the skill is within the EMCT's scope of practice skills, as specified in Table 5.1;
 2. For an ALS skill:
 - a. If authorized for the EMCT by the EMCT's administrative medical director; and
 - b. If the EMCT is able to receive on-line medical direction;
 3. For a STR skill:
 - a. If the EMCT has documentation of having completed training specific to the skill that is consistent with the knowledge, skills, and competencies established according to A.R.S. § 36-2204 and available through the Department at www.azdhs.gov/ems-regulatory-references;
 - b. If authorized for the EMCT by the EMCT's administrative medical director; and
 - c. If the EMCT is able to receive on-line medical direction;
 4. If the medication is listed as an agent in a table of agents, established according to A.R.S. § 36-2204 and available through the Department at www.azdhs.gov/ems-regula-

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tory-references, that the EMCT's administrative medical director may authorize the EMCT to administer, monitor, or assist a patient in self-administration based on the classification for which the EMCT is certified;

5. If the EMCT is authorized to administer the medication by the:
 - a. EMCT's administrative medical director, if applicable; or
 - b. If the EMCT is an EMT with no administrative medical director, emergency medical services provider or ambulance service by which the EMCT is employed or for which the EMCT volunteers; and
6. In a manner consistent with standards described in R9-25-408 and, if applicable, with the training in 9 A.A.C. 25, Article 3.

B. An administrative medical director:

1. Shall:
 - a. Ensure that an EMCT has completed training in administration or monitoring of an agent before authorizing the EMCT to administer or monitor the agent;
 - b. Ensure that an EMCT has competency in an ALS skill before authorizing the EMCT to perform the ALS skill;
 - c. Before authorizing an EMCT to perform a STR skill, ensure that the EMCT has:
 - i. Completed training specific to the skill, consistent with the knowledge, skills, and competencies established according to A.R.S. § 36-2204 and available through the Department at www.azdhs.gov/ems-regulatory-references; and
 - ii. Demonstrated competency in the skill;
 - d. Periodically thereafter assess an EMCT's competency in an authorized ALS skill and STR skill, according to policies and procedures required in R9-25-201(E)(3)(b)(ix), to ensure continued competency;
 - e. Document the EMCT's:
 - i. Completion of training in administration or monitoring of an agent required in subsection (B)(1)(a),
 - ii. Competency in performing an ALS skill required in subsection (B)(1)(b),

iii. Specific training required in subsection (B)(1)(c)(i) and competency required in subsection (B)(1)(c)(ii); and

iv. Periodic reassessment required in subsection (B)(1)(d); and

f. Maintain documentation of an EMCT's completion of training in administration or monitoring of an agent and competency in performing an authorized ALS skill or STR skill; and

2. May authorize an EMCT to perform all of the ALS skills in Table 5.1 for the applicable level of EMCT or restrict the EMCT to a subset of the ALS skills in Table 5.1 for the applicable level of EMCT.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-502 recodified from R9-25-802 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 24 A.A.R. 2955, effective September 27, 2018 (Supp. 18-3).

Table 1. Repealed

Historical Note

Table 1 adopted by exempt rulemaking at 13 A.A.R. 27, effective January 6, 2007 (Supp. 06-4). Amended by exempt rulemaking at 13 A.A.R. 578, effective January 31, 2007 (Supp. 07-1). Historical note added to Table 1; amended by exempt rulemaking 14 A.A.R. 3491, effective August 14, 2008 (Supp. 08-3). Amended by exempt rulemaking at 15 A.A.R. 234, effective January 2, 2009 (Supp. 09-1). Amended by exempt rulemaking at 14 A.A.R. 3491, effective August 14, 2008 (Supp. 08-3). Amended by exempt rulemaking at 15 A.A.R. 234, effective January 2, 2009 (Supp. 09-1). Amended by exempt rulemaking at 16 A.A.R. 2116, effective October 15, 2010 (Supp. 10-4). Amended by exempt rulemaking at 18 A.A.R. 102, effective January 1, 2012 (Supp. 11-4). Table 1 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

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Table 5.1. Arizona Scope of Practice Skills**KEY:**

✓ = Arizona Scope of Practice skill

STR = STR skill

* = With training in R9-25-505

A. Airway/Ventilation/Oxygenation	EMT	AEMT	EMT-I(99)	Paramedic
1. Airway - nasal	✓	✓	✓	✓
2. Airway - oral	✓	✓	✓	✓
3. Airway - supraglottic	STR	✓	✓	✓
4. Airway obstruction - dislodgement by direct laryngoscopy	-	-	✓	✓
5. Airway obstruction - manual dislodgement techniques	✓	✓	✓	✓
6. Automated transport ventilator	-	STR	✓	✓
7. Bag-valve-mask (BVM)	✓	✓	✓	✓
8. BiPAP	-	-	-	✓
9. CPAP	STR	✓	✓	✓
10. Chest decompression - needle	-	-	✓	✓
11. Chest tube placement - assist only	-	-	-	✓
12. Chest tube monitoring and management	-	-	-	✓
13. Cricothyrotomy	-	-	-	✓
14. End tidal CO2 monitoring and interpretation of waveform capnography	STR	✓	✓	✓
15. Gastric decompression - NG tube	-	-	✓	✓
16. Gastric decompression - OG tube	-	-	✓	✓
17. Head-tilt chin lift	✓	✓	✓	✓
18. Intubation - endotracheal	-	-	✓	✓
19. Intubation - nasotracheal	-	-	-	✓
20. Jaw-thrust	✓	✓	✓	✓
21. Medication Assisted Intubation (paralytics)	-	-	-	STR
22. Mouth-to-barrier	✓	✓	✓	✓
23. Mouth-to-mask	✓	✓	✓	✓
24. Mouth-to-mouth	✓	✓	✓	✓
25. Mouth-to-nose	✓	✓	✓	✓
26. Mouth-to-stoma	✓	✓	✓	✓
27. Oxygen therapy - high flow nasal cannula	-	-	-	✓
28. Oxygen therapy - humidifiers	✓	✓	✓	✓
29. Oxygen therapy - nasal cannula	✓	✓	✓	✓
30. Oxygen therapy - non-rebreather mask	✓	✓	✓	✓
31. Oxygen therapy - partial rebreather mask	✓	✓	✓	✓
32. Oxygen therapy - simple face mask	✓	✓	✓	✓
33. Oxygen therapy - Venturi mask	✓	✓	✓	✓
34. Pulse oximetry	✓	✓	✓	✓
35. Suctioning - upper airway	✓	✓	✓	✓
36. Suctioning - tracheobronchial of an intubated patient	-	✓	✓	✓
B. Cardiovascular/Circulation	EMT	AEMT	EMT-I (99)	Paramedic
1. Cardiac monitoring - 12-lead ECG (interpretive)	-	-	✓	✓
2. Cardiac monitoring - 12-lead ECG acquisition and transmission	✓	✓	✓	✓
3. Cardiopulmonary resuscitation	✓	✓	✓	✓
4. Cardioversion - electrical	-	-	✓	✓
5. Defibrillation - automated/semi-automated	✓	✓	✓	✓
6. Defibrillation - manual	-	-	✓	✓
7. Hemorrhage control - direct pressure	✓	✓	✓	✓
8. Hemorrhage control - tourniquet	✓	✓	✓	✓
9. Hemorrhage control - wound packing	✓	✓	✓	✓
10. Mechanical CPR device	✓	✓	✓	✓
11. Telemetric monitoring devices and transmission of clinical data, including video data	✓	✓	✓	✓
12. Transcutaneous pacing	-	-	✓	✓
13. Transvenous cardiac pacing - monitoring and maintenance	-	-	✓	✓
C. Splinting/Spinal Motion Restriction/Patient Restraint	EMT	AEMT	EMT-I (99)	Paramedic
1. Cervical collar	✓	✓	✓	✓

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2.	Long spine board	✓	✓	✓	✓
3.	Manual cervical stabilization	✓	✓	✓	✓
4.	Seated spinal motion restriction (KED, etc.)	✓	✓	✓	✓
5.	Extremity stabilization - manual	✓	✓	✓	✓
6.	Extremity splinting	✓	✓	✓	✓
7.	Splint-traction	✓	✓	✓	✓
8.	Mechanical patient restraint	✓	✓	✓	✓
9.	Emergency moves for endangered patients	✓	✓	✓	✓
D.	Medication Administration - routes/agent types	EMT	AEMT	EMT-I (99)	Paramedic
1.	Aerosolized/nebulized	✓	✓	✓	✓
2.	Endotracheal tube	-	-	✓	✓
3.	Inhaled	✓	✓	✓	✓
4.	Intradermal	-	-	-	✓
5.	Intramuscular	STR	✓	✓	✓
6.	Intramuscular - autoinjector	✓	✓	✓	✓
7.	Intranasal	✓	✓	✓	✓
8.	Intraosseous - initiation, pediatric or adult	-	✓	✓	✓
9.	Intravenous	-	✓	✓	✓
10.	Mucosal/Sublingual	✓	✓	✓	✓
11.	Nasogastric	-	-	-	✓
12.	Oral	✓	✓	✓	✓
13.	Rectal	-	-	-	✓
14.	Subcutaneous	-	✓	✓	✓
15.	Topical	-	-	-	✓
16.	Transdermal	-	-	-	✓
17.	Use/monitoring of infusion pump for agent administration during interfacility transports	-	-	STR	STR
18.	Use/monitoring of agents specified in <i>Table 3 - Special Agents Eligible for Administration and Monitoring</i> , established according to A.R.S. § 36-2204 and available through the Department at www.azdhs.gov/ems-regulatory-references	-	-	STR	STR
19.	Epinephrine anaphylaxis-prepared kit; only for anaphylaxis when no auto-injector is available	STR	✓	✓	✓
20.	Immunizations	-	-	✓*	✓*
21.	Thrombolytics	-	-	-	STR
E.	IV Initiation/Maintenance Fluids	EMT	AEMT	EMT-I (99)	Paramedic
1.	Access indwelling catheters and implanted central IV ports	-	-	-	✓
2.	Central line - monitoring	-	-	-	✓
3.	Intraosseous - initiation, pediatric or adult	-	✓	✓	✓
4.	Intravenous access	STR	✓	✓	✓
5.	Intravenous initiation - peripheral	STR	✓	✓	✓
6.	Intravenous- maintenance of medicated IV fluids	-	-	✓	✓
7.	Intravenous- maintenance of nonmedicated IV fluids	STR	✓	✓	✓
8.	Intravenous initiation - ultrasound guided IV in a hospital setting	-	-	-	STR
F.	Miscellaneous	EMT	AEMT	EMT-I (99)	Paramedic
1.	Assisted delivery (childbirth)	✓	✓	✓	✓
2.	Assisted complicated delivery (childbirth)	✓	✓	✓	✓
3.	Blood chemistry analysis	-	-	-	✓
4.	Blood glucose monitoring	✓	✓	✓	✓
5.	Blood pressure- automated	✓	✓	✓	✓
6.	Blood pressure- manual	✓	✓	✓	✓
7.	Eye irrigation	✓	✓	✓	✓
8.	Eye irrigation hands-free irrigation using sterile eye irrigation device	-	-	-	✓
9.	Urinary catheterization	STR	STR	STR	STR
10.	Venous blood sampling	STR	✓	✓	✓

Historical Note

Table 5.1 made by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final exempt rulemaking, pursuant to Laws 2014, Ch. 233, § 5 at 20 A.A.R. 3554, effective January 1, 2015 (Supp. 14-4). Amended by final exempt rulemaking, pursuant to Laws 2015,

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Ch. 222, § 3, at 21 A.A.R. 3241, effective November 24, 2015 (Supp. 15-4). Amended by final exempt rulemaking at 23 A.A.R. 1161, effective April 19, 2017 (Supp. 17-2). Amended by exempt rulemaking at 24 A.A.R. 2955, effective September 27, 2018 (Supp. 18-3). Amended by exempt rulemaking at 27 A.A.R. 1385, with an immediate effective date of August 9, 2021 (Supp. 21-3). Amended by exempt rulemaking at 28 A.A.R. 3321 (October 14, 2022), with an immediate effective date of September 22, 2022 (Supp. 22-3).

Table 5.2. Repealed**Historical Note**

Table 5.2 made by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final exempt rulemaking, pursuant to Laws 2014, Ch. 233, § 5 at 20 A.A.R. 3554, effective January 1, 2015 (Supp. 14-4). Amended by final exempt rulemaking, pursuant to Laws 2015, Ch. 222, § 3, at 21 A.A.R. 3241, effective November 24, 2015 (Supp. 15-4). Amended by final exempt rulemaking at 23 A.A.R. 1161, effective April 19, 2017 (Supp. 17-2). Amended by final exempt rulemaking at 23 A.A.R. 1161, effective April 19, 2017 (Supp. 17-2). Repealed by exempt rulemaking at 24 A.A.R. 2955, effective September 27, 2018 (Supp. 18-3).

Table 5.3. Repealed**Historical Note**

Table 5.3 made by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Repealed by exempt rulemaking at 24 A.A.R. 2955, effective September 27, 2018 (Supp. 18-3).

Table 5.4. Repealed**Historical Note**

Table 5.4 made by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Repealed by exempt rulemaking at 24 A.A.R. 2955, effective September 27, 2018 (Supp. 18-3).

R9-25-503. Testing of Medical Treatments, Procedures, Medications, and Techniques that May Be Administered or Performed by an EMCT

- A. Under A.R.S. § 36-2205, the Department may authorize the testing and evaluation of a medical treatment, procedure, technique, practice, medication, or piece of equipment for possible use by an EMCT or an emergency medical services provider.
- B. Before authorizing any test and evaluation according to subsection (A), the Department director shall approve the test and evaluation according to subsections (C), (D), (E).
- C. The Department director shall consider approval of a test and evaluation conducted according to subsection (A), only if a written request for testing and evaluation:
 1. Is submitted to the Department director from:
 - a. The Department,
 - b. A state agency other than the Department,
 - c. A political subdivision of this state,
 - d. An EMCT,
 - e. An emergency medical services provider,
 - f. An ambulance service, or
 - g. A member of the public; and
 2. Includes:
 - a. A cover letter, signed and dated by the individual making the request;
 - b. An identification of the person conducting the test and evaluation;
 - c. An identification of the medical treatment, procedure, technique, practice, medication, or piece of equipment to be tested and evaluated;
 - d. An explanation of the reasons for and the benefits of the test and evaluation;
 - e. The scope of the test and evaluation, including the:

- i. Projected number of individuals, EMCTs, emergency medical services providers, or ambulance services involved; and
 - ii. Proposed length of time required to complete the test and evaluation; and
- f. The methodology to be used to evaluate the test's and evaluation's findings.
- D. The Department director shall approve a test and evaluation if:
 1. The test and evaluation does not pose a threat to the public health, safety, or welfare;
 2. The test is necessary to evaluate the safest and most current advances in medical treatments, procedures, techniques, practices, medications, or equipment; and
 3. The medical treatment, procedure, technique, practice, medication, or piece of equipment being tested and evaluated may:
 - a. Reduce or eliminate the use of outdated or obsolete medical treatments, procedures, techniques, practices, medications, or equipment;
 - b. Improve patient care; or
 - c. Benefit the public's health, safety, or welfare.
- E. Within 180 days after receiving a written request for testing and evaluation that contains all of the information in subsection (C), the Department director shall send written notification of approval or denial of the test and evaluation to the individual making the request.
- F. Upon completion of a test and evaluation authorized by the Department director, the person conducting the test and evaluation shall submit a written report to the Department director that includes:
 1. An identification of the test and evaluation;
 2. A detailed evaluation of the test; and
 3. A recommendation regarding future use of the medical treatment, procedure, technique, practice, medication, or piece of equipment tested and evaluated.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-503 recodified from R9-25-803 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Amended by exempt rulemaking at 13 A.A.R. 27, effective January 6, 2007 (Supp. 06-4). Amended by exempt rulemaking at 13 A.A.R. 578, effective January 31, 2007 (Supp. 07-1). Amended by exempt rulemaking at 14 A.A.R. 3491, effective August 14, 2008 (Supp. 08-3). Section R9-25-503 renumbered to R9-25-505; new Section R9-25-503 renumbered from R9-25-506 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

Exhibit 1. Repealed**Historical Note**

New Exhibit 1 recodified from Article 8, Exhibit 1 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Amended by exempt rulemaking at 11 A.A.R. 1438, effective March 25, 2005 (Supp. 05-1). Amended by exempt rulemaking at 11 A.A.R. 2379, effective June 8, 2005 (Supp. 05-2). Amended by exempt rulemaking at 11 A.A.R. 3177, effective September 1, 2005 (Supp. 05-3).

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Exhibit 1 repealed by exempt rulemaking at 13 A.A.R. 27, effective January 6, 2007 (Supp. 06-4).

Exhibit 2. Repealed**Historical Note**

New Exhibit 2 recodified from Article 8, Exhibit 2 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Amended by exempt rulemaking at 11 A.A.R. 1438, effective March 25, 2005 (Supp. 05-1). Exhibit 2 repealed by exempt rulemaking at 13 A.A.R. 27, effective January 6, 2007 (Supp. 06-4).

Exhibit 3. Repealed**Historical Note**

Exhibit made by exempt rulemaking at 11 A.A.R. 1438, effective March 25, 2005 (Supp. 05-1). Exhibit 3 repealed by exempt rulemaking at 13 A.A.R. 27, effective January 6, 2007 (Supp. 06-4).

R9-25-504. Protocol for Selection of a Health Care Institution for Transport

- A. Except as provided in subsection (B), an EMCT shall transport a patient accessing emergency medical services through a call to 9-1-1 or a similar public emergency dispatch number to:
 1. An emergency receiving facility, or
 2. A special hospital that is physically connected to an emergency receiving facility.
- B. Under A.R.S. §§ 36-2205(D) and 36-2232(F), an EMCT who responds to a call made to 9-1-1 or a similar public emergency dispatch number may refer, advise, or transport the patient at the scene to a health care institution other than a health care institution specified in subsection (A), if the EMCT determines that:
 1. The patient's condition does not pose an immediate threat to life or limb, based on medical direction; and
 2. The health care institution is the most appropriate for the patient, based on the following:
 - a. The patient's:
 - i. Medical condition,
 - ii. Choice of health care institution, and
 - iii. Health care provider;
 - b. The location of the health care institution and the emergency medical resources available at the health care institution; and
 - c. A determination by the administrative medical director that the health care institution is able to accept and capable of treating the patient.
- C. Before initiating transport of a patient accessing emergency medical services through a call to 9-1-1 or a similar public emergency dispatch number, an EMCT, emergency medical services provider, or ambulance service shall:
 1. Notify, by radio or telephone communication, a health care institution that is not an emergency receiving facility of the EMCT's intent to transport the patient to the health care institution; and
 2. Receive confirmation of the willingness of the health care institution to accept the patient.
- D. An EMCT transporting a patient accessing emergency medical services through a call to 9-1-1 or a similar public emergency dispatch number to a health care institution that is not an emergency receiving facility shall transfer care of the patient to a designee authorized by:
 1. A physician,
 2. A registered nurse practitioner,
 3. A physician assistant, or
 4. A registered nurse.
- E. An emergency medical services provider or an ambulance service that implements this rule shall make available for Department

review and inspection written records relating to the transport of a patient under subsections (B), (C), and (D).

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-504 recodified from R9-25-804 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Amended by exempt rulemaking at 14 A.A.R. 3124, effective July 9, 2008 (Supp. 08-3).

Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final exempt rulemaking, pursuant to Laws 2014, Ch. 233, § 5 at 20 A.A.R. 3554, effective January 1, 2015 (Supp. 14-4).

R9-25-505. Protocol for an EMT-I(99) or a Paramedic to Become Eligible to Administer an Immunizing Agent

- A. An EMT-I(99) or a Paramedic may be authorized by the EMT-I(99)'s or Paramedic's administrative medical director to administer an immunizing agent if the EMT-I(99) or Paramedic completes training that:
 1. Includes:
 - a. Basic immunology and the human immune response;
 - b. Mechanics of immunity, adverse effects, dose, and administration schedule of available immunizing agents;
 - c. Response to an emergency situation, such as an allergic reaction, resulting from the administration of an immunization;
 - d. Routes of administration for available immunizing agents;
 - e. A description of the individuals to whom an EMCT may administer an immunizing agent; and
 - f. The requirements in 9 A.A.C. 6, Article 7 related to:
 - i. Obtaining written consent for administration of an immunizing agent,
 - ii. Providing immunization information and written immunization records, and
 - iii. Recordkeeping and reporting;
 2. Requires the EMT-I(99) or Paramedic to demonstrate competency in the subject matter listed in subsection (A)(1); and
 3. Is approved by the EMT-I(99)'s or Paramedic's administrative medical director based upon a determination that the training meets the requirements in subsections (A)(1) and (A)(2).
- B. An administrative medical director of an EMT-I(99) or a Paramedic who completes the training required in subsection (A) shall maintain for Department review and inspection written evidence that the EMT-I(99) or Paramedic has completed the training required in subsection (A), including at least:
 1. The name of the training,
 2. The date the training was completed, and
 3. A signed and dated attestation from the administrative medical director that the training is approved.
- C. Before administering an immunizing agent to an individual, an EMT-I(99) or a Paramedic shall:
 1. Receive written consent consistent with the requirements in 9 A.A.C. 6, Article 7;
 2. Provide immunization information and written immunization records consistent with the requirements in 9 A.A.C. 6, Article 7; and
 3. Provide documentary proof of immunity to the individual consistent with the requirements in 9 A.A.C. 6, Article 7.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-505 recodified

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from R9-25-805 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Section R9-25-505 repealed; new Section R9-25-505 renumbered from R9-25-503 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

Exhibit 1. Repealed**Historical Note**

New Exhibit 1 recodified from Article 8, Exhibit 1 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Exhibit 1 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

Exhibit 2. Repealed**Historical Note**

New Exhibit 2 recodified from Article 8, Exhibit 2 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Exhibit 2 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-506. Renumbered**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-506 recodified from R9-25-806 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Section R9-25-506 renumbered to R9-25-503 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-507. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-507 recodified from R9-25-807 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Section R9-25-507 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-508. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Subsection (A)(2) corrected to reflect adopted rules on file with the Office of the Secretary of State, effective October 15, 1996 (Supp. 97-1). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-508 recodified from R9-25-808 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Section R9-25-508 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-509. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New Section made by exempt rulemaking at 11 A.A.R. 2379, effective June 8, 2005 (Supp. 05-2). Section repealed by exempt rulemaking at 13 A.A.R. 3038, effective October 6, 2007 (Supp. 07-3).

R9-25-510. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New Section made by exempt rulemaking at 11 A.A.R. 1502, effective April 1, 2005 (Supp. 05-1). Amended by exempt rulemaking at 11 A.A.R. 2379, effective June 8, 2005 (Supp. 05-2). Section R9-25-510 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

Exhibit P. Repealed**Historical Note**

Exhibit P adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-511. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Subsection (C) corrected to reflect adopted rules on file with the Office of the Secretary of State, effective October 15, 1996 (Supp. 97-3). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New Section made by exempt rulemaking at 11 A.A.R. 4982, effective November 1, 2005 (Supp. 05-4). Section R9-25-511 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-512. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Subsection (A) corrected to reflect adopted rules on file with the Office of the Secretary of State, effective October 15, 1996 (Supp. 97-1). Subsection (A) corrected again to reflect adopted rules on file with the Office of the Secretary of State, effective October 15, 1996 (Supp. 97-3). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New Section made by exempt rulemaking at 13 A.A.R. 27, effective January 6, 2007 (Supp. 06-4). Section repealed by exempt rulemaking at 16 A.A.R. 2116, effective October 15, 2010 (Supp. 10-4).

R9-25-513. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New Section made by exempt rulemaking at 13 A.A.R. 3038, effective October 6, 2007 (Supp. 07-3). R9-25-513 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-514. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Amended by exempt rulemaking at 7 A.A.R. 4888, effective November 1, 2001 (Supp. 01-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-515. Repealed**Historical Note**

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Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

ARTICLE 6. STROKE CARE

Article 6, consisting of new Sections R9-25-601 and R9-25-602, made by exempt rulemaking effective April 5, 2013 (Supp. 13-1).

Article 6 repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-601. Definitions (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))

In addition to the definitions in A.R.S. § 36-2201 and R9-25-101, the following definitions apply in this Article, unless otherwise specified:

1. "Acute stroke-ready hospital" means a hospital that is certified by a national stroke center certification organization as meeting national stroke care standards for the initial assessment, diagnosis, stabilization, and either:
 - a. Transfer of a stroke patient to a primary stroke center or comprehensive stroke center, or
 - b. Care of a stroke patient with input from the staff of a primary stroke center or comprehensive stroke center.
2. "Comprehensive stroke center" means a hospital that is certified by a national stroke center certification organization as meeting national stroke care standards for the assessment, diagnosis using advanced imaging devices, and treatment of stroke patients with complex cases of ischemic stroke, caused by the loss of the blood supply to a part of the brain, or hemorrhagic stroke, caused by bleeding into a part of the brain.
3. "Council" means the emergency medical services council established under A.R.S. § 36-2203.
4. "Health care provider" means an individual licensed according to A.R.S. Title 32, Chapter 13, 15, 17, 19, 25, or 34.
5. "Local EMS coordinating system" means the same as in A.R.S. § 36-2210.
6. "National stroke care standards" means criteria for the assessment and treatment of stroke that are consistent with guidelines established by the American Heart Association/American Stroke Association, an organization that focuses on reducing the impact of stroke.
7. "National stroke center certification organization" means an entity:
 - a. Such as:
 - i. The Joint Commission;
 - ii. The Healthcare Facilities Accreditation Program;
 - iii. Det Norske Veritas Healthcare, Inc.; or
 - iv. The American Heart Association/American Stroke Association;
 - b. That assesses the compliance of a hospital with national stroke care standards; and
 - c. That documents hospitals that meet national stroke care standards.
8. "Primary stroke center" means a hospital that is certified by a national stroke center certification organization as meeting national stroke care standards for the assessment, diagnosis, and treatment of stroke patients.
9. "Stroke patient" means an individual who has signs or symptoms of a stroke and is receiving assessment or treatment for a stroke.
10. "Transport" means the same as in A.A.C. R9-10-101.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective

January 3, 2004 (Supp. 03-4). New Section made by exempt rulemaking at 19 A.A.R. 643, effective April 5, 2013 (Supp. 13-1). Amended by final rulemaking at 23 A.A.R. 1728, effective July 1, 2017 (Supp. 17-2).

R9-25-602. Emergency Stroke Care Protocols (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))

- A.** The council shall:
1. Establish emergency stroke care protocols, and
 2. Support the adoption of emergency stroke care protocols by emergency medical services providers through local EMS coordinating systems.
- B.** The council shall ensure that emergency stroke care protocols:
1. Are developed and implemented in coordination with:
 - a. Local EMS coordinating systems,
 - b. National organizations that focus on heart disease and stroke,
 - c. Emergency medical services providers, and
 - d. Health care providers;
 2. Include procedures for the pre-hospital assessment and treatment of stroke patients, which may include education about identifying stroke patients who may have an emergent large vessel occlusion, the blockage of a large blood vessel that causes an individual to have an ischemic stroke;
 3. Provide for transport of stroke patients to the most appropriate emergency receiving facility, consistent with A.R.S. § 36-2205(E), taking into account the:
 - a. Needs of a stroke patient;
 - b. Availability of resources in urban areas, suburban areas, rural areas, and wilderness areas;
 - c. Capability of an emergency receiving facility to practice telemedicine, as defined in A.R.S. § 36-3601, with specialists in stroke care;
 - d. Location of emergency receiving facilities that:
 - i. Are:
 - (1) Acute stroke-ready hospitals,
 - (2) Primary stroke centers, or
 - (3) Comprehensive stroke centers; and
 - ii. Participate in quality improvement activities, including the submission of data on stroke care provided by the emergency receiving facility that may be compiled on a statewide basis;
 - e. Capability of an emergency receiving facility that is not a primary stroke center or comprehensive stroke center to stabilize a stroke patient before initiating a transfer to a primary stroke center or comprehensive stroke center;
 - f. Capability of an emergency receiving facility that is not a primary stroke center or comprehensive stroke center to stabilize and admit a stroke patient; and
 - g. Distance and duration of transport;
 4. Are consistent with national stroke care standards; and
 5. Are based on data on stroke care from:
 - a. National organizations that focus on heart disease and stroke;
 - b. U.S. Department of Transportation, National Highway Traffic Safety Administration; and
 - c. Statewide data on stroke care, as available.
- C.** The council shall review and update, as necessary, the emergency stroke care protocols in subsection (A) after seeking input from:
1. Local EMS coordinating systems,
 2. National organizations that focus on heart disease and stroke,
 3. Nonprofit organizations that focus on the development of stroke systems of care,
 4. Emergency medical services providers, and
 5. Health care providers.

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Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New Section made by exempt rulemaking at 19 A.A.R. 643, effective April 5, 2013 (Supp. 13-1). Amended by final rulemaking at 23 A.A.R. 1728, effective July 1, 2017 (Supp. 17-2).

R9-25-603. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-604. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-605. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-606. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-607. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-608. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-609. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

Exhibit R. Repealed**Historical Note**

Exhibit R adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-610. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-611. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-612. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-613. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-614. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-615. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Amended by exempt rulemaking at 7 A.A.R. 4888, effective November 1, 2001 (Supp. 01-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

R9-25-616. Repealed**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

Exhibit S. Repealed**Historical Note**

Exhibit S adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

Exhibit G. Repealed**Historical Note**

Exhibit G adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

Exhibit L. Repealed**Historical Note**

Exhibit L adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

Exhibit M. Repealed**Historical Note**

Exhibit M adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

Exhibit N. Repealed**Historical Note**

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Exhibit N adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

Exhibit O. Repealed**Historical Note**

Exhibit O adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

Exhibit Q. Repealed**Historical Note**

Exhibit Q adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

ARTICLE 7. AIR AMBULANCE SERVICE LICENSING**R9-25-701. Definitions (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), 36-2212, 36-2213, 36-2214, and 36-2215)**

In addition to the definitions in A.R.S. § 36-2201 and R9-25-101, the following definitions apply in this Article and in Article 8 of this Chapter, unless otherwise specified:

1. "Air ambulance" means an aircraft that is an "ambulance" as defined in A.R.S. § 36-2201.
2. "Air ambulance service" means an ambulance service that operates an air ambulance.
3. "Application packet" means the information, applicable fees, and documents required by the Department when making a decision for:
 - a. Licensing an air ambulance service, or
 - b. Issuing a certificate of registration for an air ambulance.
4. "Base location" means a physical location at which a person houses an air ambulance or equipment and supplies used for the operation of an air ambulance service or provides administrative or other support for the operation of an air ambulance service.
5. "CAMTS" means the Commission on Accreditation of Medical Transport Systems, formerly known as the Commission on Accreditation of Air Medical Services.
6. "Certificate holder" means a person who holds a current and valid certificate of registration for an air ambulance.
7. "Change of ownership" means a transfer of controlling legal or controlling equitable interest and authority in an air ambulance service.
8. "Critical care" means pertaining to a patient who has an illness or injury acutely impairing one or more organ systems, such that the conditions are life-threatening and require constant monitoring to avoid deterioration of the patient's condition.
9. "Estimated time of arrival" means the number of minutes from the time that an air ambulance service agrees to perform a mission to the time that an air ambulance arrives at the scene.
10. "Interfacility" means between two health care institutions.
11. "Interfacility maternal transport" means an interfacility transport of a woman:
 - a. Whose pregnancy is considered by a physician to be high risk,
 - b. Who is in need of critical care services related to the pregnancy, and
 - c. Who is being transferred to a medical facility that has the specialized perinatal and neonatal resources and capabilities necessary to provide an appropriate level of care.
12. "Interfacility neonatal transport" means an interfacility transport of an infant who is 28 days of age or younger and who is in need of critical care services.
13. "Licensed respiratory care practitioner" has the same meaning as in A.R.S. § 32-3501.
14. "Licensee" means a person who holds a current and valid license from the Department to operate an air ambulance service.
15. "Medical team" means personnel whose main function on a mission is the medical care of the patient being transported.
16. "Mission" means a transport event that involves an air ambulance service's sending an air ambulance to a patient's location to provide transport of the patient from one location to another, whether or not transport of the patient is actually provided.
17. "Mission level" means critical care services or ALS services, based on the staffing and the services provided by the air ambulance service.
18. "Mission type" means an emergency medical services transport, interfacility transport, interfacility maternal transport, or interfacility neonatal transport provided by an air ambulance service.
19. "On-line medical guidance" means emergency medical services direction or information provided to a non-EMCT medical team member by a physician through two-way voice communication.
20. "Operate an air ambulance in this state" means:
 - a. Transporting a patient via air ambulance from a location in this state to another location in this state,
 - b. Operating an air ambulance from a base location in this state, or
 - c. Transporting a patient via air ambulance from a location in this state to a location outside of this state more than once per month.
21. "Owner" means a person that holds a controlling legal or equitable interest and authority in a business organization.
22. "Personnel" means individuals who work for an air ambulance service, with or without compensation, whether as employees, contractors, or volunteers.
23. "Premises" means each physical location of air ambulance service operations and includes all equipment and records at each location.
24. "Proficiency in neonatal resuscitation" means current and valid certification in neonatal resuscitation obtained through completing a nationally recognized training program such as the American Academy of Pediatrics and American Heart Association NRP: Neonatal Resuscitation Program.
25. "Regularly" means at recurring, fixed, or uniform intervals.
26. "Subspecialization" means:
 - a. For a physician board certified by a specialty board approved by the American Board of Medical Specialties, subspecialty certification;
 - b. For a physician board certified by a specialty board approved by the American Osteopathic Association, attainment of either a certification of special qualifications or a certification of added qualifications; and
 - c. For a physician who has completed an accredited residency program, completion of at least one year of training pertaining to the specified area of medicine.
27. "Two-way voice communication" means that two individuals are able to convey information back and forth to each other orally, either directly or through a third-party relay.
28. "Valid" means that a license, certification, or other form of authorization is in full force and effect and not suspended.

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29. "Working day" means the period between 8:00 a.m. and 5:00 p.m. on a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state holiday.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-702. Applicability (A.R.S. §§ 36-2202(A)(4) and 36-2217)

This Article and Article 8 of this Chapter do not apply to persons and vehicles exempted from the provisions of A.R.S. Title 36, Chapter 21.1 as provided in A.R.S. § 36-2217(A).

Historical Note

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1).

R9-25-703. Requirement and Eligibility for a License (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), 36-2212, 36-2213, 36-2214, and 36-2215)

- A.** A person shall not operate an air ambulance in this state unless the person has a current and valid air ambulance service license and, except as provided in A.R.S. § 36-2212(C), a current and valid certificate of registration for the air ambulance as required under Article 8 of this Chapter.
- B.** To be eligible to obtain an air ambulance service license, an applicant shall:
1. Hold current and valid registration and exemption issued by the Federal Aviation Administration under 14 CFR 298, as evidenced by a current and valid U.S. Department of Transportation OST Form 4507 showing the effective date of registration;
 2. Hold the following issued by the Federal Aviation Administration:
 - a. A current and valid Air Carrier Certificate authorizing common carriage under 14 CFR 135;
 - b. If operating a rotor-wing air ambulance, current and valid Operations Specifications authorizing aero-medical helicopter operations;
 - c. If operating a fixed-wing air ambulance, current and valid Operations Specifications authorizing airplane air ambulance operations;
 - d. A current and valid Certificate of Registration for each air ambulance to be operated; and
 - e. A current and valid Airworthiness Certificate for each air ambulance to be operated;
 3. Have applied for a certificate of registration, issued by the Department under Article 8 of this Chapter, for each air ambulance to be operated by the air ambulance service;
 4. Possess a copy of a current and valid registration, issued by the Arizona Department of Transportation under A.R.S. Title 28, Chapter 25, Article 4, to the owner of the aircraft for each air ambulance to be operated by the air ambulance service;
 5. Have current and valid liability insurance coverage for the air ambulance service that complies with A.R.S. § 36-2215 and that has at least the following maximum liability limits:
 - a. \$1 million for injuries to or death of any one person arising out of any one incident or accident;
 - b. \$3 million for injuries to or death of more than one person in any one incident or accident; and
 - c. \$500,000 for damage to property arising from any one incident or accident;

6. Have current and valid malpractice insurance coverage for the air ambulance service that complies with A.R.S. § 36-2215 and that has a maximum liability limit of at least \$1 million per occurrence; and
7. Comply with all applicable requirements of this Article, Articles 2 and 8 of this Chapter, and A.R.S. Title 36, Chapter 21.1.

- C.** To maintain eligibility for an air ambulance service license, a licensee shall meet the requirements of subsections (B)(1), (2), and (4) through (7) and hold a current and valid certificate of registration, issued by the Department under Article 8 of this Chapter, for each air ambulance operated in Arizona by the air ambulance service.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-704. Application and Licensing Process (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), 36-2213, 36-2214, and 36-2215)

- A.** An applicant for an initial license shall submit an application packet to the Department, including:
1. The following information in a Department-provided format:
 - a. The applicant's name; mailing address; e-mail address; fax number, if any; and telephone number;
 - b. The names of all other business organizations operated by the applicant related to the air ambulance service;
 - c. The physical and mailing addresses to be used for the air ambulance service, if different from the applicant's mailing address;
 - d. The name, title, address, e-mail address, and telephone number of the applicant's statutory agent or the individual designated by the applicant to accept service of process and subpoenas for the air ambulance service;
 - e. The name, title, address, e-mail address, and telephone number of the individual acting on behalf of the applicant according to R9-25-102;
 - f. If the applicant is a business organization:
 - i. The type of business organization; and
 - ii. The name; address; e-mail address; telephone number; and fax number, if any, of the individual who is to serve as the primary contact for information regarding the application;
 - g. The name and Arizona license number for the physician who is to serve as the administrative medical director for the air ambulance service;
 - h. The intended hours of operation for the air ambulance service;
 - i. The intended schedule of rates for the air ambulance service;
 - j. Which of the following mission types is to be provided:
 - i. Emergency medical services transports,
 - ii. Interfacility transports,
 - iii. Interfacility maternal transports, or
 - iv. Interfacility neonatal transports;
 - k. Which of the following mission levels is to be provided:
 - i. Critical care, or
 - ii. Advanced life support;
 - l. Whether the applicant plans to use fixed-wing or rotor-wing aircraft for the air ambulance service;
 - m. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-25-1201(C)(3);

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- n. Attestation that the applicant will comply with all applicable requirements in this Article, Articles 2 and 8 of this Chapter, and A.R.S. Title 36, Chapter 21.1;
- o. Attestation that the information provided in the application packet, including the information in the accompanying documents, is accurate and complete; and
- p. The signature of the applicant and the date signed;
- 2. Documentation for the individual specified according to subsection (A)(1)(e) that complies with A.R.S. § 41-1080;
- 3. A copy of the business organization's articles of incorporation, articles of organization, or partnership documents, if applicable;
- 4. A copy of a current and valid U.S. Department of Transportation OST Form 4507, showing the effective date of Federal Aviation Administration registration and exemption under 14 CFR 298;
- 5. A copy of the following issued by the Federal Aviation Administration:
 - a. A current and valid Air Carrier Certificate authorizing common carriage under 14 CFR 135;
 - b. If intending to operate a rotor-wing air ambulance, the following signed pages of the current and valid Operations Specifications authorizing aeromedical helicopter operations:
 - i. The page showing the certificate number issued by the Federal Aviation Administration and stating the name and contact information for the entity to which the certificate, approving the Operation Specifications authorizing aeromedical helicopter operations, was issued by the Federal Aviation Administration;
 - ii. The page stating the characteristics of the rotor-wing aircraft for which the certificate was issued by the Federal Aviation Administration;
 - iii. Each page stating the name and contact information for the individuals with controlling legal interest or controlling equitable interest in the ownership of the entity specified in subsection (A)(5)(b)(i);
 - iv. Each page stating the name and contact information for the individuals designated to act as a point of contact with the Federal Aviation Administration about the Operation Specifications for the rotor-wing aircraft;
 - v. Each page stating the name and contact information for the individuals with operational control of the rotor-wing aircraft; and
 - vi. Each page listing the tail numbers of the rotor-wing aircraft covered under the Operations Specifications; and
 - c. If intending to operate a fixed-wing air ambulance, the following signed pages of the current and valid Operations Specifications authorizing airplane air ambulance operations:
 - i. The page showing the certificate number issued by the Federal Aviation Administration and stating the name and contact information for the entity to which the certificate, approving the Operation Specifications authorizing airplane ambulance operations, was issued by the Federal Aviation Administration;
 - ii. The page stating the characteristics of the fixed-wing aircraft for which the certificate was issued by the Federal Aviation Administration;
 - iii. Each page stating the name and contact information for the individuals with controlling legal interest or controlling equitable interest in the ownership of the entity specified in subsection (A)(5)(c)(i);
- iv. Each page stating the name and contact information for the individuals designated to act as a point of contact with the Federal Aviation Administration about the Operation Specifications for the fixed-wing aircraft;
- v. Each page stating the name and contact information for the individuals with operational control of the fixed-wing aircraft; and
- vi. Each page listing the tail numbers of the fixed-wing aircraft covered under the Operations Specifications;
- 6. For each air ambulance to be operated for the air ambulance service:
 - a. An application for registration that includes all of the information and documents required under R9-25-801(B); and
 - b. A copy of a current and valid registration, issued by the Arizona Department of Transportation under A.R.S. Title 28, Chapter 25, Article 4;
- 7. A certificate of insurance establishing that the applicant has current and valid liability insurance coverage for the air ambulance service as required under R9-25-703(B)(5);
- 8. A certificate of insurance establishing that the applicant has current and valid malpractice insurance coverage for the air ambulance service as required under R9-25-703(B)(6);
- 9. A list of each entity that or physician who is to provide on-line medical direction to EMCTs of the air ambulance service, including:
 - a. For each entity, such as an ALS base hospital, centralized medical direction communications center, or physician group practice, the name, mailing address, e-mail address, and telephone number of the entity; or
 - b. For each physician who is to provide on-line medical direction, the name, professional license number, mailing address, e-mail address, and telephone number for the physician;
- 10. If the applicant holds current CAMTS accreditation for the air ambulance service, a copy of the current CAMTS accreditation report; and
- 11. If a document required under subsection (A)(4) or (5) is not issued in the name of the applicant, documentation showing the applicant can legally possess and operate the aircraft covered by the document, signed by the owner of the aircraft.
- B. No more than 30 days before the expiration date of the current license, a licensee shall submit to the Department a renewal application packet including:
 - 1. The information required in subsection (A)(1), in a Department-provided format;
 - 2. The documents required in subsections (A)(4), (5), (7), (8), (9), and, if applicable, (10); and
 - 3. For each air ambulance operated or to be operated by the air ambulance service:
 - a. Either:
 - i. A copy of a current and valid certificate of registration issued by the Department under Article 8 of this Chapter, or
 - ii. An application packet for registration that includes all of the information and documents required under R9-25-801(B); and
 - b. A copy of a current and valid registration, issued by the Arizona Department of Transportation under A.R.S. Title 28, Chapter 25, Article 4.
- C. Unless an applicant or licensee documents current CAMTS accreditation, as provided in subsection (A)(10), or is applying for an initial license because of a change of ownership as

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described in R9-25-710(D), the Department shall conduct an inspection, as required under A.R.S. § 36-2214(B) and R9-25-711, during the substantive review period for the application for a license.

- D. The Department shall review each application packet as described in Article 12 of this Chapter, and:
 - 1. Approve the application;
 - 2. Approve the application with a corrective action plan, as specified in R9-25-711(G)(2); or
 - 3. Deny the application.
- E. The Department may deny an application if an applicant or licensee:
 - 1. Fails to meet the eligibility requirements of R9-25-703(B);
 - 2. Fails or has failed to comply with any provision in A.R.S. Title 36, Chapter 21.1;
 - 3. Fails or has failed to comply with any provision in this Article or Article 2 or 8 of this Chapter;
 - 4. Knowingly or negligently provides false documentation or false or misleading information to the Department; or
 - 5. Fails to submit to the Department documents or information requested under R9-25-1201(B)(1) or (C)(3) and requests a denial as permitted under R9-25-1201(E).

Historical Note

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-705. Minimum Standards for Operations (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), and 36-2213)

- A. A licensee shall ensure that the air ambulance service:
 - 1. Maintains eligibility for licensure as required under R9-25-703(C);
 - 2. Makes a good faith effort to communicate information about its hours of operation to the general public through print media, broadcast media, the Internet, or other means;
 - 3. Makes the air ambulance service's schedule of rates available to any individual upon request and, if requested, in writing;
 - 4. Provides an accurate estimated time of arrival to the person requesting transport at the time that transport is requested and provides an amended estimated time of arrival to the person requesting transport if the estimated time of arrival changes;
 - 5. Except as provided in subsection (B), only transports patients for whom the air ambulance service has the resources to provide appropriate medical care;
 - 6. Does not perform interfacility transport of a patient unless:
 - a. The transport is initiated by the sending health care institution, and
 - b. The destination health care institution confirms that a bed is available for the patient;
 - 7. Ensures that the protocol for the transfer of information to be communicated to emergency receiving facility staff concurrent with the transfer of care, required in R9-25-201(E)(2)(d)(i), includes:
 - a. The date and time the call requesting service was received by the air ambulance service;
 - b. The unique number used by the air ambulance service to identify the mission;
 - c. The name of the air ambulance service;
 - d. The number or other identifier of the air ambulance used for the mission;
 - e. The following information about the patient:
 - i. The patient's name;

- ii. The patient's date of birth or age, as available;
 - iii. The principal reason for requesting services for the patient;
 - iv. The patient's medical history, including any chronic medical illnesses, known allergies to medications, and medications currently being taken by the patient;
 - v. The patient's level of consciousness at initial contact and when reassessed;
 - vi. The patient's pulse rate, respiratory rate, oxygen saturation, and systolic blood pressure at initial contact and when reassessed;
 - vii. The results of an electrocardiograph, if available;
 - viii. The patient's glucose level at initial contact and when reassessed, if applicable;
 - ix. The patient's level of responsiveness score, as applicable, at initial contact and when reassessed;
 - x. The results of the patient's neurological assessment, if applicable; and
 - xi. The patient's pain level at initial contact and when reassessed; and
- f. Any procedures or other treatment provided to the patient at the scene or during transport, including any agents administered to the patient;
- 8. Creates a prehospital incident history report, in a Department-provided format, for each patient that includes the following information:
 - a. The name and identification number of the air ambulance service;
 - b. Information about the software for the storage and submission of the prehospital incident history report;
 - c. The unique number assigned to the mission;
 - d. The unique number assigned to the patient;
 - e. Information about the response to the call requesting service, including:
 - i. The mission level requested;
 - ii. Information obtained by the person providing direction for response to the request;
 - iii. Information about the air ambulance assigned to the mission;
 - iv. Information about the medical team responding to the call requesting service;
 - v. The priority assigned to the response; and
 - vi. Response delays, as applicable;
 - f. Whether patient care was transferred from another EMS provider or ambulance service and, if so, identification of the EMS provider or ambulance service;
 - g. The date and time that:
 - i. The call requesting service was received;
 - ii. The request was received by the person coordinating transport;
 - iii. The air ambulance service received the transport request;
 - iv. The air ambulance left for the patient's location;
 - v. The air ambulance arrived at the patient's location;
 - vi. The medical team in the air ambulance arrived at the patient's side;
 - vii. Transfer of the patient's care occurred at a location other than the destination, if applicable;
 - viii. The air ambulance departed the patient's location;
 - ix. The air ambulance arrived at the destination;
 - x. Transfer of the patient's care occurred at the destination;
 - xi. The air ambulance was available to take another mission;
 - h. Information about the patient, including:

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- i. The patient's first and last name;
 - ii. The address of the patient's residence;
 - iii. The county of the patient's residence;
 - iv. The country of the patient's residence;
 - v. The patient's gender, race, ethnicity, and age;
 - vi. The patient's estimated weight;
 - vii. The patient's date of birth; and
 - viii. If the patient has an alternate residence, the address of the alternate residence;
 - i. The primary method of payment for services and anticipated level of payment;
 - j. Information about the scene, including:
 - i. Specific information about the location of the scene;
 - ii. Whether the air ambulance was first on the scene;
 - iii. The number of patients at the scene;
 - iv. Whether the scene was the location of a mass casualty incident; and
 - v. If the scene was the location of a mass casualty incident, triage information;
 - k. Information about the reason for requesting service for the patient, including:
 - i. The date and time of onset of symptoms and when the patient was last well;
 - ii. Information about the complaint;
 - iii. The patient's symptoms;
 - iv. The results of the medical team's initial assessment of the patient;
 - v. If the patient was injured, information about the injury and the cause of the injury;
 - vi. If the patient experienced a cardiac arrest, information about the etiology of the cardiac arrest and subsequent treatment provided; and
 - vii. For an interfacility transport, the reason for the transport;
 - l. Information about any specific barriers to providing care to the patient;
 - m. Information about the patient's medical history, including:
 - i. Known allergies to medications,
 - ii. Surgical history,
 - iii. Current medications, and
 - iv. Alcohol or drug use;
 - n. Information about the patient's current medical condition, including the information in subsections (A)(7)(e)(v) through (xi) and the time and method of assessment;
 - o. Information about agents administered to the patient, including the dose and route of administration, time of administration, and the patient's response to the agent;
 - p. If not specifically included under subsection (A)(8)(k), (m)(iv), (n), or (o), the information required in A.A.C. R9-4-602(A);
 - q. Information about any procedures performed on the patient and the patient's response to the procedure;
 - r. Whether the patient was transported and, if so, information about the transport;
 - s. Information about the destination of the transport, including the reason for choosing the destination;
 - t. Whether patient care was transferred to another EMS provider or ambulance service and, if so, identification of the EMS provider or ambulance service;
 - u. Unless patient care was transferred to another EMS provider or ambulance service, information about:
 - i. Whether the destination facility was notified that the patient being transported has a time-sensitive condition and the time of notification;
 - ii. The disposition of the patient at the destination; and
 - iii. The disposition of the mission;
 - v. Any other narrative information about the patient, care received by the patient, or transport; and
 - w. The name and certification level of the medical team member providing the information;
9. Creates a record for each mission that includes:
- a. Mission date;
 - b. Mission level;
 - c. Mission type;
 - d. Staffing of the mission;
 - e. Aircraft type—fixed-wing aircraft or rotor-wing aircraft;
 - f. Name of the person requesting the transport;
 - g. Time of receipt of the transport request;
 - h. The estimated time of arrival, as provided according to subsection (A)(4);
 - i. Departure time to the patient's location;
 - j. Address of the patient's location;
 - k. Arrival time at the patient's location;
 - l. Departure time to the destination health care institution;
 - m. Name and address of the destination health care institution;
 - n. Arrival time at the destination health care institution;
 - o. Either the:
 - i. Unique reference number used by the air ambulance service to identify the patient, or
 - ii. Unique call number used by the air ambulance service to identify the specific mission; and
 - p. Aircraft tail number for the air ambulance used on the mission;
10. Establishes, documents, and, if necessary, implements a plan to address and minimize potential issues of patient health and safety due to the air ambulance service terminating operations at a physical address used for the air ambulance service that:
- a. Is developed in conjunction with hospitals near the physical address used for the air ambulance service and other persons who may be adversely affected by the air ambulance service terminating operations;
 - b. Includes notification by the air ambulance service of the persons in subsection (A)(10)(a) of the intent to terminate operations, at least 30 calendar days before the termination of operations; and
 - c. Includes temporary measures that will be used until alternate methods may be arranged for patient transport that address patient health and safety;
11. Establishes, documents, and implements a quality improvement program, as specified in policies and procedures, through which:
- a. Data related to initial patient assessment, patient care, transport services provided, and patient status upon arrival at the destination are:
 - i. Collected continuously;
 - ii. For the information required in subsection (A)(8), submitted to the Department, in a Department-provided format and within 48 hours after the date of a mission, for quality improvement purposes; and
 - iii. If the air ambulance service is notified that the submission of information to the Department according to subsection (A)(11)(a)(ii) was unsuccessful, corrected and resubmitted within seven days after notification;
 - b. Continuous quality improvement processes are developed to identify, document, and evaluate issues related to the provision of services, including:
 - i. Care provided to patients with time-sensitive conditions;
 - ii. Transport or documentation, and
 - iii. Patient status upon arrival at the destination;

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- c. A committee consisting of the administrative medical director, the individual managing the air ambulance service or designee, and other employees as appropriate:
 - i. Review the data in subsection (A)(11)(a) and any issues identified in subsection (A)(11)(b) on at least a quarterly basis; and
 - ii. Implement activities to improve performance when deviations in patient care, transport, or documentation are identified; and
 - d. The activities in subsection (A)(11)(c) are documented, consistent with A.R.S. §§ 36-2401, 36-2402, and 36-2403; and
 - 12. Beginning within 12 months after the effective date of this Section, establish and maintain a method to electronically document patient information and treatment that is capable of being transferred.
- B. An air ambulance service may transport a patient for whom the air ambulance does not have the resources to provide appropriate medical care:
 - 1. In a rescue situation in which:
 - a. An individual's life, limb, or health is imminently threatened;
 - b. The threat may be reduced or eliminated by removing the individual from the situation to a location in which medical services may be provided; and
 - c. There is no other practical means of transport, including another air ambulance service, available; or
 - 2. For an interfacility transport of a patient if:
 - a. The sending health care institution provides medically appropriate life support measures, staff, and equipment to sustain the patient during the interfacility transport; and
 - b. Each staff member provided by the sending health care institution has completed training in the subject areas listed in R9-25-707(A) before participating in the interfacility transport.
- C. If an air ambulance service completes a mission under subsection (B) for which the air ambulance service does not have the resources to provide appropriate medical care, the licensee shall ensure that the air ambulance service creates a record within five working days after the mission, including:
 - 1. The information required under subsection (A)(8),
 - 2. The manner in which the air ambulance service deviated from subsection (A)(5), and
 - 3. The justification for operating under subsection (B).
- D. If an air ambulance service uses a single-member medical team as authorized under R9-25-706(B) and (C), the licensee shall ensure that the air ambulance service creates a record within five working days after the mission, including:
 - 1. The information required under subsection (A)(9),
 - 2. The name and qualifications of the individual comprising the single-member medical team, and
 - 3. The justification for using a single-member medical team.
- E. If an air ambulance service completes a critical care interfacility transport mission under conditions permitted in R9-25-802(F), the licensee shall ensure that the air ambulance service creates a record within five working days after the mission, including:
 - 1. The information required under subsection (A)(9),
 - 2. A description of the life-support equipment used on the mission,
 - 3. A list of the equipment and supplies required in R9-25-802(C) that were removed from the air ambulance for the mission, and
 - 4. The justification for conducting the mission as permitted under R9-25-802(F).
- F. A licensee shall ensure that an individual does not serve on the medical team for an interfacility maternal transport unless the air ambulance service's medical director has verified and attested in writing to the individual's having the proficiencies described in R9-25-706(A)(2).
- G. A licensee shall ensure that an individual does not serve on the medical team for an interfacility neonatal transport unless the air ambulance service's medical director has verified and attested in writing to the individual's having the proficiencies described in R9-25-706(A)(3).
- H. A licensee shall ensure that the air ambulance service:
 - 1. Retains each document required to be created or maintained under this Article or Article 2 or 8 of this Chapter for at least three years after the last event recorded in the document, and
 - 2. Produces each document for Department review upon request.
- I. A licensee shall ensure that, while on a mission, two-way voice communication is available:
 - 1. Between and among personnel on the air ambulance, including the pilot; and
 - 2. Between personnel on the air ambulance and the following persons on the ground:
 - a. Personnel;
 - b. Physicians providing on-line medical direction or on-line medical guidance to medical team members; and
 - c. For a rotor-wing air ambulance mission:
 - i. Emergency medical services providers, and
 - ii. Law enforcement agencies.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). R9-25-705 repealed; new Section R9-25-705 renumbered from R9-25-710 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-706. Minimum Standards for Mission Staffing (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), and 36-2213)

- A. A licensee shall ensure that, except as provided in subsection (B):
 - 1. Each critical care mission is staffed by a medical team of at least two individuals with the following qualifications:
 - a. For a critical care interfacility transport mission:
 - i. A physician or registered nurse; and
 - ii. Another physician, another registered nurse, a Paramedic, or a licensed respiratory care practitioner; and
 - b. For a critical care mission that is an emergency medical services transport:
 - i. A physician or registered nurse; and
 - ii. A Paramedic or another registered nurse;
 - 2. Each interfacility maternal transport mission is staffed by a medical team that:
 - a. Complies with the requirements for a critical care mission medical team in subsection (A)(1); and
 - b. Has the following additional qualifications:
 - i. Proficiency in advanced emergency cardiac life support that includes didactic instruction and a practical skills test, consistent with training recognized by the American Heart Association;
 - ii. Proficiency in neonatal resuscitation; and
 - iii. Proficiency in stabilization and transport of the pregnant patient;
 - 3. Each interfacility neonatal transport mission is staffed by a medical team that:
 - a. Complies with the requirements for a critical care mission medical team in subsection (A)(1); and

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- b. Has the following additional qualifications:
 - i. Proficiency in pediatric advanced emergency life support that includes didactic instruction and a practical skills test, consistent with training recognized by the American Heart Association; and
 - ii. Proficiency in neonatal resuscitation and stabilization of the neonatal patient; and
 - 4. Each advanced life support mission is staffed by a medical team of at least two individuals with the following qualifications:
 - a. For an advanced life support mission that is an emergency medical services transport:
 - i. A physician, registered nurse, or Paramedic; and
 - ii. Another Paramedic or another registered nurse;
 - b. For an advanced life support interfacility transport mission:
 - i. A physician, registered nurse, or Paramedic; and
 - ii. Another Paramedic, a licensed respiratory care practitioner, or another registered nurse.
- B. If the pilot on a mission using a rotor-wing air ambulance determines, in accordance with the air ambulance service's written guidelines required under subsection (C)(1), that the weight of a second medical team member could potentially compromise the performance of the rotor-wing air ambulance and the safety of the mission, and the use of a single-member medical team is consistent with the on-line medical direction or on-line medical guidance received as required under subsection (C)(2), an air ambulance service may use a single-member medical team consisting of an individual with the following qualification:
 - 1. For a critical care mission, a physician or registered nurse; and
 - 2. For an advanced life support mission, a physician, registered nurse, or Paramedic.
- C. A licensee shall ensure that:
 - 1. Each air ambulance service rotor-wing pilot is provided with written guidelines to use in determining when the weight of a second medical team member could potentially compromise the performance of a rotor-wing air ambulance and the safety of a mission, including the conditions of density altitude and weight that warrant the use of a single-member medical team;
 - 2. The following are done, without delay, after an air ambulance service rotor-wing pilot determines that the weight of a second medical team member could potentially compromise the performance of a rotor-wing air ambulance and the safety of a mission:
 - a. The pilot communicates that information to the medical team,
 - b. The medical team obtains on-line medical direction or on-line medical guidance regarding the use of a single-member medical team, and
 - c. The medical team proceeds in compliance with the on-line medical direction or on-line medical guidance;
 - 3. A single-member medical team has the knowledge and medical equipment to perform one-person cardiopulmonary resuscitation;
 - 4. The patient care provided by each single-member medical team, including consideration of each patient's status upon arrival at the destination health care institution, is reviewed through the quality improvement processes in R9-25-705(A)(11)(b) and (c); and

- 5. A single-member medical team is used only when no other transport team is available that would be more appropriate for delivering the level of care that a patient requires.

- D. A licensee shall ensure that the air ambulance service creates and maintains for each personnel member a file containing documentation of the personnel member's qualifications, including, as applicable, licenses, certifications, and training records.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). R9-25-706 renumbered to R9-25-710; new Section R9-25-706 renumbered from R9-25-711 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2). Amended by exempt rulemaking at 28 A.A.R. 3681 (December 2, 2022), with an immediate effective date of November 8, 2022 (Supp. 22-4).

R9-25-707. Minimum Standards for Training (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2213)

- A. A licensee shall ensure that each medical team member completes training in the following subjects before serving on a mission:
 - 1. Aviation terminology;
 - 2. Physiological aspects of flight;
 - 3. Patient loading and unloading;
 - 4. Safety in and around the aircraft;
 - 5. In-flight communications;
 - 6. Use, removal, replacement, and storage of the medical equipment installed on the aircraft;
 - 7. In-flight emergency procedures;
 - 8. Emergency landing procedures; and
 - 9. Emergency evacuation procedures.
- B. A licensee shall ensure that the air ambulance service documents each medical team member's completion of the training required under subsection (A), including the name of the medical team member, each training component completed, and the date of completion.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). R9-25-707 renumbered to R9-25-709; new Section R9-25-707 renumbered from R9-25-713 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-708. Minimum Standards for Medical Control (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), and 36-2213)

- A. A licensee shall ensure that:
 - 1. The air ambulance service has an administrative medical director who:
 - a. Meets the qualifications in subsection (B);
 - b. Supervises and evaluates the quality of medical care provided by medical team members;
 - c. Ensures the competency and current qualifications of all medical team members;
 - d. Except as provided in subsections (A)(3) and (4), ensures that:
 - i. Each EMCT medical team member receives medical direction as required under Article 2 of this Chapter; and
 - ii. Each non-EMCT medical team member receives medical guidance through written treatment protocols and according to subsection (C); and

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- e. Approves, ensures implementation of, and annually reviews treatment protocols to be followed by medical team members;
- 2. The administrative medical director reviews data related to patient care and transport services provided, documentation, and patient status upon arrival at destination that are collected through the quality management program in R9-25-705(A)(11);
- 3. For an interfacility maternal transport mission, on-line medical direction or on-line medical guidance provided to medical team member is provided by a physician who meets the qualifications of subsection (B)(2)(b)(i);
- 4. For an interfacility neonatal transport mission, on-line medical direction or on-line medical guidance provided to medical team member is provided by a physician who meets the qualifications of subsection (B)(2)(b)(ii);
- B. An administrative medical director shall:
 - 1. Be a physician; and
 - 2. Comply with one of the following:
 - a. If the air ambulance service provides emergency medical services transports, meet the qualifications of R9-25-201(A)(1); or
 - b. If the air ambulance service does not provide emergency medical services transports, meet the qualifications of R9-25-201(A)(1) or one of the following:
 - i. If the air ambulance service provides interfacility maternal transport missions, have board certification or have completed an accredited residency program in one of the following specialty areas:
 - (1) Obstetrics and gynecology, with subspecialization in critical care medicine or maternal and fetal medicine; or
 - (2) Pediatrics, with subspecialization in neonatal-perinatal medicine;
 - ii. If the air ambulance service provides interfacility neonatal transport missions, have board certification or have completed an accredited residency program in one of the following specialty areas:
 - (1) Obstetrics and gynecology, with subspecialization in maternal and fetal medicine; or
 - (2) Pediatrics, with subspecialization in neonatal-perinatal medicine, neonatology, pediatric critical care medicine, or pediatric intensive care; or
 - iii. If neither subsection (B)(2)(b)(i) or (ii) applies, have board certification or have completed an accredited residency program in one of the following specialty areas:
 - (1) Anesthesiology, with subspecialization in critical care medicine;
 - (2) Internal medicine, with subspecialization in critical care medicine;
 - (3) If the air ambulance service transports only pediatric patients, pediatrics, with subspecialization in pediatric critical care medicine or pediatric emergency medicine; or
 - (4) If the air ambulance service transports only surgical patients, surgery, with subspecialization in surgical critical care.
- C. An administrative medical director shall ensure that each non-EMCT medical team member receives on-line medical guidance provided by:
 - 1. The administrative medical director;
 - 2. Another physician designated by the administrative medical director; or

- 3. If the medical guidance needed exceeds the administrative medical director's area of expertise, a consulting specialty physician.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). R9-25-708 renumbered to R9-25-711; new Section R9-25-708 renumbered from R9-25-715 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-709. Changes Affecting a License (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2213)

- A. At least 30 days before the date of a change in an air ambulance service's name, the licensee shall send the Department written notice of the name change.
- B. At least 90 days before an air ambulance service ceases to operate, the licensee shall send the Department written notice of the intention to cease operating, effective on a specific date, and the licensee's intention to relinquish the air ambulance service's license as of that date.
- C. Within 30 days after the date of receipt of a notice described in subsection (A) or (B), the Department shall:
 - 1. For a notice described in subsection (A), issue an amended license that incorporates the name change but retains the expiration date of the current license; and
 - 2. For a notice described in subsection (B), send the licensee written confirmation of the voluntary relinquishment of the air ambulance service's license, with an effective date consistent with the written notice.
- D. A licensee shall notify the Department in writing at least 30 calendar days before:
 - 1. Changing the physical address used for the air ambulance service, as provided according to R9-25-704(A)(1)(c); or
 - 2. Terminating operations at a physical address used for the air ambulance service, as provided according to R9-25-704(A)(1)(c).
- E. A licensee shall notify the Department in writing within one working day after:
 - 1. A change in the air ambulance service's eligibility for licensure under R9-25-703(B) or (C);
 - 2. A change in the business organization information most recently submitted to the Department according to R9-25-704(A)(1)(f);
 - 3. A change in the air ambulance service's CAMTS accreditation status, including a copy of the air ambulance service's new CAMTS accreditation report, if applicable;
 - 4. A change in the air ambulance service's hours of operation, as specified according to R9-25-704(A)(1)(h);
 - 5. A change in the air ambulance service's schedule of rates, as specified according to R9-25-704(A)(1)(i); or
 - 6. A change in the mission types provided, as specified according to R9-25-704(A)(1)(j).
- F. If the Department receives a notice specified in subsection (E)(6), the Department:
 - 1. Shall reissue a license for the air ambulance service reflecting the change, but retaining the expiration date on the original license; and
 - 2. May conduct an inspection according to R9-25-711.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). R9-25-709 renumbered to R9-25-712; new Section R9-25-709 renumbered from R9-25-707 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-710. Term and Transferability of License (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), 36-2213, 36-2214,

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and 41-1092.11)

- A.** The Department shall issue an initial license:
 1. When based on current CAMTS accreditation, with a term beginning on the date of issuance of the initial license and ending on the expiration date of the CAMTS accreditation upon which licensure is based; and
 2. When based on Department inspection, with a term beginning on the date of issuance of the initial license and ending three years later.
- B.** The Department shall issue a renewal license with a term beginning on the day after the expiration date shown on the previous license and ending:
 1. When based on current CAMTS accreditation, on the expiration date of the CAMTS accreditation upon which licensure is based; and
 2. When based on Department inspection, three years after the effective date of the renewal license.
- C.** If a licensee submits an application packet for renewal as described in R9-25-704(B), the current license does not expire until the Department has made a final determination on the application for renewal, as provided in A.R.S. § 41-1092.11.
- D.** At least 30 days before an anticipated change of ownership:
 1. A licensee wanting to transfer an air ambulance service license shall submit a letter to the Department that contains:
 - a. A request that the air ambulance service license be transferred,
 - b. The name and license number of the currently licensed air ambulance service, and
 - c. The name of the person to whom the air ambulance service license is to be transferred; and
 2. The person to whom the license is to be transferred shall submit to the Department an application packet that complies with R9-25-704(A).
- E.** A new owner shall not operate an air ambulance in this state until:
 1. The new owner complies with requirements in Articles 7 and 8 of this Chapter, and
 2. The Department has issued an air ambulance service license to the new owner.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). R9-25-710 renumbered to R9-25-705; new Section R9-25-710 renumbered from R9-25-706 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-711. Inspections and Investigations (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), 36-2213, and 36-2214)

- A.** Except as provided in subsections (D) and (E), the Department shall inspect an air ambulance service, as required under A.R.S. § 36-2214(B), before issuing an initial or renewal license and as necessary to determine compliance with this Article, Articles 2 and 8 of this Chapter, and A.R.S. Title 36, Chapter 21.1.
- B.** A Department inspection may include the air ambulance service's premises, records, and equipment, and each air ambulance operated or to be operated by the air ambulance service.
- C.** If the Department receives written or verbal information alleging a violation of this Article, Article 2 or 8 of this Chapter, or A.R.S. Title 36, Chapter 21.1, the Department shall conduct an investigation.
 1. The Department may conduct an inspection as part of an investigation.
 2. A licensee shall allow the Department to inspect the air ambulance service's premises, records, and equipment, and each air ambulance and to interview personnel as part of an investigation.

- D.** Except as provided in subsection (C), the Department shall not conduct an inspection of an air ambulance service before issuing an initial or renewal license if an applicant or licensee provides documentation of current CAMTS certification as part of the application packet according to R9-25-704(A)(9).
- E.** When an application for an air ambulance service license is submitted along with a transfer request due to a change of ownership, the Department shall determine whether an inspection is necessary based upon the potential impact to public health, safety, and welfare.
- F.** The Department shall conduct each inspection in compliance with A.R.S. § 41-1009.
- G.** If the Department determines that an air ambulance service is not in compliance with the requirements in this Article, Article 2 or 8 of this Chapter, or A.R.S. Title 36, Chapter 21.1, the Department may:
 1. Take an enforcement action as described in R9-25-712; or
 2. Require that the air ambulance service submit to the Department, within 15 days after written notice from the Department, a corrective action plan to address issues of compliance that do not directly affect the health or safety of a patient that:
 - a. Describes how each identified instance of non-compliance will be corrected and reoccurrence prevented, and
 - b. Includes a date for correcting each instance of non-compliance that is appropriate to the actions necessary to correct the instance of non-compliance.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). R9-25-711 renumbered to R9-25-706; new Section R9-25-711 renumbered from R9-25-708 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-712. Enforcement Actions (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), 36-2213, 36-2214, 36-2215, 41-1092.03, and 41-1092.11(B))

- A.** The Department may take an action listed in subsection (B) against an air ambulance service that:
 1. Fails to meet the eligibility requirements of R9-25-703;
 2. Fails or has failed to comply with any provision in A.R.S. Title 36, Chapter 21.1;
 3. Fails or has failed to comply with any provision in this Article or Article 2 or 8 of this Chapter;
 4. Does not submit a corrective action plan, as provided in R9-25-711(G)(2), that is acceptable to the Department;
 5. Does not complete a corrective action plan submitted according to R9-25-711(G)(2); or
 6. Knowingly or negligently provides false documentation or false or misleading information to the Department or to a patient, third-party payor, or other person billed for service.
- B.** The Department may take the following actions against an air ambulance service:
 1. Except as provided in subsection (B)(3), after notice and an opportunity to be heard is provided under A.R.S. Title 41, Chapter 6, Article 10, suspend:
 - a. The air ambulance service license, or
 - b. The certificate of registration of an air ambulance operated by the air ambulance service;
 2. After notice and an opportunity to be heard is provided under A.R.S. Title 41, Chapter 6, Article 10, revoke:
 - a. The air ambulance service license, or
 - b. The certificate of registration of an air ambulance operated by the air ambulance service; and
 3. As permitted under A.R.S. § 41-1092.11(B), if the Department determines that the public health, safety, or

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welfare imperatively requires emergency action and incorporates a finding to that effect in the Department's order, immediately suspend:

- a. The air ambulance service license pending proceedings for revocation or other action, or
- b. The certificate of registration of an air ambulance operated by the air ambulance service pending proceedings for revocation or other action.

- C. In determining whether to take action under subsection (B), the Department shall consider:
1. The severity of each violation relative to public health and safety;
 2. The number of violations relative to the transport volume of the air ambulance service;
 3. The nature and circumstances of each violation;
 4. Whether each violation was corrected and, if so, the manner of correction; and
 5. The duration of each violation.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Section expired under A.R.S. 41-1056(E) at 18 A.A.R. 2153, effective June 30, 2012 (Supp. 12-3). New Section R9-25-712 renumbered from R9-25-709 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-713. Renumbered**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Section R9-25-713 renumbered to R9-25-707 by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-714. Repealed**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Repealed by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-715. Renumbered**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Section R9-25-715 renumbered to R9-25-708 by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-716. Repealed**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Repealed by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-717. Repealed**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Repealed by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-718. Repealed**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Repealed by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

ARTICLE 8. AIR AMBULANCE REGISTRATION

Article 8, consisting of R9-25-801 through R9-25-808, recodified to Article 5 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).

Editor's Note: Article 8, consisting of Sections R9-25-801 through R9-25-803 and Exhibits, was recodified from A.A.C. R9-13-1501 through R9-13-1503. These recodified Sections were originally filed under an exemption from A.R.S. Title 41, Chapter 6. Refer to the historical notes in 9 A.A.C. 13 for adoption dates (Supp. 98-1).

Article 8, consisting of Section R9-25-805 and Exhibits 1 through 3, was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 36-2205(C). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings on this Section. Under A.R.S. § 36-2205(D) a person may petition the Director to amend an adopted protocol pursuant to A.R.S. § 41-1033 (Supp. 97-2).

R9-25-801. Requirement, Eligibility, and Application for an Initial or Renewal Certificate of Registration for an Air Ambulance (Authorized by A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), 36-2212, 36-2213, 36-2214, 36-2232(A)(11), and 36-2240(4))

- A. To be eligible to obtain a certificate of registration for an air ambulance, an applicant shall:
1. Hold a current and valid air ambulance service license issued under Article 7 of this Chapter;
 2. Hold the following issued by the Federal Aviation Administration for the air ambulance:
 - a. A current and valid Certificate of Registration, and
 - b. A current and valid Airworthiness Certificate;
 3. Possess a copy of a current and valid registration for the air ambulance, issued by the Arizona Department of Transportation under A.R.S. Title 28, Chapter 25, Article 4, to the owner of the aircraft; and
 4. Comply with all applicable requirements of this Article, Articles 2 and 7 of this Chapter, and A.R.S. Title 36, Chapter 21.1.
- B. An applicant for an initial or renewal certificate of registration for an air ambulance shall submit an application packet to the Department, including:
1. The following information in a Department-provided format:
 - a. The applicant's name; mailing address; e-mail address; fax number, if any; and telephone number;
 - b. The names of all other business organizations operated by the applicant related to the use of an air ambulance;
 - c. The physical address of the applicant, if different from the mailing address;
 - d. If applicable, the number of the applicant's air ambulance service license;
 - e. The name, title, address, e-mail address, and telephone number of the individual acting on behalf of the applicant according to R9-25-102;

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- f. The name, address, telephone number, and e-mail address of the owner of the air ambulance, if different from the applicant;
 - g. Whether the air ambulance is a fixed-wing or rotor-wing aircraft;
 - h. The number of engines on the air ambulance;
 - i. The manufacturer's name;
 - j. The model name of the air ambulance;
 - k. The year the air ambulance was manufactured;
 - l. The serial number of the air ambulance;
 - m. The tail number of the air ambulance;
 - n. The aircraft colors, including fuselage, stripe, and lettering;
 - o. A description of any insignia, monogram, or other distinguishing characteristics of the aircraft's appearance;
 - p. The address at which the air ambulance is usually based;
 - q. The address in Arizona at which the air ambulance will be available for inspection;
 - r. The name and telephone number of the individual to contact to arrange for inspection, if the inspection is preannounced;
 - s. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-25-1201(C)(3);
 - t. Attestation that the information provided in the application packet, including the information in the accompanying documents, is accurate and complete; and
 - u. The dated signature of the applicant;
- 2. A copy of the following for the air ambulance, issued by the Federal Aviation Administration:
 - a. A current and valid Certificate of Registration, and
 - b. A current and valid Airworthiness Certificate;
 - 3. A copy of a current and valid registration for the air ambulance, issued by the Arizona Department of Transportation under A.R.S. Title 28, Chapter 25, Article 4;
 - 4. If a document required under subsection (B)(2) or (3) is not issued in the name of the applicant, documentation showing the applicant can legally possess and operate the aircraft covered by the document, signed by the owner of the aircraft; and
 - 5. Unless the applicant operates or intends to operate the air ambulance only as a volunteer not-for-profit service, the following fees:
 - a. A \$50 registration fee, as required under A.R.S. § 36-2212(D); and
 - b. A \$200 annual regulatory fee, as required under A.R.S. § 36-2240(4).
- C. The Department requires submission of a separate application and the fees in subsection (B)(5) for each air ambulance.
 - D. Except as provided in A.R.S. § 36-2232(A)(11), the Department shall inspect each air ambulance according to R9-25-805(A) and (B) to determine compliance with the provisions of A.R.S. Title 36, Chapter 21.1 and this Article:
 - 1. Within 30 calendar days before issuing an initial certificate of registration; and
 - 2. At least every 12 months thereafter, before issuing a renewal certificate of registration.
 - E. The Department shall review and approve or deny each application as described in Article 12 of this Chapter.
 - F. If the Department approves the application and sends the applicant the written notice of approval, specified in R9-25-1201(C)(5), the Department shall issue the certificate of registration to the applicant:
 - 1. For an applicant with a current and valid air ambulance service license issued under Article 7 of this Chapter, within five working days after the date on the written notice of approval; and
 - 2. For an applicant that does not have a current and valid air ambulance service license issued under Article 7 of this Chapter, when the air ambulance service license is issued.
 - G. The Department may deny a certificate of registration for an air ambulance if the applicant:
 - 1. Fails to meet the eligibility requirements of subsection (A);
 - 2. Fails or has failed to comply with any provision in A.R.S. Title 36, Chapter 21.1;
 - 3. Fails or has failed to comply with any provision in this Article or Article 2 or 7 of this Chapter;
 - 4. Knowingly or negligently provides false documentation or false or misleading information to the Department; or
 - 5. Fails to submit to the Department documents or information requested under R9-25-1201(B)(1) or (C)(3) and requests a denial as permitted under R9-25-1201(E).

Historical Note

R9-25-801 recodified from A.A.C. R9-13-1501 (Supp. 98-1). Amended by exempt rulemaking at 7 A.A.R. 4895, effective October 5, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Section recodified to R9-25-501 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Section R9-25-801 repealed; new Section R9-25-801 renumbered from R9-25-802 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-802. Minimum Standards for an Air Ambulance (Authorized by A.R.S. §§ 36-2202(A)(3), (4), and (5); 36-2209(A)(2); and 36-2212)

- A. An applicant or certificate holder shall ensure that an air ambulance has:
 - 1. A climate control system to prevent temperature extremes that would adversely affect patient care;
 - 2. If a fixed-wing air ambulance, pressurization capability;
 - 3. Interior lighting that allows for patient care and monitoring without interfering with the pilot's vision;
 - 4. For each place where a patient may be positioned, at least one electrical power outlet or other power source that is capable of operating all electrically powered medical equipment without compromising the operation of any electrical aircraft equipment;
 - 5. A back-up source of electrical power or batteries capable of operating all electrically powered life-support equipment for at least one hour;
 - 6. An entry that allows for patient loading and unloading without rotating a patient and stretcher more than 30 degrees about the longitudinal axis or 45 degrees about the lateral axis and without compromising the operation of monitoring systems, intravenous lines, or manual or mechanical ventilation;
 - 7. A configuration that allows each medical team member sufficient access to each patient to begin and maintain treatment modalities, including complete access to the patient's head and upper body for effective airway management;
 - 8. A configuration that allows for rapid exit of personnel and patients, without obstruction from stretchers and medical equipment;
 - 9. A configuration that protects the aircraft's flight controls, throttles, and communications equipment from any intentional or accidental interference from a patient or equipment and supplies;
 - 10. A padded interior or an interior that is clear of objects or projections in the head strike envelope;
 - 11. An installed self-activating emergency locator transmitter;
 - 12. A voice communications system that:

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- a. Is capable of air-to-ground communication, and
 - b. Allows the flight crew and medical team members to communicate with each other during flight;
13. Interior patient compartment wall and floor coverings that are:
 - a. Free of cuts or tears,
 - b. Made from non-absorbent material,
 - c. Capable of being disinfected, and
 - d. Maintained in a sanitary manner; and
14. If a rotor-wing air ambulance, the following:
 - a. A searchlight that:
 - i. Has a range of motion of at least 90 degrees vertically and 180 degrees horizontally,
 - ii. Is capable of illuminating a landing site, and
 - iii. Is located so that the pilot can operate the searchlight without removing the pilot's hands from the aircraft's flight controls;
 - b. Restraining devices that can be used to prevent a patient from interfering with the pilot or the aircraft's flight controls; and
 - c. A light to illuminate the tail rotor.
- B. An applicant or certificate holder shall ensure that:
 1. Except as provided in subsections (D), (E), and (F), each air ambulance has the equipment and supplies required in subsection (C) for each mission for which the air ambulance is used; and
 2. The equipment and supplies on an air ambulance are secured, stored, and maintained in a manner that prevents hazards to personnel and patients.
- C. An applicant or certificate holder shall ensure that an air ambulance used for an advanced life support mission or critical care mission has the following equipment and supplies:
 1. The following ventilation and airway equipment and supplies:
 - a. Portable and fixed suction apparatus, with wide-bore tubing, rigid pharyngeal curved suction tip, tonsillar and flexible suction catheters, 5F-14F;
 - b. Portable and fixed oxygen equipment, with variable flow regulators;
 - c. Oxygen administration equipment, including: tubing; non-rebreathing masks (adult and pediatric sizes); and nasal cannulas (adult and pediatric sizes);
 - d. Bag-valve mask, with hand-operated, self-reexpanding bag (adult size), with oxygen reservoir/accumulator; mask (adult, pediatric, infant, and neonate sizes); and valve;
 - e. Airways, oropharyngeal (adult, pediatric, and infant sizes);
 - f. Laryngoscope handle, adult and pediatric, with, if applicable, extra batteries and bulbs;
 - g. Laryngoscope blades, sizes 0, 1, and 2, straight; sizes 3 and 4, straight and curved;
 - h. Endotracheal tube cuff pressure manometer;
 - i. Endotracheal tubes, sizes 2.5-5.0 mm cuffed or uncuffed and 6.0-8.0 mm cuffed;
 - j. Stylettes for Endotracheal tubes, adult and pediatric;
 - k. Airways, nasal (adult, pediatric, and infant sizes), one each in French sizes 16 to 34;
 - l. One type of supraglottic airway device, adult and pediatric;
 - m. 10 mL straight-tip syringes;
 - n. Small volume nebulizer or nebulizers and aerosol masks, adult and pediatric;
 - o. Magill forceps, adult and pediatric;
 - p. Nasogastric tubes, sizes 5F and 8F, Salem sump sizes 14F and 18F;
 - q. End-tidal CO₂ detectors, quantitative;
 - r. Portable automatic ventilator with positive end expiratory pressure; and
 - s. In-line viral/bacterial filter;
 2. The following monitoring and defibrillation equipment and supplies:
 - a. Portable, battery-operated monitor/defibrillator, with:
 - i. Tape write-out/recorder,
 - ii. Defibrillator pads,
 - iii. Adult and pediatric paddles or hands-free patches,
 - iv. ECG leads,
 - v. Adult and pediatric chest attachment electrodes, and
 - vi. Capability to provide electrical discharge below 25 watt-seconds; and
 - b. Transcutaneous cardiac pacemaker, either stand-alone unit or integrated into monitor/defibrillator;
 3. For rotor wing aircraft only, the following immobilization devices and supplies:
 - a. Cervical collars, rigid, adjustable or in an assortment of adult and pediatric sizes;
 - b. Head immobilization device, either firm padding or another commercial device;
 - c. Lower extremity (femur) traction device, including lower extremity, limb support slings, padded ankle hitch, padded pelvic support, and traction strap; and
 - d. Upper and lower extremity immobilization splints;
 4. The following bandages:
 - a. Burn pack, including standard package, clean burn sheets;
 - b. Dressings, including:
 - i. Sterile multi-trauma dressings (various large and small sizes);
 - ii. Abdominal pads, 10" x 12" or larger; and
 - iii. 4" x 4" gauze sponges;
 - c. Gauze rolls, sterile (4" or larger);
 - d. Elastic bandages, non-sterile (4" or larger);
 - e. Occlusive dressing, sterile, 3" x 8" or larger; and
 - f. Adhesive or self-adhesive tape, including various sizes (1" or larger) hypoallergenic and various sizes (1" or larger) adhesive or self-adhesive;
 5. The following obstetrical equipment and supplies:
 - a. Separate sterile obstetrical kit, including:
 - i. Towels,
 - ii. 4" x 4" dressing,
 - iii. Umbilical tape,
 - iv. Sterile scissors or other cutting utensil,
 - v. Bulb suction,
 - vi. Clamps for cord,
 - vii. Sterile gloves,
 - viii. Blankets, and
 - ix. A head cover; and
 - b. An alternate portable patient heat source or two heat packs;
 6. The following infection control equipment and supplies, including the availability of latex-free:
 - a. Eye protection (full peripheral glasses or goggles, face shield);
 - b. Masks, at least as protective as a National Institute for Occupational Safety and Health-approved N-95 respirator, which are fit-tested;
 - c. Gloves, non-sterile;
 - d. Jumpsuits or gowns;
 - e. Shoe covers;
 - f. Disinfectant hand wash, commercial antimicrobial (towelette, spray, or liquid);
 - g. Disinfectant solution for cleaning equipment;
 - h. Standard sharps containers;
 - i. Disposable red trash bags; and
 - j. Protective facemasks or cloth face coverings for patients;
 7. The following injury prevention equipment:

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- a. Appropriate restraints, such as seat belts or, if applicable, child safety restraints, for patient, personnel, and family members;
- b. For rotor wing aircraft only, safety vest or other garment with reflective material for each personnel member;
- c. Fire extinguisher, either disposable with an indicator of a full charge or with a current inspection tag;
- d. Hazardous material reference guide; and
- e. Hearing protection for patient and personnel;
- 8. The following vascular access equipment and supplies:
 - a. Intravenous administration equipment, with fluid in bags;
 - b. Antiseptic solution (alcohol wipes and povidone-iodine wipes);
 - c. Intravenous pole or roof hook;
 - d. Intravenous catheters 14G-24G;
 - e. Intraosseous needles, adult and pediatric sizes;
 - f. Venous tourniquet;
 - g. One of each of the following types of intravenous solution administration sets:
 - i. A set with blood tubing,
 - ii. A set capable of delivering 60 drops per cc, and
 - iii. A set capable of delivering 10 or 15 drops per cc;
 - h. Intravenous arm boards, adult and pediatric;
 - i. IV pump or pumps (minimum of 3 infusion lines); and
 - j. IV pressure bag;
- 9. The agents, specified in a table of agents established according to A.R.S. § 36-2204 and available through the Department at www.azdhs.gov/ems-regulatory-references, that an administrative medical director has authorized for use, based on the EMCT classification of the medical team; and
- 10. The following miscellaneous equipment and supplies:
 - a. Sphygmomanometer (infant, pediatric, and adult regular and large sizes);
 - b. Stethoscope;
 - c. Pediatric equipment sizing reference guide;
 - d. Thermometer with low temperature capability;
 - e. Heavy bandage or paramedic scissors for cutting clothing, belts, and boots;
 - f. Cold packs;
 - g. Flashlight (1) with extra batteries or recharger, as applicable;
 - h. Blankets;
 - i. Sheets;
 - j. Disposable emesis bags or basins;
 - k. For fixed wing aircraft only, a disposable bedpan;
 - l. For fixed wing aircraft only, a disposable urinal;
 - m. Properly secured patient transport system;
 - n. Lubricating jelly (water soluble);
 - o. Glucometer or blood glucose measuring device with reagent strips;
 - p. Pulse oximeter with pediatric and adult probes;
 - q. Automatic blood pressure monitor; and
 - r. A commercially available trauma arterial tourniquet.
- D. An applicant or certificate holder shall ensure that an air ambulance used for an interfacility maternal transport mission has:
 - 1. The equipment and supplies in subsection (C); and
 - 2. The following:
 - a. A Doppler fetal heart monitor;
 - b. Unless use is not indicated for the patient as determined through on-line medical direction or on-line medical guidance provided as described in R9-25-708(A)(3), an external fetal heart and tocographic monitor with printer capability;
 - c. Tocolytic and anti-hypertensive medications;
 - d. Advanced emergency cardiac life support equipment and supplies; and
 - e. Neonatal resuscitation equipment and supplies.
- E. An applicant or certificate holder shall ensure that an air ambulance used for an interfacility neonatal transport mission has:
 - 1. The equipment and supplies in subsection (C); and
 - 2. The following:
 - a. A transport incubator with:
 - i. Battery and inverter capabilities,
 - ii. An infant safety restraint system, and
 - iii. An integrated neonatal-capable pressure ventilator with oxygen-air supply and blender;
 - b. An invasive automatic blood pressure monitor;
 - c. A neonatal monitor or monitors with heart rate, respiratory rate, temperature, non-invasive blood pressure, and pulse oximetry capabilities;
 - d. Neonatal-specific drug concentrations and doses;
 - e. Thoracostomy supplies;
 - f. Neonatal resuscitation equipment and supplies;
 - g. A neonatal size cuff (size 2, 3, or 4) for use with an automatic blood pressure monitor; and
 - h. A neonatal probe for use with a pulse oximeter.
- F. A certificate holder may conduct a critical care interfacility transport mission using an air ambulance that does not have all of the equipment and supplies required in subsection (C) if:
 - 1. Care of the patient to be transported necessitates use of life-support equipment that, because of its size or weight or both, makes it unsafe or impossible for the air ambulance to carry all of the equipment and supplies required in subsection (C), as determined by the certificate holder based upon:
 - a. The individual aircraft's capabilities,
 - b. The size and weight of the equipment and supplies required in subsection (C) and of the additional life-support equipment,
 - c. The composition of the required medical team, and
 - d. Environmental factors such as density altitude;
 - 2. The certificate holder ensures that, during the mission, the air ambulance has the equipment and supplies necessary to provide an appropriate level of medical care for the patient and to protect the health and safety of the personnel on the mission; and
 - 3. The certificate holder ensures that the air ambulance is not used for another mission until the air ambulance has all of the equipment and supplies required in subsection (C).

Historical Note

R9-25-802 recodified from A.A.C. R9-13-1502 (Supp. 98-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4092, effective September 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 8 A.A.R. 931, effective February 15, 2002 (Supp. 02-1). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Section recodified to R9-25-502 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Section R9-25-802 renumbered to R9-25-801; new Section R9-25-802 renumbered from R9-25-807 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

Exhibit 1. Repealed**Historical Note**

Section R9-25-802, Exhibit 1 recodified from A.A.C. R9-13-1502, Exhibit 1 (Supp. 98-1). Exhibit 1 repealed by

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exempt rulemaking at 7 A.A.R. 4895, effective October 5, 2001 (Supp. 01-4).

Exhibit 2. Repealed**Historical Note**

Section R9-25-802, Exhibit 2 recodified from A.A.C. R9-13-1502, Exhibit 2 (Supp. 98-1). Exhibit 2 repealed by exempt rulemaking at 7 A.A.R. 4895, effective October 5, 2001 (Supp. 01-4).

Exhibit 3. Repealed**Historical Note**

Section R9-25-802, Exhibit 3 recodified from A.A.C. R9-13-1502, Exhibit 3 (Supp. 98-1). Exhibit 3 repealed by exempt rulemaking at 7 A.A.R. 4895, effective October 5, 2001 (Supp. 01-4).

Exhibit 4. Repealed**Historical Note**

Section R9-25-802, Exhibit 4 recodified from A.A.C. R9-13-1502, Exhibit 4 (Supp. 98-1). Exhibit 4 repealed by exempt rulemaking at 7 A.A.R. 4895, effective October 5, 2001 (Supp. 01-4).

R9-25-803. Changes Affecting Registration (Authorized by A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), and 36-2212)

- A. At least 30 days before the date of a change in a certificate holder's name, the certificate holder shall send the Department written notice of the name change.
- B. No later than 10 days after a certificate holder ceases to operate an air ambulance, the certificate holder shall send the Department written notice of the date that the certificate holder ceased to operate the air ambulance and of the certificate holder's intention to relinquish the certificate of registration for the air ambulance as of that date.
- C. Within 30 days after the date of receipt of a notice described in subsection (A) or (B), the Department shall:
 1. For a notice described in subsection (A), issue an amended certificate of registration that incorporates the name change but retains the expiration date of the current certificate of registration; and
 2. For a notice described in subsection (B):
 - a. Void the certificate of registration for the air ambulance; and
 - b. Send the certificate holder written confirmation of the voluntary relinquishment of the certificate of registration, with an effective date that corresponds to the written notice.
- D. A certificate holder shall notify the Department in writing within one working day after a change in the certificate holder's eligibility to hold a certificate of registration for an air ambulance under R9-25-801(A).
- E. Upon receiving a notification required in subsection (D), the Department:
 1. Shall revoke the certificate for the air ambulance; and
 2. If the air ambulance is the only air ambulance operated by an air ambulance service, may revoke the license of the air ambulance service.

Historical Note

Section R9-25-803 recodified from A.A.C. R9-13-1503, (Supp. 98-1). Section repealed; new Section adopted effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4). Amended by exempt rulemaking at 7 A.A.R. 4888, effective November 1, 2001 (Supp. 01-4). Amended by

exempt rulemaking at 8 A.A.R. 2625, effective June 1, 2002 (Supp. 02-2). Section recodified to R9-25-503 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Section R9-25-803 renumbered to R9-25-804; new Section R9-25-803 renumbered from R9-25-804 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

Exhibit 1. Recodified**Historical Note**

Section R9-25-803, Exhibit 1 "EMT-P Drug List" and "EMT-I Drug List" recodified from A.A.C. R9-13-1503, Exhibit 1 "EMT-P Drug List" and "EMT-I Drug List" (Supp. 98-1). Exhibit 1 repealed; new Exhibit 1 adopted effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4). Amended under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) at 6 A.A.R. 1507, effective May 1, 2000 (Supp. 00-1). Amended under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) at 6 A.A.R. 3762, effective October 1, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 1654, effective March 30, 2001 (Supp. 01-1). Amended by exempt rulemaking at 8 A.A.R. 2625, effective June 1, 2002 (Supp. 02-2). Amended by exempt rulemaking at 9 A.A.R. 1703, effective May 15, 2003 (Supp. 03-2). Exhibit 1 recodified to Article 5, Exhibit 1 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).

Exhibit 2. Recodified**Historical Note**

Exhibit 2 adopted effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4). Amended under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) at 6 A.A.R. 1507, effective May 1, 2000 (Supp. 00-1). Amended under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) at 6 A.A.R. 3762, effective October 1, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 1199, effective February 13, 2001 (Supp. 01-1). Amended by exempt rulemaking at 8 A.A.R. 2625, effective June 1, 2002 (Supp. 02-2). Exhibit 2 recodified to Article 5, Exhibit 2 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).

R9-25-804. Term and Transferability of Certificate of Registration (Authorized by A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), 36-2212, and 41-1092.11)

- A. The Department shall issue an initial certificate of registration:
 1. With a term of one year from date of issuance of the initial certificate of registration; or
 2. If requested by the applicant, with a term shorter than one year that allows for the Department to conduct annual inspections of all of the applicant's air ambulances at one time.

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- B. The Department shall issue a renewal certificate of registration with a term of one year from the expiration date on the previous certificate of registration.
- C. If a certificate holder submits an application for renewal as described in R9-25-801 before the expiration date of the current certificate of registration, the current certificate of registration does not expire until the Department has made a final determination on the application for renewal, as provided in A.R.S. § 41-1092.11.
- D. A certificate of registration is not transferable from one person to another.
- E. If there is a change in the ownership of an air ambulance or the person who can legally possess and operate the air ambulance, the new owner or person who can legally possess and operate the air ambulance shall apply for and obtain a new certificate of registration before operating the air ambulance in this state.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 4888, effective November 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Section recodified to R9-25-504 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Section R9-25-804 renumbered to R9-25-803; new Section R9-25-804 renumbered from R9-25-803 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-805. Inspections (Authorized by A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), 36-2212, and 36-2232(A)(11))

- A. Except as provided in R9-25-711(C), an applicant or a certificate holder shall make an air ambulance available for inspection within Arizona within 10 working days after a request by the Department.
- B. The Department shall conduct each inspection in compliance with A.R.S. § 41-1009.
- C. As permitted under A.R.S. § 36-2232(A)(11), upon a certificate holder's request and at the certificate holder's expense, the annual inspection of an air ambulance required for renewal of a certificate of registration may be conducted by a Department-approved inspection facility.

Historical Note

Adopted under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C), effective May 19, 1997; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Section recodified to R9-25-505 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

Exhibit 1. Recodified**Historical Note**

Adopted under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C), effective May 19, 1997; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Exhibit 1 recodified to Article 5, Exhibit 1 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).

Exhibit 2. Recodified**Historical Note**

Adopted under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C), effective May 19, 1997; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Exhibit 2 recodified to Article 5, Exhibit 2 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).

Exhibit 3. Repealed**Historical Note**

Adopted under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C), effective May 19, 1997; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2). Exhibit repealed by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4).

R9-25-806. Repealed**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 4895, effective October 5, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Section recodified to R9-25-506 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Repealed by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

R9-25-807. Renumbered**Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 2633, effective June 1, 2002 (Supp. 02-2). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Section recodified to R9-25-507 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Section R9-25-807 renumbered to R9-25-802 by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

Table 8.1. Repealed**Historical Note**

New Table 8.1 renumbered from Table 1 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Table 8.1 amended by final expedited rulemaking at 24 A.A.R. 3487, with an immediate effective date of December 4, 2018 (Supp. 18-4). Table 8.1, Minimum Equipment and Supplies Required on Air Ambulances, by Mission Level and Aircraft Type, repealed by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

Table 1. Renumbered**Historical Note**

New Table 1 made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Table 1 renumbered to Table 8.1 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-808. Recodified

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Historical Note

New Section made by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Section recodified to R9-25-508 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).

ARTICLE 9. GROUND AMBULANCE CERTIFICATE OF NECESSITY**R9-25-901. Definitions (Authorized by A.R.S. § 36-2202 (A))**

In addition to the definitions in A.R.S. § 36-2201 and R9-25-101, the following definitions apply in Articles 9, 10, 11, and 12 unless otherwise specified:

1. "Adjustment" means a modification, correction, or alteration to a rate or charge.
2. "ALS base rate" means the monetary amount assessed to a patient according to A.R.S. § 36-2239(F).
3. "Ambulance Revenue and Cost Report" means Exhibit A or Exhibit B, which records and reports the financial activities of an applicant or a certificate holder.
4. "Application packet" means the fee, documents, forms, and additional information the Department requires to be submitted by an applicant or on an applicant's behalf.
5. "Back-up agreement" means a written arrangement between a certificate holder and a neighboring certificate holder for temporary coverage during limited times when the neighboring certificate holder's ambulances are not available for service in its service area.
6. "BLS base rate" means the monetary amount assessed to a patient according to A.R.S. § 36-2239(G).
7. "Certificate holder" means a person to whom the Department issues a certificate of necessity.
8. "Certificate of registration" means an authorization issued by the Department to a certificate holder to operate a ground ambulance vehicle.
9. "Change of ownership" means:
 - a. In the case of ownership by a sole proprietor, 20% or more interest or a beneficial interest is sold or transferred;
 - b. In the case of ownership by a partnership or a private corporation, 20% or more of the stock, interest, or beneficial interest is sold or transferred; or
 - c. The controlling influence changes to the extent that the management and control of the ground ambulance service is significantly altered.
10. "Charge" means the monetary amount assessed to a patient for disposable supplies, medical supplies, medication, and oxygen-related costs.
11. "Chassis" means the part of a ground ambulance vehicle consisting of all base components, including front and rear suspension, exhaust system, brakes, engine, engine hood or cover, transmission, front and rear axles, front fenders, drive train and shaft, fuel system, engine air intake and filter, accelerator pedal, steering wheel, tires, heating and cooling system, battery, and operating controls and instruments.
12. "Convalescent transport" means a scheduled transport other than an interfacility transport.
13. "Dispatch" means the direction to a ground ambulance service or vehicle to respond to a call for EMS or transport.
14. "Driver's compartment" means the part of a ground ambulance vehicle that contains the controls and instruments for operation of the ground ambulance vehicle.
15. "Financial statements" means an applicant's balance sheet, annual income statement, and annual cash flow statement.
16. "Frame" means the structural foundation on which a ground ambulance vehicle chassis is constructed.
17. "General public rate" means the monetary amount assessed to a patient by a ground ambulance service for ALS, BLS, mileage, standby waiting, or according to a subscription service contract.
18. "Generally accepted accounting principles" means the conventions, and rules and procedures for accounting, including broad and specific guidelines, established by the Financial Accounting Standards Board.
19. "Goodwill" means the difference between the purchase price of a ground ambulance service and the fair market value of the ground ambulance service's identifiable net assets.
20. "Gross revenue" means:
 - a. The sum of revenues reported in the Ambulance Revenue and Cost Report Exhibit A, page 2, lines 1, 9, and 20; or
 - b. The sum of revenues reported in the Ambulance Revenue and Cost Report Exhibit B, page 3, lines 1, 24, 25, and 26.
21. "Ground ambulance service" means an ambulance service that operates on land.
22. "Ground ambulance service contract" means a written agreement between a certificate holder and a person for the provision of ground ambulance service.
23. "Ground ambulance vehicle" means a motor vehicle, defined in A.R.S. § 28-101, specifically designed to transport ambulance attendants and patients on land.
24. "Indirect costs" means the cost of providing ground ambulance service that does not include the costs of equipment.
25. "Interfacility transport" means a scheduled transport between two health care institutions.
26. "Level of service" means ALS or BLS ground ambulance service, including the type of ambulance attendants used by the ground ambulance service.
27. "Major defect" means a condition that exists on a ground ambulance vehicle that requires the Department or the certificate holder to place the ground ambulance vehicle out-of-service.
28. "Mileage rate" means the monetary amount assessed to a patient for each mile traveled from the point of patient pick-up to the patient's destination point.
29. "Minor defect" means a condition that exists on a ground ambulance vehicle that is not a major defect.
30. "Needs assessment" means a study or statistical analysis that examines the need for ground ambulance service within a service area or proposed service area that takes into account the current or proposed service area's medical, fire, and police services.
31. "Out-of-service" means a ground ambulance vehicle cannot be operated to transport patients.
32. "Patient compartment" means the ground ambulance vehicle body part that holds a patient.
33. "Public necessity" means an identified population needs or requires all or part of the services of a ground ambulance service.
34. "Response code" means the priority assigned to a request for immediate dispatch by a ground ambulance service on the basis of the information available to the certificate holder or the certificate holder's dispatch authority.
35. "Response time" means the difference between the time a certificate holder is notified that a need exists for immediate dispatch and the time the certificate holder's first ground ambulance vehicle arrives at the scene. Response time does not include the time required to identify the patient's need, the scene, and the resources necessary to meet the patient's need.
36. "Response-time tolerance" means the percentage of actual response times for a response code and scene locality that are compliant with the response time approved by the Department for the response code and scene locality, for any 12-month period.

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37. "Rural area" means a geographic region with a population of less than 40,000 residents that is not a suburban area.
38. "Scene locality" means an urban, suburban, rural, or wilderness area.
39. "Scheduled transport" means to convey a patient at a pre-arranged time by a ground ambulance vehicle for which an immediate dispatch and response is not necessary.
40. "Service area" means the geographical boundary designated in a certificate of necessity using the criteria in A.R.S. § 36-2233(E).
41. "Settlement" means the difference between the monetary amount Medicare establishes or AHCCCS pays as an allowable rate and the general public rate a ground ambulance service assesses a patient.
42. "Standby waiting rate" means the monetary amount assessed to a patient by a certificate holder when a ground ambulance vehicle is required to wait in excess of 15 minutes to load or unload the patient, unless the excess delay is caused by the ground ambulance vehicle or the ambulance attendants on the ground ambulance vehicle.
43. "Subscription service" means the provision of EMS or transport by a certificate holder to a group of individuals within the certificate holder's service area and the allocation of annual costs among the group of individuals.
44. "Subscription service contract" means a written agreement for subscription service.
45. "Subscription service rate" means the monetary amount assessed to a person under a subscription service contract.
46. "Substandard performance" means a certificate holder's:
 - a. Noncompliance with A.R.S. Title 36, Chapter 21.1, Articles 1 and 2, or 9 A.A.C. 25, or the terms of the certificate holder's certificate of necessity, including all decisions and orders issued by the Director to the certificate holder;
 - b. Failure to ensure that an ambulance attendant complies with A.R.S. Title 36, Chapter 21.1, Articles 1 and 2, or 9 A.A.C. 25, for the level of ground ambulance service provided by the certificate holder; or
 - c. Failure to meet the requirements in 9 A.A.C. 25, Article 10.
47. "Suburban area" means a geographic region within a 10-mile radius of an urban area that has a population density equal to or greater than 1,000 residents per square mile.
48. "Third-party payor" means a person, other than a patient, who is financially responsible for the payment of a patient's assessed general public rates and charges for EMS or transport provided to the patient by a ground ambulance service.
49. "Transfer" means:
 - a. A change of ownership or type of business entity; or
 - b. To move a patient from a ground ambulance vehicle to an air ambulance.
50. "Transport" means the conveyance of one or more patients in a ground ambulance vehicle from the point of patient pick-up to the patient's initial destination.
51. "Type of ground ambulance service" means an interfacility transport, a convalescent transport, or a transport that requires an immediate response.
52. "Urban area" means a geographic region delineated as an urbanized area by the United States Department of Commerce, Bureau of the Census.
53. "Wilderness area" means a geographic region that has a population density of less than one resident per square mile.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-902. Application for an Initial Certificate of Necessity; Provision of ALS Services; Transfer of a Certificate of Necessity (Authorized by A.R.S. §§ 36-2204, 36-2232, 36-2233(B), 36-2236(A) and (B), 36-2240)

- A.** An applicant for an initial certificate of necessity shall submit to the Department an application packet, in a Department-provided format, that includes:
1. An application form that contains:
 - a. The legal business or corporate name, address, telephone number, and facsimile number of the ground ambulance service;
 - b. The name, title, address, e-mail address, and telephone number of the following:
 - i. Each applicant and individual responsible for managing the ground ambulance service;
 - ii. The business representative or designated manager;
 - iii. The individual to contact to access the ground ambulance service's records required in R9-25-910; and
 - iv. The statutory agent for the ground ambulance service, if applicable;
 - c. The name, address, and telephone number of the base hospital or centralized medical direction communications center for the ground ambulance service;
 - d. The address and telephone number of the ground ambulance service's dispatch center;
 - e. The address and telephone number of each suboperation station located within the proposed service area;
 - f. Whether the ground ambulance service is a corporation, partnership, sole proprietorship, limited liability corporation, or other;
 - g. Whether the business entity is proprietary, non-profit, or governmental;
 - h. A description of the communication equipment to be used in each ground ambulance vehicle and suboperation station;
 - i. The make and year of each ground ambulance vehicle to be used by the ground ambulance service;
 - j. The number of ambulance attendants and the type of licensure, certification, or registration for each attendant;
 - k. The proposed hours of operation for the ground ambulance service;
 - l. The type of ground ambulance service;
 - m. The level of ground ambulance service;
 - n. Acknowledgment that the applicant:
 - i. Is requesting to operate ground ambulance vehicles and a ground ambulance service in this state;
 - ii. Has received a copy of 9 A.A.C. 25 and A.R.S. Title 36, Chapter 21.1; and
 - iii. Will comply with the Department's statutes and rules in any matter relating to or affecting the ground ambulance service;
 - o. A statement that any information or documents submitted to the Department are true and correct; and
 - p. The signature of the applicant or the applicant's designated representative and the date signed;
 2. The following information:
 - a. Where the ground ambulance vehicles in subsection (A)(1)(i) are located within the applicant's proposed service area;
 - b. A statement of the proposed general public rates;
 - c. A statement of the proposed charges;

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- d. The applicant's proposed response times, response codes, and response-time tolerances for each scene locality in the proposed service area, based on the following:
 - i. The population demographics within the proposed service area;
 - ii. The square miles within the proposed service area;
 - iii. The medical needs of the population within the proposed service area;
 - iv. The number of anticipated requests for each type and level of ground ambulance service in the proposed service area;
 - v. The available routes of travel within the proposed service area;
 - vi. The geographic features and environmental conditions within the proposed service area; and
 - vii. The available medical and emergency medical resources within the proposed service area;
 - e. A plan to provide temporary ground ambulance service to the proposed service area for a limited time when the applicant is unable to provide ground ambulance service to the proposed service area;
 - f. Whether a ground ambulance service currently operates in all or part of the proposed service area and if so, where; and
 - g. Whether an applicant or a designated manager:
 - i. Has ever been convicted of a felony or a misdemeanor involving moral turpitude,
 - ii. Has ever had a license or certificate of necessity for a ground ambulance service suspended or revoked by any state or political subdivision, or
 - iii. Has ever operated a ground ambulance service without the required certification or licensure in this or any other state;
3. The following documents:
 - a. A description of the proposed service area by any method specified in A.R.S. § 36-2233(E) and a map that illustrates the proposed service area;
 - b. A projected Ambulance Revenue and Cost Report;
 - c. The financing agreement for all capital acquisitions exceeding \$5,000;
 - d. The source and amount of funding for cash flow from the date the ground ambulance service commences operation until the date cash flow covers monthly expenses;
 - e. Any proposed ground ambulance service contract under A.R.S. §§ 36-2232(A)(1) and 36-2234(K);
 - f. The information and documents specified in R9-25-1101, if the applicant is requesting to establish general public rates;
 - g. Any subscription service contract under A.R.S. §§ 36-2232(A)(1) and 36-2237(B);
 - h. A certificate of insurance or documentation of self-insurance required in A.R.S. § 36-2237(A) and R9-25-909;
 - i. A surety bond if required under A.R.S. § 36-2237(B); and
 - j. The applicant's and designated manager's resume or other description of experience and qualification to operate a ground ambulance service; and
 4. Any documents, exhibits, or statements that may assist the Director in evaluating the application or any other information or documents needed by the Director to clarify incomplete or ambiguous information or documents.
- B.** Before an applicant provides ALS, the applicant shall submit to the Department the application packet required in subsection (A) and the following:
1. A current written contract for ALS medical direction; and
 2. Proof of professional liability insurance for ALS personnel required in R9-25-909(A)(1)(b).
- C.** When requesting a transfer of a certificate of necessity:
1. The person wanting to transfer the certificate of necessity shall submit a letter to the Department that contains:
 - a. A request that the certificate of necessity be transferred, and
 - b. The name of the person to whom the certificate of necessity is to be transferred; and
 2. The person identified in subsection (C)(1)(b) shall submit:
 - a. The application packet in subsection (A); and
 - b. The information in subsection (B), if ALS is provided.
- D.** An applicant shall submit the following fees:
1. \$100 application filing fee for an initial certificate of necessity, or
 2. \$50 application filing fee for a transfer of a certificate of necessity.
- E.** The Department shall approve or deny an application under this Section according to 9 A.A.C. 25, Article 12.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R.

1098, effective February 13, 2001 (Supp. 01-1).

Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-903. Determining Public Necessity (A.R.S. § 36-2233(B)(2))

- A.** In determining public necessity for an initial or amended certificate of necessity, the Director shall consider the following:
1. The response times, response codes, and response-time tolerances proposed by the applicant for the service area;
 2. The population demographics within the proposed service area;
 3. The geographic distribution of health care institutions within and surrounding the service area;
 4. Whether issuing a certificate of necessity to more than one ambulance service within the same service area is in the public's best interest, based on:
 - a. The existence of ground ambulance service to all or part of the service area;
 - b. The response times of and response-time tolerances for ground ambulance service to all or part of the service area;
 - c. The availability of certificate holders in all or part of the service area; and
 - d. The availability of emergency medical services in all or part of the service area;
 5. The information in R9-25-902(A)(1) and (A)(2); and
 6. Other matters determined by the Director or the applicant to be relevant to the determination of public necessity.
- B.** In deciding whether to issue a certificate of necessity to more than one ground ambulance service for convalescent or interfacility transport for the same service area or overlapping service areas, the Director shall consider the following:
1. The factors in subsections (A)(2), (A)(3), (A)(4)(a), (A)(4)(c), (A)(4)(d), (A)(5), and (A)(6);
 2. The financial impact on certificate holders whose service area includes all or part of the service area in the requested certificate of necessity;
 3. The need for additional convalescent or interfacility transport; and
 4. Whether a certificate holder for the service area has demonstrated substandard performance.
- C.** In deciding whether to issue a certificate of necessity to more than one ground ambulance service for a 9-1-1 or similarly

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dispatched transport within the same service area or overlapping service areas, the Director shall consider the following:

1. The factors in subsections (A), (B)(2), and (B)(4);
2. The difference between the response times in the service area and proposed response times by the applicant;
3. A needs assessment adopted by a political subdivision, if any; and
4. A needs assessment, referenced in A.R.S. § 36-2210, adopted by a local emergency medical services coordinating system, if any.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

R9-25-904. Application for Renewal of a Certificate of Necessity (A.R.S. §§ 36-2233, 36-2235, 36-2240)

- A. An applicant for a renewal of a certificate of necessity shall submit to the Department, not less than 60 days before the expiration date of the certificate of necessity, an application packet that includes:
 1. An application form that contains the information in R9-25-902(A)(1)(a) through (A)(1)(m) and the signature of the applicant;
 2. Proof of continuous insurance coverage or a statement of continuing self-insurance, including a copy of the current certificate of insurance or current statement of self-insurance required in R9-25-909;
 3. Proof of continued coverage by a surety bond if required under A.R.S. §§ 36-2237(B);
 4. A copy of the list of current charges required in R9-25-1109;
 5. An affirmation that the certificate holder has and is continuing to meet the conditions of the certificate of necessity, including assessing only those rates and charges approved and set by the Director; and
 6. \$50 application filing fee.
- B. A certificate holder who fails to file a timely application for renewal of the certificate of necessity according to A.R.S. § 36-2235 and this Section, shall cease operations at 12:01 a.m. on the date the certificate of necessity expires.
- C. To commence operations after failing to file a timely renewal application, a person shall file an initial certificate of necessity application according to R9-25-902 and meet all the requirements for an initial certificate of necessity.
- D. The Department shall approve or deny an application under this Section according to 9 A.A.C. 25, Article 12.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

R9-25-905. Application for Amendment of a Certificate of Necessity (A.R.S. §§ 36-2232(A)(4), 36-2240)

- A. A certificate holder that wants to amend its certificate of necessity shall submit to the Department the application form in R9-25-902(A)(1) and an application filing fee of \$50 for changes in:
 1. The legal name of the ground ambulance service;
 2. The legal address of the ground ambulance service;
 3. The level of ground ambulance service;
 4. The type of ground ambulance service;
 5. The service area; or
 6. The response times, response codes, or response-time tolerances.
- B. In addition to the application form in subsection (A), an amending certificate holder shall submit:
 1. For the addition of ALS ground ambulance service, the information required in R9-25-902(B)(1) and (B)(2).
 2. For a change in the service area, the information required in R9-25-902(A)(3)(a);

3. For a change in response times, the information required in subsection R9-25-902(A)(2)(d);
 4. A statement explaining the financial impact and impact on patient care anticipated by the proposed amendment;
 5. Any other information or documents requested by the Director to clarify incomplete or ambiguous information or documents; and
 6. Any documents, exhibits, or statements that the amending certificate holder wishes to submit to assist the Director in evaluating the proposed amendment.
- C. The Department shall approve or deny an application under this Section according to 9 A.A.C. 25, Article 12.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

R9-25-906. Determining Response Times, Response Codes, and Response-Time Tolerances for Certificates of Necessity and Provision of ALS Services (A.R.S. §§ 36-2232, 36-2233)

In determining response times, response codes, and response-time tolerances for all or part of a service area, the Director may consider the following:

1. Differences in scene locality, if applicable;
2. Requirements of a 9-1-1 or similar dispatch system for all or part of the service area;
3. Requirements in a contract approved by the Department between a ground ambulance service and a political subdivision;
4. Medical prioritization for the dispatch of a ground ambulance vehicle according to procedures established by the certificate holder's medical direction authority; and
5. Other matters determined by the Director to be relevant to the measurement of response times, response codes, and response-time tolerances.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

R9-25-907. Observance of Service Area; Exceptions (A.R.S. § 36-2232)

A certificate holder shall not provide EMS or transport within an area other than the service area identified in the certificate holder's certificate of necessity except:

1. When authorized by a service area's dispatch, before the service area's ground ambulance vehicle arrives at the scene; or
2. According to a back-up agreement.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

R9-25-908. Transport Requirements; Exceptions (A.R.S. §§ 36-2224, 36-2232)

A certificate holder shall transport a patient except:

1. As limited by A.R.S. § 36-2224;
2. If the patient is in a health care institution and the patient's medical condition requires a level of care or monitoring during transport that exceeds the scope of practice of the ambulance attendants' certification;
3. If the transport may result in an immediate threat to the ambulance attendant's safety, as determined by the ambulance attendant, certificate holder, or medical direction authority;
4. If the patient is more than 17 years old and refuses to be transported; or
5. If the patient is in a health care institution and does not meet the federal requirements for medically necessary ground vehicle ambulance transport as identified in 42 CFR 410.40.

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Historical Note

New Section adopted by final rulemaking at 7 A.A.R.
1098, effective February 13, 2001 (Supp. 01-1).

R9-25-909. Certificate of Insurance or Self-Insurance (A.R.S. §§ 36-2232, 36-2233, 36-2237)

- A.** A certificate holder shall:
1. Maintain with an insurance company authorized to transact business in this state:
 - a. A minimum single occurrence automobile liability insurance coverage of \$500,000 for ground ambulance vehicles; and
 - b. A minimum single occurrence malpractice or professional liability insurance coverage of \$500,000; or
 2. Be self-insured for the amounts in subsection (A)(1).
- B.** A certificate holder shall submit to the Department:
1. A copy of the certificate of insurance; or
 2. Documentation of self-insurance.
- C.** A certificate holder shall submit a copy of the certificate of insurance to the Department no later than five days after the date of issuance of:
1. A renewal of the insurance policy; or
 2. A change in insurance coverage or insurance company.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R.
1098, effective February 13, 2001 (Supp. 01-1).

R9-25-910. Record and Reporting Requirements (A.R.S. §§ 36-2232, 36-2241, 36-2246)

- A.** A certificate holder shall submit to the Department, no later than 180 days after the certificate holder's fiscal year end, the appropriate Ambulance Revenue and Cost Report.
- B.** According to A.R.S. § 36-2241, a certificate holder shall maintain the following records for the Department's review and inspection:
1. The certificate holder's financial statements;
 2. All federal and state income tax records;
 3. All employee-related expense reports and payroll records;
 4. All bank statements and documents verifying reconciliation;
 5. All documents establishing the depreciation of assets, such as schedules or accounting records on ground ambulance vehicles, equipment, office furniture, and other plant and equipment assets subject to depreciation;
 6. All first care forms required in R9-25-514 and R9-25-615;
 7. All patient billing and reimbursement records;
 8. All dispatch records, including the following:
 - a. The name of the ground ambulance service;
 - b. The month of the record;
 - c. The date of each transport;
 - d. The number assigned to the ground ambulance vehicle by the certificate holder;
 - e. Names of the ambulance attendants;
 - f. The scene;
 - g. The actual response time;
 - h. The response code;
 - i. The scene locality;
 - j. Whether the scene to which the ground ambulance vehicle is dispatched is outside of the certificate holder's service area; and
 - k. Whether the dispatch is a scheduled transport;
 9. All ground ambulance service back-up agreements, contracts, grants, and financial assistance records related to ground ambulance vehicles, EMS, and transport;

10. All written ground ambulance service complaints; and
11. Information about destroyed or otherwise irretrievable records in a file including:
 - a. A list of each record destroyed or otherwise irretrievable;
 - b. A description of the circumstances under which each record became destroyed or otherwise irretrievable; and
 - c. The date each record was destroyed or became otherwise irretrievable.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R.
1098, effective February 13, 2001 (Supp. 01-1).

R9-25-911. Ground Ambulance Service Advertising (A.R.S. § 36-2232)

- A.** A certificate holder shall not advertise that it provides a type or level of ground ambulance service or operates in a service area different from that granted in the certificate of necessity.
- B.** When advertising, a certificate holder shall not direct the circumvention of the use of 9-1-1 or another similarly designated emergency telephone number.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R.
1098, effective February 13, 2001 (Supp. 01-1).

R9-25-912. Disciplinary Action (A.R.S. §§ 36-2244, 36-2245)

- A.** After notice and opportunity to be heard is given according to the procedures in A.R.S. Title 41, Chapter 6, Article 10, a certificate of necessity may be suspended, revoked, or other disciplinary action taken for the following reasons:
1. The certificate holder has:
 - a. Demonstrated substandard performance; or
 - b. Been determined not to be fit and proper by the Director;
 2. The certificate holder has provided false information or documents:
 - a. On an application for a certificate of necessity;
 - b. Regarding any matter relating to its ground ambulance vehicles or ground ambulance service; or
 - c. To a patient, third-party payor, or other person billed for service; or
 3. The certificate holder has failed to:
 - a. Comply with the applicable requirements of A.R.S. Title 36, Chapter 21.1, Articles 1 and 2 or 9 A.A.C. 25; or
 - b. Comply with any term of its certificate of necessity or any rates and charges schedule filed by the certificate holder and approved by the Department.
- B.** In determining the type of disciplinary action to impose under A.R.S. § 36-2245, the Director shall consider:
1. The severity of the violation relative to public health and safety;
 2. The number of violations relative to the annual transport volume of the certificate holder;
 3. The nature and circumstances of the violation;
 4. Whether the violation was corrected, the manner of correction, and the time-frame involved; and
 5. The impact of the penalty or assessment on the provision of ground ambulance service in the certificate holder's service area.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R.
1098, effective February 13, 2001 (Supp. 01-1).

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Exhibit 9A. Ambulance Revenue and Cost Report, General Information and Certification

Legal Name of Company: _____ CON No. _____
 D.B.A. (Doing Business As): _____ Business Phone: () _____
 Financial Records Address: _____ City: _____ Zip Code _____
 Mailing Address (If Different): _____ City: _____ Zip Code _____
 Owner/Manager: _____
 Report Contact Person: _____ Phone: () _____ Ext. _____
 Report for Period From: _____ To: _____
 Method of Valuing Inventory: LIFO: () FIFO: () Other (Explain): _____

Please attach a list of all affiliated organizations (parents/subsidiaries) that exhibit at least 5% ownership/ vesting.

CERTIFICATION

I hereby certify that I have directed the preparation of the Arizona Ambulance Revenue and Cost Report for the facility listed above in accordance with the reporting requirements of the State of Arizona.

I have read this report and hereby certify that the information provided is true and correct to the best of my knowledge.

This report has been prepared using the accrual basis of accounting.

Authorized Signature: _____

Title: _____ *Date:* _____

Mail to:

Department of Health Services
 Bureau of Emergency Medical Services and Trauma System
 Certificate of Necessity and Rates Section
 150 North 18th Avenue, Suite 540, Phoenix, AZ 85007
 Telephone: (602) 364-3150
 Fax: (602) 364-3567

Revised December 2013

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AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

STATISTICAL SUPPORT DATA

Line No.	DESCRIPTION	(1) SUBSCRIPTION SERVICE TRANSPORTS	(2)** TRANSPORTS UNDER CONTRACT	(3) TRANSPORTS NOT UNDER CONTRACT	(4) TOTALS
01	Number of ALS Billable Runs.	_____	_____	_____	_____
02	Number of BLS Billable Runs.	_____	_____	_____	_____
03	Number of Loaded Billable Miles.	_____	_____	_____	_____
04	Waiting Time (Hr. & Min.)	_____	_____	_____	_____
05	Total Canceled (Non-Billable) Runs	_____	_____	_____	Number
					Donated Hours
Volunteer Services: (OPTIONAL)					
06	Paramedic, EMT-I(99) and AEMT	_____	_____	_____	_____
07	Emergency Medical Technician (EMT)	_____	_____	_____	_____
08	Other Ambulance Attendants	_____	_____	_____	_____
09	Total Volunteer Hours	_____	_____	_____	_____

**This column reports only those runs where a contracted discount rate was applied. See Page 7 to provide additional information regarding discounted contract runs.

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AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

STATISTICAL SUPPORT DATA

Line No.	TYPE OF SERVICE	(1) SUBSIDIZED PATIENTS	(2) NON- SUBSIDIZED PATIENTS	(3) TOTALS
01	Number of Advanced Life Support Billable Runs.	_____	_____	_____
02	Number of Basic Life Support Billable Runs	_____	_____	_____
03	Number of Loaded Billable Miles	_____	_____	_____
04	Waiting Time (Hours and Minutes)	_____	_____	_____
05	Total Canceled (Non-Billable) Runs	_____	_____	_____

Number

Volunteer Services: (OPTIONAL)Donated
Hours

06	Paramedic, EMT-I(99), and AEMT	_____
07	Emergency Medical Technician (EMT)	_____
08	Other Ambulance Attendants	_____
09	Total Volunteer Hours	_____

Note: This page and page 3.1, Routine Operating Revenue, are only for those governmental agencies that apply subsidy to patient billings.

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AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

STATEMENT OF INCOME

<u>Line</u> <u>No.</u>	<u>DESCRIPTION</u>	<u>FROM</u>		
Operating Revenue:				
01	Ambulance Service Routine Operating Revenue	Page 3 Line 10	\$ _____
Less:				
02	AHCCCS Settlement		_____	
03	Medicare Settlement		_____	
04	Contractual Discounts	Page 7 Line 22	_____	
05	Subscription Service Settlement	Page 8 Line 4	_____	
06	Other (Attach Schedule)		_____	
07	Total			_____
08	Net Revenue from Ambulance Runs			\$ _____
09	Sales of Subscription Service Contracts	Page 8 Line 8		_____
10	Total Operating Revenue			\$ _____
Ambulance Operating Expenses:				
11	Bad Debt (Includes Subscription Services Bad Debt) ...		\$ _____	
12	Wages, Payroll Taxes, and Employee Benefits	Page 4 Line 22	_____	
13	General and Administrative Expenses	Page 5 Line 20	_____	
14	Cost of Goods Sold	Page 3 Line 15	_____	
15	Other Operating Expenses	Page 6 Line 28	_____	
16	Interest Expense (Attach Schedule IV)	Page 14 CI 4 & 5 Line 28	_____	
17	Subscription Service Direct Selling	Page 8 Line 23	_____	
18	Total Operating Expenses			_____
19	Ambulance Service Income (Loss) (Line 10 minus Line 18)			\$ _____
Other Revenue/Expenses:				
20	Other Operating Revenue and Expenses	Page 9 Line 17	\$ _____	
21	Non-Operating Revenue and Expense		_____	
22	Non-Deductible Expenses (Attach Schedule)		_____	
23	Total Other Revenues/Expenses			_____
24	Ambulance Service Income (Loss) - Before Income Taxes			\$ _____
Provision for Income Taxes:				
25	Federal Income Tax		\$ _____	
26	State Income Tax		_____	
27	Total Income Tax			_____
28	Ambulance Service - Net Income (Loss)			\$ _____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

ROUTINE OPERATING REVENUE

Line

No. DESCRIPTION

Ambulance Service Routine Operating Revenue:	
01 ALS Base Rate.....	\$ _____
02 BLS Base Rate.....	_____
03 Mileage Charge.....	_____
04 Waiting Charge	_____
05 Medical Supplies (Gross Charges).....	_____
06 Nurses Charges	_____
07 Total	\$ _____
08 Standby Revenue (Attach Schedule)	_____
09 Other Ambulance Service Revenue (Attach Schedule)	_____
10 Total Ambulance Service Routine Operating Revenue (To Page 2, Line 01)	\$ _____

COST OF GOODS SOLD: (MEDICAL SUPPLIES)

11 Inventory at Beginning of Year	_____
12 Plus Purchases.....	_____
13 Plus Other Costs.....	_____
14 Less Inventory at End of Year.....	(_____)
15 Cost of Goods Sold (To Page 2, Line 14)	\$ _____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

ROUTINE OPERATING REVENUE

Line No.	TYPE OF SERVICE	(1) SUBSIDIZED PATIENTS	(2) NON- SUBSIDIZED PATIENTS	(3) TOTALS
AMBULANCE SERVICE OPERATING REVENUE				
01	ALS Base Rate	\$ _____	\$ _____	\$ _____
02	BLS Base Rate	_____	_____	_____
03	Mileage Charge	_____	_____	_____
04	Waiting Charge	_____	_____	_____
05	Medical Supplies (Gross Charges)	_____	_____	_____
06	Nurses' Charges	_____	_____	_____
07	Total	\$ _____	\$ _____	\$ _____
08	Standby Revenue (Attach Schedule)			_____
09	Other Ambulance Service Revenue (Attach Schedule)			_____
10	Total Ambulance Service Routine Operating Revenue (Column 3 to Page 2, Line 01)			\$ _____
Less:				
11	AHCCCS Settlement	\$ _____	\$ _____	\$ _____
12	Medicare Settlement	_____	_____	_____
13	Subsidy	_____	XXXXXXXXXXXXX	_____
14	Other (Attach Schedule)	_____	_____	_____
15	Total Settlements (Column 3 to Page 2, Line 06)	\$ _____	\$ _____	\$ _____
Cost of Goods Sold:				
16	Inventory at Beginning of Year			\$ _____
17	Plus Purchases			_____
18	Plus Other Costs			_____
19	Less Inventory at End of Year			(_____)
20	Cost of Goods Sold (Column 3 to Page 2, Line 14)			\$ _____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

WAGES, PAYROLL TAXES, AND EMPLOYEE BENEFITS

Line No.	DESCRIPTION	No. of *F.T.E.s	AMOUNT
01	Gross Wages - OFFICERS/OWNERS (Attach Schedule1, Page 10, Line 7)	_____	\$ _____
02	Payroll Taxes	_____	_____
03	Employee Fringe Benefits	_____	_____
04	Total	_____	\$ _____
05	Gross Wages - MANAGEMENT (Attach Schedule II)	_____	\$ _____
06	Payroll Taxes	_____	_____
07	Employee Fringe Benefits	_____	_____
08	Total	_____	\$ _____
Gross Wages - AMBULANCE PERSONNEL (Attach Schedule II)			
	**Casual Labor	Wages	
09	Paramedic, EMT-I(99) and AEMT	_____	\$ _____
10	Emergency Medical Technician (EMT). _____	_____	_____
11	Nurses	_____	_____
12	Payroll Taxes	_____	_____
13	Employee Fringe Benefits	_____	_____
14	Total	_____	\$ _____
Gross Wages - OTHER PERSONNEL (Attach Schedule II)			
15	Dispatch	_____	\$ _____
16	Mechanics	_____	_____
17	Office and Clerical	_____	_____
18	Other	_____	_____
19	Payroll Taxes	_____	_____
20	Employee Fringe Benefits	_____	_____
21	Total	_____	\$ _____
22	Total F.T.E.s' Wages, Payroll Taxes, & Employee Benefits (To Page 2, Line 12)	_____	\$ _____

* Full-time equivalents (F.T.E.) is the sum of all hours for which employee wages were paid during the year divided by 2,080.

** The sum of Casual Labor (wages paid on a per run basis) plus Wages paid is entered in Column 2 by line item. However, when calculating F.T.E.s, do not include casual labor hours worked or expenses incurred.

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

WAGES, PAYROLL TAXES, AND EMPLOYEE BENEFITS

Line No.	DESCRIPTION	(1) No. of *F.T.E.s	(2) Total Expenditure	(3) Allocation Percentage	(4) Ambulance Amount
01	Gross Wages - Management (Attach Schedule II).	_____	\$ _____	_____	_____
02	Payroll Taxes.	_____	_____	_____	_____
03	Employee Fringe Benefits.	_____	_____	_____	_____
04	Total.	_____	\$ _____	_____	_____
Gross Wages - Ambulance Personnel (Attach Schedule):					
	**Contractual Wages				
05	Paramedic, EMT-I(99) and AEMT	_____	\$ _____	_____	_____
06	Emergency Medical Technician (EMT) _____	_____	_____	_____	_____
07	Nurses.	_____	_____	_____	_____
08	Drivers.	_____	_____	_____	_____
09	Payroll Taxes.	_____	_____	_____	_____
10	Employee Fringe Benefits.	_____	_____	_____	_____
11	Total.	_____	\$ _____	_____	_____
Gross Wages - Other Personnel (Attach Schedule II):					
12	Dispatch.	_____	\$ _____	_____	_____
13	Mechanics	_____	_____	_____	_____
14	Office and Clerical	_____	_____	_____	_____
15	Other	_____	_____	_____	_____
16	Payroll Taxes.	_____	_____	_____	_____
17	Employee Fringe Benefits	_____	_____	_____	_____
18	Total.	_____	\$ _____	_____	_____
19	Total F.T.E.s' Wages, Payroll Taxes, and Employee Benefits (To Page 2, Line 12) _____	_____	\$ _____	_____	_____

* Full-Time Equivalents (F.T.E.) is the sum of all hours for which employee wages were paid during the year divided by 2,080.

** The sum of Contractual + Wages paid is entered in Column 2 by line item. However, when calculating F.T.E.s, do not include contractual hours worked or expenses incurred.

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

WAGES, PAYROLL TAXES, AND EMPLOYEE BENEFITS

Line No.	<u>DESCRIPTION</u>	<u>Basis of Allocations</u>	
01	Gross Wages - Management	_____	
02	Payroll Taxes	_____	
03	Employee Fringe Benefits	_____	
04	Total	_____	
Gross Wages - Ambulance Personnel:		<u>Contractual</u>	<u>Wages</u>
05	Paramedic, EMT-I(99) and AEMT	_____	_____
06	Emergency Medical Technician (EMT)	_____	_____
06	Emergency Medical Technician (EMT)	_____	_____
07	Nurses	_____	_____
08	Drivers	_____	_____
09	Payroll Taxes	_____	_____
10	Employee Fringe Benefits	_____	_____
11	Total	_____	_____
Gross Wages - Other Personnel:			
12	Dispatch	_____	_____
13	Mechanics	_____	_____
14	Office and Clerical	_____	_____
15	Other	_____	_____
16	Payroll Taxes	_____	_____
17	Employee Fringe Benefits	_____	_____
18	Total	_____	_____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

GENERAL AND ADMINISTRATIVE EXPENSES

Line

No. DESCRIPTION

Professional Services:

01	Legal Fees	\$ _____	
02	Collection Fees	_____	
03	Accounting and Auditing	_____	
04	Data Processing Fees	_____	
05	Other (Attach Schedule)	_____	
06	Total		\$ _____

Travel and Entertainment:

07	Meals and Entertainment	\$ _____	
08	Transportation - Other Company Vehicles	_____	
09	Travel	_____	
10	Other (Attach Schedule)	_____	
11	Total		\$ _____

Other General and Administrative:

12	Office Supplies	\$ _____	
13	Postage	_____	
14	Telephone	_____	
15	Advertising	_____	
16	Professional Liability Insurance	_____	
17	Dues and Subscriptions	_____	
18	Other (Attach Schedule)	_____	
19	Total		\$ _____
20	Total General and Administrative Expenses (To Page 2, Line 13)		\$ _____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

GENERAL AND ADMINISTRATIVE EXPENSES

Line No.	DESCRIPTION	(1) Total Expenditure	(2) Allocation Percentage	(3) Ambulance Amount
Professional Services:				
01	Legal Fees	\$ _____	_____	\$ _____
02	Collection Fees	_____	_____	_____
03	Accounting and Auditing	_____	_____	_____
04	Data Processing Fees	_____	_____	_____
05	Other (Attach Schedule)	_____	_____	_____
06	Total	\$ _____		\$ _____
Travel and Entertainment:				
07	Meals and Entertainment	\$ _____	_____	\$ _____
08	Transportation - Other Company Vehicles	_____	_____	_____
09	Travel	_____	_____	_____
10	Other (Attach Schedule)	_____	_____	_____
11	Total	\$ _____		\$ _____
Other General and Administrative:				
12	Office Supplies	\$ _____	_____	\$ _____
13	Postage	_____	_____	_____
14	Telephone	_____	_____	_____
15	Advertising	_____	_____	_____
16	Professional Liability Insurance	_____	_____	_____
17	Dues and Subscriptions	_____	_____	_____
18	Other (Attach Schedule)	_____	_____	_____
19	Total	\$ _____		\$ _____
20	Total General & Administrative Expenses (to Page 2, Line 13)	\$ _____		\$ _____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

GENERAL AND ADMINISTRATIVE EXPENSES (cont.)

Line No.	<u>DESCRIPTION</u>	<u>Basis of Allocations</u>
Professional Services:		
01	Legal Fees	_____
02	Collection Fees	_____
03	Accounting and Auditing	_____
04	Data Processing Fees	_____
05	Other (Attach Schedule)	_____
06	Total	_____
Travel and Entertainment:		
07	Meals and Entertainment	_____
08	Transportation - Other Company Vehicles	_____
09	Travel	_____
10	Other (Attach Schedule)	_____
11	Total	_____
Other General and Administrative:		
12	Office Supplies	_____
13	Postage	_____
14	Telephone	_____
15	Advertising	_____
16	Professional Liability Insurance	_____
17	Dues and Subscriptions	_____
18	Other (Attach Schedule)	_____
19	Total	_____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

OTHER OPERATING EXPENSES

Line

No. OTHER OPERATING EXPENSES**Depreciation and Amortization:**

01	Depreciation (Attach Schedule III) (From Line 20, Col I, Page 13)	\$ _____	
02	Amortization	_____	
03	Total		\$ _____
04	Rent/Lease (Attach Schedule III) (From Line 20, Col K, Page 13)		\$ _____

Building/Station Expense:

05	Building and Cleaning Supplies	\$ _____	
06	Utilities	_____	
07	Property Taxes	_____	
08	Property Insurance	_____	
09	Repairs and Maintenance	_____	
10	Other (Attach Schedule)	_____	
11	Total		\$ _____

Vehicle Expense - Ambulance Units:

12	License/Registration	\$ _____	
13	Fuel	_____	
14	General Vehicle Service and Maintenance	_____	
15	Major Repairs	_____	
16	Insurance - Service Vehicles	_____	
17	Other (Attach Schedule)	_____	
18	Total		\$ _____

Other Expenses:

19	Dispatch	_____	
20	Education/Training	_____	
21	Uniforms and Uniform Cleaning	_____	
22	Meals and Travel for Ambulance Personnel	_____	
23	Maintenance Contracts	_____	
24	Minor Equipment - Not Capitalized	_____	
25	Ambulance Supplies - Nonchargeable	_____	
26	Other (Attach Schedule)	_____	
27	Total		\$ _____
28	Total Other Operating Expenses (To Page 2, Line 15)		\$ _____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

OTHER OPERATING EXPENSES

<u>OTHER OPERATING EXPENSES</u>	(1) Total Expenditure	(2) Allocation Percentage	(3) Ambulance Amount
Depreciation and Amortization:			
Depreciation (Attach Schedule III) (From Line 20, Col I, Page 12) .	\$ _____	_____	_____
Amortization	_____	_____	_____
Total	\$ _____	_____	_____
Rent/Lease (Attach Schedule III) Line 20, Col K, Page 12	\$ _____	_____	_____
Building/Station Expense:			
Building and Cleaning Supplies	\$ _____	_____	_____
Utilities	_____	_____	_____
Property Taxes	_____	_____	_____
Property Insurance	_____	_____	_____
Repairs and Maintenance	_____	_____	_____
Other (Attach Schedule)	_____	_____	_____
Total	\$ _____	_____	_____
Vehicle Expense - Ambulance Units:			
License/Registration	\$ _____	_____	_____
Fuel.	_____	_____	_____
General Vehicle Service and Maintenance.	_____	_____	_____
Major Repairs	_____	_____	_____
Insurance - Service Vehicles.	_____	_____	_____
Other (Attach Schedule).	_____	_____	_____
Total	\$ _____	_____	_____
Other Expenses:			
Dispatch	\$ _____	_____	_____
Education/Training	_____	_____	_____
Uniforms and Uniform Cleaning	_____	_____	_____
Meals and Travel for Ambulance Personnel	_____	_____	_____
Maintenance Contracts.	_____	_____	_____
Minor Equipment - Not Capitalized.	_____	_____	_____
Ambulance Supplies - Nonchargeable	_____	_____	_____
Other (Attach Schedule).	_____	_____	_____
Total.	\$ _____	_____	_____
Total Other Operating Expenses (To Page 2, Line 15)	\$ _____	_____	_____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

OTHER OPERATING EXPENSES

Line No.	<u>OTHER OPERATING EXPENSES</u>	<u>Basis of Allocations</u>
	Depreciation and Amortization:	
01	Depreciation	_____
02	Amortization	_____
03	Total	_____
04	Rent/Lease	_____
	Building/Station Expense:	
05	Building and Cleaning Supplies	_____
06	Utilities	_____
07	Property Taxes	_____
08	Property Insurance	_____
09	Repairs and Maintenance	_____
10	Other (Attach Schedule)	_____
11	Total	_____
	Vehicle Expense - Ambulance Units:	
12	License/Registration	_____
13	Fuel	_____
14	General Vehicle Service and Maintenance	_____
15	Major Repairs	_____
16	Insurance - Service Vehicles	_____
17	Other (Attach Schedule)	_____
18	Total	_____
	Other Expenses:	
19	Dispatch	_____
20	Education/Training	_____
21	Uniforms and Uniform Cleaning	_____
22	Meals and Travel for Ambulance Personnel	_____
23	Maintenance Contracts	_____
24	Minor Equipment - Not Capitalized	_____
25	Ambulance Supplies - Nonchargeable	_____
26	Other (Attach Schedule)	_____
27	Total	_____

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TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

DETAIL OF CONTRACTUAL ALLOWANCES

Line No.	Name of Contracting Entity	Total Billable Runs	Gross Billing	Percent Discount	Allowance
01	_____	_____	_____	_____	_____
02	_____	_____	_____	_____	_____
03	_____	_____	_____	_____	_____
04	_____	_____	_____	_____	_____
05	_____	_____	_____	_____	_____
06	_____	_____	_____	_____	_____
07	_____	_____	_____	_____	_____
08	_____	_____	_____	_____	_____
09	_____	_____	_____	_____	_____
10	_____	_____	_____	_____	_____
11	_____	_____	_____	_____	_____
12	_____	_____	_____	_____	_____
13	_____	_____	_____	_____	_____
14	_____	_____	_____	_____	_____
15	_____	_____	_____	_____	_____
16	_____	_____	_____	_____	_____
17	_____	_____	_____	_____	_____
18	_____	_____	_____	_____	_____
19	_____	_____	_____	_____	_____
20	_____	_____	_____	_____	_____
21	_____	_____	_____	_____	_____
22	Total (To Page 2, Line 4)				_____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

**SUBSCRIPTION SERVICE REVENUE AND
DIRECT SELLING EXPENSES**

Line

No. Description**To**

01 Billings at Fully Established Rate \$ _____

Less:

02	AHCCCS Settlement	_____	
03	Medicare Settlement	_____	
04	Subscription Service Settlements	(To Page 2, Line 5)	_____
05	Subscription Service Bad Debt	_____	
06	Total		\$ _____

07 Net Revenue from Subscription Service Runs _____

08 Sales of Subscription Service (To Page 2, Line 9) _____

09 Other Revenue (Attach Schedule) _____

10 Total Subscription Service Revenue \$ _____

Direct Expenses Incurred Selling Subscription Contracts:

11	Salaries/Wages	\$ _____
12	Payroll Taxes	_____
13	Employee Fringe Benefits	_____
14	Professional Services	_____
15	Contract Labor	_____
16	Travel	_____
17	Other General and Administrative Expenses	_____
18	Depreciation/Amortization	_____
19	Rent/Lease	_____
20	Building/Station Expense	_____
21	Transportation/Vehicles	_____
22	Other (Attach Schedule)	_____
23	Total Subscription Service Expenses (To Page 2, Line 17).	\$ _____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

OTHER OPERATING REVENUES AND EXPENSES

Line

No. DESCRIPTION

Other Operating Revenues:

01	Supportive Funding - Local (Attach Schedule)	\$ _____
02	Grant Funds - State (Attach Schedule)	_____
03	Grant Funds - Federal (Attach Schedule)	_____
04	Grant Funds - Other (Attach Schedule)	_____
05	Patient Finance Charges	_____
06	Patient Late Payment Charges	_____
07	Interest Earned - Related Person/Organization	_____
08	Interest Earned - Other	_____
09	Gain on Sale of Operating Property	_____
10	Other: _____	_____
11	Other: _____	_____
12	Total Operating Revenue	\$ _____

Other Operating Expenses:

13	Loss on Sale of Operating Property	\$ _____
14	Other: _____	_____
15	Other: _____	_____
16	Total Other Operating Expenses	\$ _____
17	Net Other Operating Revenues and Expenses (To Page 2, Line 20)	\$ _____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

**DETAIL OF SALARIES/WAGES
OFFICERS/OWNERS
SCHEDULE 1****Wages Paid by Category**

Line No.	Name	Title	% of Owner- ship	Manage- ment	*FTE	EMCT		Office	*FTE	Other	*FTE	<u>Totals</u>	
						*FTE						Wages Paid To Owners	*FTE
01	_____	_____	_____	\$ _____	_____	\$ _____	_____	\$ _____	_____	\$ _____	_____	\$ _____	_____
02	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
03	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
04	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
05	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
06	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____1	_____
07	TOTAL	=====	=====	\$ =====	=====	\$ =====	=====	\$ =====	=====	\$ =====	=====	\$ =====	=====

*Full-time equivalents (F.T.E.) Is the sum of all hours for which employee wages were paid during the year divided by 2080.

1 Total wages paid to owners to Page 4 Col 2 Line 01

2 Total FTEs to Page 4 Col 1 Line 01

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

**OPERATING EXPENSES
DETAIL OF SALARIES/WAGES
SCHEDULE II**

Line
No. Detail of Salaries/Wages - Other Than Officers/Owners

01 MANAGEMENT:

METHOD OF COMPENSATION:

Certification and/or Title	Scheduled Shifts (i.e. 40 or 60 hours a week)	Hourly Wage	Annual Salary	\$s Per Run or Shift
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

02 AMBULANCE PERSONNEL:

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

03 OTHER PERSONNEL:

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

DEPRECIATION AND/OR RENT/LEASE EXPENSE
SCHEDULE IIIAMBULANCE VEHICLES AND
ACCESSORIAL EQUIPMENT ONLY

	A	B	C	D	E	F	G	H	I	J	K
Line No.	Description of Property	Date Placed in Service	Cost or Other Basis	Business Use Percent	Basis for Depreciation	Method	Recovery Period	Depreciation Prior Years	Current Year Depreciation	Remaining Basis	Rent/Lease Amount*
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20	SUBTOTAL	XXX	XXX	XXX	XXX	XXX	XXX	XXX	1	XXX	2

* Complete Description of property, date placed in service, and rent/lease amount only.

1 To Page 13, Line 19, Column I

2 To Page 13, Line 19, Column K

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

**DEPRECIATION AND/OR RENT/LEASE EXPENSE
SCHEDULE III****ALL OTHER ITEMS**

	A	B	C	D	E	F	G	H	I	J	K
Line No.	Description of Property	Date Placed in Service	Cost or Other Basis	Business Use Percent	Basis for Depreciation	Method	Recovery Period	Depreciation Prior Years	Current Year Depreciation	Remaining Basis	Rent/Lease Amount*
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											
11											
12											
13											
14											
15											
16											
17											
18	SUBTOTAL	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX	
19	SUBTOTAL from Page 12, Line 20	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX	
20	SUM of Line 18 and 19	XXX	XXX	XXX	XXX	XXX	XXX	XXX	3	XXX	4

* Complete Description of property, date placed in service, and rent/lease amount only.

3 To Page 6, Line 01

4 To Page 6, Line 04

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

DETAIL OF INTEREST - Schedule IV

Line No.	Description	(1) Interest Rate	(2) Principal Balance Beginning of Period	(3) End of Period	(4) Interest Expense Related Persons or Organizations	(5) Other
	Service Vehicles & Accessorial Equipment Name of Payee:					
01	_____	_____ %	\$ _____	\$ _____	\$ _____	\$ _____
02	_____	_____	_____	_____	_____	_____
03	_____	_____	_____	_____	_____	_____
04	_____	_____	_____	_____	_____	_____
	Communication Equipment Name of Payee:					
05	_____	_____ %	\$ _____	\$ _____	\$ _____	\$ _____
06	_____	_____	_____	_____	_____	_____
07	_____	_____	_____	_____	_____	_____
	Other Property and Equipment Name of Payee:					
08	_____	_____ %	\$ _____	\$ _____	\$ _____	\$ _____
09	_____	_____	_____	_____	_____	_____
10	_____	_____	_____	_____	_____	_____
	Working Capital Name of Payee:					
11	_____	_____ %	\$ _____	\$ _____	\$ _____	\$ _____
12	_____	_____	_____	_____	_____	_____
13	_____	_____	_____	_____	_____	_____
	Other Name of Payee:					
14	_____	_____ %	\$ _____	\$ _____	\$ _____	\$ _____
15	TOTAL		\$ _____	\$ _____	\$ _____	\$ _____

----- (To Page 2, Column 2, Line 16) -----

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

BALANCE SHEET**ASSETS**

CURRENT ASSETS

01	Cash	\$	_____	
02	Accounts Receivable		_____	
03	Less: Allowance for Doubtful Accounts		_____	
04	Inventory		_____	
05	Prepaid Expenses		_____	
06	Other Current Assets		_____	

07	TOTAL CURRENT ASSETS			\$	_____
----	----------------------	--	--	----	-------

PROPERTY & EQUIPMENT

08	Less: Accumulated Depreciation			\$	_____
----	--------------------------------	--	--	----	-------

09	OTHER NONCURRENT ASSETS			\$	_____
----	-------------------------	--	--	----	-------

10	TOTAL ASSETS			\$	_____
----	--------------	--	--	----	-------

LIABILITIES AND EQUITY

CURRENT LIABILITIES

11	Accounts Payable	\$	_____	
12	Current Portion of Notes Payable		_____	
13	Current Portion of Long Term Debt		_____	
14	Deferred Subscription Income		_____	
15	Accrued Expenses and Other		_____	
16	_____		_____	
17	_____		_____	

18	TOTAL CURRENT LIABILITIES			\$	_____
----	---------------------------	--	--	----	-------

19	NOTES PAYABLE		_____	
----	---------------	--	-------	--

20	LONG TERM DEBT OTHER		_____	
----	----------------------	--	-------	--

21	TOTAL LONG-TERM DEBT			\$	_____
----	----------------------	--	--	----	-------

EQUITY AND OTHER CREDITS

Paid-in Capital:

22	Common Stock	\$	_____	
23	Paid-In Capital in Excess of Par Value		_____	
24	Contributed Capital		_____	
25	Retained Earnings		_____	
26	Fund Balances		_____	

27	TOTAL EQUITY			\$	_____
----	--------------	--	--	----	-------

28	TOTAL LIABILITIES & EQUITY			\$	_____
----	----------------------------	--	--	----	-------

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

STATEMENT OF CASH FLOWS**OPERATING ACTIVITIES:**

01	<u>Net (loss) Income</u>	\$ _____	
	Adjustments to reconcile net income to net cash provided by operating activities:		
02	Depreciation Expense	_____	
03	Deferred Income Tax	_____	
04	Loss (gain) on Disposal of Property and Equipment	_____	
	<u>(Increase) Decrease in:</u>		
05	Accounts Receivable	_____	
06	Inventories	_____	
07	Prepaid Expenses	_____	
	<u>(Increase) Decrease in:</u>		
08	Accounts Payable	_____	
09	Accrued Expenses	_____	
10	Deferred Subscription Income	_____	
11	Net Cash Provided (Used) by Operating Activities	\$ _____	

INVESTING ACTIVITIES:

12	Purchases of Property and Equipment	\$ _____	
13	Proceeds from Disposal of Property and Equipment	_____	
14	Purchases of Investments	_____	
15	Proceeds from Disposal of Investments	_____	
16	Loans Made	_____	
17	Collections on Loans	_____	
18	Other _____	_____	
19	Net Cash Provided (Used) by Investing Activities	\$ _____	

FINANCING ACTIVITIES:New Borrowings:

20	Long-Term	\$ _____	
21	Short-Term	_____	

Debt Reduction:

22	Long-Term	_____	
23	Short-Term	_____	

24	Capital Contributions	_____	
25	Dividends paid	_____	

26	Net Cash Provided (Used) by Financing Activities	\$ _____	
27	Net Increase (Decrease) in Cash	\$ _____	
28	Cash at Beginning of Year	\$ _____	
29	Cash at End of Year	\$ _____	

SUPPLEMENTAL DISCLOSURES:Non-cash Investing and Financing Transactions:

31	_____	\$ _____	
32	_____	_____	
33	Interest Paid (Net of Amounts Capitalized)	_____	
34	Income Taxes Paid	_____	

Historical Note

Exhibit 9A renumbered from Exhibit A and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). The Department requested (file number R22-134) that two corrections be made to page 1 of Exhibit 9(A) as amended at 19 A.A.R. 4032 (December 13, 2013); missing form fields have also been added due to clerical errors when formatting this Exhibit (Supp. 22-3).

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

Exhibit A. Renumbered

Historical Note

New Exhibit adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). New Exhibit A recodified from Article 12 at 12 A.A.R. 2243, effective June 2, 2006 (Supp. 06-2). Exhibit A renumbered to Exhibit 9A by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

Exhibit 9B. Ambulance Revenue and Cost Report, Fire District and Small Rural Company

Department of Health Services

Annual Ambulance Financial Report

Reporting Ambulance Service

Report Fiscal Year
From: / / **To:** / /
 Mo. Day Year Mo. Day Year

CERTIFICATION

I hereby certify that I have directed the preparation of the enclosed annual report in accordance with the reporting requirements of the State of Arizona.

I have read this report and hereby certify that the information provided is true and correct to the best of my knowledge.

This report has been prepared using the accrual basis of accounting.

Authorized Signature: _____ *Date:* _____

Print Name and Title: _____

Mail to:

Department of Health Services
 Bureau of Emergency Medical Services and Trauma System
 Certificate of Necessity and Rates Section
 150 North 18th Avenue, Suite 540
 Phoenix, AZ 85007
 Telephone: (602) 364-3150
 Fax: (602) 364-3567

Revised December 2013

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

STATISTICAL SUPPORT DATA

Line No.	DESCRIPTION	(1) SUBSCRIPTION SERVICE TRANSPORTS	*(2) TRANSPORTS UNDER CONTRACT	(3) TRANSPORTS NOT UNDER CONTRACT	(4) TOTALS
01	Number of ALS Billable Transports:	_____	_____	_____	_____
02	Number of BLS Billable Transports:	_____	_____	_____	_____
03	Number of Loaded Billable Miles:	_____	_____	_____	_____
04	Waiting Time (Hr. & Min.):	_____	_____	_____	_____
05	Canceled (Non-Billable) Runs:	_____	_____	_____	_____

AMBULANCE SERVICE ROUTINE OPERATING REVENUE

06	ALS Base Rate Revenue		\$	_____
07	BLS Base Rate Revenue			_____
08	Mileage Charge Revenue			_____
09	Waiting Charge Revenue			_____
10	Medical Supplies Charge Revenue			_____
11	Nurses Charge Revenue			_____
12	Standby Charge Revenue (Attach Schedule).....			_____
13	TOTAL AMBULANCE SERVICE ROUTINE OPERATING REVENUE		\$	_____

SALARY AND WAGE EXPENSE DETAILGROSS WAGES:**No. of F.T.E.s

14	Management	\$	_____	\$	_____
15	Paramedics, EMT-I(99)s, and AEMTs.....	\$	_____	\$	_____
16	Emergency Medical Technician (EMT).....	\$	_____	\$	_____
17	Other Personnel	\$	_____	\$	_____
18	Payroll Taxes and Fringe Benefits - All Personnel	\$	_____	\$	_____

*This column reports only those runs where a contracted discount rate was applied.

**Full-time equivalents (F.T.E.) is the sum of all hours for which employees' wages were paid during the year divided by 2080.

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

SCHEDULE OF REVENUES AND EXPENSES

Line

No. DESCRIPTION**FROM****Operating Revenues:**

01 Total Ambulance Service Operating RevenuePage 2, Line 13 \$ _____

Settlement Amounts:

02 AHCCCS ()

03 Medicare ()

04 Subscription Service ()

05 Contractual ()

06 Other ()

07 Total (Sum of Lines 02 through 06)..... ()

08 Total Operating Revenue (Line 01 minus Line 07) \$ _____

Operating Expenses:

09 Bad Debt

10 Total Salaries, Wages, and Employee- Related Expenses \$ _____

11 Professional Services _____

12 Travel and Entertainment _____

13 Other General Administrative _____

14 Depreciation..... _____

15 Rent/Leasing _____

16 Building/Station _____

17 Vehicle Expense _____

18 Other Operating Expense..... _____

19 Cost of Medical Supplies Charged to Patients..... _____

20 Interest _____

21 Subscription Service Sales Expense _____

22 Total Operating Expense (Sum of Lines 09 through 21) _____

23 Total Operating Income or Loss (Line 08 minus Line 22) \$ _____

24 Subscription Contract Sales _____

25 Other Operating Revenue _____

26 Local Supportive Funding _____

27 Other Non-Operating Income (Attach Schedule) _____

28 Other Non-Operating Expense (Attach Schedule)..... _____

29 NET INCOME/(LOSS) (Line 23 plus Sum of Lines 24 through 28)..... \$ _____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

BALANCE SHEET**ASSETS**

CURRENT ASSETS

01	Cash	\$ _____
02	Accounts Receivable.....	_____
03	Less: Allowance for Doubtful Accounts	_____
04	Inventory	_____
05	Prepaid Expenses	_____
06	Other Current Assets.....	_____
07	TOTAL CURRENT ASSETS	\$ _____

PROPERTY & EQUIPMENT

08	Less: Accumulated Depreciation	\$ _____
----	--------------------------------------	----------

09	OTHER NONCURRENT ASSETS.....	\$ _____
----	------------------------------	----------

10	TOTAL ASSETS.....	\$ _____
----	-------------------	----------

LIABILITIES AND EQUITY

CURRENT LIABILITIES

11	Accounts Payable.....	\$ _____
12	Current Portion of Notes Payable	_____
13	Current Portion of Long term Debt.....	_____
14	Deferred Subscription Income	_____
15	Accrued Expenses and Other.....	_____
16	_____	_____
17	_____	_____
18	TOTAL CURRENT LIABILITIES	\$ _____

19	NOTES PAYABLE	_____
----	---------------------	-------

20	LONG TERM DEBT OTHER.....	_____
----	---------------------------	-------

21	TOTAL LONG-TERM DEBT	\$ _____
----	----------------------------	----------

EQUITY AND OTHER CREDITS

Paid-in Capital:

22	Common Stock	\$ _____
23	Paid-In Capital in Excess of Par Value	_____
24	Contributed Capital	_____
25	Retained Earnings	_____
26	Fund Balances.....	_____

27	TOTAL EQUITY	\$ _____
----	--------------------	----------

28	TOTAL LIABILITIES & EQUITY	\$ _____
----	----------------------------------	----------

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

AMBULANCE REVENUE AND COST REPORT

AMBULANCE SERVICE ENTITY: _____

FOR THE PERIOD FROM: _____ TO: _____

STATEMENT OF CASH FLOWS

OPERATING ACTIVITIES:		
01	Net (loss) Income	\$ _____
	Adjustments to reconcile net income to net cash provided by operating activities:	
02	Depreciation Expense	_____
03	Deferred Income Tax	_____
04	Loss (gain) on Disposal of Property and Equipment	_____
	(Increase) Decrease in:	
05	Accounts Receivable	_____
06	Inventories	_____
07	Prepaid Expenses	_____
	(Increase) Decrease in:	
08	Accounts Payable	_____
09	Accrued Expenses	_____
10	Deferred Subscription Income	_____
11	Net Cash Provided (Used) by Operating Activities	\$ _____
INVESTING ACTIVITIES:		
12	Purchases of Property and Equipment	_____
13	Proceeds from Disposal of Property and Equipment	_____
14	Purchases of Investments	_____
15	Proceeds from Disposal of Investments	_____
16	Loans Made	_____
17	Collections on Loans	_____
18	Other _____	_____
19	Net Cash Provided (Used) by Investing Activities	\$ _____
FINANCING ACTIVITIES:		
	New Borrowings:	
20	Long-Term	_____
21	Short-Term	_____
	Debt Reduction:	
22	Long-Term	_____
23	Short-Term	_____
24	Capital Contributions	_____
25	Dividends paid	_____
26	Net Cash Provided (Used) by Financing Activities	\$ _____
27	Net Increase (Decrease) in Cash	\$ _____
28	Cash at Beginning of Year	\$ _____
29	Cash at End of Year	\$ _____
30 SUPPLEMENTAL DISCLOSURES:		
	Non-cash Investing and Financing Transactions:	
31	_____	\$ _____
32	_____	_____
33	Interest Paid (Net of Amounts Capitalized)	_____
34	Income Taxes Paid	_____

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

INSTRUCTIONS

Page 1: COVER

1. Enter the name of the ambulance service on the line "Reporting Ambulance Service."
2. Print the name and title of the ambulance service's authorized representative on the lines indicated; enter the date of signature; authorized representative must sign the report.

Page 2: STATISTICAL SUPPORT DATA and ROUTINE OPERATING REVENUE

Enter the ambulance service's business name and the appropriate reporting period.

Statistical Support Data:

- Lines 01-02: Enter the number of billable ALS and BLS transports for each of the three categories. Subscription Service Transports should not be included with Transports Under Contract.
- Lines 03-04: Enter the total of patient loaded transport miles and waiting times for each of the transport categories.
- Line 05: List TOTAL of canceled/non-billable runs.

Ambulance Service Routine Operating Revenue:

- Line 06: Enter the total amount of all ALS Base Rate gross billings.
- Line 07: Enter the total amount of all BLS Base Rate gross billings.
- Line 08: Enter the total of Mileage Charge gross billings.
- Line 09: Enter the total Waiting Time gross billings.
- Line 10: Enter the total of all gross billings of Medical Supplies to patients.
- Line 11: RESERVED FOR FUTURE USE - Charges for Nurses currently are not allowed.
- Line 12: Enter the total of all Standby Time charges. (Attach a schedule showing sources.)
- Line 13: Add the totals from Line 06 through Line 12. Enter sum on Line 13.

Salary and Wage Expense Detail:

- Line 14: Enter the total salary amount allocated and paid to Management of the ambulance service.
- Line 15: Enter the total salary amount allocated and paid to Paramedics, EMT-I(99)s, and AEMTs.
- Line 16: Enter the total salary amount allocated and paid to Emergency Medical Technicians (EMTs).
- Line 17: Enter the total salary amount allocated and paid to Other Personnel involved with the ambulance service. (Examples: Dispatch, Mechanics, Office)
- Line 18: Enter the total allocated amount of Payroll Taxes and Fringe Benefits paid to employees included in lines 14 through 17.

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

ANNUAL AMBULANCE FINANCIAL REPORT

EXPENSE CATEGORIES FOR USE ON PAGE 3

- Line 09 Bad Debt
- Line 10 Total Salaries, Wages, and Employee-Related Expenses
 - Salaries, Wages, Payroll Taxes, and Employee Benefits
- Line 11 Professional Services
 - Legal/Management Fees
 - Collection Fees
 - Accounting/Auditing
 - Data Processing Fees
- Line 12 Travel and Entertainment (Administrative)
 - Meals and Entertainment
 - Travel/Transportation
- Line 13 Other General and Administrative
 - Office Related (Supplies, Phone, Postage, Advertising)
 - Professional Liability Insurance
 - Dues, Subscriptions, Miscellaneous
- Line 14 Depreciation
- Line 15 Rent/Leasing
- Line 16 Building/Station
 - Utilities, Property Taxes/Insurance, Cleaning/Maintenance
- Line 17 Vehicle Expenses
 - License/Registration
 - Repairs/Maintenance
 - Insurance
- Line 18 Other Operating Expenses
 - Dispatch Contracts
 - Employee Education/Training, Uniforms, Travel/Meals
 - Maintenance Contracts
 - Minor Equipment, Non-Chargeable Ambulance Supplies
- Line 19 Cost of Medical Supplies Charged to Patients
- Line 20 Interest Expense
 - Interest on: Bank Loans/Lines of Credit
- Line 21 Subscription Service Sales Expenses
 - Sales Commissions, Printing

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

INSTRUCTIONS (cont'd)

Page 3: SCHEDULE OF REVENUES AND EXPENSES**Operating Revenues:**

- Line 01: Transfer appropriate total from Page 2 as indicated.
 Line 02: Enter settlement amounts from AHCCCS transports. (DO NOT include settlement amounts resulting from a transport made under a SUBSCRIPTION SERVICE CONTRACT)
 Line 03: Enter settlement amounts from Medicare transports. (DO NOT include settlement amounts resulting from a transport made under a SUBSCRIPTION SERVICE CONTRACT)
 Line 04: Enter total of ALL settlement amounts from Subscription Service Contract transports.
 Line 05: Enter total of ALL settlement amounts from Contractual transports only.
 Line 06: Enter total from any other settlement sources.
 Line 07: Enter sum of lines 02 through 06.
 Line 08: Total Operating Revenue (The amount from Line 01 minus Line 07).

Operating Expenses:

- Lines 09-21: Report as either actual or allocated from expenses shared with Fire or other departments.
 Line 22: Enter the total sum of lines 09 through 21.
 Line 23: Enter the difference of line 08 minus line 22.
 Line 24: Enter the gross amount of sales from Subscription Service Contracts.
 Line 25: Enter the amount of Other Operating Revenues.
 Ex: Federal, State or Local Grants, Interest Earned, Patient Finance Charges.
 Line 26: Enter the total of Local Supportive Funding.
 Line 27: List other non-operating revenues (Ex: Donations, sales of assets, fund raisers).
 Line 28: List other non-operating expenses (Ex: Civil fines or penalties, loss on sale of assets).
 Line 29: Net Income (Line 23 plus Lines 24 through 27, minus Line 28).

Page 4: BALANCE SHEET

Current audited financial statements may be submitted in lieu of this page.

Page 5: STATEMENT OF CASH FLOWS

Current audited financial statements may be submitted in lieu of this page.

Questions regarding this reporting form can be submitted to:

Arizona Department of Health Services
 Bureau of Emergency Medical Services and Trauma System
 Certificate of Necessity and Rates Section

150 North 18th Avenue, Suite 540
 Phoenix, AZ 85007
 Telephone: (602) 364-3150
 Fax: (602) 364-3567

Page 8**Historical Note**

Exhibit 9B renumbered from Exhibit B and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

Exhibit B. Renumbered**Historical Note**

New Table adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). New Exhibit B recodified from Article 12 at 12 A.A.R. 2243, effective June 2, 2006 (Supp. 06-2). Exhibit B renumbered to Exhibit 9B by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

ARTICLE 10. GROUND AMBULANCE VEHICLE REGISTRATION**R9-25-1001. Initial and Renewal Application for a Certificate****of Registration (A.R.S. §§ 36-2212, 36-2232, 36-2240)**

- A. A person applying for an initial or renewal certificate of registration of a ground ambulance vehicle shall submit an application form to the Department that contains:
1. The applicant's legal business or corporate name;
 2. The applicant's mailing address, physical address of the business, and business, facsimile, and emergency telephone numbers;
 3. The identifying information of the ground ambulance vehicle, including:
 - a. The make of the ground ambulance vehicle;
 - b. The ground ambulance vehicle manufacture year;
 - c. The ground ambulance vehicle identification number;

TITLE 9. HEALTH SERVICES

CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

- d. The unit number of the ground ambulance vehicle;
 - e. The ground ambulance vehicle's state license number; and
 - f. The location at which the ground ambulance vehicle will be available for inspection;
 - 4. The identification number of the certificate of necessity to which the ground ambulance vehicle is registered;
 - 5. The name and telephone number of the person to contact to arrange for inspection, if the inspection is pre-announced; and
 - 6. The signature of the applicant or applicant's designated representative.
 - B. Under A.R.S. § 36-2232(A)(11), the Department shall inspect each ambulance before an initial certificate of registration is issued by the Department.
 - C. Under A.R.S. § 36-2232(A)(11), the Department shall either inspect an ambulance or receive an inspection report that meets the requirements in this Article by a Department-approved inspection facility before a renewal certificate of registration is issued by the Department.
 - D. An applicant shall submit the following fees:
 - 1. \$50 application filing fee for an initial certificate of registration;
 - 2. \$200 annual regulatory fee for each ground ambulance vehicle issued a certificate of registration; and
 - 3. \$50 application filing fee for the renewal of a certificate of registration.
 - E. The Department shall approve or deny an application under this Section according to 9 A.A.C. 25, Article 12.
- Historical Note**
- New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).
- R9-25-1002. Minimum Standards for Ground Ambulance Vehicles (Authorized by A.R.S. § 36-2202(A)(5))**
- An applicant for a certificate of registration or certificate holder shall ensure a ground ambulance vehicle is equipped with the following:
- 1. An engine intake air cleaner that meets the ground ambulance vehicle manufacturer's engine specifications;
 - 2. A brake system that meets the requirements in A.R.S. § 28-952;
 - 3. A cooling system in the engine compartment that maintains the engine temperature operating range required to prevent damage to the ground ambulance vehicle engine;
 - 4. A battery:
 - a. With no leaks, corrosion, or other visible defects; and
 - b. As measured by a voltage meter, capable of generating:
 - i. 12.6 volts at rest, and
 - ii. 13.2 to 14.2 volts on high idle with all electrical equipment turned on;
 - 5. A wiring system in the engine compartment designed to prevent the wire from being cut by or tangled in the engine or hood;
 - 6. Hoses, belts, and wiring with no visible defects;
 - 7. An electrical system capable of maintaining a positive amperage charge while the ground ambulance vehicle is stationary and operating at high idle with headlights, running lights, patient compartment lights, environmental systems, and all warning devices turned on;
 - 8. An exhaust pipe, muffler, and tailpipe under the ground ambulance vehicle and securely attached to the chassis;
 - 9. A frame capable of supporting the gross vehicle weight of the ground ambulance vehicle;
 - 10. A horn that meets the requirements in A.R.S. § 28-954(A);
 - 11. A siren that meets the requirements in A.R.S. § 28-954(E);
 - 12. A front bumper that is positioned at the forward-most part of the ground ambulance vehicle extending to the ground ambulance vehicle's outer edges;
 - 13. A fuel cap of a type specified by the manufacturer for each fuel tank;
 - 14. A steering system to include:
 - a. Power-steering belts free from frays, cracks, or slip-page;
 - b. Power-steering that is free from leaks;
 - c. Fluid in the power-steering system that fills the reservoir between the full level and the add level indicator on the dipstick; and
 - d. Bracing extending from the center of the steering wheel to the steering wheel ring that is not cracked;
 - 15. Front and rear shock absorbers that are free from leaks;
 - 16. Tires on each axle that:
 - a. Are properly inflated;
 - b. Are of equal size, equal ply ratings, and equal type;
 - c. Are free of bumps, knots, or bulges;
 - d. Have no exposed ply or belting; and
 - e. Have tread groove depth equal to or more than 4/32 inch;
 - 17. An air cooling system capable of achieving and maintaining a 20° F difference between the air intake and the cool air outlet;
 - 18. Air cooling and heater hoses secured in all areas of the ground ambulance vehicle and chassis to prevent wear due to vibration;
 - 19. Body free of damage or rust that interferes with the physical operation of the ground ambulance vehicle or creates a hole in the driver's compartment or the patient compartment;
 - 20. Windshield defrosting and defogging equipment;
 - 21. Emergency warning lights that provide 360° conspicuity;
 - 22. At least one 5-lb. ABC dry, chemical, multi-purpose fire extinguisher in a quick release bracket with a current inspection tag;
 - 23. A heating system capable of achieving and maintaining a temperature of not less than 68° F in the patient compartment within 30 minutes;
 - 24. Sides of the ground ambulance vehicle insulated and sealed to prevent dust, dirt, water, carbon monoxide, and gas fumes from entering the interior of the patient compartment and to reduce noise;
 - 25. Interior patient compartment wall and floor coverings that are:
 - a. In good repair and capable of being disinfected, and
 - b. Maintained in a sanitary manner;
 - 26. Padding over exit areas from the patient compartment and over sharp edges in the patient compartment;
 - 27. Secured interior equipment and other objects;
 - 28. When present, hangers or supports for equipment mounted not to protrude more than 2 inches when not in use;
 - 29. Functional lamps and signals, including:
 - a. Bright and dim headlights,
 - b. Brake lamps,
 - c. Parking lamps,
 - d. Backup lamps,
 - e. Tail lamps,
 - f. Turn signal lamps,
 - g. Side marker lamps,
 - h. Hazard lamps,
 - i. Patient loading door lamps and side spot lamps,
 - j. Spot lamp in the driver's compartment and within reach of the ambulance attendant, and
 - k. Patient compartment interior lamps;
 - 30. Side-mounted rear vision mirrors and wide vision mirror mounted on, or attached to, the side-mounted rear vision mirrors;

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31. A patient loading door that permits the safe loading and unloading of a patient occupying a stretcher in a supine position;
 32. At least two means of egress from the patient compartment to the outside through a window or door;
 33. Functional open door securing devices on a patient loading door;
 34. Patient compartment upholstery free of cuts or tears and capable of being disinfected;
 35. A seat belt installed for each seat in the driver's compartment;
 36. Belts or devices installed on a stretcher to be used to secure a patient;
 37. A seat belt installed for each seat in the patient compartment;
 38. A crash stable side or center mounting fastener of the quick release type to secure a stretcher to a ground ambulance vehicle;
 39. Windshield and windows free of obstruction;
 40. A windshield free from unrepaired starred cracks and line cracks that extend more than 1 inch from the bottom and sides of the windshield or that extend more than 2 inches from the top of the windshield;
 41. A windshield-washer system that applies enough cleaning solution to clear the windshield;
 42. Operable windshield wipers with a minimum of two speeds;
 43. Functional hood latch for the engine compartment;
 44. Fuel system with fuel tanks and lines that meets manufacturer's specifications;
 45. Suspension system that meets the ground ambulance vehicle manufacturer's specifications;
 46. Instrument panel that meets the ground ambulance vehicle manufacturer's specifications; and
 47. Wheels that meet and are mounted according to manufacturer's specifications.
9. Two large-size, two medium-size, and two small-size cervical immobilization devices;
 10. Two small-size, two medium-size, and two large size upper extremities splints;
 11. Two small-size, two medium-size, and two large size lower extremities splints;
 12. One child-size and one adult-size lower extremity traction splints;
 13. Two full-length spine boards;
 14. Supplies to secure a patient to a spine board;
 15. One cervical-thoracic spinal immobilization device for extrication;
 16. Two sterile burn sheets;
 17. Two triangular bandages;
 18. Three sterile multi-trauma dressings, 10" x 30" or larger;
 19. Fifty non-sterile 4" x 4" gauze sponges;
 20. Ten non-sterile soft roller bandages, 4" or larger;
 21. Four sterile occlusive dressings, 3" x 8" or larger;
 22. Two 2" or 3" adhesive tape rolls;
 23. Containers for biohazardous medical waste that comply with requirements in 18 A.A.C. 13, Article 14;
 24. A sterile obstetrical kit containing towels, 4" x 4" dressing, scissors, bulb suction, and clamps or tape for cord;
 25. One blood glucose testing kit;
 26. A meconium aspirator adapter;
 27. A length/weight-based pediatric reference guide to determine the appropriate size of medical equipment and drug dosing;
 28. A pulse oximeter with both pediatric and adult probes;
 29. One child-size, one adult-size, and one large adult-size sphygmomanometer;
 30. One stethoscope;
 31. One heavy duty scissors capable of cutting clothing, belts, or boots;
 32. Two blankets;
 33. One thermal absorbent blanket with head cover or blanket of other appropriate heat-reflective material;
 34. Two sheets;
 35. Body substance isolation equipment, including:
 - a. Two pairs of non-sterile disposable gloves;
 - b. Two gowns;
 - c. Two masks that are at least as protective as a National Institute for Occupational Safety and Health-approved N-95 respirator, which may be of universal size;
 - d. Two pairs of shoe coverings; and
 - e. Two sets of protective eye wear;
 36. At least three pairs of non-latex gloves; and
 37. A wheeled, multi-level stretcher that is:
 - a. Suitable for supporting a patient at each level,
 - b. At least 69 inches long and 20 inches wide,
 - c. Rated for use with a patient weighing up to or more than 350 pounds,
 - d. Adjustable to allow a patient to recline and to elevate the patient's head and upper torso to an angle at least 70° from the horizontal plane,
 - e. Equipped with a mattress that has a protective cover,
 - f. Equipped with at least two attached straps to secure a patient during transport, and
 - g. Equipped to secure the stretcher to the interior of the vehicle during transport using the fastener required under R9-25-1002(38).

Historical Note

New Section adopted by final rulemaking at 7 A.A.R.

1098, effective February 13, 2001 (Supp. 01-1).

Amended by exempt rulemaking at 19 A.A.R. 4032,
effective December 1, 2013 (Supp. 13-4).

R9-25-1003. Minimum Equipment and Supplies for Ground Ambulance Vehicles (Authorized by A.R.S. § 36-2202(A)(5))

- A.** A ground ambulance vehicle used for either BLS or ALS level of service shall contain the following operational equipment and supplies:
1. A portable and a fixed suction apparatus;
 2. Wide-bore tubing, a rigid pharyngeal curved suction tip, and a flexible suction catheter in the following French sizes:
 - a. Two in 6, 8, or 10; and
 - b. Two in 12, 14, or 16;
 3. One fixed oxygen cylinder or equivalent with a minimum capacity of 106 cubic feet, a minimum pressure of 500 p.s.i., and a variable flow regulator;
 4. One portable oxygen cylinder with a minimum capacity of 13 cubic feet, a minimum pressure of 500 p.s.i., and a variable flow regulator;
 5. Oxygen administration equipment including: tubing, two adult-size and two pediatric-size non-rebreather masks, and two adult-size and two pediatric-size nasal cannula;
 6. One adult-size, one child-size, one infant-size, and one neonate-size hand-operated, disposable, self-expanding bag-valve with one of each size bag-valve mask;
 7. Nasal airways in the following French sizes:
 - a. One in 16, 18, 20, 22, or 24; and
 - b. One in 26, 28, 30, 32, or 34;
 8. Two adult-size, two child-size, and two infant-size oropharyngeal airways;
- B.** In addition to the equipment and supplies in subsection (A), a ground ambulance vehicle equipped to provide BLS shall contain at least:
1. The minimum supply of agents required in a table of agents, established according to A.R.S. § 36-2204 and available through the Department at www.azdhs.gov/ems-regulatory-references, that an administrative medical director may authorize for an EMT;

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2. The capability of providing automated external defibrillation;
 3. Two 3 mL syringes; and
 4. Two 10-12 mL syringes.
- C. In addition to the equipment and supplies in subsection (A), a ground ambulance vehicle equipped to provide ALS shall contain at least the minimum supply of agents required in a table of agents, established according to A.R.S. § 36-2204 and available through the Department at www.azdhs.gov/ems-regulatory-references, that an administrative medical director may authorize for the highest level of service to be provided by the ambulance's crew and at least the following:
1. Four intravenous solution administration sets capable of delivering 10 drops per cc;
 2. Four intravenous solution administration sets capable of delivering 60 drops per cc;
 3. Intravenous catheters in:
 - a. Three different sizes from 14 gauge to 20 gauge, and
 - b. Either 22 or 24 gauge;
 4. One child-size and one adult-size intraosseous needle;
 5. Venous tourniquet;
 6. Two endotracheal tubes in each of the following sizes: 2.5 mm, 3.0 mm, 3.5 mm, 4.0 mm, 4.5 mm, 5.0 mm, 5.5 mm, 6.0 mm, 7.0 mm, 8.0 mm, and 9.0 mm;
 7. One pediatric-size and one adult-size stylette for endotracheal tubes;
 8. End tidal CO₂ monitoring/capnography equipment with capability for pediatric and adult patients;
 9. One laryngoscope with blades in sizes 0-4, straight or curved or both;
 10. One pediatric-size and one adult-size Magill forceps;
 11. One scalpel;
 12. One portable, battery-operated cardiac monitor-defibrillator with strip chart recorder and adult and pediatric EKG electrodes and defibrillation capabilities;
 13. Electrocardiogram leads;
 14. The following syringes:
 - a. Two 1 mL tuberculin,
 - b. Four 3 mL,
 - c. Four 5 mL,
 - d. Four 10-12 mL,
 - e. Two 20 mL, and
 - f. Two 50-60 mL;
 15. Three 5 micron filter needles; and
 16. Assorted sizes of non-filter needles.
- D. A ground ambulance vehicle shall be equipped to provide, and capable of providing, voice communication between:

1. The ambulance attendant and the dispatch center;
2. The ambulance attendant and the ground ambulance service's assigned medical direction authority, if any; and
3. The ambulance attendant in the patient compartment and the ground ambulance service's assigned medical direction authority, if any.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R.

1098, effective February 13, 2001 (Supp. 01-1).

Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 3487, with an immediate effective date of December 4, 2018 (Supp. 18-4).

R9-25-1004. Minimum Staffing Requirements for Ground Ambulance Vehicles (Authorized by A.R.S. §§ 36-2201(4), 36-2202(A)(5))

When transporting a patient, a ground ambulance service shall staff a ground ambulance vehicle according to A.R.S. § 36-2202(J).

Historical Note

New Section adopted by final rulemaking at 7 A.A.R.

1098, effective February 13, 2001 (Supp. 01-1).

Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

R9-25-1005. Ground Ambulance Vehicle Inspection; Major and Minor Defects (A.R.S. §§ 36-2202(A)(5), 36-2212, 36-2232, 36-2234)

- A. A certificate holder shall make the ground ambulance vehicle, equipment, and supplies available for inspection at the request of the Director or the Director's authorized representative.
- B. If inspected by the Department, a certificate holder shall allow the Director or the Director's authorized representative to ride in or operate the ground ambulance vehicle being inspected.
- C. A certificate holder may request the Department to inspect all of the certificate holder's ground ambulance vehicles at the same date and location.
- D. A Department-approved inspection facility may inspect a ground ambulance vehicle under A.R.S. § 36-2232(A)(11).
- E. The Department classifies defects on a ground ambulance vehicle as major or minor as follows:

INSPECTION ITEM	MAJOR DEFECT	MINOR DEFECT
LAMPS:		
Emergency warning lights	Lack of 360° of conspicuity	Cracked, broken, or missing lens Inoperative lamps
Back-up lamps		Inoperative Cracked, broken, or missing lens
Brake lamps	Both inoperative	1 inoperative
Hazard lamps		Inoperative
Head lamps	Inoperative	High beam inoperative Low beam inoperative Inoperative dimmer switch
Loading lamps		Inoperative Cracked, broken, or missing lens
Parking lamps		Inoperative
Patient Compartment interior lamps	All lamps inoperative	Inoperative individual lamps Missing lens
Side marker lamps		Inoperative Cracked, broken, or missing lens
Spot lamp in driver's compartment		Inoperative

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Tail lamps	Both inoperative	1 inoperative Cracked, broken, or missing lens
Turn signal lamps		Any turn signal lamp inoperative Cracked, broken, or missing lens
MECHANICAL, STRUCTURAL, ELECTRICAL:		
Bumpers		Loose or missing bumper
Defroster		Inoperative Ventilation system openings partially blocked
Electrical system	Does not comply with R9-25-1002(6)	
Engine compartment		Inoperative hood latch Deterioration of hoses, belts, or wiring Deterioration of battery hold-down clamps Corrosive acid buildup on battery terminals Incapable of generating voltage in compliance with R9-25-1002(4)(b)
Engine compartment wiring system		Does not comply with R9-25-1002(5)
Engine cooling system	Does not comply with R9-25-1002(3)	Leaks in system
Engine intake air cleaner		Does not comply with R9-25-1002(1)
Exhaust	Exhaust fumes in the patient or driver compartment	Exhaust pipe brackets not securely attached to the chassis and tailpipe End of tailpipe pinched or bent
Frame	Cracks in frame	
Fuel system	Fuel tank not mounted according to manufacturer's specifications Fuel tank brackets cracked or broken Leaking fuel tanks or fuel lines Fuel caps missing or of a type not specified by the manufacturer	
Ground ambulance vehicle body	Damage or rust to the exterior of the ground ambulance vehicle, which interferes with the operation of the ground ambulance vehicle Damage resulting in a hole in the driver's compartment or the patient compartment Holes that may allow exhaust or dust to enter the patient compartment Bolts attaching body to chassis loose, broken, or missing	Damage resulting in cuts or rips to the exterior of the ground ambulance vehicle
Heating and air conditioning systems		Unsecured hoses Does not maintain minimum temperature required in R9-25-1002(23) and 1002(17)
Horn		Inoperative
Parking brake		Inoperative
Siren	Inoperative	
Steering	Steering wheel bracing cracked Inoperative	Power steering belts slipping Power steering belts cracked or frayed Fluid leaks Fluid does not fill the reservoir between the full level and the add level indicator on the dipstick
Suspension	Broken suspension parts U-bolts loose or missing	Bent suspension parts Leaking shock absorbers Cracks or breaks in shock absorber mounting brackets
Vehicle brakes	Inoperative	Fluid leaks
INTERIOR:		
Communication equipment	Lack of operative communication equipment	Inoperative communication equipment in the patient compartment
Edges		Presence of exposed sharp edges
Equipment	Inability to secure oxygen tanks	Inability to secure other equipment
Fire extinguisher	Absent	Not at full charge Expired inspection tag
Hangers		Supports or hangers protruding more than 2" when not in use

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Instrument panel		Inoperative gauges, switches, or illumination
Padding		Missing padding over exits in the patient compartment
Patient compartment	Visible blood, body fluids, or tissue	Unrepaired cuts or holes in seats Missing pieces of floor covering
Seat belts and securing belts	Absence of seat belt or inoperative seat belt in the driver's compartment More than one inoperative seat belt in the patient compartment Absence of securing belts on a stretcher	Frayed seat belt or securing belt material One inoperative seat belt in the patient compartment
Stretcher fastener	Does not comply with R9-25-1002(36)	
EXTERIOR:		
Patient compartment doors	Completely or partially missing window panel	Inoperative open door securing devices Cracked window panels
Marking		Missing company identification Incorrect size or location
Mirrors	Exterior rear vision or wide vision mirrors missing	Cracked mirror glass Loose mounting bracket bolts or screws Broken mirrors Loose or broken mounting brackets Missing mounting bracket bolts or screws
Tires	Tires on each axle are not of equal size, equal ply ratings, and equal type Bumps, knots, or bulges on any tire Exposed ply or belting on any tire Flat tire on any wheel	Tread groove depth less than 4/32" measured in a tread groove on any tire
Wheels	Loose or missing lug nuts Broken lugs Cracked or bent rims	
Windows		Placement of nontransparent materials which obstruct view Cracked or broken
Windshield	Windshield that is obstructed Placement of nontransparent materials which obstruct view	Unrepaired starred cracks or line cracks extending more than 1 inch from the bottom or side of the windshield Unrepaired starred cracks or line cracks extending more than 2 inches from the top of the windshield
Windshield- washer system		Does not comply with R9-25-1002(39)
Windshield wipers	Inoperative wiper on driver's side	Inoperative speed control Split or cracked wiper blade Inoperative wiper on passenger's side

- F.** If the Department determines that there is a major defect on the ground ambulance vehicle after inspection, the certificate holder shall take the ground ambulance vehicle out-of-service until the defect is corrected.
- G.** If the Department finds a minor defect on the ground ambulance vehicle after inspection, the ground ambulance vehicle may be operated to transport patients for up to 15 days until the minor defect is corrected.
1. The Department may grant an extension of time to repair the minor defect upon a written request from the certificate holder detailing the reasons for the need of an extension of time.
 2. If the minor defect is not repaired within the time prescribed by the Department, and an extension has not been granted, the certificate holder shall take the ground ambulance vehicle out-of-service until the minor defect is corrected.
- H.** Within 15 days of the date of repair of the major or minor defect, the certificate holder shall submit written notice of the repair to the Department.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R.
1098, effective February 13, 2001 (Supp. 01-1).

R9-25-1006. Ground Ambulance Vehicle Identification (A.R.S. §§ 36-2212, 36-2232)

- A.** A ground ambulance vehicle shall be marked on its sides with the certificate of registration applicant's legal business or corporate name with letters not less than 6 inches in height.
- B.** A ground ambulance vehicle marked with a level of ground ambulance service shall be equipped and staffed to provide the level of ground ambulance service identified while in service.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R.
1098, effective February 13, 2001 (Supp. 01-1).

ARTICLE 11. GROUND AMBULANCE SERVICE RATES AND CHARGES; CONTRACTS**R9-25-1101. Application for Establishment of Initial General Public Rates (A.R.S. §§ 36-2232, 36-2239)**

- A.** An applicant for a certificate of necessity or a certificate holder applying for initial general public rates shall submit an application packet to the Department that includes:
1. The applicant's name;

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2. The requested general public rates;
 3. A copy of the applicant's most recent financial statements or an Ambulance Revenue and Cost Report;
 4. For a consecutive 12-month period:
 - a. A projected income statement; and
 - b. A projected cash-flow statement;
 5. A list of all purchase agreements or lease agreements for real estate, ground ambulance vehicles, and equipment exceeding \$5,000 used in connection with the ground ambulance service, that includes the monetary amount and duration of each agreement;
 6. The identification of:
 - a. Each of the applicant's affiliations, such as a parent company or subsidiary owned or operated by the applicant; and
 - b. The methodology and calculations used in allocating costs among the applicant and government entities or profit or not-for-profit businesses;
 7. A copy of the applicant's contract with each federal or tribal entity for ground ambulance service, if applicable;
 8. Other documents, exhibits, or statements that may assist the Department in setting the general public rates;
 9. An attestation signed by the applicant that the information and documents provided by the applicant are true and correct; and
 10. Any other information or documents requested by the Director to clarify or complete the application.
- B.** The Department shall approve or deny an application under this Section according to 9 A.A.C. 25, Article 12.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

R9-25-1102. Application for Adjustment of General Public Rates (A.R.S. §§ 36-2234, 36-2239)

- A.** A certificate of necessity holder applying for an adjustment of general public rates not exceeding the monetary amount calculated according to A.R.S. § 36-2234(E) shall submit an application form to the Department that includes:
1. The name of the applicant;
 2. A statement that the applicant is making the request according to A.R.S. § 36-2234(E);
 3. A statement that the applicant has not applied for an adjustment to its general public rates within the last six months;
 4. The effective date of the proposed general public rate adjustment; and
 5. An attestation signed by the applicant that the information and documents provided by the applicant are true and correct.
- B.** An applicant requesting an adjustment of general public rates exceeding the monetary amount calculated according to A.R.S. § 36-2234(E) shall submit an application packet to the Department that includes:
1. The name of the applicant;
 2. A statement that the applicant is making the request according to A.R.S. § 36-2234(A);
 3. The reason for the general public rate adjustment request;
 4. A statement that the applicant has not applied for an adjustment to its general public rates within the last six months;
 5. The effective date of the proposed general public rate adjustment;
 6. A copy of the applicant's most recent financial statements;
 7. A copy of the Ambulance Revenue and Cost Report;
 8. For a consecutive 12-month period:
 - a. A projected income statement; and
 - b. A projected cash-flow statement;
 9. A list of all purchase agreements or lease agreements for real estate, ground ambulance vehicle, and equipment

exceeding \$5,000 used in connection with the ground ambulance service, that includes the monetary amount and duration of each agreement;

10. The identification of:
 - a. Each of the applicant's affiliations, such as a parent company or subsidiary owned or operated by the applicant; and
 - b. The methodology and calculations used in allocating costs among the applicant and government entities or profit or not for profit businesses;
 11. A copy of the applicant's contract with each federal or tribal entity for a ground ambulance service, if applicable;
 12. Other documents, exhibits, or statements that may assist the Department in setting the general public rates;
 13. An attestation signed by the applicant that the information and documents provided by the applicant are true and correct; and
 14. Any other information or documents requested by the Director to clarify or complete the application.
- C.** The Department shall approve or deny an application under this Section according to 9 A.A.C. 25, Article 12.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

R9-25-1103. Application for a Contract Rate or Range of Rates Less than General Public Rates (A.R.S. §§ 36-2234(G) and (I), 36-2239)

- A.** Before providing interfacility transports or convalescent transports, a certificate holder shall apply to the Department for approval of a contract rate or range of contract rates under A.R.S. § 36-2234(G).
1. For a contract rate or range of rates under A.R.S. § 36-2234(G), the certificate holder shall submit an application form to the Department that contains:
 - a. The name of the certificate holder;
 - b. A statement that the certificate holder is making the request under A.R.S. § 36-2234(G);
 - c. The contract rate or range of rates being requested; and
 - d. Information demonstrating the cost and economics of providing the transports for the requested contract rate or range of rates.
 2. For a contract rate or range of rates under A.R.S. § 36-2234(I), the certificate holder shall submit the information required in R9-25-1102(B)(1) and (B)(6) through (B)(14).
- B.** The Department shall approve or deny an application under this Section according to 9 A.A.C. 25, Article 12.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

R9-25-1104. Ground Ambulance Service Contracts (A.R.S. §§ 36-2232, 36-2234(K))

- A.** Before implementing a ground ambulance service contract, a certificate holder shall submit to the Department for approval a copy of the contract with a cover letter that indicates the total number of pages in the contract. The contract shall:
1. Include the certificate holder's legal name and any other name listed on the certificate holder's initial application required in R9-25-902(A)(1)(a);
 2. List the contract rate or range of rates approved by the Director according to R9-25-1101, R9-25-1102, or R9-25-1103;
 3. Comply with A.R.S. §§ 36-2201 through 36-2246 and 9 A.A.C. 25; and
 4. Not preclude use of the 9-1-1 system or a similarly designated emergency telephone number.

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

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

R9-25-1105. Application for Provision of Subscription Service or to Establish a Subscription Service Rate (A.R.S. § 36-2232(A)(1))

- A. A certificate holder applying to provide subscription service, establish a subscription service rate, or request approval of a subscription service contract shall submit an application packet to the Department that includes:
- The following information:
 - The number of estimated subscription service contracts and documents supporting the estimate, such as a survey of the service area;
 - An estimate of the number of annual subscription service transports for the service area;
 - The proposed subscription service rate;
 - An estimate of the cost of providing subscription service to the service area; and
 - Any other information or documents that the certificate holder believes may assist the Department in setting a subscription service rate; and
 - A copy of the proposed subscription service contract.
- B. The Department shall approve or deny a subscription service rate under this Section according to 9 A.A.C. 25, Article 12.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Section heading corrected at request of the Department, Office File No. M11-313, filed September 12, 2011 (Supp. 10-4).

R9-25-1106. Rate of Return Setting Considerations (A.R.S. §§ 36-2232, 36-2239)

- A. In determining the rate of return on gross revenue in A.R.S. § 36-2239(I)(4), the Director shall consider a ground ambulance service's:
- Direct and indirect costs for operating the ground ambulance service within its service area;
 - Balance sheet;
 - Income statement;
 - Cash flow statement;
 - Ratio between variable and fixed costs on the financial statements;
 - Method of indirect costs allocation to specific cost-center areas;
 - Return on equity;
 - Reimbursable and non-reimbursable charges;
 - Type of business entity;
 - Monetary amount and type of debt financing;
 - Replacement and expansion costs;
 - Number of calls, transports, and billable miles;
 - Costs associated with rules, inspections, and audits;
 - Substantiated prior reported losses;
 - Medicare and AHCCCS settlements; and
 - Any other information or documents needed by the Director to clarify incomplete or ambiguous information or documents.
- B. In determining the rate of return on gross revenue in A.R.S. § 36-2239(I)(4), the Director shall not consider:
- Depreciation of the portion of ground ambulance vehicles and equipment obtained through Department funding,
 - The certificate holder's travel and entertainment expenses that do not directly relate to providing the ground ambulance service,

- The monetary value of any goodwill accumulated by the certificate holder,
 - Any penalties or fines imposed on the certificate holder by a court or government agency, and
 - Any financial contributions received by the certificate holder.
- C. In determining just, reasonable, and sufficient rates in A.R.S. § 36-2232(A)(1) the director shall establish rates to provide for a rate of return that is at least 7% of gross revenue, calculated using the accrual method of accounting according to generally accepted accounting principles, unless the certificate holder requests a lower rate of return.
- D. Rate of return on gross revenue is calculated by dividing Ambulance Revenue and Cost Report Exhibit A or Exhibit B net income or loss by gross revenue.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

R9-25-1107. Rate Calculation Factors (A.R.S. § 36-2232)

- A. When evaluating a proposed mileage rate, the Department shall consider the following factors:
- The cost of licensure and registration of each ground ambulance vehicle;
 - The cost of fuel;
 - The cost of ground ambulance vehicle maintenance;
 - The cost of ground ambulance vehicle repair;
 - The cost of tires;
 - The cost of ground ambulance vehicle insurance;
 - The cost of mechanic wages, benefits, and payroll taxes;
 - The cost of loan interest related to the ground ambulance vehicles;
 - The cost of the weighted allocation of overhead;
 - The cost of ground ambulance vehicle depreciation;
 - The cost of reserves for replacement of ground ambulance vehicles and equipment; and
 - Mileage reimbursement as established by Medicare guidelines for ground ambulance service.
- B. When evaluating a proposed BLS base rate, the Department shall consider the costs associated with providing EMS and transport.
- C. When evaluating a proposed ALS base rate, the Department shall consider the factors in subsection (B) and the additional costs of ALS ambulance equipment and ALS personnel.
- D. In evaluating rates, the Director shall make adjustments to a certificate holder's rates to maximize Medicare reimbursements.
- E. The Department shall determine the standby waiting rate by dividing the BLS base rate by 4.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

R9-25-1108. Implementation of Rates and Charges (A.R.S. §§ 36-2232, 36-2239)

- A. A certificate holder shall assess rates and charges as follows:
- When calculating a rate or charge, the certificate holder shall:
 - Omit fractions of less than 1/2 of 1 cent; or
 - Increase to the next whole cent, fractions of 1/2 of 1 cent or greater.
 - The certificate holder shall calculate the number of miles for a transport by using:
 - The ground ambulance vehicle's odometer reading; or
 - A regional map.
 - The certificate holder shall calculate the reimbursement amount for mileage of a transport by multiplying the number of miles for the transport by the mileage rate.

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4. When transporting two or more patients in the same ground ambulance vehicle, the certificate holder shall assess each patient:
 - a. Fifty percent of the mileage rate and one hundred percent of the ALS or BLS base rate; and
 - b. One hundred percent of:
 - i. The charge for each disposable supply, medical supply, medication, and oxygen-related cost used on the patient; and
 - ii. Waiting time assessed according to subsection (C).
5. When agreed upon by prior arrangement to transport a patient to one destination and return to the point of pick-up or to one destination and then to a subsequent destination, assess only the ALS or BLS base rate, mileage rate, and standby waiting rate for the transport.
- B. When a certificate holder transfers a patient to an air ambulance, the certificate holder shall assess the patient the rates and charges for EMS and transport provided to the patient before the transfer.
- C. A certificate holder shall assess a standby waiting rate in quarter-hour increments, except for:
 1. The first 15 minutes after arrival to load the patient at the point of pick-up;
 2. The time, exceeding the first 15 minutes, required by ambulance attendants to provide necessary medical treatment and stabilization of the patient at the point of pick-up; and
 3. The first 15 minutes to unload the patient at the point of destination.
- D. When a certificate holder responds to a request outside the certificate holder's service area, the certificate holder shall assess its own rates and charges for EMS or transport provided to the patient.
- E. When the Department or the certificate holder determines that a refund of a rate or a charge is required, the certificate holder shall refund the rate or charge within 90 days from the date of the determination.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

R9-25-1109. Charges (A.R.S. §§ 36-2232, 36-2239(D))

- A. A certificate holder that charges patients for disposable supplies, medical supplies, medications, and oxygen-related costs shall submit to the Department a list of the items and the proposed charges. The list shall include a non-retroactive effective date.
- B. A certificate holder shall submit to the Department a new list each time the certificate holder proposes a change in the items or the amount charged. The list shall contain the information required in subsection (A), including a non-retroactive effective date.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

R9-25-1110. Invoices (A.R.S. §§ 36-2234, 36-2239)

- A. Each invoice for rates and charges shall contain the following:
 1. The patient's name;
 2. The certificate holder's name, address, and telephone number;
 3. The date of service;
 4. An itemized list of the rates and charges assessed;
 5. The total monetary amount owed the certificate holder; and
 6. The payment due date.
- B. Any subsequent invoice to the same patient for the same EMS or transport shall contain all the information in subsection (A) except the information in subsection (A)(4).

- C. Charges may be combined into one line item if the supplies are used for a specific purpose and the name of the combined item is included in the certificate holder's disposable medical supply listing provided to the Department under R9-25-1109.
- D. A certificate holder may combine rates and charges into one line item if required by a third-party payor.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

ARTICLE 12. TIME-FRAMES FOR DEPARTMENT APPROVALS**R9-25-1201. Time-frames (Authorized by A.R.S. §§ 41-1072 through 41-1079)**

- A. The overall time-frame described in A.R.S. § 41-1072 for each type of approval granted by the Department is listed in Table 12.1. The applicant and the Director may agree in writing to extend the overall time-frame. The substantive review time-frame shall not be extended by more than 25% of the overall time-frame.
- B. The administrative completeness review time-frame described in A.R.S. § 41-1072 for each type of approval granted by the Department is listed in Table 12.1. The administrative completeness review time-frame begins on the date that the Department receives an application form or an application packet.
 1. If the application packet is incomplete, the Department shall send to the applicant a written notice specifying the missing document or incomplete information. The administrative completeness review time-frame and the overall time-frame are suspended from the postmark date of the written request until the date the Department receives a complete application packet from the applicant.
 2. When an application packet is complete, the Department shall send a written notice of administrative completeness.
 3. If the Department grants an approval during the time provided to assess administrative completeness, the Department shall not issue a separate written notice of administrative completeness.
- C. The substantive review time-frame described in A.R.S. § 41-1072 is listed in Table 12.1 and begins on the postmark date of the notice of administrative completeness.
 1. As part of the substantive review time-frame for an application for an approval other than renewal of an ambulance registration, the Department shall conduct inspections, conduct investigations, or hold hearings required by law.
 2. If required under R9-25-402, the Department shall fix the period and terms of probation as part of the substantive review.
 3. During the substantive review time-frame, the Department may make one comprehensive written request for additional documents or information and may make supplemental requests for additional information with the applicant's written consent.
 4. The substantive review time-frame and the overall time-frame are suspended from the postmark date of the written request for additional information or documents until the Department receives the additional information or documents.
 5. The Department shall send a written notice of approval to an applicant who:
 - a. Meets the qualifications in A.R.S. Title 36, Chapter 21.1 and this Chapter for the type of application submitted; or
 - b. Is not in compliance with requirements in A.R.S. Title 36, Chapter 21.1 and this Chapter, for the type of application submitted, that do not directly affect

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the health or safety of a patient and submits to the Department a corrective action plan that is acceptable to the Department to address issues of compliance.

6. The Department shall send a written notice of denial to an applicant who fails to meet the qualifications in A.R.S. Title 36, Chapter 21.1, and this Chapter for the type of application submitted.
- D. If an applicant fails to supply the documents or information under subsections (B)(1) and (C)(3) within the number of days specified in Table 12.1 from the postmark date of the written notice or comprehensive written request, the Department shall consider the application withdrawn.
- E. An applicant that does not wish an application to be considered withdrawn may request a denial in writing within the number of days specified in Table 12.1 from the postmark date of the written notice or comprehensive written request for documents or information under subsections (B)(1) and (C)(3).

- F. If a time-frame's last day falls on a Saturday, Sunday, or an official state holiday, the Department shall consider the next business day as the time-frame's last day.

Historical Note

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Amended by final rulemaking at 8 A.A.R. 2352, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

Table 12.1. Time-frames (in days)

Type of Application	Statutory Authority	Overall Time-frame	Administrative Completeness Time-frame	Time to Respond to Written Notice	Substantive Review Time-frame	Time to Respond to Comprehensive Written Request
ALS Base Hospital Certification (R9-25-204)	A.R.S. §§ 36-2201, 36-2202(A)(3), and 36-2204(5)	45	15	60	30	60
Training Program Certification (R9-25-301)	A.R.S. §§ 36-2202(A)(3) and 36-2204(1) and (3)	120	30	60	90	60
Addition of a Course (R9-25-303)	A.R.S. §§ 36-2202(A)(3) and 36-2204(1) and (3)	90	30	60	60	60
EMCT Certification (R9-25-403)	A.R.S. §§ 36-2202(A)(2), (3), and (4), 36-2202(G), and 36-2204(1)	120	30	90	90	270
EMCT Recertification (R9-25-404)	A.R.S. §§ 36-2202(A)(2), (3), (4), and (6), 36-2202(G), and 36-2204(1) and (4)	120	30	60	90	60
Extension to File for EMCT Recertification (R9-25-405)	A.R.S. §§ 36-2202(A)(2), (3), (4), and (6), 36-2202(G), and 36-2204(1) and (7)	30	15	60	15	60
Downgrading of Certification (R9-25-406)	A.R.S. §§ 36-2202(A)(2), (3), and (4), 36-2202(G), and 36-2204(1) and (6)	30	15	60	15	60
Initial Air Ambulance Service License (R9-25-704)	A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), 36-2213, 36-2214, and 36-2215	150	30	60	120	60
Renewal of an Air Ambulance Service License (R9-25-704)	A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), 36-2213, 36-2214, and 36-2215	90	30	60	60	60
Initial Certificate of Registration for an Air Ambulance (R9-25-801)	A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), 36-2212, 36-2213, 36-2214, and 36-2240(4)	90	30	60	60	60
Renewal of a Certificate of Registration for an Air Ambulance (R9-25-801)	A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), 36-2212, 36-2213, 36-2214, and 36-2240(4)	90	30	60	60	60
Initial Certificate of Necessity (R9-25-902)	A.R.S. §§ 36-2204, 36-2232, 36-2233, 36-2240	450	30	60	420	60
Provision of ALS Services (R9-25-902)	A.R.S. §§ 36-2232, 36-2233, 36-2240	450	30	60	420	60

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Transfer of a Certificate of Necessity (R9-25-902)	A.R.S. §§ 36-2236(A) and (B), 36-2240	450	30	60	420	60
Renewal of a Certificate of Necessity (R9-25-904)	A.R.S. §§ 36-2233, 36-2235, 36-2240	90	30	60	60	60
Amendment of a Certificate of Necessity (R9-25-905)	A.R.S. §§ 36-2232(A)(4), 36-2240	450	30	60	420	60
Initial Registration of a Ground Ambulance Vehicle (R9-25-1001)	A.R.S. §§ 36-2212, 36-2232, 36-2240	90	30	60	60	60
Renewal of a Ground Ambulance Vehicle Registration (R9-25-1001)	A.R.S. §§ 36-2212, 36-2232, 36-2240	90	30	60	60	60
Establishment of Initial General Public Rates (R9-25-1101)	A.R.S. §§ 36-2232, 36-2239	450	30	60	420	60
Adjustment of General Public Rates (R9-25-1102)	A.R.S. §§ 36-2234, 36-2239	450	30	60	420	60
Contract Rate or Range of Rates Less than General Public Rates (R9-25-1103)	A.R.S. §§ 36-2234, 36-2239	450	30	60	420	60
Ground Ambulance Service Contracts (R9-25-1104)	A.R.S. § 36-2232	450	30	60	420	60
Ground Ambulance Service Contracts with Political Subdivisions (R9-25-1104)	A.R.S. §§ 36-2232, 36-2234(K)	30	15	15	15	Not Applicable
Subscription Service Rate (R9-25-1105)	A.R.S. § 36-2232(A)(1)	450	30	60	420	60

Historical Note

Table 12.1 renumbered from Table 1 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1). Amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

Table 1. Renumbered**Historical Note**

New Table adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Amended by final rulemaking at 8 A.A.R. 2352, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Table 1 renumbered to Table 12.1 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

Exhibit A. Recodified**Historical Note**

New Exhibit adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Exhibit

A recodified to Article 9 at 12 A.A.R. 2243, effective June 2, 2006 (Supp. 06-2).

Exhibit B. Recodified**Historical Note**

New Table adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Exhibit B recodified to Article 9 at 12 A.A.R. 2243, effective June 2, 2006 (Supp. 06-2).

ARTICLE 13. TRAUMA CENTERS AND TRAUMA REGISTRIES**R9-25-1301. Definitions (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))**

In addition to the definitions in A.R.S. § 36-2201 and R9-25-101, the following definitions apply in this Article, unless otherwise specified:

1. "Admitted" means when a patient is either:
 - a. Held for observation of a trauma-related injury; or

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- b. Considered an inpatient, as defined in A.A.C. R9-10-201.
2. "Business day" means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state holiday.
3. "Designation" means a formal determination by the Department that a health care institution complies with requirements in A.R.S. § 36-2225 and this Article for providing a particular Level of trauma service.
4. "Emergency department" means a designated area of a hospital that provides emergency services, as defined in A.A.C. R9-10-201, as an organized service, 24 hours per day, seven days per week, to individuals who present for immediate medical services.
5. "ICD-code" means an International Classification of Diseases code, a set of numbers or letters or a combination of letters and numbers that specify a disease, condition, or injury; the location of the disease, condition, or injury; or the circumstances under which a patient may have incurred the disease, condition, or injury, which is used by a health care institution for billing purposes.
6. "Level I Pediatric trauma center" means a Level I trauma center that has a trauma service specifically intended to meet the needs of children requiring trauma care.
7. "Level II Pediatric trauma center" means a Level II trauma center that has a trauma service specifically intended to meet the needs of children requiring trauma care.
8. "Medical services" means the services pertaining to the "practice of medicine," as defined in A.R.S. § 32-1401, or "medicine," as defined in A.R.S. § 32-1800, performed at the direction of a physician.
9. "National verification organization" has the same meaning as in A.R.S. § 36-2225.
10. "Nursing services" means services that pertain to the curative, restorative, and preventive aspects of "registered nursing," as defined in A.R.S. § 32-1601, performed:
 - a. At the direction of a physician; and
 - b. By or under the supervision of a registered nurse licensed:
 - i. According to Title 32, Chapter 15; or
 - ii. When performed in a health care institution operating under federal or tribal law as an administrative unit of the U.S. government or a sovereign tribal nation, by a similar licensing board in another state.
11. "On-call" means assigned to respond and, if necessary, come to a health care institution when notified by a personnel member of the health care institution.
12. "Organized service" has the same meaning as in A.A.C. R9-10-201.
13. "Owner" means one of the following:
 - a. For a health care institution licensed under 9 A.A.C. 10, the licensee;
 - b. For a health care institution operated under federal or tribal laws, the administrative unit of the U.S. government or sovereign tribal nation operating the health care institution.
14. "Personnel member" means an individual providing medical services, nursing services, or health-related services, as defined in A.R.S. § 36-401, to a patient.
15. "Physician" means an individual licensed:
 - a. According to A.R.S. Title 32, Chapter 13 or 17; or
 - b. When working in a health care institution operating under federal or tribal law as an administrative unit of the U.S. government or a sovereign tribal nation, by a similar licensing board in another state.
16. "Signature" means:
 - a. A handwritten or stamped representation of an individual's name or a symbol intended to represent an individual's name, or
 - b. An "electronic signature" as defined in A.R.S. § 44-7002.
17. "Substantial compliance" has the same meaning as in A.R.S. § 36-401.
18. "Transport" means the conveyance of a patient by ground ambulance or air ambulance from one location to another location.
19. "Trauma care" means medical services and nursing services provided to a patient suffering from a sudden physical injury.
20. "Trauma center" has the same meaning as in A.R.S. § 36-2225.
21. "Trauma critical care course" means a multidisciplinary class or series of classes consisting of interactive tutorials, skills teaching, and simulated patient management scenarios of trauma care, consistent with training recognized by the American College of Surgeons.
22. "Trauma facility" means a health care institution that provides trauma care to a patient as an organized trauma service.
23. "Trauma service" means designated personnel members, equipment, and area within a health care institution and the associated policies and procedures for the personnel members to follow when providing trauma care to a patient.
24. "Trauma team" means a group of personnel members with defined roles and responsibilities in providing trauma care to a patient.
25. "Trauma team activation" means a notification to respond that is sent to trauma team personnel members in reaction to triage information received concerning a patient with injury or suspected injury.
26. "Verification" means formal confirmation by a national verification organization that a health care institution meets the national verification organization's standards for providing trauma care at a specific Level of trauma service.

Historical Note

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1302. Eligibility for Designation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

- A. A health care institution is eligible for designation as a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, Level II Pediatric trauma center, or Level III trauma center if the health care institution:
 1. Is either:
 - a. Licensed by the Department under 9 A.A.C. 10 to operate as a hospital; or
 - b. Operating as a hospital under federal or tribal law as an administrative unit of the U.S. government or a sovereign tribal nation; and
 2. For designation as a:
 - a. Level I trauma center:
 - i. Holds verification, issued within the six months before the date of designation, as a Level I trauma facility;
 - ii. Has documentation issued by a national verification organization, within the six months before the date of designation, stating that the health care institution meets the standards specified in R9-25-1308 and Table 13.1 for a Level I trauma center; or
 - iii. Meets the requirements in subsection (C);
 - b. Level I Pediatric trauma center:

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- i. Holds verification, issued within the six months before the date of designation, as a Level I Pediatric trauma facility;
 - ii. Has documentation issued by a national verification organization, within the six months before the date of designation, stating that the health care institution meets the standards specified in R9-25-1308 and Table 13.1 for a Level I Pediatric trauma center; or
 - iii. Meets the requirements in subsection (C);
 - c. Level II trauma center:
 - i. Holds verification, issued within the six months before the date of designation, as a Level II trauma facility; or
 - ii. Has documentation issued by a national verification organization, within the six months before the date of designation, stating that the health care institution meets the standards specified in R9-25-1308 and Table 13.1 for a Level II trauma center; or
 - iii. Meets the requirements in subsection (C);
 - d. Level II Pediatric trauma center:
 - i. Holds verification, issued within the six months before the date of designation, as a Level II Pediatric trauma facility;
 - ii. Has documentation issued by a national verification organization, within the six months before the date of designation, stating that the health care institution meets the standards specified in R9-25-1308 and Table 13.1 for a Level II Pediatric trauma center; or
 - iii. Meets the requirements in subsection (C); or
 - e. Level III trauma center:
 - i. Holds verification, issued within the six months before the date of designation, as a Level III trauma facility; or
 - ii. Has documentation issued by a national verification organization or the Department, within the six months before the date of designation, stating that the health care institution meets the standards specified in R9-25-1308 and Table 13.1 for a Level III trauma center.
- B. A health care institution is eligible for designation as a Level IV trauma center if the health care institution:
 - 1. Is either:
 - a. Licensed by the Department under 9 A.A.C. 10 to operate as:
 - i. A hospital; or
 - ii. An outpatient treatment center authorized to provide emergency room services, as defined in A.A.C. R9-10-1001, according to A.A.C. R9-10-1019; or
 - b. Operating as a hospital or an outpatient treatment center providing emergency services under federal or tribal law as an administrative unit of the U.S. government or a sovereign tribal nation; and
 - 2. Either:
 - a. Holds verification, issued within the six months before the date of designation, as a Level IV trauma facility; or
 - b. Has documentation issued by a national verification organization or the Department, within the six months before the date of designation, stating that the health care institution meets the standards specified in R9-25-1308 and Table 13.1 for a Level IV trauma center.
- C. A health care institution is eligible for designation as a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, or Level II Pediatric trauma center based on assessment by the Department that the health care institution meets the standards specified in R9-25-1308 and Table 13.1 for the
 - Level of trauma center for which designation is requested if the health care institution:
 - 1. Applies for verification from a national verification organization;
 - 2. Informs the Department, at least 30 calendar days before, of the dates the national verification organization will be on the premises of the health care institution to assess the health care institution for compliance with the national verification organization's standards for verification;
 - 3. Invites the Department to review the facility and documentation of capabilities of the health care institution during the national verification organization's assessment in subsection (C)(2);
 - 4. Is not issued verification from the national verification organization at the Level of designation sought;
 - 5. Does not receive the documentation required in subsection (A)(2)(a)(ii), (b)(ii), (c)(ii), or (d)(ii), as applicable; and
 - 6. Receives the documentation specified in R9-25-1306(G) and, if applicable, submits to the Department a written plan in R9-25-1306(H), acceptable to the Department, to correct instances of non-compliance.
- D. A health care institution is eligible to retain designation as a specific Level of trauma center if the health care institution complies with the applicable requirements in this Article for the specific Level of trauma center.

Historical Note

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1303. Application and Designation Process (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

- A. An owner applying for initial designation or to renew designation for a health care institution shall submit to the Department an application including:
 - 1. The following information, in a Department-provided format:
 - a. The name, address, and telephone number of the health care institution for which the owner is requesting designation;
 - b. The owner's name, address, e-mail address, telephone number, and, if available, fax number;
 - c. The name, e-mail address, telephone number, and, if available, fax number of the chief administrative officer, as defined in A.A.C. R9-10-101, for the health care institution for which the owner is requesting designation;
 - d. The designation Level for which the owner is applying;
 - e. Whether the owner is requesting designation for the health care institution based on:
 - i. Verification, or
 - ii. Meeting the applicable standards specified in R9-25-1308 and Table 13.1;
 - f. If the owner is requesting designation for the health care institution based on verification:
 - i. The name of the national verification organization;
 - ii. The name, telephone number, and e-mail address for a representative of the national verification organization;
 - iii. The Level of verification held;
 - iv. The effective date of the verification, and
 - v. The expiration date of the verification;
 - g. If the owner is requesting designation for the health care institution based on the health care institution meeting the applicable standards specified in R9-25-1308 and Table 13.1:

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- i. Whether:
 - (1) A national verification organization has assessed the health care institution, or
 - (2) The Department will be assessing the health care institution;
 - ii. If a national verification organization has assessed the health care institution:
 - (1) The name of the national verification organization;
 - (2) The name, telephone number, and e-mail address for a representative of the national verification organization; and
 - (3) The date the national verification organization assessed the health care institution; and
 - iii. If the Department will be assessing the health care institution, the date the health care institution will be ready for the Department to assess the health care institution;
 - h. Unless the owner is an administrative unit of the U.S. government or a sovereign tribal nation, the license number, issued by the Department, for the health care institution for which designation is being requested;
 - i. The name, e-mail address, telephone number, and, if available, fax number of the health care institution's trauma program manager;
 - j. Whether the health care institution's trauma registry will be located at the health care institution or be part of a centralized trauma registry;
 - k. The name, e-mail address, telephone number, and, if available, fax number of the health care institution's trauma registrar;
 - l. If applying for designation as a Level IV trauma center, whether the health care institution plans to submit, in addition to the information required in R9-25-1309(A), the information specified in R9-25-1309(B);
 - m. If not already submitting trauma registry information to the Department, the time period for which the health care institution plans to begin submitting trauma registry information;
 - n. Except for a health care institution applying for designation as a Level IV trauma center, the name, e-mail address, telephone number, and, if available, fax number of the health care institution's trauma medical director;
 - o. The name, title, address, and telephone number of the owner's statutory agent or the individual designated by the owner to accept service of process and subpoenas;
 - p. Attestation that:
 - i. The owner will comply with all applicable requirements in A.R.S. Title 36, Chapter 21.1 and this Article; and
 - ii. The information and documents provided as part of the application are accurate and complete; and
 - q. The dated signature of the applicable individual according to R9-25-102;
 2. If applicable, documentation demonstrating that the health care institution is operating as a hospital or an outpatient treatment center providing emergency services under federal or tribal law as an administrative unit of the U.S. government or a sovereign tribal nation; and
 3. One of the following:
 - a. Documentation from the national verification organization, identified according to subsection (A)(1)(f)(i), establishing that the owner holds verification for the health care institution at the Level of designation being requested and showing the effective date and expiration date of the verification;
 - b. Documentation from the national verification organization, identified according to subsection (A)(1)(g)(ii)(1), demonstrating that the health care institution meets the applicable standards specified in R9-25-1308 and Table 13.1; or
 - c. The information and documents required in R9-25-1307(C), (D), or (F), as applicable.
- B.** An owner applying to renew designation for a health care institution shall submit the application in subsection (A) to the Department at least 60 calendar days and no more than 90 calendar days before the expiration of the current designation.
- C.** Within 30 calendar days after receiving an application submitted according to subsection (A), the Department shall review the application submitted for completeness, and, if the application is:
1. Incomplete, provide to the owner a written notice listing each missing item and the information or items needed to complete the application; and
 2. Complete and based on:
 - a. Verification, comply with R9-25-1307(A);
 - b. A national verification organization assessing the health care institution's meeting the applicable standards specified in R9-25-1308 and Table 13.1, comply with R9-25-1307(B); or
 - c. The Department assessing the health care institution's meeting the applicable standards specified in R9-25-1308 and Table 13.1, assess compliance with applicable requirements in A.R.S. Title 36, Chapter 21.1 and this Article according to R9-25-1307(E) or (G).
- D.** The Department shall consider an application withdrawn if an owner:
1. Fails to submit to the Department all of the information or items listed in a notice of missing items within 60 calendar days after the date on the notice of missing items, unless the Department and the owner agree to an extension of this time; or
 2. Submits a written request withdrawing the application.
- E.** If an owner submits an application for renewal of designation for a health care institution according to subsection (A) before the expiration date of the current designation, the designation of the health care institution remains in effect until the:
1. Department has determined whether or not to issue a renewal of the designation, or
 2. Application is withdrawn.

Historical Note

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section expired under A.R.S. 41-1056(E) at 18 A.A.R. 2153, effective June 30, 2012 (Supp. 12-3). New Section R9-25-1303 renumbered from R9-25-1304 and amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1303.01. Expired**Historical Note**

New Section made by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3). Section expired under A.R.S. 41-1056(J) at 29 A.A.R. 421 (January 27, 2023), with an immediate effective date of January 4, 2023 (Supp. 23-1).

R9-25-1304. Changes Affecting Designation Status (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

- A.** An owner of a trauma center shall:

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1. Notify the Department, in writing or in a Department-provided format, no later than 60 calendar days after the date of a change in the health care institution's:
 - a. Name,
 - b. Trauma program manager, or
 - c. If applicable, trauma medical director; and
 2. Provide the effective date of the change and, as applicable, the:
 - a. Current and new name of the health care institution, or
 - b. Name of the new trauma program manager or trauma medical director.
- B.** An owner of a trauma center shall notify the Department in writing within three business days after:
1. The trauma center's health care institution license expires or is suspended or revoked;
 2. The trauma center's health care institution license is changed to a provisional license under A.R.S. § 36-425;
 3. The trauma center no longer holds verification; or
 4. A change, which is expected to last for more than seven consecutive calendar days, in the trauma center's ability to meet:
 - a. The applicable standards specified in R9-25-1308 and Table 13.1, or
 - b. If designation is based on verification, the national verification organization's standards for verification.
- C.** At least 90 calendar days before a trauma center ceases to provide a trauma service, the owner of the trauma center shall notify the Department, in writing or in a Department-provided format, of the owner's intention to cease providing the trauma service and to relinquish designation, including the effective date.
- D.** The Department shall, upon receiving a notice described in:
1. Subsection (A), issue an amended designation that incorporates the name change but retains the expiration date of the current designation;
 2. Subsection (B)(1), send the owner a written notice stating that the health care institution no longer meets the definition of a trauma center and that the Department intends to dedesignate the health care institution, according to R9-25-1307(J)(2);
 3. Subsection (B)(2), evaluate the restrictions on the provisional license to determine if the trauma service was affected and may send the owner a written notice of the Department's intention to:
 - a. Dedesignate the health care institution, according to R9-25-1307(J) through (M);
 - b. Require a modification of the health care institution's designation within 15 calendar days after the date of the notice, according to R9-25-1305; or
 - c. Require a corrective action plan to address issues of compliance with the applicable standards specified in R9-25-1308 and Table 13.1, according to R9-25-1306(E);
 4. Subsection (B)(3), send the owner written notice that the owner is required, within 15 calendar days after the date of the notice, to submit to the Department:
 - a. An application for designation at a specific Level of trauma center, according to R9-25-1303, based on meeting the applicable standards specified in R9-25-1308 and Table 13.1; or
 - b. Written notification of the owner's intention to relinquish designation;
 5. Subsection (B)(4), send the owner written notice that the owner is required, within 15 calendar days after the date of the notice, to submit to the Department:
 - a. An application for modification of the health care institution's designation, according to R9-25-1305;
 - b. A corrective action plan to address issues of compliance with the applicable standards specified in R9-25-1308 and Table 13.1, according to R9-25-1306(E); or
 - c. Written notification of the owner's intention to relinquish designation; or
- E.** An owner of a trauma center, who obtains verification for the trauma center during a term of designation that was based on the trauma center meeting the applicable standards specified in R9-25-1308 and Table 13.1, may obtain a new initial designation based on verification, with a designation term based on the dates of the verification, by submitting an application according to R9-25-1303.

Historical Note

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1304 renumbered to R9-25-1303; new Section R9-25-1304 renumbered from R9-25-1308 and amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1305. Modification of Designation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

- A.** Except as provided in R9-25-1304(D)(3)(b) and (5)(a), at least 30 calendar days before ceasing to provide a trauma service consistent with a trauma center's current designation, an owner of a trauma center may request a designation that requires fewer resources and capabilities than the trauma center's current designation by submitting to the Department an application for modification of the trauma center's designation, in a Department-provided format, that includes:
1. The name and address of the trauma center for which the owner is requesting modification of designation;
 2. A list of the criteria for the current designation with which the owner no longer intends to comply;
 3. An explanation of the changes being made in the trauma center's resources or operations, related to each criterion specified according to subsection (A)(2), to ensure the health and safety of a patient;
 4. The Level of designation being requested;
 5. An attestation that:
 - a. The owner will be in compliance with all applicable requirements in A.R.S. Title 36, Chapter 21.1 and this Article for the Level of designation requested if modified designation is issued; and
 - b. The information provided in the application is accurate and complete; and
 6. The dated signature of the applicable individual according to R9-25-102.
- B.** The Department shall review the application submitted according to R9-25-1307(I) to determine whether, with the changes being made in the trauma center's resources and operations, the trauma center will be in substantial compliance based the applicable standards specified in R9-25-1308 and Table 13.1 for the Level of designation requested.
- C.** To retain trauma center designation for a health care institution, an owner who holds modified designation shall, before the expiration date of the modified designation:
1. Apply for renewal of designation according to R9-25-1303, based on the health care institution's meeting the applicable standards specified in R9-25-1308 and Table 13.1, for the Level of the modified designation; or
 2. Apply for initial designation according to R9-25-1303, based on the health care institution meeting the applicable standards specified in R9-25-1308 and Table 13.1, for a Level other than the Level of the modified designation.

Historical Note

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New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1305 repealed; new Section R9-25-1305 renumbered from R9-25-1309 and amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1306. Inspections (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

- A.** When the Department inspects a health care institution applying for a trauma center designation or a health care institution designated as a trauma center to determine compliance with the applicable requirements in this Article, the Department:
1. Shall use criteria for assessing compliance developed using recommendations from the State Trauma Advisory Board, according to A.R.S. § 36-2222(E)(1); and
 2. May:
 - a. Evaluate the health care institution's equipment and physical plant;
 - b. Interview the health care institution's personnel members, including any individuals providing trauma care; and
 - c. Review any of the following:
 - i. Medical records;
 - ii. Patient discharge summaries;
 - iii. Patient care logs;
 - iv. Rosters and schedules of personnel members and individuals who provide trauma care as part of the trauma service;
 - v. Performance-improvement-related documents, including quality management program documents required in A.A.C. R9-10-204 or R9-10-1004 as applicable; and
 - vi. Other documents relevant to the provision of trauma care as part of the trauma service.
- B.** The Department shall determine whether there is a need for an inspection of a health care institution and which components in subsection (A)(2) to include in an inspection, based on the health care institution's application; previous inspections, if applicable; and the operating history of the health care institution and may conduct an announced inspection of the identified components:
1. Before issuing an initial, renewal, or modified designation to an owner applying for designation of a health care institution as a trauma center;
 2. If an owner of a health care institution designated as a trauma center has submitted a corrective action plan under subsection (E); or
 3. A health care institution designated as a trauma center is randomly selected to receive an inspection.
- C.** If the Department has reason to believe that a trauma center is not complying with applicable requirements in A.R.S. Title 36, Chapter 21.1 and this Article, the Department may conduct an announced or unannounced inspection of the trauma center according to subsection (A).
- D.** Within 30 calendar days after completing an inspection, the Department shall send to an owner a written report of the Department's findings, including, if applicable, a list of any instances of non-compliance identified during the inspection and a request for a written corrective action plan.
- E.** Within 15 calendar days after receiving a request for a written corrective action plan, an owner shall submit to the Department a written corrective action plan that includes for each identified instance of non-compliance:
1. A description of how the instance of non-compliance will be corrected and reoccurrence prevented, and
 2. A date of correction for the instance of non-compliance.
- F.** The Department shall accept a written corrective action plan if the corrective action plan:
1. Describes how each identified instance of non-compliance will be corrected and reoccurrence prevented, and

2. Includes a date for correcting each instance of non-compliance that is appropriate to the actions necessary to correct the instance of non-compliance.
- G.** If the Department reviews a health care institution's facility and documentation of capabilities during a national verification organization's assessment according to R9-25-1302(C)(3) and the health care institution is not issued verification from the national verification organization at the Level of designation sought, the Department shall send to an owner of the health care institution, within 30 calendar days after the review, a written report of the Department's findings, including, if applicable, a list of any instances of non-compliance with requirements in R9-25-1308 and Table 13.1 identified during the review.
- H.** A health care institution receiving a written report in subsection (G) containing a list of instances of non-compliance with requirements in R9-25-1308 and Table 13.1 identified during a review of the health care institution's facility and documentation of capabilities may submit to the Department a written plan to correct instances of non-compliance that includes:
1. A description of how the health care institution will correct each instance of non-compliance and prevent the reoccurrence, and
 2. A date by which the health care institution plans to correct each instance of non-compliance.

Historical Note

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1306 repealed; new Section R9-25-1306 made by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1307. Designation and Designation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

- A.** For designation of a health care institution based on verification, the Department shall, within 45 calendar days after receiving a complete application from an owner:
1. If the application complies with the applicable requirements in this Article, issue a designation for the health care institution that is valid for the duration of the verification; or
 2. If the application does not comply with the applicable requirements in this Article, provide a written notice that complies with A.R.S. Title 41, Chapter 6, Article 10 that the Department intends to decline to issue a designation for the health care institution.
- B.** Except as provided in subsection (F), for designation of a health care institution based on an assessment by a national verification organization, the Department shall, within 60 calendar days after receiving a complete application from an owner, review the application and, if the Department determines that:
1. The application and the health care institution comply with the applicable requirements in this Article, issue a designation for the health care institution that is valid for three years from the issue date;
 2. The application complies with the applicable requirements in this Article, the health care institution is in substantial compliance with the applicable requirements in this Article, and the Department has accepted a written corrective action plan submitted according to R9-25-1306(E), issue a designation for the health care institution that is valid for one year from the issue date; or
 3. The application or the health care institution does not comply with the applicable requirements in this Article, provide a written notice that complies with A.R.S. Title 41, Chapter 6, Article 10 that the Department intends to decline to issue a designation for the health care institution.

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- C. Except as provided in subsection (F) for renewal of a one-year designation, for designation of a health care institution as a Level III trauma center or a Level IV trauma center based on an assessment by the Department, an owner shall include as part of the application required in R9-25-1303(A):
1. The following information in a Department-provided format:
 - a. The name of the health care institution for which the owner is requesting designation;
 - b. The services the health care institution is providing or plans to provide as part of the trauma service;
 - c. The name and title of the liaison to the trauma service from each of the services listed according to subsection (C)(1)(b);
 - d. If applicable, the name, e-mail address, telephone number, and, if available, fax number of the health care institution's emergency department physician director;
 - e. If applicable, the name, e-mail address, telephone number, and, if available, fax number of the health care institution's surgical director or co-director;
 - f. If a multidisciplinary peer review committee is required according to Table 13.1 for the Level of the trauma center, the name and title of each member of the multidisciplinary peer review committee;
 - g. If the health care institution's trauma registry will be part of a centralized trauma registry, a description of the training provided to the trauma program manager to enable the trauma program manager to comply with R9-25-1308(D)(2);
 - h. If applicable, for an application for initial designation, a description of the health care institution's plans for the continuing education activities related to trauma care, required in R9-25-1308(G)(4);
 - i. For renewal of designation, a description of the continuing education activities conducted during the term of the designation;
 - j. If applicable, the name, e-mail address, telephone number, and, if available, fax number of the health care institution's injury prevention coordinator;
 - k. A description of the methods by which trauma team personnel members communicate with EMS personnel;
 - l. A description of the trauma-related training received by registered nurses in the intensive care unit;
 - m. An attestation that the owner of the health care institution will prohibit:
 - i. The trauma medical director from serving as trauma medical director for another health care institution; and
 - ii. A physician on-call for general surgery, neurosurgery, or orthopedic surgery to be on-call or on a back-up call list at another health care institution; and
 - n. The dated signature of the applicable individual according to R9-25-102;
 2. A copy of the policies and procedures required in R9-25-1308(B)(6) for the health care institution's trauma registry;
 3. A copy of the policies and procedures required in R9-25-1308(B)(7) for the health care institution's performance improvement program;
 4. A copy of the policies and procedures required in R9-25-1308(F)(2) for the health care institution's trauma service;
 5. If applicable, a copy of the policies and procedures required in R9-25-1308(F)(9) for operating rooms;
 6. A copy of the applicable policies and procedures required in R9-25-1308(H)(4);
 7. A copy of the health care institution's clinical practice guidelines, describing the health care institution's capability to resuscitate, stabilize, and transfer pediatric patients;
 8. If applicable, a copy of the bylaws of the health care institution's multidisciplinary peer review committee;
 9. Copies of the job descriptions for the health care institution's:
 - a. Trauma program manager;
 - b. Trauma registrar; and
 - c. If applicable, injury prevention coordinator;
 10. A list of the trauma care parameters the health care institution is or will be monitoring as part of the performance improvement program;
 11. A list of trauma team members, including:
 - a. Name,
 - b. Title, and
 - c. Role on the trauma team;
 12. If required for an individual listed according to subsection (C)(11), a copy of documentation of the individual's:
 - a. Board certification or board eligibility,
 - b. Most recent certification in a trauma critical care course,
 - c. Pediatric-specific credentials, and
 - d. Other trauma-related training; and
 13. If the trauma medical director is not a member of the trauma team, the applicable documentation required in subsection (C)(12) for the trauma medical director.
- D. Except as provided in subsection (F) for renewal of a one-year designation, for designation of a health care institution as a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, or Level II Pediatric trauma center based on an assessment by the Department under R9-25-1302(C), an owner shall include as part of the application required in R9-25-1303(A):
1. A copy of the documentation submitted to the national verification organization as part of an application for verification;
 2. If not included in the documentation in subsection (D)(1):
 - a. Any information or documents required in subsection (C);
 - b. For an application for initial designation, a description of the health care institution's plans for:
 - i. Injury prevention activities, required in R9-25-1308(G)(5)(a); and
 - ii. Educational outreach activities, required in R9-25-1308(G)(5)(b); and
 - c. For an application for renewal of designation, a description of the injury prevention activities and educational outreach activities conducted during the term of the designation;
 3. A copy of the national verification's organization's written report to the health care institution describing the results of the national verification organization's assessment of the health care organization;
 4. A copy of the written report in R9-25-1306(G); and
 5. If applicable, the written plan to correct instances of non-compliance in R9-25-1306(H).
- E. Except as provided in subsection (G) for renewal of a one-year designation, for designation of a health care institution based on an assessment by the Department, the Department shall, within 90 calendar days after receiving a complete application from an owner, review the application, inspect the health care institution, if applicable, and, if the Department determines that:
1. The application and the health care institution comply with the applicable requirements in this Article, issue a designation for the health care institution that is valid for three years from the issue date;
 2. The application complies with the applicable requirements in this Article, the health care institution is in substantial compliance with the applicable requirements in this Article, and the Department has accepted the docu-

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ment submitted according to R9-25-1306(E) or subsection (D)(5), issue a designation for the health care institution that is valid for one year from the issue date; or

3. The application or the health care institution does not comply with the applicable requirements in this Article, provide a written notice that complies with A.R.S. Title 41, Chapter 6, Article 10 that the Department intends to decline to issue a designation for the health care institution.
- F. For renewal, at the same Level of trauma center, of a one-year designation issued according to subsection (B)(2) or (E)(2), an owner shall include, as part of the application required in R9-25-1303(A), documentation related to the completion of the plan specified in the document accepted by the Department in subsection (B)(2) or (E)(2).
- G. Except as specified in subsection (H), the Department shall, within 60 calendar days after receiving from an owner an application submitted according to subsection (F), review the information and documentation, inspect the health care institution if applicable, and:
 1. Issue a designation for the health care institution that is valid for two years from the issue date if the Department determines that:
 - a. The application and the health care institution comply with the applicable requirements in this Article; and
 - b. The owner has completed the plan specified in the document accepted by the Department in subsection (B)(2) or (E)(2), as applicable; or
 2. Provide a written notice that complies with A.R.S. Title 41, Chapter 6, Article 10 that the Department intends to decline to issue a designation for the health care institution if the Department determines that:
 - a. The application or the health care institution do not comply with the applicable requirements in this Article; or
 - b. The owner has not completed all of the components of the plan specified in the document accepted by the Department in subsection (B)(2) or (E)(2), as applicable.
- H. The Department shall review according to R9-25-1303(C) and subsection (A), (B), or (E), as applicable, an application for renewal of designation submitted by the owner of a trauma center that:
 1. Had been issued a one-year designation according to subsection (B)(2) or (E)(2); and
 2. Has not completed all of the components of the plan specified in the document accepted by the Department in subsection (B)(2) or (E)(2), as applicable.
- I. For modification of a designation according to R9-25-1305, the Department shall, within 30 calendar days after receiving a complete application for modification in R9-25-1305(A) from an owner, review the application, inspect the health care institution, if applicable, and:
 1. Issue a modified designation for the Level of designation requested for the health care institution that is valid for the duration of the original designation or one year from the issue date, whichever is longer, if the Department determines that:
 - a. The application and the health care institution comply with the applicable requirements in this Article for the Level of designation requested; or
 - b. The application complies with the applicable requirements in this Article, the health care institution is in substantial compliance with the applicable requirements in this Article for the Level of designation requested, and the Department has accepted a written corrective action plan submitted according to R9-25-1306(E);
 2. Issue a modified designation for a lower Level of designation than the Level of designation requested for the health care institution that is valid for the duration of the original designation or one year from the issue date, whichever is longer, if the Department determines that:
 - a. The application and the health care institution comply with the applicable requirements in this Article for the lower Level of designation and the health care institution:
 - i. Does not comply with the applicable requirements in this Article for the Level of designation requested; or
 - ii. Is in substantial compliance with the applicable requirements in this Article for the Level of designation requested, and the Department has not accepted a written corrective action plan submitted according to R9-25-1306(E); or
 - b. The application complies with the applicable requirements in this Article, the health care institution is in substantial compliance with the applicable requirements in this Article for the lower Level of designation, and the Department has accepted a written corrective action plan according to R9-25-1306(E); or
 3. Provide a written notice that complies with A.R.S. Title 41, Chapter 6, Article 10 that the Department intends to decline to issue a modified designation for the health care institution if the Department determines that the application or the health care institution does not comply with the applicable requirements in this Article.
- J. The Department may dedesignate a health care institution as a trauma center if an owner:
 1. Has provided false or misleading information to the Department;
 2. Is not eligible for designation under R9-25-1302(A) or (B); or
 3. Fails to comply with an applicable requirement in A.R.S. Title 36, Chapter 21.1 or this Article.
- K. In determining whether to dedesignate a health care institution as a trauma center, the Department shall consider:
 1. The severity of each instance relative to public health and safety;
 2. The number of instances;
 3. The nature and circumstances of each instance;
 4. Whether each instance was corrected, the manner of correction, and the duration of the instance; and
 5. Whether the instances indicate a lack of commitment to having the trauma center meet the verification standards of a national verification organization or, if applicable, the standards specified in R9-25-1308 and Table 13.1.
- L. If the Department intends to dedesignate a health care institution, the Department shall send to the owner a written notice that complies with A.R.S. Title 41, Chapter 6, Article 10.
- M. An owner who receives a written notice in subsection (A)(2), (B)(3), (E)(3), (G)(2), (I)(3), or (J) may file a written notice of appeal with the Department that complies with A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1307 repealed; new Section R9-25-1307 renumbered from R9-25-1312 and amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1308. Trauma Center Responsibilities (A.R.S. §§ 36-2202(A)(4), 36-2208(A), 36-2209(A)(2), 36-2221, and 36-2225(A)(4), (5), and (6))

- A. The owner of a trauma center shall ensure that:
 1. If designation is based on:
 - a. Verification, the trauma center meets the applicable standards of the verifying national verification organization; or

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- b. Meeting the applicable standards specified in this Section and Table 13.1, the trauma center meets the applicable standards for the Level of trauma center for which designation has been issued;
 - 2. The trauma center complies with a written corrective action plan accepted by the Department according to R9-25-1306(F); and
 - 3. The Department has access to:
 - a. The trauma center and to personnel members present in the trauma center; and
 - b. Documents that are requested by the Department and not confidential under A.R.S. Title 36, Chapter 4, Article 4 or 5, within two hours after the Department's request.
- B. The owner of a trauma center shall ensure that the trauma center:
 - 1. Except as provided in subsection (D), establishes a trauma registry of patients receiving trauma care who meet the criteria specified in subsection (C)(1) that contains the information required in R9-25-1309, as applicable for the specific Level of the trauma center;
 - 2. Appoint an individual to act as trauma registrar to coordinate trauma registry activities;
 - 3. If necessary to comply with subsections (C)(2) and (3), provides sufficient additional individuals to assist with trauma registry activities;
 - 4. Establishes a performance improvement program for the trauma service to develop and implement processes to improve trauma care parameters;
 - 5. If required according to Table 13.1 for the Level of the trauma center, establishes as part of the performance improvement program, established according to subsection (B)(4), a multidisciplinary peer review committee to review the quality of trauma care provided by the trauma center, including information from the trauma registry, and suggest methods to improve the quality of trauma care;
 - 6. Establishes, documents, and implements policies and procedures for the trauma registry established according to subsection (B)(1) that include:
 - a. Ensuring that individuals responsible for collecting, entering, or reviewing information in the trauma registry have received training in gaining access to, and retrieving information from, the trauma registry;
 - b. Collection of the information required in R9-25-1309 about the patients specified in subsection (C)(1) receiving trauma care;
 - c. Submission to the Department of the information required in subsection (C)(2);
 - d. Review of information in the trauma center's trauma registry; and
 - e. Performance improvement activities required in R9-25-1310; and
 - 7. Establishes, documents, and implements policies and procedures for the performance improvement program established according to subsection (B)(4), including:
 - a. A list of the positions of personnel members who have defined roles in the performance improvement program and, if applicable, a list of positions that are dedicated to performance improvement activities for patients receiving trauma care from the trauma center;
 - b. The qualifications, skills, and knowledge required of the personnel members in the positions specified according to subsection (B)(6)(a);
 - c. The role each personnel member specified according to subsection (B)(6)(a) plays in the performance improvement program;
 - d. The trauma care parameters to be reviewed as part of the performance improvement program;
 - e. The frequency of review of trauma care parameters;
- f. If an issue related to trauma care or to trauma care parameters is identified:
 - i. How a plan to address the issue is developed to reduce the chance of the issue recurring in the future;
 - ii. How the plan is documented;
 - iii. The mechanism and criteria by which the plan is reviewed and approved;
 - iv. How the plan is implemented; and
 - v. How implementation of the plan and future recurrences are monitored;
 - g. If applicable, the composition, duties, responsibilities, and frequency of meetings of the multidisciplinary peer review committee established according to subsection (B)(5);
 - h. If applicable, how the multidisciplinary peer review committee collaborates with the trauma center's quality management program; and
 - i. How changes proposed by the performance improvement program are reviewed by the trauma center's quality management program.
- C. The owner of a trauma center shall ensure that:
 - 1. The trauma registry, established according to subsection (B)(1), includes the information required in R9-25-1309 for each patient with whom the trauma center had contact who meets one or more of the following criteria:
 - a. A patient with injury or suspected injury who is:
 - i. Transported from a scene to a trauma center or an emergency department based on the responding emergency medical services provider's or ambulance service's triage protocol required in R9-25-201(E)(2)(b), or
 - ii. Transferred from one health care institution to another health care institution by an emergency medical services provider or ambulance service;
 - b. A patient with injury or suspected injury for whom a trauma team activation occurs; or
 - c. A patient with injury, who is admitted as a result of the injury or who dies as a result of the injury, and whose medical record includes one or more of specific ICD-codes indicating that:
 - i. At the initial encounter with the patient, the patient had:
 - (1) An injury or injuries to specific body parts,
 - (2) Unspecified multiple injuries,
 - (3) Injury of an unspecified body region,
 - (4) A burn or burns to specific body parts,
 - (5) Burns assessed through Total Body Surface Area percentages, or
 - (6) Traumatic Compartment Syndrome; and
 - ii. The patient's injuries or burns were not only:
 - (1) An isolated distal extremity fracture from a same-level fall,
 - (2) An isolated femoral neck fracture from a same-level fall,
 - (3) Effects resulting from an injury or burn that developed after the initial encounter,
 - (4) A superficial injury or contusion, or
 - (5) A foreign body entering through an orifice;
 - 2. The following information is submitted to the Department, in a Department-provided format, according to subsection (C)(3):
 - a. The name and physical address of the trauma center;
 - b. The date the trauma registry information is being submitted to the Department;
 - c. The total number of patients whose trauma registry information is being submitted;

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- d. The quarter and year for which the trauma registry information is being submitted;
 - e. The range of emergency department or hospital arrival dates for the patients for whom trauma registry information is being submitted;
 - f. The name, title, e-mail address, telephone number, and, if available, fax number of the trauma center's point of contact for the trauma registry information;
 - g. Any special instructions or comments to the Department from the trauma center's point of contact;
 - h. The information from the trauma registry for patients identified during the quarter specified according to subsection (C)(2)(d); and
 - i. Updated information for any patients identified during the previous quarter, including the patient's name, medical record number, and admission date; and
3. The information required in subsection (C)(2) is submitted:
- a. For patients identified between January 1 and March 31, so that the information in subsections (C)(2)(a) through (h) is received by the Department by July 1 of the same calendar year;
 - b. For patients identified between April 1 and June 30, so that the information in subsections (C)(2)(a) through (h) is received by the Department by October 1 of the same calendar year;
 - c. For patients identified between July 1 and September 30, so that the information in subsections (C)(2)(a) through (h) is received by the Department by January 2 of the following calendar year; and
 - d. For patients identified between October 1 and December 31, so that the information in subsections (C)(2)(a) through (h) is received by the Department by April 1 of the following calendar year.
- D.** Trauma centers under the same governing authority, as defined in A.R.S. § 36-401, may establish a single, centralized trauma registry and submit to the Department consolidated information from the trauma registry, according to subsections (C)(2) and (3), if:
- 1. The information submitted to the Department specifies for each patient in the trauma registry the trauma center that had contact with the patient, and
 - 2. Each trauma center contributing information to the centralized trauma registry is able to:
 - a. Access, edit, and update the information contributed by the trauma center to the centralized trauma registry; and
 - b. Use the information contributed by the trauma center to the centralized trauma registry when complying with performance improvement program requirements in this Section.
- E.** As part of the performance improvement program, the owner of a trauma center shall ensure that the trauma program manager and, if applicable, trauma medical director periodically, according to policies and procedures:
- 1. Review the information in the trauma center's trauma registry; and
 - 2. Monitor at least the following trauma care parameters, as applicable, for patients in the trauma registry:
 - a. EMS received by a patient;
 - b. Length of stay longer than two hours in the emergency department before transfer;
 - c. Instances of trauma team activation to determine if trauma team activation was timely and appropriate;
 - d. Instances where trauma care was provided to a patient but trauma team activation did not occur;
 - e. Time from notification of a surgeon on the trauma team that a patient described in subsection (H)(6)(b)(i) is in the emergency department to when the surgeon arrives in the emergency department;
 - f. Documentation of the nursing services provided to a patient;
 - g. Instances and reasons for transfer of a patient;
 - h. Instances and reasons for transfer to a hospital not designated as a trauma center;
 - i. For a hospital designated as a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, or Level II Pediatric trauma center, instances and reasons for diversion, as defined in A.A.C. R9-10-201, of a patient requiring trauma care;
 - j. Instances of and circumstances related to the death of a patient;
 - k. Other patient outcomes;
 - l. Trauma care parameters for pediatric patients, including pediatric-specific measures; and
 - m. The completeness and timeliness of trauma data submission.
- F.** In addition to the requirements in subsections (A) through (E), the owner of a trauma center designated based on meeting the applicable standards specified in this Section and Table 13.1 shall:
- 1. Ensure that a trauma service is established if required by Table 13.1;
 - 2. Ensure that policies and procedures for the trauma service are established, documented, and implemented that include:
 - a. The composition of the trauma team;
 - b. The qualifications, skills, and knowledge required of each personnel member of the trauma team;
 - c. Continuing education or continuing medical education requirements for each personnel member of the trauma team;
 - d. The roles and responsibilities of each personnel member of the trauma team;
 - e. Under what circumstances the trauma team is activated; and
 - f. How the trauma team is activated;
 - 3. Ensure that the personnel members on the trauma team have the qualifications, skills, and knowledge required in the policies and procedures;
 - 4. If the trauma center is required according to Table 13.1 to have a trauma medical director, appoint a board-certified or board-eligible surgeon as trauma medical director;
 - 5. Prohibit a physician from serving as trauma medical director for the trauma center if the physician is serving as trauma medical director for another health care institution;
 - 6. Ensure that the trauma medical director completes:
 - a. If the trauma center's designation is for a three-year period, at least 48 hours of external trauma-related continuing medical education during the term of the designation;
 - b. If the trauma center's designation is for a one-year period, at least 16 hours of external trauma-related continuing medical education during the term of the designation; and
 - c. If the trauma center is designated as a Level I Pediatric trauma center or Level II Pediatric trauma center, at least 12 of the 48 hours required in subsection (F)(6)(a) or four of the 16 hours required in subsection (F)(6)(b) in pediatric trauma-related continuing medical education;
 - 7. Appoint an individual to act as trauma program manager to coordinate trauma service activities;
 - 8. If the trauma center is required by Table 13.1 to have a multidisciplinary peer review committee, ensure that each surgeon on the trauma team designated according to subsection (F)(3) attends at least 50% of the meetings of the multidisciplinary peer review committee;
 - 9. If the trauma center provides surgical services, ensure that policies and procedures for operating rooms and an

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operating room team are established, documented, and implemented that include:

- a. The availability of an operating room for trauma care;
 - b. The composition of an operating room team;
 - c. The qualifications, skills, and knowledge required of each personnel member of an operating room team;
 - d. The roles and responsibilities of each personnel member of an operating room team;
 - e. If an operating room team is not on the premises of the health care institution 24 hours a day, under what circumstances the operating room team is notified to come to the trauma center; and
 - f. How the operating room team is notified;
10. Ensure that the following personnel members on the trauma team:
 - a. Hold current certification in a trauma critical care course:
 - i. Trauma medical director, if applicable;
 - ii. Each emergency medicine physician who is not board-certified or board-eligible; and
 - iii. Each physician assistant or registered nurse practitioner who is responsible for patients in an emergency department in the absence of an emergency physician; or
 - b. Have held certification in a trauma critical care course:
 - i. Each general surgeon other than the trauma medical director, and
 - ii. Each emergency medicine physician who is board-certified or board-eligible;
 11. If the trauma center is designated as a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, or Level II Pediatric trauma center, ensure that each of the trauma team personnel members required in Table 13.1(C)(2) and (C)(3)(a) through (f) are board-certified or board-eligible;
 12. If the trauma center is designated as a Level I Pediatric trauma center, ensure that the following trauma team members are fellowship-trained:
 - a. The surgeon credentialed for pediatric trauma care required in Table 13.1(C)(2)(a)(iii),
 - b. The pediatric emergency medicine physician required in Table 13.1(C)(2)(c),
 - c. The pediatric-credentialed orthopedic surgeon required in Table 13.1(C)(3)(b),
 - d. The pediatric-credentialed neurosurgeon required in Table 13.1(C)(3)(d), and
 - e. The pediatric-credentialed critical care medicine physician required in Table 13.1(C)(3)(f);
 13. If the trauma center is designated as a Level II Pediatric trauma center, ensure that:
 - a. The pediatric-credentialed critical care medicine physician required in Table 13.1(C)(3)(f) is fellowship-trained, and
 - b. A fellowship-trained pediatric emergency medicine physician provides supervision for pediatric emergency trauma care and is appointed as a liaison to the multidisciplinary peer review committee established according to subsection (B)(5); and
 14. If the trauma center is not designated as a Level I Pediatric trauma center or Level II Pediatric trauma center and annually provides trauma care to 100 or more injured children younger than 15 years of age, ensure that the trauma center:
 - a. Complies with subsection (F)(13) and Table 13.1(C)(2)(a)(iii), (3)(b), (3)(d), and (3)(f) and (F)(2); and
 - b. Has a:
 - i. Pediatric emergency department area,
 - ii. Pediatric intensive care area, and
 - iii. Pediatric-specific trauma performance improvement program.
- G. In addition to the requirements in subsections (A) through (E), the owner of a trauma center designated based on meeting the applicable standards specified in this Section and Table 13.1 shall ensure that the trauma center:
 1. Establishes, documents, and implements a patient transfer plan, consistent with A.A.C. R9-10-211, that include:
 - a. The criteria for transferring a patient,
 - b. The health care institution to which a patient meeting specific criteria will be transferred,
 - c. The personnel members who are responsible for coordinating the transfer of a patient, and
 - d. The process for transferring a patient;
 2. Participates in state, local, or regional trauma-related activities such as:
 - a. The State Trauma Advisory Board, established by A.R.S. § 36-2222;
 - b. A regional emergency medical services coordinating council described in A.R.S. § 36-2222(A)(3);
 - c. Trauma Registry Users Group, established by the Department;
 - d. Trauma Managers Workgroup, established by the Department; or
 - e. Injury Prevention Council;
 3. Participates in injury prevention programs specific to the trauma center's patient population at the national, regional, state, or local levels;
 4. Except for a Level IV trauma center, conducts trauma care continuing education activities for physicians, trauma center personnel members, and EMCTs;
 5. If the trauma center holds a designation as a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, or Level II Pediatric trauma center, establishes and maintains:
 - a. An injury prevention program:
 - i. Independently or in collaboration with other health care institutions, health advocacy groups, or the Department; and
 - ii. That includes:
 - (1) Designating a prevention coordinator who serves as the trauma center's representative for injury prevention and injury control activities;
 - (2) Carrying out injury prevention and injury control activities, including activities specific to the patient population;
 - (3) Conducting injury control studies;
 - (4) Monitoring the progress and effect of the injury prevention program; and
 - (5) Providing injury prevention and injury control information resources for the public; and
 - b. An educational outreach program:
 - i. Independently or in collaboration with other health care institutions, health advocacy groups, or the Department;
 - ii. That includes providing education to physicians, trauma center personnel members, EMCTs, and the general public; and
 - iii. That may include education about:
 - (1) Injury prevention,
 - (2) Trauma care,
 - (3) Other topics specific to the patient population,
 - (4) Criteria for assessing a patient who may require trauma care,
 - (5) Criteria for the transfer of a patient requiring trauma care; and
 6. If the trauma center holds a designation as a Level I trauma center or Level I Pediatric trauma center:

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- a. Establishes and maintains, either independently or in collaboration with other hospitals, a residency program or fellowship program that provides advanced medical training in emergency medicine, general surgery, orthopedic surgery, or neurosurgery;
 - b. Participates in the provision of a trauma critical care course;
 - c. Conducts or participates in research related to trauma and trauma care; and
 - d. Maintains an Institutional Review Board, established consistent with 45 CFR Part 46, to review biomedical and behavioral research related to trauma and trauma care involving human subjects, conducted, funded, or sponsored by the trauma center, in order to protect the rights of the human subjects of such research.
- H. In addition to the requirements in subsections (A) through (E), the owner of a trauma center designated based on meeting the applicable standards specified in this Section and Table 13.1 shall:
 - 1. Ensure the presence of a surgeon at all operative procedures;
 - 2. If the trauma center provides emergency medicine, neurosurgery, orthopedic surgery, anesthesiology, critical care, or radiology as an organized service, ensure that:
 - a. A physician from the organized service is appointed to act as a liaison between the organized service and the trauma center's trauma service;
 - b. The physician in subsection (H)(2)(a) completes:
 - i. If the trauma center's designation is for a three-year period, at least 48 hours of trauma-related continuing medical education during the term of the designation;
 - ii. If the trauma center's designation is for a one-year period, at least 16 hours of trauma-related continuing medical education during the term of the designation; and
 - iii. If the trauma center is designated as a Level I Pediatric trauma center or Level II Pediatric trauma center, at least 12 of the 48 hours required in subsection (H)(2)(b)(i) or four of the 16 hours required in subsection (H)(2)(b)(ii) in pediatric trauma-related continuing medical education; and
 - c. If the trauma center is required by Table 13.1 to have a multidisciplinary peer review committee, ensure the physician in subsection (H)(2)(a) attends at least 50% of the meetings of the multidisciplinary peer review committee;
 - 3. Ensure that, when a physician is on-call for general surgery, neurosurgery, or orthopedic surgery, the physician is not on-call or on a back-up call list at another health care institution;
 - 4. Ensure that policies and procedures are established, documented, and implemented for:
 - a. Except for a Level IV trauma center, the formulation of blood products to be available during an event requiring multiple blood transfusions for a patient or patients; and
 - b. For a Level IV trauma center, the expedited release of blood products during an event requiring multiple blood transfusions for a patient or patients;
 - 5. Ensure that the patient transfer plan required in subsection (G)(1) includes processes for transferring a patient needing:
 - a. Acute hemodialysis or pediatric trauma care to a hospital providing the required service if the trauma center is designated as a:
 - i. Level III or Level IV trauma center; or
 - ii. Level II trauma center and does not provide, as applicable, acute hemodialysis or pediatric trauma care;
 - b. Burn care as an organized service, acute spinal cord management, microvascular surgery, or replant surgery to a hospital providing the required service if the trauma center is designated as a:
 - i. Level III or Level IV trauma center; or
 - ii. Level I or Level II trauma center and does not provide, as applicable, burn care as an organized service, acute spinal cord management, microvascular surgery, or replant surgery; or
 - c. Another service that the trauma center is not authorized or not able to provide to a hospital providing the required service;
- 6. Except for a Level IV trauma center or as provided in subsection (I), require that:
 - a. An emergency medicine physician is present in the emergency department at all times;
 - b. A surgeon on the trauma team is present in the emergency department:
 - i. For a patient:
 - (1) If an adult, with a systolic blood pressure less than 90 mm Hg or, if a child, with confirmed age-specific hypotension;
 - (2) With respiratory compromise, respiratory obstruction, or intubation;
 - (3) Who is transferred from another hospital and is receiving blood to maintain vital signs;
 - (4) Who has a gunshot wound to the abdomen, neck, or chest;
 - (5) Who has a Glasgow Coma Scale score less than 8 associated with an injury attributed to trauma; or
 - (6) Who is determined by an emergency department physician to have an injury that has the potential to cause prolonged disability or death; and
 - ii. No later than the following times:
 - (1) For a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, or Level II Pediatric trauma center, within 15 minutes after notification or at the time the patient arrives in the emergency department, whichever is later; or
 - (2) For a Level III trauma center, within 30 minutes after notification or at the time the patient arrives in the emergency department, whichever is later; and
 - c. One of the following anesthesia personnel members is available for an operative procedure on a patient at the indicated time point:
 - i. For a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, or Level II Pediatric trauma center, an anesthesiologist, anesthesiology chief resident, or certified registered nurse anesthetist is present in the emergency department or in an operating room area awaiting the patient no later than 15 minutes after patient arrival in the emergency department; and
 - ii. For a Level III trauma center, an anesthesiologist, anesthesiology chief resident, or certified registered nurse anesthetist is present in the emergency department or in an operating room area awaiting the patient no later than 30 minutes after patient arrival in the emergency department;
- 7. For a clinical capability required for the trauma center according to Table 13.1(C)(3), require that the on-call

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radiologist, critical care medicine physician, or surgical specialist is available to provide medical services, as applicable to the specialist, for a patient requiring trauma care within 45 minutes after notification; and

8. For personnel members assigned to an operating room team according to subsection (F)(9), require that the personnel members on the operating room team are on the premises of the trauma center while on duty or:
 - a. For a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, Level II Pediatric trauma center:
 - i. Are available to provide operative services for a patient requiring trauma care within 15 minutes after notification or patient arrival at the trauma center, whichever is later; and
 - ii. Have response times and patient outcomes monitored through the performance improvement program; and
 - b. For a Level III trauma center or Level IV trauma center, if the Level IV trauma center provides surgical services:
 - i. Are available to provide operative services for a patient requiring trauma care within 30 minutes after notification or patient arrival at the trauma center, whichever is later; and
 - ii. Have response times and patient outcomes monitored through the performance improvement program.
- I. The Department shall consider a trauma center designated based on meeting the applicable standards specified in this Section and Table 13.1 to be in compliance with subsection (H)(6)(a), (b), or (c), as applicable, if the trauma center has documentation showing that:
 1. The individual required to be present at the indicated location and within the indicated time period was present 80% or more of the time, and
 2. The trauma center monitors the rate of compliance with subsection (H)(6) and patient outcomes through the performance improvement program.
- J. The requirement in subsection (H)(6)(b) applies whether or not the owner of a trauma center allows a surgery resident in the fourth or fifth year of residency training to begin treating a patient described in subsection (H)(6)(b)(i) while awaiting the arrival of the surgeon on the trauma team, as required in subsection (H)(6)(b)(ii)(1) or (2).
- K. An ALS base hospital certificate holder that chooses to submit trauma registry information to the Department, as allowed by A.R.S. § 36-2221(A), shall:
 1. Include in the ALS base hospital's trauma registry at least the information required in R9-25-1309(A) for each patient who meets one or more of the criteria in subsections (C)(1)(a) through (c), and
 2. Comply with the submission requirements in subsections (C)(2) and (3).

Historical Note

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1308 renumbered to R9-25-1304; new Section R9-25-1308 renumbered from R9-25-1313 and amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3). Incomplete citations to Table 13.1(C)(3)(f) under subsections (F)(12)(e) and (F)(13)(a) corrected at the request of the Department (Supp. 18-4).

R9-25-1309. Trauma Registry Data (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2208(A), 36-2209(A)(2), 36-2221, and 36-2225(A)(5) and (6))

- A. A trauma registry established according to R9-25-1308(B)(1) includes the following in the record of a patient's episode of

care, as defined in A.A.C. R9-11-101, for each patient meeting the criteria in R9-25-1308(C)(1):

1. An identification code specific to the health care institution that had contact with the patient during the episode of care;
2. Demographic information about the patient:
 - a. The unique number assigned by the health care institution to the patient;
 - b. A code indicating whether the patient's record will be submitted to the Department as required in R9-25-1308(C)(2);
 - c. The unique number assigned by the health care institution for the episode of care;
 - d. The date the patient arrived at the health care institution for the episode of care;
 - e. For the episode of care, a code indicating whether the patient:
 - i. Was directly admitted to the health care institution,
 - ii. Was admitted to the health care institution through the emergency department,
 - iii. Was seen in the emergency department then transferred to another health care institution by an ambulance service or emergency medical services provider,
 - iv. Was seen in the emergency department and discharged, or
 - v. Died in the emergency department or was dead on arrival;
 - f. The patient's first name, middle initial, and last name;
 - g. The patient's Social Security Number;
 - h. The patient's date of birth and age;
 - i. Codes indicating the patient's gender, race, and ethnicity;
 - j. The zip code of the patient's residence or, if applicable, an indication of why no zip code was reported; and
 - k. The city, state, and county of the patient's residence;
3. Information about the occurrence of the patient's injury:
 - a. The date and time the injury occurred;
 - b. The ICD-code describing the type of location where the injury occurred;
 - c. The zip code of the location where the injury occurred;
 - d. The city, state, and county where the injury occurred;
 - e. A code indicating whether the patient's injury resulted from blunt force trauma, a penetrating wound, or a burn;
 - f. The ICD-code indicating the primary mechanism or cause of the patient's injury resulting in the episode of care and the manner or intent through which the injury occurred;
 - g. A description of the cause and circumstances leading to the patient's injury;
 - h. Whether the patient was using a protective device or safety equipment at the time of the injury and, if so, the type or types of protective device or safety equipment being used;
 - i. If the patient was subject to the requirements in A.R.S. § 28-907 at the time of the injury, whether the patient was using a child restraint system, as defined in A.R.S. § 28-907, at the time of the injury and, if so, the type of child restraint system being used; and
 - j. If the patient's injury resulted from a motor vehicle crash, a code describing the status of airbag deployment;
4. Information about the patient's arrival at the health care institution:

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- a. A code identifying the mode of transportation by which the patient arrived at the health care institution; and
- b. If applicable:
 - i. The ambulance service or emergency medical services provider that transported the patient to the health care institution;
 - ii. The unique identifier given by the ambulance service or emergency medical services provider to the incident during which the patient received EMS;
 - iii. The date the ambulance service or emergency medical services provider transported the patient to the trauma center; and
 - iv. If the patient was transferred from another health care institution, the name of the other health care institution;
5. Information about the health care institution's assessment or treatment of the patient in the emergency department:
 - a. A code indicating which of the criteria in R9-25-1308(C)(1) the patient met;
 - b. A code indicating whether an ambulance service or emergency medical services provider transported the patient to the health care institution and, if so, the criteria used by the transporting ambulance service or emergency medical services provider for transporting the patient to the health care institution;
 - c. The date and time the patient arrived at the emergency department of the health care institution for the episode of care;
 - d. The date and time the patient died or left the emergency department of the health care institution for the episode of care;
 - e. The length of time in hours and in minutes that the patient remained in the emergency department of the health care institution during the episode of care;
 - f. If trauma team activation occurred, the time when the last trauma team personnel member arrived at their assigned location in the health care institution;
 - g. Whether the patient showed signs of life when the patient arrived at the health care institution;
 - h. The values of the following for the patient at the time of their first assessment at the health care institution:
 - i. Pulse rate;
 - ii. Respiratory rate;
 - iii. Oxygen saturation;
 - iv. Systolic blood pressure; and
 - v. Temperature, including the units of temperature and the route used to measure the patient's temperature;
 - i. A code indicating whether the patient was receiving respiratory assistance at the time the patient's respiratory rate was assessed;
 - j. A code indicating whether the patient was receiving supplemental oxygen at the time the patient's oxygen saturation was assessed;
 - k. Codes indicating the Glasgow Coma Score for:
 - i. Eye opening,
 - ii. Verbal response to stimulus, and
 - iii. Motor response to stimulus;
 - l. The patient's total Glasgow Coma Score;
 - m. Whether the patient was intubated at the time of the patient's assessments in subsections (A)(5)(h)(ii), (k)(ii), and (l);
 - n. A code indicating whether a paralytic agent or sedative had been administered to the patient at the time the patient's Glasgow Coma Score was measured;
 - o. A code indicating another factor that may have affected the patient's Glasgow Coma Score;
 - p. A revised trauma score for the patient, auto-calculated based on the patient's systolic blood pressure, respiratory rate, and Glasgow Coma Score;
 - q. A code indicating the status of alcohol use by the patient and, if applicable, the blood alcohol concentration in the patient's blood;
 - r. A code indicating the status of drug use by the patient and, if applicable, the code for each drug class detected in the patient's blood;
 - s. A code indicating the disposition of the patient at the time the patient was discharged from the emergency department; and
 - t. If the patient was transferred to another health care institution upon discharge from the emergency department:
 - i. The name of the health care institution to which the patient was transferred;
 - ii. The name of the ambulance service or emergency medical services provider providing the interfacility transport;
 - iii. A code indicating the reason for transfer; and
 - iv. If there was a delay in transferring the patient to another health care institution, a code indicating the reason for the delay;
6. Information about the patient's discharge from the health care institution:
 - a. The date and time the patient was discharged from the health care institution;
 - b. The length of time the patient remained as an inpatient, as defined in A.A.C. R9-10-201, in the health care institution;
 - c. The length of time the patient remained in the health care institution's intensive care unit;
 - d. A code indicating whether the patient was alive or dead at the time of discharge from the health care institution;
 - e. The ICD-code for each injury identified in the patient, including an indication of whether the ICD-code is for:
 - i. The principle diagnosis, the reason believed by the health care institution to be chiefly responsible for the patient's need for the episode of care; or
 - ii. A secondary diagnosis, another reason believed by the health care institution to have contributed to the patient's need for the episode of care;
 - f. The patient's Injury Severity Score;
 - g. A code indicating the disposition of the patient at the time the patient was discharged from the health care institution;
 - h. Whether a report of suspected physical abuse was reported to law enforcement or as required by A.R.S. § 13-3620 or 46-454, if applicable, and, if so:
 - i. Whether an investigation into the suspected physical abuse was initiated by an entity to which the suspected physical abuse was reported; and
 - ii. If the patient is a child, whether the patient was discharged in the care of a person other than the person responsible for the care of the patient at the time the patient arrived at the health care institution; and
 - i. If the patient was transferred to a hospital upon discharge from the health care institution:
 - i. The name of the hospital to which the patient was transferred,
 - ii. The name of the ambulance service or emergency medical services provider providing the interfacility transport, and
 - iii. A code indicating the reason for transfer; and

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7. Financial information about the episode of care:
 - a. A code for the primary source of payment for the episode of care;
 - b. A code for a secondary source of payment for the episode of care, if applicable;
 - c. The total amount of charges for the episode of care; and
 - d. The total amount collected by the health care institution for the episode of care.
- B. In addition to the information required in subsection (A), a trauma registry established according to R9-25-1308(B)(1) by a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, Level II Pediatric trauma center, or Level III trauma center includes the following in the record of a patient's episode of care, as defined in A.A.C. R9-11-101, for each patient meeting the criteria in R9-25-1308(C)(1):
 1. Demographic information about the patient:
 - a. The country of the patient's residence;
 - b. The country where the patient was found or from which an ambulance service or emergency medical services provider transported the patient; and
 - c. Any pre-existing medical conditions diagnosed for the patient, unrelated to the reason for the episode of care;
 2. Information about the occurrence of the patient's injury:
 - a. Whether the time specified according to subsection (A)(3)(a) is the actual time of occurrence or an estimate;
 - b. The street address of the location where the injury occurred or, if the location at which the injury occurred does not have a street address, another indicator of the location at which the injury occurred;
 - c. Any additional ICD-code describing the mechanism or cause of the patient's injury resulting in the episode of care and the manner or intent through which the injury occurred;
 - d. The ICD-code indicating the activity the patient was engaged in that resulted in the patient's injury;
 - e. If the patient's injury resulted from a crash involving a means of transportation, including a motor vehicle, other motorized means of transportation, watercraft, bicycle, or aircraft, a code describing the type of vehicle in use at the time of the injury and the patient's location in the vehicle;
 - f. A description of any issues related to a protective device or safety equipment in use at the time of the patient's injury; and
 - g. Whether the patient's injury occurred during the patient's paid employment and, if so, a code indicating:
 - i. The type of occupation associated with the patient's employment, and
 - ii. The patient's occupation;
 3. A code indicating whether EMS was provided to the patient and, if applicable, the type of transport provided to the patient;
 4. If EMS was provided to the patient, whether a prehospital incident history report was provided to the trauma center and, if so:
 - a. The date on the prehospital incident history report;
 - b. The identifying number on the prehospital incident history report assigned by the ambulance service or emergency medical services provider;
 - c. The date and time the ambulance service or emergency medical services provider was dispatched, as defined in R9-25-901, to the scene;
 - d. The date and time the ambulance service or emergency medical services provider responded to the dispatch;
 - e. The date and time the ambulance service or emergency medical services provider arrived at the scene;
 - f. The date and time the ambulance service or emergency medical services provider established contact with the patient;
 - g. The date and time the ambulance service or emergency medical services provider left the scene;
 - h. The date and time the ambulance service or emergency medical services provider arrived at the health care institution that was the transport destination;
 - i. The date and time the patient's pulse, respiration, oxygen saturation, and systolic blood pressure were first measured;
 - j. At the date and time the patient's pulse, respiration, oxygen saturation, and systolic blood pressure were first measured, the patient's:
 - i. Pulse rate,
 - ii. Respiratory rate,
 - iii. Oxygen saturation, and
 - iv. Systolic blood pressure;
 - k. Whether the patient was intubated at the date and time the patient's pulse, respiration, and oxygen saturation were first measured;
 - l. Codes indicating the Glasgow Coma Score for:
 - i. Eye opening,
 - ii. Verbal response to stimulus, and
 - iii. Motor response to stimulus;
 - m. The patient's total Glasgow Coma Score;
 - n. A code indicating whether a paralytic agent or sedative had been administered to the patient at the date and time the patient's Glasgow Coma Score was measured;
 - o. A revised trauma score for the patient, auto-calculated based on the patient's systolic blood pressure, respiratory rate, and Glasgow Coma Score;
 - p. Codes indicating all airway management procedures performed on the patient by an ambulance service or emergency medical services provider before the patient's arrival at the first health care institution; and
 - q. Whether the patient experienced cardiac arrest subsequent to the injury before the patient's arrival at the first health care institution;
 5. The amount of time that elapsed from the date and time the ambulance service or emergency medical services provider:
 - a. Was dispatched and the date and time the ambulance service or emergency medical services provider arrived at the scene,
 - b. Arrived at the scene and the date and time the ambulance service or emergency medical services provider left the scene,
 - c. Left the scene and the date and time the ambulance service or emergency medical services provider arrived at the transport destination, and
 - d. Was dispatched and the date and time the ambulance service or emergency medical services provider arrived at the transport destination;
 6. Whether the patient arrived at the trauma center for treatment of the injury resulting in the episode of care through an interfacility transport;
 7. If the patient arrived at the trauma center through an interfacility transport, the following information about the health care institution at which the patient was seen immediately before arriving at the trauma center:
 - a. The name of the health care institution;
 - b. The date and time the patient arrived at the health care institution in subsection (B)(7)(a); and
 - c. The date and time the patient left the health care institution in subsection (B)(7)(a);

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8. If the patient arrived at the health care institution in subsection (B)(7)(a) through an interfacility transport, the information in subsections (B)(7)(a) through (c) about each health care institution at which the patient was seen for the injury resulting in the episode of care before arriving at the health care institution in subsection (B)(7)(a);
9. If the patient arrived at the trauma center through an interfacility transport, for each health care institution at which the patient was seen for the injury resulting in the episode of care before arriving at the trauma center, information for the first instance of assessing the patient's:
 - a. Respiratory rate,
 - b. Systolic blood pressure,
 - c. The patient's total Glasgow Coma Score, and
 - d. Revised trauma score; and
10. Information about the patient's episode of care at the trauma center and the patient's discharge from the trauma center:
 - a. The patient's height and weight when the patient arrived at the trauma center;
 - b. The number of days the patient spent on a mechanical ventilator;
 - c. If applicable, the identification number assigned by a medical examiner or alternate medical examiner, as defined in A.R.S. § 11-591, to the documentation of the patient's autopsy;
 - d. The total length of time the patient remained at the trauma center before discharge;
 - e. For each ICD-code identified according to subsection (A)(6)(e), a code that reflects the severity of the injury to which the ICD-code refers;
 - f. For each ICD-code identified according to subsection (A)(6)(e) that does not include an indication of the part of the patient's body that was injured, a code supplementing the ICD-code that indicates the part of the body that was injured;
 - g. For each procedure performed on the patient:
 - i. The ICD-code for the procedure,
 - ii. The health care institution at which the procedure was performed,
 - iii. A code indicating the organized service unit within the health care institution in which the procedure was performed, and
 - iv. The date and time the procedure was begun;
 - h. Any complications experienced by the patient while the patient remained at the trauma center;
 - i. The Abbreviated Injury Scale code indicating the severity of each of the patient's injuries;
 - j. The Abbreviated Injury Scale code indicating the body region affected by each of the patient's injuries;
 - k. If the trauma center is designated as a Level I trauma center or Level I Pediatric trauma center, the six-digit Abbreviated Injury Scale code and the software version used to calculate the six-digit Abbreviated Injury Scale code; and
 - l. The patient's probability of survival.

Historical Note

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1309 renumbered to R9-25-1305; new Section R9-25-1309 made by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1310. Trauma Registry Data Quality Assurance (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2208(A), 36-2209(A)(2), 36-2220(A), 36-2221, and 36-2225(A)(5) and (6))

- A. To ensure the completeness and accuracy of trauma registry reporting, a health care institution submitting trauma registry information to the Department shall allow the Department to

review the following, upon prior notice from the Department of at least five business days:

1. The health care institution's trauma registry or other database containing trauma registry information;
 2. Patient medical records; and
 3. Any record, other than those specified in subsections (A)(1) and (2), that may contain information about diagnostic evaluation or treatment provided to a patient receiving trauma care.
- B. Upon prior notice from the Department of at least five business days, a health care institution submitting trauma registry information to the Department shall provide the Department with all patient medical records for a time period specified by the Department, to allow the Department to determine the accuracy and completeness of the information submitted to the trauma registry for patients receiving trauma care during the period.
- C. For purposes of subsection (B), the Department considers a health care institution to be in compliance with R9-25-1308(C)(2) if the health care institution submitted to the Department trauma registry information for 97% of the patients receiving trauma care during the period.
- D. If trauma registry information submitted to the Department by a health care institution according to R9-25-1308(C)(2) and (3) is not in compliance with requirements in R9-25-1308 or R9-25-1309, the Department shall:
1. Notify the health care institution that the trauma registry information submitted to the Department is not in compliance with requirements in R9-25-1308 or R9-25-1309, and
 2. Identify the revisions or actions that are needed to bring the data into compliance with R9-25-1308 and R9-25-1309.
- E. A health care institution that has trauma registry information returned, as provided in subsection (D), shall:
1. Revise the trauma registry information as identified by the Department, and
 2. Submit the revised data to the Department within 15 business days after the date the Department notified the health care institution according to subsection (D)(1) or within a longer period agreed upon between the Department and the health care institution.
- F. Within 15 business days after receiving a written request from the Department that includes a simulated patient medical record, a health care institution submitting trauma registry information to the Department shall prepare and submit to the Department the information required in R9-25-1309, applicable to the Level of health care institution, for the patient described in the simulated patient medical record.

Historical Note

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1310 repealed; new Section R9-25-1310 renumbered from R9-25-1406 and amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1311. Repealed**Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1311 repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1312. Renumbered**Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-

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1312 renumbered to R9-25-1307 by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1313. Renumbered**Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1313 renumbered to R9-25-1308 by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1314. Expired**Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section expired under A.R.S. 41-1056(E) at 18 A.A.R. 2153, effective June 30, 2012 (Supp. 12-3).

R9-25-1315. Repealed**Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

Table 1. Repealed**Historical Note**

New Table made by final rulemaking at 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Table 1 Application Processing Time Periods repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

Exhibit I. Repealed**Historical Note**

New Exhibit made by final rulemaking at 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Exhibit 1 Arizona Trauma Center Standards repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

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Table 13.1. Arizona Trauma Center Standards (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))**Key:**

E = Essential and required

I(P) = Level I Pediatric trauma center

II(P) = Level II Pediatric trauma center

ICU = Intensive care unit

In-house = On the premises of the health care institution

ISS = Injury severity score, the sum of the squares of the abbreviated injury scale scores of the three most severely injured body regions

Child life = A program of support to injured children and their families to reduce stress and anxiety by:

- a. Explaining medical equipment and procedures to children in a non-threatening and age-appropriate manner,
- b. Explaining a diagnosis to a child in an age-appropriate manner, and
- c. Helping children and their families develop strategies to cope with the diagnosis and expected outcome

Trauma Facilities Criteria	Levels					
	I	I(P)	II	II(P)	III	IV
A. Institutional Organization						
1. Trauma service	E	E	E	E	E	-
2. Trauma program medical director	E	E	E	E	E	-
3. Trauma multidisciplinary peer review committee	E	E	E	E	E	-
B. Hospital Departments/Divisions/Sections						
1. Surgery	E	E	E	E	E	-
2. Neurosurgery	E	E	E	E	-	-
3. Orthopedic surgery	E	E	E	E	E	-
4. Emergency medicine	E	E	E	E	E	-
5. Pediatric emergency department area	-	E	-	E	-	-
6. Anesthesia	E	E	E	E	E	-
C. Clinical Capabilities						
1. Written on-call schedule for each component of the trauma service if a team member is not in-house	E	E	E	E	E	E
2. Physician specialist available 24 hours/day						
a. General surgeon	E	E	E	E	E	-
i. Published back-up schedule	E	E	E	E	-	-
ii. Dedicated to single hospital when on-call	E	E	E	E	-	-
iii. Surgeon credentialed for pediatric trauma care	-	E	-	E	-	-
b. Emergency medicine physician	E	E	E	E	E	-
c. Pediatric emergency medicine physician	-	E	-	-	-	-
3. Specialist on-call and available 24 hours/day						
a. Orthopedic surgeon	E	E	E	E	E	-
b. Pediatric-credentialed orthopedic surgeon	-	E	-	E	-	-
c. Neurosurgeon	E	E	E	E	-	-
d. Pediatric-credentialed neurosurgeon	-	E	-	E	-	-
e. Critical care medicine physician	E	E	E	E	-	-
f. Pediatric-credentialed critical care medicine physician	-	E	-	E	-	-
g. Radiologist	E	E	E	E	E	
h. Hand surgeon	E	E	E	E	-	-
i. Ophthalmic surgeon	E	E	E	E	-	-
j. Plastic surgeon	E	E	E	E	-	-
k. Thoracic surgeon	E	E	E	E	-	-
l. Cardiac surgeon	E	E	-	-	-	-
m. Obstetrics/gynecologic surgeon	E	E	-	-	-	-
n. Oral/maxillofacial surgeon (plastic surgeon, otolaryngologist, or oral/maxillofacial surgeon)	E	E	E	E	-	-

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Table 13.1 Continued, Arizona Trauma Center Standards

Trauma Facilities Criteria	Levels					
	I	I(P)	II	II(P)	III	IV
4. Qualified anesthesia personnel member on-call and available 24 hours/day						
a. Physician or certified nurse anesthetist	E	E	E	E	E	-
b. Physician or certified nurse anesthetist with a pediatric credential	-	E	-	E	-	-
5. Volume performance standards:						
a. 1200 trauma admissions per year,	E	-	-	-	-	-
b. 240 admissions with ISS > 15 per year, or						
c. Average of 35 patients with ISS > 15 for each trauma team surgeon per year						
d. 200 trauma admissions < 15 years of age per year,	-	E	-	-	-	-
D. Facilities/Resources/Capabilities						
1. Emergency department						
a. Designated physician director	E	E	E	E	E	-
b. Personnel members with pediatric-specific trauma-related training	-	E	-	E	-	-
c. Resuscitation equipment for patients of all sizes						
i. Airway control and ventilation equipment	E	E	E	E	E	E
ii. Pulse oximetry	E	E	E	E	E	E
iii. Suction devices	E	E	E	E	E	E
iv. Electrocardiograph-oscilloscope-defibrillator	E	E	E	E	E	E
v. Color-coded, length-based tool to assist with medication dosing and equipment selection for children	E	E	E	E	E	E
vi. Central venous pressure monitoring equipment	E	E	E	E	E	-
vii. Standard intravenous fluids and administration sets	E	E	E	E	E	E
viii. Large-bore intravenous catheters	E	E	E	E	E	E
ix. Sterile surgical sets for:						
(1) Airway control/cricothyrotomy	E	E	E	E	E	E
(2) Thoracostomy	E	E	E	E	E	E
(3) Central line insertion	E	E	E	E	E	-
(4) Thoracotomy	E	E	E	E	E	-
x. Arterial catheters	E	E	E	E	-	-
xi. X-ray availability 24 hours/day	E	E	E	E	E	-
xii. Thermal control equipment						
(1) For patient	E	E	E	E	E	E
(2) For fluids and blood	E	E	E	E	E	E
xiii. Rapid infusion system/capability	E	E	E	E	E	E
xiv. Qualitative end-tidal CO2 monitoring	E	E	E	E	E	E
d. Communication with EMS personnel	E	E	E	E	E	E
e. Capability to resuscitate, stabilize, and transfer pediatric patients	E	E	E	E	E	E
2. Operating room						
a. Immediately available 24 hours/day	E	E	E	E	-	-
b. Size-specific equipment						
i. Cardiopulmonary bypass	E	E	-	-	-	-
ii. Operating microscope	E	E	-	-	-	-
c. Thermal control equipment						
i. For patient	E	E	E	E	E	E
ii. For fluids and blood	E	E	E	E	E	E
d. X-ray capability including C-arm image intensifier	E	E	E	E	E	-
e. Endoscopes, bronchoscope	E	E	E	E	E	-
f. Craniotomy instruments	E	E	E	E	-	-

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g. Equipment for long bone and pelvic fixation	E	E	E	E	E	-
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Table 13.1 Continued, Arizona Trauma Center Standards (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

Trauma Facilities Criteria	Levels					
	I	I(P)	II	II(P)	III	IV
h. Rapid infusion system/capability	E	E	E	E	E	E
3. Postanesthesia recovery room or surgical ICU						
a. Registered nurses available 24 hours/day	E	E	E	E	E	E
b. Equipment for monitoring and resuscitation	E	E	E	E	E	E
c. Intracranial pressure monitoring equipment	E	E	E	E	-	-
d. Pulse oximetry	E	E	E	E	E	E
e. Thermal control equipment						
i. For patient	E	E	E	E	E	E
ii. For fluids and blood	E	E	E	E	E	E
4. ICU or critical care unit for injured patients						
a. Pediatric ICU	-	E	-	E	-	-
b. Registered nurses with trauma-related training	E	E	E	E	E	-
c. Registered nurses with pediatric-specific trauma-related training	-	E	-	E	-	-
d. Designated surgical director or surgical co-director	E	E	E	E	E	-
e. Physician (fourth year of residency training or higher) assigned to surgical ICU service and in-house 24 hours/day	E	E	-	-	-	-
f. Physician (fourth year of residency training or higher) with a pediatric credential assigned to surgical ICU service and in-house 24 hours/day	-	E	-	-	-	-
g. Surgically directed and staffed ICU service	E	E	E	E	-	-
h. Equipment for monitoring and resuscitation	E	E	E	E	E	-
i. Intracranial pressure monitoring equipment	E	E	E	E	-	-
5. Respiratory therapy services (Available 24 hours/day)						
a. Available in-house	E	E	E	E	-	-
b. On-call and available within 45 minutes after notification	-	-	-	-	E	-
6. Radiological services (Available 24 hours/day)						
a. In-house radiology technologist	E	E	E	E	-E	-
b. Radiology technologist on-call and available within 45 minutes after notification	-	-	-	-	-	E
c. Resuscitation equipment for patients of all sizes, as specified in subsection (D)(1)(c)(i) to (v)	E	E	E	E	E	E
d. Angiography	E	E	E	E	-	-
e. Sonography	E	E	E	E	E	-
f. Computed tomography (CT)	E	E	E	E	E	-
i. In-house CT technician	E	E	E	E	-	-
ii. CT technician on-call and available within 45 minutes after notification	-	-	-	-	E	-
f. Magnetic resonance imaging	E	E	E	E	-	-
7. Clinical laboratory service (Available 24 hours/day)						
a. Standard analyses of blood, urine, and other body fluids	E	E	E	E	E	E
b. Blood typing and cross-matching	E	E	E	E	E	-
c. Coagulation studies	E	E	E	E	E	E
d. Comprehensive blood bank or access to a community central blood bank and adequate storage facilities	E	E	E	E	E	-
e. Blood gases and pH determinations	E	E	E	E	E	E
f. Microbiology	E	E	E	E	E	-
8. Child maltreatment assessment capability	E	E	E	E	E	E
E. Rehabilitation Services Specific to the Patient Population						
1. Physical therapy	E	E	E	E	E	-

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2. Occupational therapy	E	E	E	E	-	-
3. Speech therapy	E	E	E	E	-	-

Table 13.1 Continued, Arizona Trauma Center Standards (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

Trauma Facilities Criteria	Levels					
	I	I(P)	II	II(P)	III	IV
F. Social Services Specific to the Patient Population						
1. Social services	E	E	E	E	E	-
2. Child life program	-	E	-	E	-	-
G. Performance Improvement						
1. Multidisciplinary peer review committee	E	E	E	E	E	-
2. Performance improvement personnel dedicated to the trauma service	E	E	E	E	-	-

(A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

Historical Note

Table 13.1, Arizona Trauma Center Standards, made by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3). Subsections under (D)(2) were incorrectly labeled at 23 A.A.R. 2656; clerical error corrected and labeled as f through h (Supp. 22-2).

ARTICLE 14. REPEALED**R9-25-1401. Repealed****Historical Note**

New Section made by final rulemaking at 13 A.A.R. 4301, effective January 12, 2008 (Supp. 07-4). Section repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1402. Repealed**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 4301, effective January 12, 2008 (Supp. 07-4). Section repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

Table 1. Repealed**Historical Note**

New Table 1 made by final rulemaking at 13 A.A.R. 4301, effective January 12, 2008 (Supp. 07-4). Table 1 Trauma Registry Data Set, repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1403. Repealed**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 4301, effective January 12, 2008 (Supp. 07-4). Section repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1404. Expired**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 4301, effective January 12, 2008 (Supp. 07-4). Section expired under A.R.S. 41-1056(E) at 18 A.A.R. 2153, effective June 30, 2012 (Supp. 12-3).

R9-25-1405. Repealed**Historical Note**

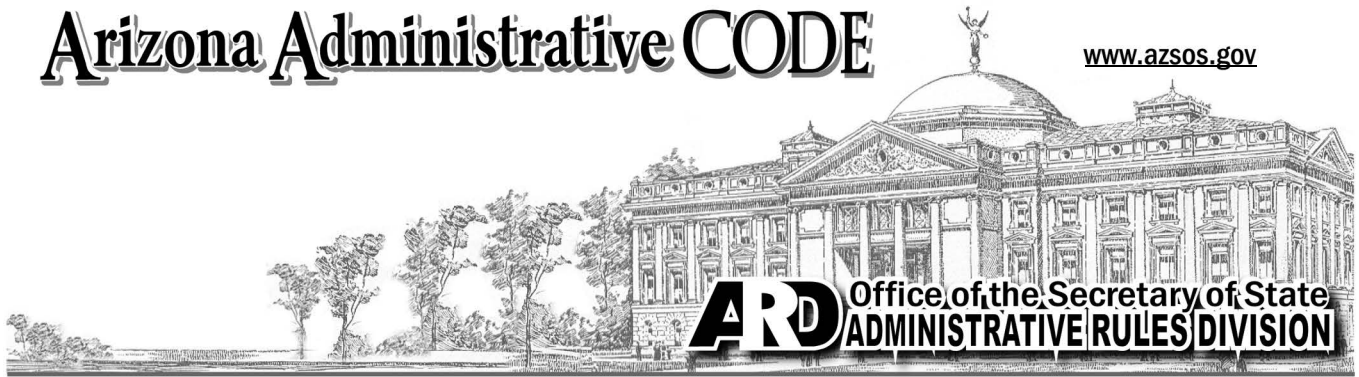
New Section made by final rulemaking at 13 A.A.R. 4301, effective January 12, 2008 (Supp. 07-4). Section heading corrected at request of the Department, Office File No. M12-82, filed March 5, 2012 (Supp. 11-4). Section repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

R9-25-1406. Renumbered**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 4301, effective January 12, 2008 (Supp. 07-4). Section R9-25-1406 renumbered to R9-25-1310, effective January 1, 2018 (Supp. 17-3).

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TITLE 18. ENVIRONMENTAL QUALITY

CHAPTER 8. DEPARTMENT OF ENVIRONMENTAL QUALITY - HAZARDOUS WASTE MANAGEMENT

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of
January 1, 2023 through March 31, 2023

[R18-8-260.](#) [Hazardous Waste Management System: General](#) 4 [R18-8-270.](#) [Hazardous Waste Permit Program](#) 17

Questions about these rules? Contact:

Department: The Department of Environmental Quality
Division: Waste Programs Division
Address: 1110 W. Washington St.
Phoenix, AZ 85007
Fax: (602) 771-4272
Website: www.azdeq.gov/WPD

Contact: Mark Lewandowski
Telephone: (602) 771-2230
E-mail: lewandowski.mark@azdeq.gov

The release of this Chapter in Supp. 23-1 replaces Supp. 21-4, 1-30 pages.

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, www.azsos.gov under Services-> Legislative Filings.

EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

PERSONAL USE/COMMERCIAL USE

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Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.

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TITLE 18. ENVIRONMENTAL QUALITY

CHAPTER 8. DEPARTMENT OF ENVIRONMENTAL QUALITY - HAZARDOUS WASTE MANAGEMENT

Supp. 23-1

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Editor's Note: Article 1 was exempt from the regular rulemaking process (Laws 1995, Ch. 232 § 5). However the Department was required to provide a notice of hearing and public hearing before adoption of this rule. The emergency rules were approved by the Attorney General. (Supp. 96-1). Editor's Note added to clarify exemptions of emergency adoption (Supp. 97-1). The Article was adopted permanently effective December 4, 1997 (Supp. 97-4).

ARTICLE 1. REMEDIAL ACTION REQUIREMENTS

Article 1, consisting of R18-8-101, adopted permanently through the regular rulemaking process, effective December 4, 1997 (Supp. 97-4).

Article 1, consisting of R18-8-101, adopted by emergency action effective March 22, 1996, pursuant to A.R.S. § 41-1026; in effect until permanent rules are adopted pursuant to Laws 1995, Chapter 232 § 5 (Supp. 96-1).

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ARTICLE 2. HAZARDOUS WASTES

Article 2, reserved Sections R18-8-202 through R18-8-258, now listed in full, numerical order to maintain consistency in this Chapter:

Article 2 consisting of Section R18-8-273 adopted effective June 13, 1996 (Supp. 96-2).

Article 2 consisting of Sections R9-8-1860 through R9-8-1866, R9-8-1869 through R9-8-1871, and R9-8-1880 amended and renumbered as Article 2, Sections R18-8-260 through R18-8-266, R18-8-269 through R18-8-271, and R18-8-280 (Supp. 87-2).

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ARTICLE 3. RECODIFIED

Title 18, Chapter 8, Article 3, consisting of Sections R18-8-301 through R18-8-305, R18-8-307, Table A, Exhibit 1, and Appendices A and B, recodified to Title 18, Chapter 13, Article 13, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

Article 3, consisting of Sections R18-8-301 through R18-8-305, adopted effective August 16, 1993 (Supp. 93-3).

Article 3, consisting of Section R18-8-306, adopted again by emergency action effective May 26, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-2).

Article 3, consisting of Section R18-8-306, adopted by emergency action effective February 22, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-1). Emergency expired.

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ARTICLE 4. RECODIFIED

Title 18, Chapter 8, Article 4, consisting of Section R18-8-402, recodified to Title 18, Chapter 13, Article 9, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

Article 17 consisting of Sections R9-8-1711 and R9-8-1717 renumbered as Article 4, Sections R18-8-401 and R18-8-402 (Supp. 87-3).

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Title 18, Chapter 8, Article 5, consisting of Sections R18-8-502 through R18-8-512, recodified to Title 18, Chapter 13, Article 3, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

Article 4 consisting of Sections R9-8-411 through R9-8-416, R9-8-421, R9-8-426 through R9-8-428, and R9-8-431 through R9-8-433 renumbered as Article 5, Sections R18-8-501 through R18-8-513 (Supp. 87-3).

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Existing Sections in Article 6 recodified to 18 A.A.C. 13, Article 11 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

Article 12 consisting of Sections R9-8-1211 through R9-8-1216, R9-8-1221 through R9-8-1225, R9-8-1231 through R9-8-1236, and R9-8-1241 through R9-8-1244 renumbered as Article 6, Sections R18-8-601 through R18-8-621 (Supp. 87-3).

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ARTICLE 7. RECODIFIED

18 A.A.C. 8, Article 7, consisting of Sections R18-8-701 through R18-8-710, recodified to Title 18, Chapter 13, Article 12, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

Article 7, consisting of Sections R18-8-701 through R18-8-708, adopted permanently with changes effective July 6, 1993 (Supp. 93-3).

Article 7, consisting of Sections R18-8-709 and R18-8-710, adopted again by emergency action effective May 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-2). Emergency expired.

Article 7, consisting of Sections R18-8-709 and R18-8-710, adopted by emergency action effective February 5, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-1).

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ARTICLE 16. RECODIFIED

Article 16, consisting of Sections R18-8-1601 through R18-8-1614, recodified to 18 A.A.C. 13, Article 16 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

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ARTICLE 1. REMEDIAL ACTION REQUIREMENTS**R18-8-101. Remedial Action Requirements; Level and Extent of Cleanup**

- A. This Article is applicable to Chapter 8 of this Title.
- B. In any instance where soil remediation is done under this Chapter, it shall be conducted in accordance with 18 A.A.C. 7, Article 2.

Historical Note

Emergency rule adopted effective March 22, 1996, pursuant to A.R.S. §§ 49-152 and 41-1026; in effect until permanent rules are adopted (Supp. 96-1). Historical note revised to clarify exemptions of emergency adoption (Supp. 97-1 & Supp. 97-3). Adopted permanently through the regular rulemaking process, effective December 4, 1997 (Supp. 97-4). Amended by final rulemaking at 25 A.A.R. 435, effective February 5, 2019 (Supp. 19-1).

ARTICLE 2. HAZARDOUS WASTES**R18-8-201. Expired****Historical Note**

New Section made by exempt rulemaking at 16 A.A.R. 846, effective July 1, 2010 (Supp. 10-2). Section expired pursuant to A.R.S. § 41-1056(J), at 22 A.A.R. 2983, effective September 15, 2016 (Supp. 16-2).

R18-8-202. Reserved

R18-8-203. Reserved

R18-8-204. Reserved

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R18-8-256. Reserved

R18-8-257. Reserved

R18-8-258. Reserved

R18-8-259. Reserved

R18-8-260. Hazardous Waste Management System: General

- A. All Federal regulations cited in this Article are those revised as of July 1, 2020 (and no future editions), unless otherwise noted, and are applicable only as incorporated by this Article. 40 CFR 124, 260 through 266, 268, 270 and 273 or portions of these regulations, are incorporated by reference, as noted in the text. Federal statutes and regulations that are cited within 40 CFR 124, 260 through 270, and 273 that are not incorporated by reference may be used as guidance in interpreting federal regulatory language.
- B. Any reference or citation to 40 CFR 124, 260 through 266, 268, 270, and 273, or portions of these regulations, appearing in the body of this Article and regulations incorporated by reference, includes any modification to the CFR section made by this Article. When federal regulatory language that has been

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incorporated by reference has been amended, brackets [] enclose the new language. The subsection labeling in this Article may or may not conform to the Secretary of State's formatting requirements, because the formatting reflects the structure of the incorporated federal regulations.

- C. All of 40 CFR 260, revised as of July 1, 2020 (and no future editions), is incorporated by reference, modified by the following subsections, and on file with the Department of Environmental Quality (DEQ) with the exception of the following:
1. 40 CFR 260.1(b)(4) through (6), 260.20(a), 260.21, 260.22, 260.30, 260.31, 260.32, and 260.33; and
 2. The revisions for standardized permits as published at 70 FR 53419. Copies of 40 CFR 260 are available at <https://www.eCFR.gov>. Copies of the Federal Register (FR) are available at <https://www.federalregister.gov>.
- D. § 260.2, titled "Availability of information; confidentiality of information" is amended by the following:
1. § 260.2(a). Any information provided to [the DEQ] under [R18-8-260 through R18-8-266 and R18-8-268 shall] be made available to the public to the extent and in the manner authorized by the [Hazardous Waste Management Act (HWMA), A.R.S. § 49-921 et seq.; the Open Meeting Law, A.R.S. § 38-431 et seq.; the Public Records Statute, A.R.S. § 39-121 et seq.; the Administrative Procedure Act, A.R.S. § 41-1001 et seq.; and rules promulgated pursuant to the above-referenced statutes], as applicable.
 2. § 260.2(b) is replaced with the following:
 - a. The DEQ shall make a record or other information, such as a document, a writing, a photograph, a drawing, sound or a magnetic recording, furnished to or obtained by the DEQ pursuant to the HWMA and regulations promulgated thereunder, available to the public to the extent authorized by the Public Records Statute, A.R.S. §§ 39-121 et seq.; the Administrative Procedure Act, A.R.S. §§ 41-1001 et seq.; and the HWMA, A.R.S. §§ 49-921 et seq. Specifically, the DEQ shall disclose the records or other information to the public unless:
 - i. A statutory exemption authorizes the withholding of the information; or
 - ii. The record or other information contains a trade secret concerning processes, operations, style of work, or apparatus of a person, or other information that the Director determines is likely to cause substantial harm to the person's competitive position.
 - b. Notwithstanding subsection (a):
 - i. The DEQ shall make records and other information available to the EPA upon request without restriction;
 - ii. As required by the HWMA and regulations promulgated thereunder the DEQ shall disclose the name and address of a person who applies for, or receives, a HWM facility permit;
 - iii. The DEQ and any other appropriate governmental agency may publish quantitative and qualitative statistics pertaining to the generation, transportation, treatment, storage, or disposal of hazardous waste; and
 - iv. An owner or operator may expressly agree to the publication or to the public availability of records or other information.
 - c. A person submitting records or other information to the DEQ may claim that the information contains a

confidential trade secret or other information likely to cause substantial harm to the person's competitive position. In the absence of such claim, the DEQ shall make the information available to the public on request without further notice. No claim of confidentiality may be asserted by any person with respect to information entered on a Hazardous Waste Manifest (EPA Form 8700-22), a Hazardous Waste Manifest Continuation Sheet (EPA Form 8700-22A), or an electronic manifest format that may be prepared and used in accordance with 40 CFR 262.20(a)(3). EPA will make any electronic manifest that is prepared and used in accordance with § 262.20(a)(3), or any paper manifest that is submitted to the system under §§ 264.71(a)(6) or 265.71(a)(6) available to the public under this section when the electronic or paper manifest is a complete and final document. Electronic manifests and paper manifests submitted to the system are considered by EPA to be complete and final documents and publicly available information after 90 days have passed since the delivery to the designated facility of the hazardous waste shipment identified in the manifest. A person making a claim of confidentiality shall assert the claim:

- i. At the time the information is submitted to, or otherwise obtained by, the DEQ;
 - ii. By either stamping or clearly marking the words "confidential trade secret" or "confidential information" on each page of the material containing the information. The person may assert the claim only for those portions or pages that actually contain a confidential trade secret or confidential information; and
 - iii. During the course of a DEQ inspection, or other observation, pursuant to the administration of the HWMA Program, by clearly indicating to the inspector which specific processes, operations, styles of work, or apparatus constitute a trade secret. The inspector shall record the claim on the inspection report and the claimant shall sign the report.
- d. The Director shall provide the claimant with an opportunity to submit written comments to demonstrate that the information constitutes a legitimate confidential trade secret or confidential information. The comments shall be limited to confidential use by the DEQ pursuant to A.R.S. § 49-928. Pertinent factors to be considered by the Director for making a determination of confidentiality, and that the claimant may address in the claimant's written comments, include the following:
- i. Whether the information is proprietary;
 - ii. Whether the information has been disclosed to persons other than the employees, agents, or other representatives of the owner; and
 - iii. Whether public disclosure would harm the competitive position of the claimant.
- e. The Director shall make a determination of each confidentiality claim using the following procedures:
- i. When a claim of confidentiality is asserted for information submitted as part of a HWM facility permit application:

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- (1) The claimant shall submit written comments demonstrating the legitimacy of the claim of confidentiality; and
- (2) The Director shall evaluate the confidentiality claim and notify the claimant of the result of that determination as part of the completeness review pursuant to R18-8-271(C).
- ii. When a claim of confidentiality is asserted for information submitted or obtained during an inspection, or for any other information submitted to or obtained by the DEQ pursuant to this Article, but not as part of a HWM facility permit application:
 - (1) The claimant may submit written comments demonstrating the legitimacy of the claim of a confidential trade secret or other confidential information within 10 working days of asserting the confidentiality claim; and
 - (2) If a request for disclosure is made, the Director shall evaluate the confidentiality claim and notify the claimant of the result of that determination. In all other instances, the Director may, on the Director's own initiative, evaluate the confidentiality claim and notify the claimant of the result of that determination within 20 working days after the time for submission of comments.
- iii. When any person, hereinafter referred to as the "requestor," submits a request to the DEQ for public disclosure of records or information, the DEQ shall disclose the records or information to the requestor unless the information has been determined to be confidential by the Director, or is subject to a claim of confidentiality that is being considered for determination by the Director.
 - (1) If a confidentiality claim is under consideration by the Director, the requestor shall be notified that the information requested is under a confidentiality claim consideration and therefore is unavailable for public disclosure pending the Director's determination pursuant to subsection (D)(2)(e)(ii)(2).
 - (2) When a request for disclosure is made, the claimant shall be notified, within seven working days by certified mail with return receipt requested, that the information under a claim of confidentiality has been requested and is subject to the Director's determination pursuant to subsection (D)(2)(e)(ii)(2).
 - (3) If the Director disagrees with the confidentiality claim, the claimant shall have 20 working days to submit written comments either agreeing or disagreeing with the Director's evaluation.
 - (4) If a confidentiality claim is denied by the Director, the Director may request the attorney general to seek a court order authorizing disclosure pursuant to A.R.S. § 49-928.
- f. Records or information determined by the Director to be legitimate confidential trade secrets or other confidential information shall not be disclosed by the DEQ at administrative proceedings pursuant to A.R.S. § 49-923(A) unless the following procedure is observed:
 - i. The DEQ shall notify both the claimant and the hearing officer of its intention to disclose the information at least 30 days prior to the hearing date. The DEQ shall send with the notice a copy of the confidential information that the DEQ intends to disclose;
 - ii. The claimant and the DEQ shall be allowed 10 days to present to the hearing officer comments concerning the disclosure of such information;
 - iii. The hearing officer shall determine whether the confidential information is relevant to the subject of the administrative proceeding and shall allow disclosure upon finding that the information is relevant to the subject of the administrative proceeding;
 - iv. The hearing officer may set conditions for disclosure of confidential and relevant information or the making of protective arrangements and commitments as warranted; and
 - v. The hearing officer shall give the claimant at least five days' notice before allowing disclosure of the information in the course of the administrative proceeding.
- E. § 260.10, titled "Definitions," is amended by adding all definitions from § 270.2 to this Section, including the following changes, applicable throughout this Article unless specified otherwise:
 1. ["Acute Hazardous Waste" means waste found to be fatal to humans in low doses or, in the absence of data on human toxicity, that has been shown in studies to have an oral lethal dose (LD) 50 toxicity (rat) of less than 50 milligrams per kilogram, an inhalation lethal concentration (LC) 50 toxicity (rat) of less than 2 milligrams per liter, or a dermal LD 50 toxicity (rabbit) of less than 200 milligrams per kilogram or that is otherwise capable of causing or significantly contributing to an increase in serious irreversible, or incapacitating reversible, illness,] and therefore are either listed in § 261.31 with the assigned hazard code of (H) or are listed in § 261.33(e).
 2. ["Application" means the standard United States Environmental Protection Agency forms for applying for a permit, including any additions, revisions or modifications to the forms. Application also includes the information required pursuant to §§ 270.14 through 270.29 (regarding the contents of a Part B HWM facility permit application).]
 3. ["Chapter" means "Article" except in § 264.52(b), see R18-8-264, and § 265.52(b), see R18-8-265.]
 4. "Closure" means [, for facilities with effective hazardous waste permits, the act of securing a HWM facility pursuant to the requirements of R18-8-264. For facilities subject to interim status requirements, "closure" means the act of securing a HWM facility pursuant to the requirements of R18-8-265.]
 5. ["Concentration" means the amount of a substance in weight contained in a unit volume or weight.]

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6. ["Department" or "the DEQ" means the Arizona Department of Environmental Quality.]
7. "Department of Transportation" or "DOT" means the U.S. Department of Transportation.
8. ["Director" or "state Director" means the Director of the Department of Environmental Quality or an authorized representative, except in §§ 262.80 through 262.84, 268.5 through 268.6, 268.42(b), and 268.44 which are non-delegable to the state of Arizona.]
9. ["Draft permit" means a document prepared under § 124.6 indicating the Director's tentative decision to issue, deny, modify, revoke, reissue, or terminate a permit. A denial of a request for modification, revocation, reissuance or termination, as discussed in § 124.5, is not a draft permit.]
10. ["Emergency permit" means a permit that is issued in accordance with § 270.61.]
11. ["EPA," "Environmental Protection Agency," "United States Environmental Protection Agency," "U.S. EPA," "EPA HQ," "EPA Regions," and "Agency" mean the DEQ with the following exceptions:
 - a. Any references to EPA identification numbers;
 - b. Any references to EPA hazardous waste numbers;
 - c. Any reference to EPA test methods or documents;
 - d. Any reference to EPA forms;
 - e. Any reference to EPA publications;
 - f. Any reference to EPA manuals;
 - g. Any reference to EPA guidance;
 - h. Any reference to EPA Acknowledgment of Consent;
 - i. References in §§ 260.1(b); 260.2(d); 260.4(a)(4); 260.10 (definitions of "Administrator," "EPA region," "Federal agency," "Person," and "Regional Administrator"); 260.11(a); 260.34; 261, Appendix IX; 261.4(a)(24), but in § 261.24(a)(24)(v)(B)(2), "EPA" means "DEQ"; 261.4(a)(25); 261.39(a)(5); 261.41; 262.21; 262.24(a)(3); 262.25; 262.32(b); Part 262, subpart H; 263.10(a) Note; 264.12(a)(2), 264.71(a)(3), 264.71(d), 265.12(a)(2), 265.71(a)(3), 265.71(d); 268.1(e)(3); 268.5, 268.6, 268.42(b), and 268.44, which are non-delegable to the state of Arizona; 270.1(a)(1); 270.1(b); 270.2 (definitions of "Administrator," "Approved program or Approved state," "Director," "Environmental Protection Agency," "EPA," "Final authorization," "Permit," "Person," "Regional Administrator," and "State/EPA agreement"); 270.3; 270.5; 270.10(e)(1) through (2); 270.11(a)(3); 270.32(a) and (c); 270.51; 270.72(a)(5) and (b)(5); 273.32(a)(3); 124.1(f); 124.5(d); 124.6(e); 124.10(c)(1)(ii); and 124.13.]
12. ["Federal Register" means a daily or weekly major local newspaper of general circulation, within the area affected by the facility or activity, except in §§ 260.11(b) and 270.10(c)(2).]
13. ["HWMA" or "State HWMA" means the State Hazardous Waste Management Act, A.R.S. § 49-921 et seq., as amended.]
14. ["Hazardous Waste Management facility" or "HWM facility" means any facility or activity, including land or appurtenances thereto, that is subject to regulation under this Article.]
15. ["Key employee" means any person employed by an applicant or permittee in a supervisory capacity or empowered to make discretionary decisions with respect to the solid waste or hazardous waste operations of the applicant or permittee. Key employee does not include an employee exclusively engaged in the physical or mechanical collection, transportation, treatment, storage, or disposal of solid or hazardous waste.]
16. ["National" means "state" in §§ 264.1(a) and 265.1(a).]
17. ["Off-site" means any site that is not on-site.]
18. ["Permit" means an authorization, license, or equivalent control document issued by the DEQ to implement the requirements of this Article. Permit includes "permit-by-rule" in § 270.60 and "emergency permit" in § 270.61, and it does not include interim status as in § 270.70 or any permit which has not yet been the subject of final action, such as a "draft permit" or a "proposed permit."]
19. ["Permit-by-rule" means a provision of this Article stating that a facility or activity is considered to have a HWM facility permit if it meets the requirements of the provision.]
20. ["Physical construction" means excavation, movement of earth, erection of forms or structures, or similar activity to prepare a HWM facility to accept hazardous waste.]
21. ["RCRA," "Resource Conservation and Recovery Act," "Subtitle C of RCRA," "RCRA Subtitle C," or "Subtitle C" when referring either to an operating permit or to the federal hazardous waste program as a whole, mean the "State Hazardous Waste Management Act, A.R.S. § 49-921 et seq., as amended" with the following exceptions:
 - a. Any reference to a specific provision of "RCRA," "Resource Conservation and Recovery Act," "Subtitle C of RCRA," "RCRA Subtitle C," or "Subtitle C";
 - b. References in §§ 260.10 (definition of "Act or RCRA"); 260, Appendix I; 261, Appendix IX; Part 262, subpart H, 270.1(a)(2); 270.2, definition of "RCRA,"; and 270.51, "EPA-issued RCRA permit,".]
22. [Following any references to a specific provision of "RCRA," "Resource Conservation and Recovery Act," or "Subtitle C," the phrase "or any comparable provisions of the state Hazardous Waste Management Act, A.R.S. § 49-

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- 921 et seq., as amended” shall be deemed to be added except in §§ 270.72(a)(5) and (b)(5).]
23. [“RCRA § 3005(a) and (e)” means “A.R.S. § 49-922.”]
 24. [“RCRA § 3007” means “A.R.S. § 49-922.”]
 25. [“RCRA § 3008” means “A.R.S. §§ 49-921 through 49-926”]
 26. [“RCRA § 3010” means “A.R.S. § 49-922.”]
 27. [“Recyclable Materials” mean hazardous wastes that are recycled.]
 28. [“Region” or “Region IX” means “state” or “state of Arizona.”]
 29. [“Schedule of compliance” means a schedule of remedial measures included in a permit, including an enforceable sequence of interim requirements, such as actions, operations, or milestone events, leading to compliance with the HWMA and this Article.]
 30. [“Site” means the land or water area where any facility or activity is physically located or conducted, including adjacent land used in connection with the facility or activity.]
 31. [“State,” “authorized state,” “approved state,” or “approved program” means the state of Arizona with the following exceptions:
 - References at §§ 260.10, definitions of “person,” “state,” and “United States,”; 262;
 - 264.143(e)(1);
 - 264.145(e)(1);
 - 264.147(a)(1)(ii);
 - 264.147(b)(1)(ii);
 - 264.147(g)(2);
 - 264.147(i)(4);
 - 265.143(d)(1);
 - 265.145(d)(1);
 - 265.147(a)(1)(ii);
 - 265.147(g)(2);
 - 265.147(i)(4); and
 - 270.2, definitions of “Approved program or Approved state,” “Director,” “Final authorization,” “Person,” and “state”.]
 32. [“The effective date of these regulations” means the following dates: “May 19, 1981,” in §§ 265.112(a) and (d), 265.118(a) and (d), 265.142(a) and 265.144(a); “November 19, 1981,” in §§ 265.112(d) and 265.118(d);.]
 33. [“TSD facility” means a “Hazardous Waste Management facility” or “HWM facility.”]
- F. § 260.10, titled “Definitions,” as amended by subsection (E) also is amended as follows, with all definitions in § 260.10, applicable throughout this Article unless specified otherwise.
1. “Act” or [“the Act” means the state Hazardous Waste Management Act or HWMA, except in R18-8-261(B) and R18-8-262(B).]
 2. “Administrator,” “Regional Administrator,” “EPA Regional Administrator,” “state Director,” or “Assistant Administrator for Solid Waste and Emergency Response” mean the [Director or the Director’s authorized representative, except in §§:
 - 260.10, in the definitions of “Administrator,” “AES filing compliance date,” “Electronic import-export reporting compliance date,” “Regional Administrator,” and “hazardous waste constituent”;
 - 260.20
 - 260.40
 - 260.41;
 - 261, Appendix IX;
 - 262.11(c);
 - 262.41;
 - 262.43;
 - 262, Subpart H;
 - 264.12(a);
 - 264.71;
 - 265.12(a);
 - 265.71;
 - 268.2(j);
 - 268.5, 268.6, 268.42(b), and 268.44, which are non-delegable to the state of Arizona; 270.2, in the definitions of “Administrator,” “Director,” “Major facility,” “Regional Administrator,” and “State/EPA agreement”;
 - 270.3;
 - 270.5;
 - 270.10(e)(1), (2), and (4);
 - 270.10(f) and (g);
 - 270.11(a)(3);
 - 270.14(b)(20);
 - 270.32(b)(2);
 - 270.51;
 - 124.5(d);
 - 124.6(e);
 - 124.10(b)].
 3. “Facility” [or “activity” means:
 - [a]. Any HWM facility or other facility or activity, including] all contiguous land, and structures, other appurtenances, and improvements on the land [which are] used for treating, storing, or disposing of hazardous waste, [that is subject to regulation under the HWMA program] or for managing hazardous secondary materials prior to reclamation. A facility may consist of several treatment, storage, or disposal operational units ([that is], one or more landfills, surface impoundments, or combinations of them).
 - [b]. For the purpose of implementing corrective action under 40 CFR 264.101, all contiguous property under the control of the owner or operator seeking a permit under Subtitle C of RCRA. This definition also applies to facilities implementing corrective action under RCRA Section 3008(h).
 - [c]. Notwithstanding paragraph (b) of this definition, a remediation waste management site is not a facility that is subject to 40 CFR 264.101, but is subject to corrective action requirements if the site is located within such a facility.
 4. “Final closure” means the closure of all hazardous waste management units at the facility in accordance with all applicable closure requirements so that hazardous waste management activities under parts 264 and 265 of this chapter are no longer conducted at the facility unless subject to the provisions in [§§ 262.15 and 262.17.]
 5. “New HWM facility” or “new facility” means a HWM facility which began operation, or for which construction commenced, [after November 19, 1980].
 6. “Person” means an individual, trust, firm, joint stock company, federal agency, corporation, including a government corporation, [or a limited liability corporation], partnership, association, state, municipality, commission, political subdivision of a state, or any interstate body, [state agency, or an agent or employee of a state agency].
 7. “United States” or “U.S.” means [Arizona except for the following:

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- a. The definitions of “CRT exporter” and “recognized trader” in § 260.10.
 - b. §§ 261.4(a)(23) and 261.4(a)(25).
 - c. § 261.4(d)(4) and (e)(4).
 - d. § 261.39(a)(5).
 - e. § 262.14(a)(5).
 - f. Part 262, subpart H.
 - g. All references in Part 263 except §§ 263.10(a) and 263.22(c).
 - h. § 266.80.]
- G.** § 260.20(a), titled “General” pertaining to rulemaking petitions, is replaced by the following:
- Where the Administrator of EPA has granted a rulemaking petition pursuant to 40 CFR 260.20(a), 260.21, or 260.22, the Director may accept the Administrator’s determination and amend the Arizona rules accordingly, if the Director determines the action to be consistent with the policies and purposes of the HWMA.
- H.** § 260.23, titled “Petitions to amend 40 CFR 273 to include additional hazardous wastes” pertaining to rulemaking petitions, is amended as follows: (a) Any person seeking to add a hazardous waste or a category of hazardous waste to the universal waste regulations of part 273 of this chapter may petition for a regulatory amendment under this Section, 40 CFR 260.20(b) through (e), and Subpart G of 40 CFR 273.
- I.** § 260.30, titled “Non-waste determinations and variances from classification as a solid waste,” is replaced by the following: Any person wishing to submit a variance petition shall submit the petition, under this subsection, to the EPA. Where the administrator of EPA has granted a variance from classification as a solid waste under 40 CFR 260.30, 260.31, 260.33, and 260.34, the director shall accept the determination, if the director determines the action is consistent with the policies and purposes of the HWMA.
- J.** § 260.32, titled “Variances to be classified as a boiler,” is replaced by the following:
- Any person wishing to submit a variance petition shall submit the petition, under this subsection, to the EPA. Where the administrator of EPA has granted a variance from classification as a boiler pursuant to 40 CFR 260.32 and 260.33, the director shall accept the determination, if the director determines the action is consistent with the policies and purposes of the HWMA.
- K.** 40 CFR 260.41, titled “Procedures for case-by-case regulation of hazardous waste recycling activities,” is amended by deleting the following from the end of paragraph (a):
- “or unless review by the Administrator is requested. The order may be appealed to the Administrator by any person who participated in the public hearing. The Administrator may choose to grant or to deny the appeal.”
- L.** As required by A.R.S. § 49-929, generators and transporters of hazardous waste shall register annually with DEQ and submit the appropriate registration fee, prescribed below, with their registration. Registration shall be done through DEQ’s myDEQ portal. For registration, go to <http://www.azdeq.gov/mydeq>.
1. A hazardous waste transporter that picks up or delivers hazardous waste in Arizona shall pay \$200 by March 1 of the year following the date of the pick-up or delivery;
 2. A large-quantity generator that generated 1,000 kilograms or more of hazardous waste in any month of the previous calendar year shall pay \$300; or
 3. A small-quantity generator that generated 100 kilograms or more but less than 1,000 kilograms of hazardous waste in any month of the previous year shall pay \$100.
- M.** A person shall pay hazardous waste generation and disposal fees as required under A.R.S. § 49-931 after the rates are updated for the billing period. The billing period for large-quantity generators shall be quarterly and for small-quantity generators, including very small quantity generators who become a small quantity generator due to an episodic event, annually. The person shall pay the fee within 30 days of the close of the billing period. The following hazardous waste fees shall apply:
1. A person who generates hazardous waste in calendar year 2023 that is shipped off site shall pay \$87.00 per ton but not more than \$258,000 per generator site per year of hazardous waste generated. For each succeeding calendar year, these rates shall be adjusted according to subsection (4).
 2. An owner or operator of a facility that disposes of hazardous waste in calendar year 2023 shall pay \$348 per ton but not more than \$6,245,000 per disposal site per year of hazardous waste disposed. For each succeeding calendar year, these rates shall be adjusted according to subsection (4).
 3. A person who generates hazardous waste in calendar year 2023 that is retained on site for disposal or that is shipped off site for disposal to a facility that is owned and operated by that generator shall pay \$34.83 per ton but not more than \$206,000 per generator site per year of hazardous waste disposed. For each succeeding calendar year, these rates shall be adjusted according to subsection (4).
 4. From and after January 1, 2024, the amounts in subsections (1), (2) and (3), and R18-8-270(G)(6) shall be updated annually before each April 1 by the following method:
 - a. On or about January 15 after the calendar year to be updated, ADEQ shall use the United States Bureau of Labor Statistics CPI Inflation Calculator at bls.gov/data/inflation_calculator.htm, as follows unless updated:
 - i. Insert the current maximum fee, per ton rate, or hourly rate in the first box.
 - ii. Insert December of the calendar year 13 months previous in the before-inflation box. Insert the previous December in the after-inflation box.
 - iii. Select “Calculate”. The new maximum, per ton rate, or hourly rate for the billing period beginning January 1 will be shown.
 - b. ADEQ shall post the new rates on its webpage and install them in the billing software as soon as practicable.

Historical Note

Adopted effective July 24, 1984 (Supp. 84-4). Amended subsections (A), (C), and (E) effective June 27, 1985 (Supp. 85-3). Amended subsections (A) and (C) effective August 5, 1986 (Supp. 86-4). Former Section R9-8-1860 renumbered as Section R18-8-260, and subsections (A) and (C) amended effective May 29, 1987 (Supp. 87-2). Amended subsections (D) and (E) effective December 1, 1988 (Supp. 88-4). Amended effective October 11, 1989 (Supp. 89-4). Amended effective August 14, 1991 (Supp. 91-3). Amended effective October 6, 1992 (Supp. 92-4).

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Amended effective December 2, 1994 (Supp. 94-4).
 Amended effective December 7, 1995 (Supp. 95-4).
 Amended effective June 13, 1996 (Supp. 96-2). Amended effective August 8, 1997 (Supp. 97-3). Amended effective June 4, 1998; R18-8-260 corrected, text was inadvertently omitted (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 4625, effective November 15, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3093, effective July 24, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 816, effective April 15, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 4364, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5523, effective February 4, 2006 (Supp. 05-4). Amended by final rulemaking at 12 A.A.R. 3061, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 14 A.A.R. 409, effective March 8, 2008 (Supp. 08-1). Subsections in R18-8-260(F)(2) reinstated at request of the Department after a clerical error in 9 A.A.C. 816 omitted the subsections from the rule text, Office File No. M10-288, filed July 20, 2010 (Supp. 10-2). Amended by final rulemaking at 18 A.A.R. 1202, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 21 A.A.R. 1246, effective September 5, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 435, effective February 5, 2019 (Supp. 19-1). Amended by final rulemaking at 26 A.A.R. 2949, with an immediate effective date of November 3, 2020 (Supp. 20-4). Subsection (J) published after subsection (M) removed; this clerical error was published in Supp. 20-4 and corrected in Supp. 21-4. Amended by final rulemaking at 29 A.A.R. 729 (March 17, 2023), with an immediate effective date of March 8, 2023 (Supp. 23-1).

R18-8-261. Identification and Listing of Hazardous Waste

- A.** All of 40 CFR 261 and accompanying appendices, revised as of July 1, 2020 (and no future editions), is incorporated by reference, modified by the following subsections, and on file with the DEQ with the exception of the following:
1. The revisions for standardized permits as published at 70 FR 53419; and
 2. 40 CFR §§ 261.149, 261.400(a), 261.400(b), 261.410(e), 261.410(f), 261.411, and 261.420; Copies of 40 CFR 261 are available at <https://www.eCFR.gov>. Copies of the Federal Register (FR) are available at <https://www.federalregister.gov>.
- B.** In the above-adopted federal regulations “section 1004(5) of RCRA” or “section 1004(5) of the Act” means A.R.S. § 49-921(5).
- C.** § 261.4, titled “Exclusions,” paragraph (b)(6)(i), is amended as follows:
- (i) Wastes which fail the test for the Toxicity Characteristic because chromium is present or are listed in subpart D due to the presence of chromium, which do not fail the test for the Toxicity Characteristic for any other constituent or are not listed due to the presence of any other constituent, and which do not fail the test for any other characteristic, if [documentation is provided to the Director] by a waste generator or by waste generators that:
 - (A) The chromium in the waste is exclusively (or nearly exclusively) trivalent chromium; and
 - (B) The waste is generated from an industrial process which uses trivalent chromium exclusively (or nearly exclusively) and the process does not generate hexavalent chromium; and
 - (C) The waste is typically and frequently managed in non-oxidizing environments.
- D.** § 261.4, titled “Exclusions,” paragraph (e)(1) is amended as follows:
- (1) Except as provided in paragraphs (e)(2) and (4) of this section, persons who generate or collect samples for the purpose of conducting treatability studies as defined in 40 CFR 260.10, are not subject to any requirement of 40 CFR parts 261 through 263 or to the notification requirements of Section 3010 of RCRA, nor are such samples included in the quantity determinations of [40 CFR 262.13 and 262.16(b)] when:
 - (i) The sample is being collected and prepared for transportation by the generator or sample collector; or
 - (ii) The sample is being accumulated or stored by the generator or sample collector prior to transportation to a laboratory or testing facility; or
 - (iii) The sample is being transported to the laboratory or testing facility for the purpose of conducting a treatability study.
- E.** § 261.4, titled “Exclusions,” is amended by deleting the phrase “in the Region where the sample is collected” in paragraph (e)(3)iii.
- F.** § 261.6, titled “Requirements for recyclable materials,” paragraphs (a)(1) through (a)(3) are amended as follows:
- (a)(1) Hazardous wastes that are recycled are subject to the requirements for generators, transporters, and storage facilities of paragraphs (b) and (c) of this section, except for the materials listed in paragraphs (a)(2) and (a)(3) of this section. Hazardous wastes that are recycled [shall] be known as “recyclable materials.”
 - (2) The following recyclable materials are not subject to the requirements of this section but are regulated under [40 CFR 266, subparts C through N] and all applicable provisions in parts 268, 270 and 124 of this chapter:
 - (i) Recyclable materials used in a manner constituting disposal (40 CFR part 266, subpart C);
 - (ii) Hazardous wastes burned (as defined in section 266.100(a)) in boilers and industrial furnaces that are not regulated under [40 CFR 264 or 265, subpart O] (40 CFR part 266, subpart H);
 - (iii) Recyclable materials from which precious metals are reclaimed (40 CFR part 266, subpart F);
 - (iv) Spent lead acid batteries that are being reclaimed (40 CFR part 266, subpart G).
 - (3) The following recyclable materials are not subject to regulation under [40 CFR 262 through 266, 268, 270, or 124] and are not subject to the notification requirements of section 3010 of RCRA:
 - (i) Industrial ethyl alcohol that is reclaimed except that exports and imports of such recyclable materials [shall] comply with the requirements of 40 CFR part 262, subpart H.
 - (A) A person initiating a shipment for reclamation in a foreign country, and any intermediary arranging for the shipment, [shall] comply with the requirements applicable to a primary exporter in [§ 262.83(b), (g) and (i),] export such materials only upon consent of the receiving country and in conformance with the EPA Acknowledgment of Consent as defined in [subpart H] of part 262, and provide a copy of the EPA Acknowledgment of Consent to the

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shipment to the transporter transporting the shipment for export;

- (B) Transporters transporting a shipment for export may not accept a shipment if [the transporter] knows the shipment does not conform to the EPA Acknowledgment of Consent, [shall] ensure that a copy of the EPA Acknowledgment of Consent accompanies the shipment and [shall] ensure that [the EPA Acknowledgment of Consent] is delivered to the [subsequent transporter or] facility designated by the person initiating the shipment.

- (ii) Scrap metal that is not excluded under § 261.4(a)(13);
- (iii) Fuels produced from the refining of oil-bearing hazardous waste along with normal process streams at a petroleum refining facility if such wastes result from normal petroleum refining, production, and transportation practices (this exemption does not apply to fuels produced from oil recovered from oil-bearing hazardous waste, where such recovered oil is already excluded under § 261.4(a)(12);
- (iv)(A) Hazardous waste fuel produced from oil-bearing hazardous wastes from petroleum refining, production, or transportation practices, or produced from oil reclaimed from such hazardous wastes, where such hazardous wastes are reintroduced into a process that does not use distillation or does not produce products from crude oil so long as the resulting fuel meets the used oil specification under [A.R.S. § 49-801] and so long as no other hazardous wastes are used to produce the hazardous waste fuel;
- (B) Hazardous waste fuel produced from oil-bearing hazardous waste from petroleum refining[,] production, and transportation practices, where such hazardous wastes are reintroduced into a refining process after a point at which contaminants are removed, so long as the fuel meets the used oil fuel specification under [A.R.S. § 49-801]; and
- (C) Oil reclaimed from oil-bearing hazardous wastes from petroleum refining, production, and transportation practices, which reclaimed oil is burned as a fuel without reintroduction to a refining process, so long as the reclaimed oil meets the used oil fuel specification under [A.R.S. § 49-801].

- G. § 261.11, titled "Criteria for listing hazardous waste," paragraph (a) is amended as follows:
- (a) The [Director] shall list a solid waste as a hazardous waste only upon determining that the solid waste meets one of the following criteria:

- (1) It exhibits any of the characteristics of hazardous waste identified in subpart C.
- (2) It has been found to be fatal to humans in low doses or, in the absence of data on human toxicity, it has been shown in studies to have an oral LD 50 toxicity (rat) of less than 50 milligrams per kilogram, an inhalation LC 50 toxicity (rat) of less than 2 milligrams per liter, or a dermal LD 50 toxicity (rabbit) of less than 200 milligrams per kilogram or is otherwise capable of causing or significantly contributing to an increase in serious irreversible, or incapacitating reversible, illness. (Waste listed in accordance

with these criteria shall be designated Acute Hazardous Waste.)

- (3) It contains any of the toxic constituents listed in Appendix VIII and, after considering the following factors, the [Director] concludes that the waste is capable of posing a substantial present or potential hazard to human health or the environment when improperly treated, stored, transported, or disposed of, or otherwise managed:
- (i) The nature of the toxicity presented by the constituent.
- (ii) The concentration of the constituent in the waste.
- (iii) The potential of the constituent or any toxic degradation product of the constituent to migrate from the waste into the environment under the types of improper management considered in (a)(3)(vii) of this [subsection].
- (iv) The persistence of the constituent or any toxic degradation product of the constituent.
- (v) The potential for the constituent or any toxic degradation product of the constituent to degrade into nonharmful constituents and the rate of degradation.
- (vi) The degree to which the constituent or any degradation product of the constituent bioaccumulates in ecosystems.
- (vii) The plausible types of improper management to which the waste could be subjected.
- (viii) The quantities of the waste generated at individual generation sites or on a regional or national basis.
- (ix) The nature and severity of the human health and environmental damage that has occurred as a result of the improper management of wastes containing the constituent.
- (x) Action taken by other governmental agencies or regulatory programs based on the health or environmental hazard posed by the waste or waste constituent.
- (xi) Such other factors as may be appropriate.

- H. § 261.11, titled "Criteria for listing hazardous waste," paragraph (c) is amended as follows:

- (c) The Administrator will use the criteria for listing specified in this section to establish the exclusion limits referred to in [§ 262.13(c).]

- I. § 261.30, titled "General", paragraph (d) is amended as follows:

- (d) The following hazardous wastes listed in § 261.31 are subject to the exclusion limits for acutely hazardous wastes established in [§ 261.13:] EPA Hazardous Wastes Nos. F020, F021, F022, F023, F026 and F027.

- J. Notwithstanding the definitions of "EPA" and "EPA Regional Administrator" in R18-8-260(E)(11) and (F)(2):

1. In § 261.151(g), the third sentence is replaced by the following: "If the facilities covered by the mechanism are in more than one State, identical evidence of financial assurance must be submitted to and maintained with each state agency regulating hazardous waste or with the appropriate Regional Administrator if a facility is located in an unauthorized State."
2. § 261.151 is amended by adding at the end: "Whenever this section requires that the owner or operator of a reclamation or intermediate facility notify several Regional

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Administrators of their financial obligations, the notice shall be to both DEQ and all Regional Administrators of the United States Environmental Protection Agency of Regions that are affected by the owner or operator's financial assurance mechanisms."

Historical Note

Adopted effective July 24, 1984 (Supp. 84-4). Amended subsection (A) effective June 27, 1985 (Supp. 85-3). Amended subsections (A) and (E) effective August 5, 1986 (Supp. 86-4). Former Section R9-8-1861 renumbered as Section R18-8-261, and subsections (A), (D) and (F) amended effective May 29, 1987 (Supp. 87-2). Amended subsection (B) effective December 1, 1988 (Supp. 88-4). Amended effective October 11, 1989 (Supp. 89-4). Amended effective August 14, 1991 (Supp. 91-3). Amended effective October 6, 1992 (Supp. 92-4). Amended effective December 2, 1994 (Supp. 94-4). Amended effective December 7, 1995 (Supp. 95-4). Amended effective June 13, 1996 (Supp. 96-2). Amended effective August 8, 1997 (Supp. 97-3). Amended effective June 4, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 4625, effective November 15, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3093, effective July 24, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 816, effective April 15, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 4364, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5523, effective February 4, 2006 (Supp. 05-4). Amended by final rulemaking at 12 A.A.R. 3061, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 14 A.A.R. 409, effective March 8, 2008 (Supp. 08-1). Amended by final rulemaking at 21 A.A.R. 1246, effective September 5, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 435, effective February 5, 2019 (Supp. 19-1). Amended by final rulemaking at 26 A.A.R. 2949, with an immediate effective date of November 3, 2020 (Supp. 20-4). Due to a clerical error, subsection (J) was inadvertently published with text underlined in Supp. 20-4; the underlining has been removed in Supp. 21-4.

R18-8-262. Standards Applicable to Generators of Hazardous Waste

- A. All of 40 CFR 262, revised as of July 1, 2020 (and no future editions), is incorporated by reference, modified by the following subsections, and on file with the DEQ. Copies of 40 CFR 262 are available at <https://www.eCFR.gov>.
- B. In 40 CFR 262:
 - 1. ["Section 3008 of RCRA" means both section 3008 of RCRA and A.R.S. §§ 49-923, 49-924 and 49-925.]
 - 2. ["Section 2002(a) of the Act" means A.R.S. § 49-922.]
 - 3. ["Section 3002(6) of the Act" means A.R.S. § 49-922.]
- C. § 262.10, titled "Purpose, scope, and applicability," paragraph (i) is amended as follows:
 - (i) [For the limited time period required to control, mitigate, or eliminate the immediate threat,] persons responding to an explosives or munitions emergency in accordance with 40 CFR 264.1(g)(8)(i)(D) or (iv), or 265.1(c)(11)(i)(D) or (iv), and 270.1(c)(3)(i)(D) or (iii) are not required to comply with the standards of this part. [As soon as the immediate response activities are completed, all standards of this part apply. For purposes of this rule, DEQ does not consider emergency response personnel to be generators of residuals resulting from immediate responses, unless

they are also the owner of the object of an emergency response. The owner of the object of an emergency response, the owner of the property on which the object of an emergency rests or where the emergency response initiates, or the requestor for an emergency response is responsible for addressing any residual contamination that results from an emergency response.]

- D. § 262.11, titled "Hazardous waste determination and record-keeping," paragraphs (d)(1) and (d)(2) are amended by deleting the following:
 - " , or an equivalent test method approved by the Administrator under 40 CFR 260.21,"
- E. § 262.13, titled "Generator category determinations", paragraph (f)(1)(iii) is amended as follows:
 - (iii) If a very small quantity generator's wastes are mixed with used oil, the mixture is subject to 40 CFR 279 [(as incorporated by A.R.S. § 49-802)]. Any material produced from such a mixture by processing, blending, or other treatment is also [so regulated].
- F. § 262.16, titled "Conditions for exemption for a small quantity generator that accumulates hazardous waste", paragraph (b)(9)(iv)(C) is amended as follows:
 - (C) In the event of a fire, explosion, or other release that could threaten human health outside the facility or when the small quantity generator has knowledge that a spill has reached surface water [or when a spill has discharged into a storm sewer or dry well, or such an event has resulted in any other discharge that may reach groundwater], the small quantity generator immediately [shall] notify the National Response Center (using their 24-hour toll-free number 800/424-8802) [and the DEQ (using their 24-hour number (602) 771-2330 or 800/234-5677)]. The report [shall contain] the following information:
 - (1) The name, address, and [the EPA Identification Number] of the generator;
 - (2) Date, time, [location,] and type of incident (for example, spill or fire);
 - (3) Quantity and type of hazardous waste involved in the incident;
 - (4) Extent of injuries, if any; and
 - (5) Estimated quantity and disposition of recovered materials, if any.
- G. Any generator who must comply with 40 CFR 262.16 or 262.17 shall keep a written log of the inspections of container, tank, drip pad, and containment building areas and for the containers, tanks, and other equipment located in these storage areas in accordance with 40 CFR 265.174, 265.195, 265.444, and 265.1101(c)(4). The inspection log shall be kept by the generator for three years from the date of the inspection. The generator shall ensure that the inspection log is filled in after each inspection and includes the following information: inspection date, inspector's name and signature, and remarks or corrections.
- H. § 262.17, titled "Conditions for exemption for a large quantity generator that accumulates hazardous waste", paragraph (f)(1) is amended as follows:
 - (1) The large quantity generator notifies [DEQ] at least 30 days prior to receiving the first shipment from a very small quantity generator(s) using EPA Form 8700-12; and
- I. § 262.18, titled "EPA identification numbers and re-notification for small quantity generators and large quantity generators," paragraphs (a), (b) and (d) are amended as follows:

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- (a) A generator must not treat, store, dispose of, transport, or offer for transportation, hazardous waste without having received an EPA identification number from the [DEQ].
- (b) A generator who has not received an EPA identification number may obtain one by applying to the [DEQ] using EPA form 8700-12. [The completed form shall be submitted to DEQ through the myDEQ online portal.] Upon receiving the request, the [DEQ] will assign an EPA identification number to the generator.
- (d) Re-notification. (1) A small quantity generator must re-notify [DEQ] starting in 2021 and every four years thereafter using EPA Form 8700-12. This re-notification must be submitted through the myDEQ online portal by September 1 of each year in which re-notifications are required.
- (2) A large quantity generator must re-notify [DEQ] by March 1 of each even numbered year thereafter using EPA Form 8700-12. A large quantity generator may submit this re-notification as part of its Report required under § 262.41.
- J. § 262.20, titled “General requirements”, paragraph (a)(2) is amended as follows:
 - (2) The revised manifest form and procedures in 40 CFR 260.10, 261.7, [262.16, 262.17, 262.20, 262.21, 262.27, 262.32, 262.83(c) through (e), 262.84,] shall not apply until September 5, 2006. The manifest form and procedures in 40 CFR 260.10, 261.7, [262.16, 262.17, 262.20, 262.21, 262.32, 262.83(c) through (e), 262.84,] contained in the 40 CFR, parts 260 to 265, edition revised as of July 1, 2004, shall be applicable until September 5, 2006.
- K. § 262.212, titled “Making the hazardous waste determination at an on-site interim status or permitted treatment, storage or disposal facility”, paragraph (e)(3) is amended as follows:
 - (3) Count the hazardous waste toward the eligible academic entity’s generator status, pursuant to [§ 262.13(c) and (d)] in the calendar month that the hazardous waste determination was made, and
- L. § 262.265, titled “Emergency procedures”, paragraph (d)(2) is amended as follows:
 - (2) The emergency coordinator [shall] immediately notify either the government official designated as the on-scene coordinator for that geographical area, or the National Response Center (using their 24-hour toll free number 800/424-8802) [and the DEQ (using their 24-hour number (602) 771-2330 or 800/234-5677)]. The report [shall contain the following information:]
 - (i) The name, address, and [the EPA Identification Number] of the generator;
 - (ii) Date, time, [location,] and type of incident (for example, spill or fire);
 - (iii) Quantity and type of hazardous waste involved in the incident;
 - (iv) Extent of injuries, if any; and
 - (v) Estimated quantity and disposition of recovered materials, if any.]
- M. A generator who accumulates ignitable, reactive, or incompatible waste shall comply with 40 CFR 265.17.
 - (Supp. 88-4). Amended effective October 11, 1989 (Supp. 89-4). Amended effective August 14, 1991 (Supp. 91-3). Amended effective October 6, 1992 (Supp. 92-4). Amended effective December 2, 1994 (Supp. 94-4). Amended effective December 7, 1995 (Supp. 95-4). Amended effective June 13, 1996 (Supp. 96-2). Amended effective August 8, 1997 (Supp. 97-3). Amended effective June 4, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 4625, effective November 15, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3093, effective July 24, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 816, effective April 15, 2003 (Supp. 03-1). Amended by final rulemaking at 11 A.A.R. 5523, effective February 4, 2006 (Supp. 05-4). Amended by final rulemaking at 12 A.A.R. 3061, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 14 A.A.R. 409, effective March 8, 2008 (Supp. 08-1). Amended by final rulemaking at 21 A.A.R. 1246, effective September 5, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 435, effective February 5, 2019 (Supp. 19-1). Amended by final rulemaking at 26 A.A.R. 2949, with an immediate effective date of November 3, 2020 (Supp. 20-4).

R18-8-263. Standards Applicable to Transporters of Hazardous Waste

- A. All of 40 CFR 263, revised as of July 1, 2020 (and no future editions), is incorporated by reference, modified by the following subsections, and on file with the DEQ. Copies of 40 CFR 263 are available at <https://www.eCFR.gov>.
- B. § 263.11, titled “EPA identification numbers,” is amended by the following:
 - (a) A transporter must not transport hazardous wastes without having received an EPA identification number from the [DEQ].
 - (b) A transporter who has not received an EPA identification number may obtain one by applying to the [DEQ] using EPA form 8700-12. [The completed form shall be submitted to DEQ through the myDEQ online portal.] Upon receiving the request, the [DEQ] will assign an EPA identification number to the transporter.
- C. § 263.30, titled “Immediate action,” paragraph (c)(2) is amended by the following:
 - (2) Report in writing as required by 49 CFR 171.16 to the Director, Office of Hazardous Materials Regulations, Materials Transportation Bureau, Department of Transportation, Washington, DC 20590 [and send a copy to the DEQ, Hazardous Waste Unit, 1110 W. Washington St., Phoenix, AZ 85007.]

Historical Note

Adopted effective July 24, 1984 (Supp. 84-4). Amended subsection (A) effective June 27, 1985 (Supp. 85-3). Amended subsection (A) effective August 5, 1986 (Supp. 86-5). Former Section R9-8-1863 renumbered as R18-8-263, and subsection (A) amended effective May 29, 1987 (Supp. 87-2). Amended subsection (A) effective October 11, 1989 (Supp. 89-4). Amended effective August 14, 1991 (Supp. 91-3). Amended effective October 6, 1992 (Supp. 92-4). Amended effective December 2, 1994 (Supp. 94-4). Amended effective December 7, 1995 (Supp. 95-4). Amended effective June 13, 1996 (Supp. 96-2). Amended effective August 8, 1997 (Supp. 97-3). Amended effective June 4, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 4625, effective Novem-

Historical Note
 Adopted effective July 24, 1984 (Supp. 84-4). Amended subsection (A) effective June 27, 1985 (Supp. 85-3). Amended subsections (A) and (D) effective August 5, 1986 (Supp. 86-4). Former Section R9-8-1862 renumbered as R18-8-262, and amended effective May 29, 1987 (Supp. 87-2). Amended effective December 1, 1988

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ber 15, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3093, effective July 24, 2000 (Supp. 00-3). Amended by final rulemaking at 10 A.A.R. 4364, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5523, effective February 4, 2006 (Supp. 05-4). Amended by final rulemaking at 12 A.A.R. 3061, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 14 A.A.R. 409, effective March 8, 2008 (Supp. 08-1). Amended by final rulemaking at 21 A.A.R. 1246, effective September 5, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 435, effective February 5, 2019 (Supp. 19-1). Amended by final rulemaking at 26 A.A.R. 2949, with an immediate effective date of November 3, 2020 (Supp. 20-4).

R18-8-264. Standards for Owners and Operators of Hazardous Waste Treatment, Storage, and Disposal Facilities

- A.** All of 40 CFR 264 and accompanying appendices, revised as of July 1, 2020 (and no future editions), with the exception of §§ 264.1(d) and (f), 264.149, 264.150, and 264.301(l), is incorporated by reference, modified by the following subsections, and on file with the DEQ. Copies of 40 CFR 264 are available at <https://www.eCFR.gov>.
- B.** § 264.1, titled “Purpose, scope and applicability,” paragraph (g)(1) is amended as follows:
- (1) The owner or operator of a facility [with operational approval from the Director] to manage [public, private,] municipal or industrial solid waste [pursuant to R18-13-312, A.R.S. §§ 49-104 and 49-762], if the only hazardous waste the facility treats, stores, or disposes of is excluded from regulation under [R18-8-264] pursuant to § 262.14;
- C.** § 264.1, titled “Purpose, scope, and applicability,” paragraph (g)(8)(i)(D) is amended as follows:
- (D) An immediate threat to human health, public safety, property, or the environment, from the known or suspected presence of military munitions, other explosive material, or an explosive device, as determined by an explosive or munitions emergency response specialist as defined in 40 CFR 260.10. [The DEQ Emergency Response Unit shall be notified as soon as possible, using the 24-hour number (602) 771-2330 or (800) 234-5677.]
- D.** § 264.11, titled “Identification number,” is replaced by the following:
1. A facility owner or operator shall not treat, store, dispose of, transport, or offer for transportation, hazardous waste without having received an EPA identification number from the DEQ.
 2. A facility owner or operator who has not received an EPA identification number may obtain one by applying to the DEQ using EPA form 8700-12. The completed form shall be submitted to DEQ through the myDEQ online portal. Upon receiving the request, the DEQ will assign an EPA identification number to the facility owner or operator.
- E.** § 264.18, titled “Location standards,” paragraph (c) is amended by deleting the following:
- (c) “, except for the Department of Energy Waste Isolation Pilot Project in New Mexico.”
- F.** § 264.56, titled “Emergency procedures,” paragraph (d)(2) is amended as follows:
- (2) [The emergency coordinator, or designee, shall] immediately notify [the DEQ at (602) 771-2330 or (800) 234-5677, extension 771-2330, and notify] either the government official designated as the on-scene coordinator for that geographical area, or the National Response Center (using their 24-hour toll free number (800) 424-8802). The report [shall include the following]:
- (i) Name and telephone number of reporter;
 - (ii) Name and address of facility;
 - (iii) Time and type of incident (for example, release, fire);
 - (iv) Name and quantity of material(s) involved, to the extent known;
 - (v) The extent of injuries, if any; and
 - (vi) The possible hazards to human health, or the environment, outside the facility.
- G.** § 264.93, titled “Hazardous constituents,” paragraph (c) is amended as follows:
- (c) In making any determination under [§ 264.93(b)] about the use of ground water in the area around the facility, the [Director shall] consider any identification of underground sources of drinking water and exempted aquifers made under [40 CFR] § 144.7, [and any identification of uses of ground water made pursuant to 18 A.A.C. 9 or 11].
- H.** § 264.94, titled “Concentration limits,” paragraph (c) is amended as follows:
- (c) In making any determination under [§ 264.94(b)] about the use of ground water in the area around the facility, the [Director shall] consider any identification of underground sources of drinking water and exempted aquifers made under [40 CFR] 144.7, [and any identification of uses of ground water made pursuant to 18 A.A.C. 9 or 11].
- I.** § 264.143, titled “Financial assurance for closure,” paragraph (h), and 264.145, titled “Financial assurance for post-closure care,” paragraph (h), are amended by replacing the third sentence in each citation with the following: “Evidence of financial assurance must be submitted to and maintained with the Director for those facilities located in Arizona.”
- J.** § 264.147, titled “Liability requirements,” paragraphs (a)(1)(i) and (b)(1)(i) are amended by deleting the following from the fourth sentence in each citation: “, or Regional Administrators if the facilities are located in more than one Region.”
- K.** § 264.151, titled “Wording of the instruments,” is adopted except any reference to “{of/for} the Regions in which the facilities are located” is deleted and “an agency of the United States Government” is deleted from the second paragraph of the Trust Agreements.
- L.** § 264.301, titled “Design and operating requirements,” is amended by adding the following:
- [The DEQ may require that hazardous waste disposed in a landfill operation be treated prior to landfilling to reduce the water content, water solubility, and toxicity of the waste. The decision by the DEQ shall be based upon the following criteria:
1. Whether the action is necessary to protect public health;
 2. Whether the action is necessary to protect the groundwater, particularly where the groundwater is a source, or potential source, of a drinking water supply;
 3. The type of hazardous waste involved and whether the waste may be made less hazardous through treatment;
 4. The degree of water content, water solubility, and toxicity of the waste;
 5. The existence or likelihood of other wastes in the landfill and the compatibility or incompati-

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bility of the wastes with the wastes being considered for treatment;

6. Consistency with other laws, rules and regulations, but not necessarily limited to laws, rules, and regulations relating to landfills and solid wastes.]

M. § 264.1030, titled “Applicability”, paragraph (b)(3) is amended as follows:

- (3) A unit that is exempt from permitting under the provisions of [40 CFR 262.17(a)] (i.e., a “90-day” tank or container) and is not a recycling unit under the provisions of 40 CFR 261.6.

N. § 264.1050, titled “Applicability”, paragraph (b)(2) is amended as follows:

- (2) A unit (including a hazardous waste recycling unit) that is not exempt from permitting under the provisions of [40 CFR 262.17(a)] (i.e., a hazardous waste recycling unit that is not a “90-day” tank or container) and that is located at a hazardous waste management facility otherwise subject to the permitting requirements of 40 CFR part 270, or

Historical Note

Adopted effective July 24, 1984 (Supp. 84-4). Amended subsection (A) effective June 27, 1985 (Supp. 85-3). Amended subsection (A) effective August 5, 1986 (Supp. 86-4). Former Section R9-8-1864 renumbered as Section R18-8-264, and subsection (A) amended effective May 29, 1987 (Supp. 87-2). Amended subsection (B) effective December 1, 1988 (Supp. 88-4). Amended effective October 11, 1989 (Supp. 89-4). Amended effective August 14, 1991 (Supp. 91-3). Amended effective October 6, 1992 (Supp. 92-4). Amended effective December 2, 1994 (Supp. 94-4). Amended effective December 7, 1995 (Supp. 95-4). Amended effective June 13, 1996 (Supp. 96-2). Amended effective August 8, 1997 (Supp. 97-3). Amended effective June 4, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 4625, effective November 15, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3093, effective July 24, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 816, effective April 15, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 4364, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5523, effective February 4, 2006 (Supp. 05-4). Amended by final rulemaking at 12 A.A.R. 3061, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 14 A.A.R. 409, effective March 8, 2008 (Supp. 08-1). Amended by final rulemaking at 21 A.A.R. 1246, effective September 5, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 435, effective February 5, 2019 (Supp. 19-1). Amended by final rulemaking at 26 A.A.R. 2949, with an immediate effective date of November 3, 2020 (Supp. 20-4).

R18-8-265. Interim Status Standards for Owners and Operators of Hazardous Waste Treatment, Storage, and Disposal Facilities

- A.** All of 40 CFR 265 and accompanying appendices, revised as of July 1, 2020 (and no future editions), with the exception of §§ 265.1(c)(2), 265.1(c)(4), 265.149, 265.150, and 265.430, is incorporated by reference, modified by the following subsections, and on file with the DEQ. Copies of 40 CFR 265 are available at <https://www.eCFR.gov>

B. § 265.1, titled “Purpose, scope, and applicability,” paragraph (c)(5) is amended as follows:

- (5) The owner or operator of a facility [with operational approval from the Director] to manage [public, private,] municipal or industrial solid waste [pursuant to R18-13-312, A.R.S. §§ 49-104 and 49-762], if the only hazardous waste the facility treats, stores, or disposes of is excluded from regulation under § 261.5;

C. § 265.1, titled “Purpose, scope, and applicability,” paragraph (c)(11)(i)(D) is amended as follows:

- (D) An immediate threat to human health, public safety, property, or the environment, from the known or suspected presence of military munitions, other explosive material, or an explosive device, as determined by an explosive or munitions emergency response specialist as defined in 40 CFR 260.10. [The DEQ Emergency Response Unit shall be notified as soon as possible, using the 24-hour number (602) 771-2330 or (800) 234-5677]

D. § 265.11, titled “Identification number,” is replaced by the following:

1. A facility owner or operator shall not treat, store, dispose of, transport, or offer for transportation, hazardous waste without having received an EPA identification number from the DEQ.
2. A facility owner or operator who has not received an EPA identification number may obtain one by applying to the DEQ using EPA form 8700-12. The completed form shall be submitted to DEQ through the myDEQ online portal. Upon receiving the request, the DEQ shall assign an EPA identification number to the facility owner or operator.]

E. § 265.18, titled “Location standards,” is amended by deleting the following:

“, except for the Department of Energy Waste Isolation Pilot Project in New Mexico.”

F. § 265.56, titled “Emergency procedures,” paragraph (d)(2) is amended as follows:

- (2) [The emergency coordinator, or designee, immediately shall] notify [the DEQ at (602) 771-2330 or 800/234-5677, and notify] either the government official designated as the on-scene coordinator for that geographical area, or the National Response Center (using their 24-hour toll-free number 800/424-8802). The report [shall include the following]:
 - (i) Name and telephone number of the reporter;
 - (ii) Name and address of the facility;
 - (iii) Time and type of incident (for example, release, fire);
 - (iv) Name and quantity of material(s) involved, to the extent known;
 - (v) The extent of injuries, if any; and
 - (vi) The possible hazards to human health, or the environment, outside the facility.

G. § 265.71, titled “Use of the manifest system”, is amended in the Comment following paragraph (c) as follows:

Comment: The provisions of [§§ 262.15, 262.16 and 262.17] are applicable to the on-site accumulation of hazardous wastes by generators. Therefore, the provisions of [§§ 262.15, 262.16 and 262.17] only apply to owners or operators who are shipping hazardous waste which they generated at that facility.

H. § 265.90, titled “Applicability,” paragraphs (a) and (d)(1), and § 265.93, titled “Preparation, evaluation, and response,” paragraph (a), are amended by deleting the following phrase: “within one year”; and § 265.90, titled “Applicability,” para-

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graph (d)(2), is amended by deleting the following phrase: “Not later than one year.”

- I. § 265.112(d), titled “Notification of partial closure and final closure,” subparagraph (1) is amended as follows:

1. The owner or operator must submit the closure plan to the [Director] at least 180 days prior to the date on which [the owner or operator] expects to begin closure of the first surface impoundment, waste pile, land treatment, or land-fill unit, [tank, container storage, or incinerator unit], or final closure if it involves such a unit, whichever [occurs earlier. The owner or operator with approved closure plans shall notify the Director] in writing at least 60 days prior to the date on which [the owner or operator expects] to begin closure of a surface impoundment, waste pile, landfill, or land treatment unit, or final closure of a facility [if it involves such a unit. The owner or operator] with approved closure plans must notify the [Director] in writing at least 45 days prior to the date on which [the owner or operator expects] to begin final closure of a facility with only tanks, container storage, or incinerator units.

- J. §§ 265.143, titled “Financial assurance for closure,” paragraph (g), and 265.145, titled “Financial assurance for post-closure care,” paragraph (g), are amended by replacing the third sentence in each citation with the following: “Evidence of financial assurance must be submitted to and maintained with the Director for those facilities located in Arizona.”

- K. § 265.193, titled “Containment and detection of releases”, is amended by adding the following:

[For existing underground tanks and associated piping systems not yet retrofitted in accordance with § 265.193, the owner or operator shall ensure that:

1. A level is measured daily;
2. A material balance is calculated and recorded daily; and
3. A yearly test for leaks in the tank and piping system, using a method approved by the DEQ is performed.]

Historical Note

Adopted effective July 24, 1984 (Supp. 84-4). Amended subsection (A) effective June 27, 1985 (Supp. 85-3). Amended subsection (A) effective August 5, 1986 (Supp. 86-4). Former Section R9-8-1865 renumbered as Section R18-8-265, subsection (A) amended and a new subsection (I) added effective May 29, 1987 (Supp. 87-2). Amended subsection (B) effective December 1, 1988 (Supp. 88-4). Amended effective October 11, 1989 (Supp. 89-4). Amended effective August 14, 1991 (Supp. 91-3). Amended effective October 6, 1992 (Supp. 92-4). Amended effective December 2, 1994 (Supp. 94-4). Amended effective December 7, 1995 (Supp. 95-4). Amended effective June 13, 1996 (Supp. 96-2). Amended effective August 8, 1997 (Supp. 97-3). Amended effective June 4, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 4625, effective November 15, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3093, effective July 24, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 816, effective April 15, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 4364, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5523, effective February 4, 2006 (Supp. 05-4). Amended by final rulemaking at 12 A.A.R. 3061, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 14 A.A.R. 409, effective March 8, 2008 (Supp. 08-1). Amended by final rulemaking at 21 A.A.R. 1246, effective

September 5, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 435, effective February 5, 2019 (Supp. 19-1). Amended by final rulemaking at 26 A.A.R. 2949, with an immediate effective date of November 3, 2020 (Supp. 20-4).

R18-8-266. Standards for the Management of Specific Hazardous Wastes and Specific Hazardous Waste Management Facilities

- A. All of 40 CFR 266 and accompanying appendices, revised as of July 1, 2020 (and no future editions), is incorporated by reference, modified by the following subsections, and on file with the DEQ. Copies of 40 CFR 266 are available at <https://www.eCFR.gov>.

- B. § 266.100, titled “Applicability” paragraph (c) is amended as follows:

(c) The following hazardous wastes and facilities are not subject to regulation under this subpart:

- (1) Used oil burned for energy recovery that is also a hazardous waste solely because it exhibits a characteristic of hazardous waste identified in subpart C of part 261 of this chapter. Such used oil is subject to regulation under [A.R.S. §§ 49-801 through 49-818];
- (2) Gas recovered from hazardous or solid waste landfills when such gas is burned for energy recovery;
- (3) Hazardous wastes that are exempt from regulation under §§ 261.4 and 261.6(a)(3)(iii) and (iv) of this chapter, and hazardous wastes that are subject to the special requirements for [very] small quantity generators under [§§ 262.13 and 262.14] of this chapter; and
- (4) Coke ovens, if the only hazardous waste burned is EPA Hazardous Waste No. K087, decanter tank tar sludge from coking operations.

- C. § 266.108, titled “Small quantity on-site burner exemption” is amended in the Note following paragraph (c) as follows:

Note: Hazardous wastes that are subject to the special requirements for small quantity generators under [§§ 262.13 and 262.14] of this chapter may be burned in an off-site device under the exemption provided by § 266.108, but must be included in the quantity determination for the exemption.

Historical Note

Adopted effective August 5, 1986 (Supp. 86-4). Former Section R9-8-1866 renumbered as Section R18-8-266, and amended effective May 29, 1987 (Supp. 87-2). Amended effective October 11, 1989 (Supp. 89-4). Amended effective August 14, 1991 (Supp. 91-3). Amended effective October 6, 1992 (Supp. 92-4). Amended effective December 2, 1994 (Supp. 94-4). Amended effective December 7, 1995 (Supp. 95-4). Amended effective June 13, 1996 (Supp. 96-2). Amended effective August 8, 1997 (Supp. 97-3). Amended effective June 4, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 4625, effective November 15, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3093, effective July 24, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 816, effective April 15, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 4364, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5523, effective February 4, 2006 (Supp. 05-4). Amended by final rulemaking at 12 A.A.R. 3061, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 14

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A.A.R. 409, effective March 8, 2008 (Supp. 08-1). Amended by final rulemaking at 21 A.A.R. 1246, effective September 5, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 435, effective February 5, 2019 (Supp. 19-1). Amended by final rulemaking at 26 A.A.R. 2949, with an immediate effective date of November 3, 2020 (Supp. 20-4).

R18-8-267. Reserved

R18-8-268. Land Disposal Restrictions

All of 40 CFR 268 and accompanying appendices, revised as of July 1, 2020 (and no future editions), with the exception of Part 268, Subpart B, is incorporated by reference and on file with the DEQ. Copies of 40 CFR 268 are available at <https://www.eCFR.gov>.

Historical Note

Adopted effective October 11, 1989 (Supp. 89-4). Amended effective August 14, 1991 (Supp. 91-3). Amended effective October 6, 1992 (Supp. 92-4). Amended effective December 2, 1994 (Supp. 94-4). Amended effective December 7, 1995 (Supp. 95-4). Amended effective June 13, 1996 (Supp. 96-2). Amended effective August 8, 1997 (Supp. 97-3). Amended effective June 4, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 4625, effective November 15, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3093, effective July 24, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 816, effective April 15, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 4364, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5523, effective February 4, 2006 (Supp. 05-4). Amended by final rulemaking at 12 A.A.R. 3061, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 14 A.A.R. 409, effective March 8, 2008 (Supp. 08-1). Amended by final rulemaking at 25 A.A.R. 435, effective February 5, 2019 (Supp. 19-1). Amended by final rulemaking at 26 A.A.R. 2949, with an immediate effective date of November 3, 2020 (Supp. 20-4).

R18-8-269. Expired

Historical Note

Adopted effective July 24, 1984 (Supp. 84-4). Former Section R9-8-1869 renumbered without change as Section R18-8-269 (Supp. 87-2). Amended subsections (A) and (B) effective December 1, 1988 (Supp. 88-4). Amended effective December 2, 1994 (Supp. 94-4). Section expired pursuant to A.R.S. § 41-1056(J), at 23 A.A.R. 3428, effective October 10, 2017 (Supp. 17-4).

R18-8-270. Hazardous Waste Permit Program

- A. All of 40 CFR 270 and the accompanying appendices, revised as of July 1, 2020 (and no future editions), is incorporated by reference, modified by the following subsections, and on file with the DEQ with the exception of the following:
 1. §§ 270.1(a), 270.1(c)(1)(i), 270.3, 270.10(g)(1)(i), 270.60(a) and (b), and 270.64; and
 2. The revisions for standardized permits as published at 70 FR 53419. Copies of 40 CFR 270 are available at <https://www.eCFR.gov>. Copies of the Federal Register are available at <https://www.federalregister.gov>.
- B. § 270.1, titled “Purpose and scope of these regulations,” paragraph (b) is replaced by the following:

1. [After the effective date of these regulations the treatment, storage, or disposal of any hazardous waste is prohibited except as follows:
 - a. As allowed under § 270.1(c)(2) and (3);
 - b. Under the conditions of a permit issued pursuant to these regulations; or
 - c. At an existing facility accorded interim status under the provisions of § 270.70.
2. The direct disposal or discharge of hazardous waste into or onto any of the following is prohibited:
 - a. Waters of the state as defined in A.R.S. § 49-201, excluding surface impoundments as defined in § 260.10; and
 - b. Injection well, ditch, alleyway, storm drain, leach-field, or roadway.]
- C. § 270.1, titled “Purpose and scope of these regulations,” paragraph (c)(3)(i)(D) is amended as follows:
 - (D) An immediate threat to human health, public safety, property, or the environment, from the known or suspected presence of military munitions, other explosive material, or an explosive device, as determined by an explosive or munitions emergency response specialist as defined in 40 CFR 260.10. [The DEQ Emergency Response Unit shall be notified as soon as possible, using the 24-hour number (602) 771-2330 or (800) 234-5677.]
- D. § 270.10, titled “General application requirements,” paragraph (e)(2), is amended as follows:
 - (2) The [Director] may extend the date by which owners and operators of specified classes of existing [HWM facilities shall submit Part A of their permit application if the Administrator has published in the Federal Register that EPA is granting an extension under 40 CFR § 270.10(e)(2) for those classes of facilities.]
- E. § 270.10(g), titled “Updating permit applications,” subparagraph (1)(ii) is amended as follows:
 - (ii) With the [Director] no later than the effective date of regulatory provisions listing or designating wastes as hazardous in [the] state if the facility is treating, storing, or disposing of any of those newly listed or designated wastes; or
- F. § 270.10(g), titled “Updating permit applications,” subparagraph (1)(iii), is amended as follows:
 - (iii) As necessary to comply with provisions of § 270.72 for changes during interim [status]. Revised Part A applications necessary to comply with the provisions of § 270.72 [shall be filed with the [Director].]
- G. § 270.10, titled “General application requirements,” is amended by adding the following:
 1. When submitting an application for any of the license types in the Table below, an applicant shall remit to the DEQ an application fee as shown in the Table.

Table - Hazardous Waste Permitting Application and Maximum Fees For Various License Types

License Type	Application Fee	Maximum Fee
Permit for: Container Storage/Container Treatment	\$20,000	\$250,000
Permit for: Tank Storage/Tank Treatment	\$20,000	\$300,000
Permit for: Surface Impoundment	\$20,000	\$400,000
Permit for: Incinerator/Boiler and Industrial Furnace (BIF)/Landfill/Miscellaneous Unit	\$20,000	\$500,000

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Permit for: Waste Pile/Land Treatment/Drip Pad/Containment Building/Research, Development, and Demonstration	\$20,000	\$300,000
Corrective Action Permit/Remedial Action Plan (RAP) Approval	\$20,000	\$300,000
Post-Closure Permit	\$20,000	\$400,000
Closure of Container/Tank/Drip Pad/Containment Building	\$5,000/unit	\$100,000
Closure of Miscellaneous Unit/Incinerator/BIF/Surface Impoundment/Waste Pile/Land Treatment Unit/Landfill	\$5,000/unit	\$300,000
Class 1 Modification (requiring Director Approval)	\$1,000	\$50,000
Class 2 Modification	\$5,000	\$250,000
Class 3 Modification (for a permit with an Incinerator, BIF, Surface Impoundment, Waste Pile, Land Treatment Unit, or Landfill)	\$20,000	\$400,000
Class 3 Modification (for a permit without an Incinerator, BIF, Surface Impoundment, Waste Pile, Land Treatment Unit, or Landfill)	\$10,000	\$250,000

2. If the total cost of processing the application identified in the Table is less than the application fee listed in the Table, the DEQ shall refund the difference between the total cost and the amount listed in the Table to the applicant.
 - a. Permits and permit modifications other than post-closure permits and closure plans. If the total cost of processing the application is greater than the amount listed plus other amounts paid, the DEQ shall bill the applicant for the difference upon permit approval. The applicant shall pay the difference in full before the DEQ issues the permit.
 - b. Post-closure permits. If the total cost of processing the application is greater than the amount listed plus other amounts paid, the DEQ shall bill the applicant for the difference upon permit issuance. The applicant shall pay the difference in full within 45 days of the date of the bill.
 - c. Withdrawals. In the event of a valid withdrawal of the permit application by the applicant, if the total costs of processing the application are less than the amount paid, the DEQ shall refund the difference. If the total costs are greater than the amount paid, the DEQ shall bill the applicant for the difference, and the applicant shall pay the difference within 45 days of the date of the bill.
3. With an application for a closure plan for a facility, the applicant shall remit to the DEQ an application fee of \$5,000 for each hazardous waste management unit involved in the closure plan or \$20,000, whichever is less. If the total cost of processing the application, including review and approval of the closure report, is more than the application fee paid, the applicant shall be billed for the difference, and the difference shall be paid in full after the DEQ completes review and approval of the closure report and within 30 days of notification by the Director. If the reasonable cost is less than the fee paid by the applicant, the DEQ shall refund the difference within 30 days of the closure report review and approval. The maximum fee for a closure plan is shown in the Table.
4. The fee for a land treatment demonstration permit issued under § 270.63 for hazardous waste applies toward the \$20,000 permit fee for a Part B land treatment permit when the owner or operator seeks to treat or dispose of hazardous waste in land treatment units based on the successful treatment demonstration.
5. The DEQ shall provide the applicant itemized bills at least semiannually for the expenses associated with evaluating the application and approving or denying the permit or permit modification. The following information shall be included in each bill:
 - a. The dates of the billing period;
 - b. The date and number of review hours performed during the billing period itemized by employee name, position type and specifically describing:
 - i. Each review task performed;
 - ii. The facility and operational unit involved;
 - iii. The hourly rate;
 - c. A description and amount of review-related costs as described in subsection (G)(6)(b); and
 - d. The total fees paid to date, the total fees due for the billing period, the date when the fees are due, and the maximum fee for the project.
6. Fees shall consist of processing charges and review-related costs as follows:
 - a. Processing charges. From and after April 1, 2023 until April 1, 2024, the DEQ shall calculate the processing charges using a rate of \$175 per hour, multiplied by the number of review hours used to evaluate and approve or deny the permit or permit modification. From and after April 1, 2024, the hourly rate shall be adjusted annually each April 1 according to R18-8-260(M)(4).
 - b. Review-related costs means any of the following costs applicable to a specific application:
 - i. Per diem expenses,
 - ii. Transportation costs,
 - iii. Reproduction costs,
 - iv. Laboratory analysis charges performed during the review of the permit or permit modification,
 - v. Public notice advertising and mailing costs,
 - vi. Presiding officer expenses for public hearings on a permitting decision,
 - vii. Court reporter expenses for public hearings on a permitting decision,
 - viii. Facility rentals for public hearings on a permitting decision, and
 - ix. Other reasonable and necessary review-related expenses documented in writing by the DEQ and agreed to by the applicant.
 - c. Total itemized billings for an application shall not exceed the maximum amounts listed in the Table in this Section.
7. A person may seek review of a bill by filing a written request for reconsideration with the Director.
 - a. The request shall specify, in detail, why the bill is in dispute and shall include any supporting documentation.
 - b. The written request for reconsideration shall be delivered to the Director in person, by mail, or by facsimile on or before the payment due date or within 35 days of the invoice date, whichever is later.

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8. The Director shall make a final decision on the request for reconsideration of the bill and mail a final written decision to the person within 20 working days after the date the Director receives the written request.
 9. For the purposes of subsection (G), "review hours" means the hours or portions of hours that the DEQ's staff spends on a permit or permit modification. Review hours include the time spent by the project manager and technical review team members, and if requested by the applicant, the supervisor or unit manager.
- H.** § 270.12, titled "Confidentiality of information," paragraph (a) is amended as follows:
- (a) In accordance with [R18-8-260(D)(2)], any information submitted to [the DEQ] pursuant to these regulations may be claimed as confidential by the submitter. [Such a claim shall] be asserted at the time of submission in the manner prescribed [in R18-8-260(D)(2)(c)(ii)]. If no [such] claim is made at the time of submission, [the DEQ] may make the information available to the public without further notice. If a claim is asserted, the information [shall] be treated in accordance with the procedures in [R18-8-260(D)(2)(d) and (e).]
- I.** § 270.13, titled "Contents of Part A of the permit application," paragraph (k)(9) is amended as follows:
- (9) Other relevant environmental permits, including [any federal, state, county, city, or fire department] permits.
- J.** § 270.14, titled "Contents of Part B: General requirements," paragraph (b) is amended by adding the following:
- [(23) Any additional information required by the DEQ to evaluate compliance with facility standards and informational requirements of R18-8-264 and R18-8-270.
- (24)(i) A signed statement, submitted on a form supplied by the DEQ that demonstrates:
- (A) An individual owner or operator has sufficient reliability, expertise, integrity and competence to operate a HWM facility, and has not been convicted of, or pled guilty or no contest to, a felony in any state or federal court during the five years before the date of the permit application; or
 - (B) In the case of a corporation or business entity, no officer, director, partner, key employee, other person, or business entity who holds 10% or more of the equity or debt liability has been convicted of, or pled guilty or no contest to, a felony in any state or federal court during the five years before the date of the permit application.
- (ii) Failure to comply with subsection (i), the requirements of A.R.S. § 49-922(C)(1), and the requirements of § 270.43 and §§ 124.3(d) and 124.5(a), may cause the Director to refuse to issue a permit to a TSD facility pursuant to A.R.S. § 49-922(C) as amended, including requirements in § 270.43 and §§ 124.3(d) and 124.5(a).]
- K.** § 270.30, titled "Conditions applicable to all permits" paragraph (l)(10) is amended as follows:
- (10) Other noncompliance. The permittee shall report all instances of noncompliance not reported under [§ 270.30(l)(4),(5), and (6)] at the same time monitoring [(including annual)] reports are submitted. The reports shall contain the information listed in [§ 270.30(l)(6)].
- L.** § 270.30, titled "Conditions applicable to all permits" paragraph (l) is amended by adding the following:
- [All reports listed above shall be submitted to the Director in such a manner that the reports are received within the time periods required under this Article.]
- M.** § 270.32, titled "Establishing permit conditions," paragraph (a), is amended by deleting the following:
- "and 270.3 (considerations under Federal law)."
- N.** § 270.32, titled "Establishing permit conditions," paragraph (b) is amended by deleting the reference to 40 CFR 267.
- O.** § 270.32, titled "Establishing permit conditions," paragraph (c) is amended by deleting the second sentence.
- P.** § 270.42, titled "Permit modification at the request of permittee", paragraph (f)(3), is amended as follows:
- (3) An automatic authorization that goes into effect under paragraph (b)(6)(iii) or (v) of this section may be appealed under [Title 41, Chapter 6, Article 10, Arizona Revised Statutes.]
- Q.** § 270.51, titled "Continuation of expiring permits," paragraph (a) is amended by deleting the following:
- "under 5 USC 558(c)."
- R.** § 270.51, titled "Continuation of expiring permits," paragraph (d) is amended by replacing "EPA-issued" with "EPA, joint EPA/DEQ, or DEQ-issued."
- S.** § 270.65, titled "Research, development, and demonstration permits," is amended as follows:
- (a) The [Director] may issue a research, development, and demonstration permit for any hazardous waste treatment facility which proposes to utilize an innovative and experimental hazardous waste treatment technology or process for which permit standards for such experimental activity have not been promulgated under part 264 or 266. [A research, development, and demonstration] permit shall include such terms and conditions as will assure protection of human health and the environment. Such permits:
 - (1) Shall provide for the construction of such facilities as necessary, and for operation of the facility for not longer than one year unless renewed as provided in paragraph (d) of this section, and
 - (2) Shall provide for the receipt and treatment by the facility of only those types and quantities of hazardous waste which the [Director] deems necessary for purposes of determining the efficacy and performance capabilities of the technology or process and the effects of such technology or process on human health and the environment, and
 - (3) Shall include such requirements as the [Director] deems necessary to protect human health and the environment [, including requirements regarding monitoring, operation, financial responsibility, closure, and remedial action, and such requirements as the Director] deems necessary regarding testing and providing of information [relevant] to the [Director] with respect to the operation of the facility.
 - (b) For the purpose of expediting review and issuance of permits under this section, the [Director] may, consistent with the protection of human health and the environment, modify or waive permit application and permit issuance requirements [, or add conditions to the permit in accordance with the permitting procedures set forth in R18-8-270 and R18-8-271.] except that there may be no modification or waiver of regulations regarding financial responsibility (including insurance) or of procedures regarding public participation.
 - (c) The [Director] may order an immediate termination of all operations at the facility at any time [the Director] determines that termination is necessary to protect human health and the environment.

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- (d) Any permit issued under this section may be renewed not more than three times. Each such renewal shall be for a period of not more than one year.
- T. § 270.110, titled “What must I include in my application for a RAP?,” is amended by adding paragraphs (j) and (k) as follows:
- (j) A signed statement, submitted on a form supplied by DEQ that demonstrates:
- (1) An individual owner or operator has sufficient reliability, expertise, integrity and competence to operate a HWM facility, and has not been convicted of, or pled guilty or no contest to, a felony in any state or federal court during the five years before the date of the RAP application.
 - (2) In the case of a corporation or business entity, no officer, director, partner, key employee, other person or business entity who holds 10% or more of the equity or debt liability has been convicted of, or pled guilty or no contest to, a felony in any state or federal court during the five years before the date of the RAP application.
- (k) Failure to comply with subsection (j), the requirements of A.R.S. § 49-922(C)(1), and the requirements of § 270.43 and §§ 124.3(d) and 124.5(a), may cause the Director to refuse to issue a permit to a TSD facility pursuant to A.R.S. § 49-922(C) as amended, including requirements in § 270.43 and §§ 124.3(d) and 124.5(a).]
- U. § 270.155 titled “May the decision to approve or deny my RAP application be administratively appealed?,” paragraph (a), is amended as follows:
- (a) Any commenter on the draft RAP or notice of intent to deny, or any participant in any public hearing(s) on the draft RAP, may appeal the Director’s decision to approve or deny your RAP application [under Title 41, Chapter 6, Article 10, Arizona Revised Statutes.] Any person who did not file comments, or did not participate in any public hearing(s) on the draft RAP, may petition for administrative review only to the extent of the changes from the draft to the final RAP decision. Appeals of RAPs may be made to the same extent as for final permit decisions under § 124.15 of this chapter (or a decision under § 270.29 to deny a permit for the active life of a RCRA hazardous waste management facility or unit.)

Historical Note

Adopted effective July 24, 1984 (Supp. 84-4). Amended subsections (A) and (K) effective June 27, 1985 (Supp. 85-3). Amended subsection (A) effective August 5, 1986 (Supp. 86-4). Former Section R9-8-1870 renumbered as R18-8-270, subsection (A) amended and a new subsection (S) added effective May 29, 1987 (Supp. 87-2). Amended subsections (B) and (K) effective December 1, 1988 (Supp. 88-4). Amended effective October 11, 1989 (Supp. 89-4). Amended effective August 14, 1991 (Supp. 91-3). Amended effective October 6, 1992 (Supp. 92-4). Amended effective December 2, 1994 (Supp. 94-4). Amended effective December 7, 1995 (Supp. 95-4). Amended effective June 13, 1996 (Supp. 96-2). Amended effective August 8, 1997 (Supp. 97-3). Amended effective June 4, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 4625, effective November 15, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3093, effective July 24, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 816, effective April 15, 2003 (Supp. 03-1). Amended by final rulemak-

ing at 10 A.A.R. 4364, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5523, effective February 4, 2006 (Supp. 05-4). Amended by final rulemaking at 12 A.A.R. 3061, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 14 A.A.R. 409, effective March 8, 2008 (Supp. 08-1). Amended by final rulemaking at 18 A.A.R. 1202, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 21 A.A.R. 1246, effective September 5, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 435, effective February 5, 2019 (Supp. 19-1). R18-8-271(B)(2) corrected at the request of the Department to reflect the final rulemaking amendments made at 25 A.A.R. 435 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 2949, with an immediate effective date of November 3, 2020 (Supp. 20-4). Amended by final rulemaking at 29 A.A.R. 729 (March 17, 2023), with an immediate effective date of March 8, 2023 (Supp. 23-1).

R18-8-271. Procedures for Permit Administration

- A. All of 40 CFR 124, revised as of July 1, 2020 (and no future editions), with the exception of §§ 124.1 (b) through (e), 124.2, 124.4, 124.16, 124.20, 124.21, and subparts C, D, and G, and with the exception of the revisions for standardized permits as published at 70 FR 53419, is incorporated by reference, modified by the following subsections, and on file with the DEQ. Copies of 40 CFR 124 are available at <https://www.eCFR.gov>. Copies of the Federal Register are available at <https://www.federalregister.gov>.
- B. § 124.1, titled “Purpose and scope,” paragraph (a) is replaced by the following:
- [This Section contains the DEQ procedures for issuing, modifying, revoking and reissuing, or terminating all hazardous waste management facility permits. This Section describes the procedures the DEQ shall follow in reviewing permit applications, preparing draft permits, issuing public notice, inviting public comment, and holding public hearings on draft permits. This Section also includes procedures for assembling an administrative record, responding to comments, issuing a final permit decision, and allowing for administrative appeal of the final permit decision. The procedures of this Section also apply to denial of a permit for the active life of a RCRA HWM facility or unit under § 270.29.]
- C. § 124.3, titled “Application for a permit,” is replaced by the following:
- [(a)(1) Any person who requires a permit under this Article shall complete, sign, and submit to the Director an application for each permit required under § 270.1. Applications are not required for RCRA permits-by-rule in § 270.60.
- (2) The Director shall not begin processing a permit until the applicant has fully complied with the application requirements for that permit. (Refer to §§ 270.10 and 270.13).
- (3) An applicant for a permit shall comply with the signature and certification requirements of § 270.11.
- (b) Reserved.
- (c) The Director shall review for completeness every application for a permit. Each application submitted by a new HWM facility shall be reviewed for completeness by the Director in the order of priority on the basis of hazardous waste capacity established in a list by the Director. The Director shall make the list available upon request. Upon completing the review, the Director shall notify the appli-

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cant in writing whether the application is complete. If the application is incomplete, the Director shall list the information necessary to make the application complete. When the application is for an existing HWM facility, the Director shall specify in the notice of deficiency a date for submitting the necessary information. The Director shall notify the applicant that the application is complete upon receiving this information. After the application is completed, the Director may request additional information from an applicant but only when necessary to clarify, modify, or supplement previously submitted material. Requests for additional information do not render an application incomplete.

- (d) If an applicant fails or refuses to correct deficiencies in the application, the permit may be denied and the Director may take appropriate enforcement actions against an existing HWM facility pursuant to A.R.S. §§ 49-923, 49-924 and 49-925.
 - (e) If the Director decides that a site visit is necessary for any reason in conjunction with the processing of an application, the Director shall notify the applicant and schedule a date for a site visit.
 - (f) The effective date of an application is the date on which the Director notifies the applicant that the application is complete as provided in paragraph (c) of this subsection.
 - (g) For each application from a new HWM facility, the Director shall, no later than the effective date of the application, prepare and mail to the applicant a project decision schedule. The schedule shall specify target dates by which the Director intends to do the following:
 - (1) Prepare a draft permit or Notice of Intent to Deny;
 - (2) Give public notice;
 - (3) Complete the public comment period, including any public hearing;
 - (4) Make a decision to issue or deny a final permit; and
 - (5) Issue a final decision.
- D.** § 124.5, titled "Modification, revocation and reissuance, or termination of permits," is replaced by the following:
- [(a) Permits may be modified, revoked and reissued, or terminated either at the request of any interested person (including the permittee) or upon the Director's initiative. However, permits may only be modified, revoked and reissued, or terminated for the reasons specified in §§ 270.41 or 270.43. All requests shall be in writing and shall contain facts or reasons supporting the request.
 - (b) If the Director decides the request is not justified, the Director shall send the requester a brief written response giving a reason for the decision. Denials of requests for modification, revocation and reissuance, or termination are not subject to public notice, comment, or hearings.
 - (c) Modification, revocation or reissuance of permits procedures.
 - (1) If the Director tentatively decides to modify or revoke and reissue a permit under §§ 270.41 or 270.42(c), the Director shall prepare a draft permit under § 124.6, incorporating the proposed changes. The Director may request additional information and, in the case of a modified permit, may require the submission of an updated application. In the case of revoked and reissued permits, the Director shall require the submission of a new application.
 - (2) In a permit modification under this [subsection], only those conditions to be modified shall be reopened when a new draft permit is prepared. All

other aspects of the existing permit shall remain in effect for the duration of the unmodified permit. The permit modification shall have the same expiration date as the unmodified permit. When a permit is revoked and reissued under this subsection, the entire permit is reopened just as if the permit had expired and was being reissued. During any revocation and reissuance proceeding the permittee shall comply with all conditions of the existing permit until a new final permit is reissued.

- (3) "Classes 1 and 2 modifications" as defined in § 270.42 are not subject to the requirements of this subsection.
 - (d) If the Director tentatively decides to terminate a permit under § 270.43, the Director shall issue a notice of intent to terminate. A notice of intent to terminate is a type of draft permit which follows the same procedures as any draft permit prepared under § 124.6. In the case of permits that are processed or issued jointly by both the DEQ and the EPA, a notice of intent to terminate shall not be issued if the Regional Administrator and the permittee agree to termination in the course of transferring permit responsibilities from the EPA to the state.
 - (e) The Director shall base all draft permits, including notices of intent to terminate, prepared under this subsection on the administrative record as defined in § 124.9.]
- E.** § 124.6, titled "Draft permits," is replaced by the following:
- (a) Once an application is complete, the Director shall tentatively decide whether to prepare a draft permit or to deny the application.
 - (b) If the Director tentatively decides to deny the permit application, the Director shall issue a notice of intent to deny. A notice of intent to deny the permit application is a type of draft permit which follows the same procedures as any draft permit prepared under (e) of this subsection.
 - (c) Reserved.
 - (d) If the Director decides to prepare a draft permit, the Director shall prepare a draft permit that contains the following information:
 - (1) All conditions under §§ 270.30 and 270.32, unless not required under 40 CFR 264 and 265;
 - (2) All compliance schedules under § 270.33;
 - (3) All monitoring requirements under § 270.31; and
 - (4) Standards for treatment, storage, and/or disposal and other permit conditions under § 270.30.
 - (e) All draft permits prepared by the DEQ under this subsection shall be accompanied by a statement of basis (§ 124.7,) or fact sheet (§ 124.8,) and shall be based on the administrative record (§ 124.9,) publicly noticed (§ 124.10,) and made available for public comment (§ 124.11,). The Director shall give notice of opportunity for a public hearing (§ 124.12,) issue a final decision (§ 124.15,) and respond to comments (§ 124.17,).
- F.** § 124.7, titled "Statement of basis," is replaced by the following:
- The DEQ shall prepare a statement of basis for every draft permit for which a fact sheet under § 124.8 is not prepared. The statement of basis shall briefly describe the derivation of the conditions of the draft permit and the reasons for them or, in the case of notices of intent to deny or terminate, reasons supporting the tentative decision. The statement of basis shall be sent to the applicant and, on request, to any other person.
- G.** § 124.8, titled "Fact sheet," is replaced by the following:

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- (a) The DEQ shall prepare a fact sheet for every draft permit for a new HWM facility, and for every draft permit that the Director finds is the subject of widespread public interest or raises major issues. The fact sheet shall briefly set forth the principal facts and the significant factual, legal, methodological and policy questions considered in preparing the draft permit. The Director shall send this fact sheet to the applicant and, on request, to any other person.
- (b) The fact sheet shall include, when applicable:
 - (1) A brief description of the type of facility or activity that is the subject of the draft permit;
 - (2) The type and quantity of wastes, that are proposed to be or are being treated, stored, or disposed;
 - (3) Reserved.
 - (4) A brief summary of the basis for the draft permit conditions including references to applicable statutory or regulatory provisions and appropriate supporting references to the administrative record required by § 124.9;
 - (5) Reasons why any requested variances or alternatives to required standards do or do not appear justified;
 - (6) A description of the procedures for reaching a final decision on the draft permit including:
 - (i) The beginning and ending dates of the comment period under §§ 124.10 and the address where comments will be received;
 - (ii) Procedures for requesting a hearing and the nature of that hearing; and
 - (iii) Any other procedures by which the public may participate in the final decision; and
 - (7) Name and telephone number of a person to contact for additional information.
 - (8) Reserved.
- H.** § 124.9 titled “Administrative record for draft permits” is replaced by the following:
 - (a) The provisions of a draft permit prepared under § 124.6 shall be based on the administrative record defined in this subsection.
 - (b) For preparing a draft permit under § 124.6, the record consists of:
 - (1) The application, if required, and any supporting data furnished by the applicant, subject to paragraph (e) of this subsection;
 - (2) The draft permit or notice of intent to deny the application or to terminate the permit;
 - (3) The statement of basis under §§ 124.7 or fact sheet under § 124.8;
 - (4) All documents cited in the statement of basis or fact sheet; and
 - (5) Other documents contained in the supporting file for the draft permit.
 - (6) Reserved.
 - (c) Material readily available at the DEQ or published material that is generally available, and that is included in the administrative record under paragraphs (b) and (c) of this subsection, need not be physically included with the rest of the record as long as it is specifically referred to in the statement of basis or the fact sheet.
 - (d) This subsection applies to all draft permits when public notice was given after the effective date of these rules.
 - (e) All items deemed confidential pursuant to A.R.S. § 49-928 shall be maintained separately and not disclosed to the public.
- I.** § 124.10, titled “Public notice of permit actions and public comment period,” is replaced by the following:
 - (a) Scope.
 - (1) The Director shall give public notice that the following actions have occurred:
 - (i) A permit application has been tentatively denied under § 124.6(b);
 - (ii) A draft permit has been prepared under § 124.6(d); and
 - (iii) A hearing has been scheduled under § 124.12.
 - (2) No public notice is required when a request for permit modification, revocation and reissuance, or termination is denied under § 124.5(b). Written notice of that denial shall be given to the requester and to the permittee.
 - (3) Public notices may describe more than one permit or permit actions.
 - (b) Timing.
 - (1) Public notice of the preparation of a draft permit (including a notice of intent to deny a permit application) required under paragraph (a) of this subsection shall allow at least 45 days for public comment.
 - (2) Public notice of a public hearing shall be given at least 30 days before the hearing. (Public notice of the hearing may be given at the same time as public notice of the draft permit and the two notices may be combined.)
 - (c) Methods. Public notice of activities described in paragraph (a)(1) of this subsection shall be given by the following methods:
 - (1) By mailing a copy of a notice to the following persons (any person otherwise entitled to receive notice under this subparagraph may waive his or her rights to receive notice for any classes and categories of permits):
 - (i) An applicant;
 - (ii) Any other agency which the Director knows has issued or is required to issue a HWM facility permit or any other federal environmental permit for the same facility or activity;
 - (iii) Federal and state agencies with jurisdiction over fish, shellfish, and wildlife resources, the Advisory Council on Historic Preservation, State Historic Preservation Officers, including any affected states (Indian Tribes). For purposes of this paragraph, and in the context of the Underground Injection Control Program only, the term State includes Indian Tribes treated as States;
 - (iv) Reserved.
 - (v) Reserved.
 - (vi) Reserved.
 - (vii) Reserved.
 - (viii) Reserved.
 - (ix) Persons on a mailing list developed by:
 - (A) Including those who request in writing to be on the list;
 - (B) Soliciting persons for “area lists” from participants in past permit proceedings in that area; and
 - (C) Notifying the public of the opportunity to be put on the mailing list through periodic publication in the public press and in such publications as regional and state-funded

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- newsletters, environmental bulletins, or state law journals. (The Director may update the mailing list from time to time by requesting written indication of continued interest from those listed. The Director may delete from the list the name of any person who fails to respond to the request.); and
- (x) (A) To any unit of local government having jurisdiction over the area where the facility is proposed to be located; and
 - (B) To each state agency having any authority under state law with respect to the construction or operation of the facility;
- (2) By newspaper publication and radio announcement broadcast, as follows:
 - (i) Reserved.
 - (ii) For all permits, publication of a notice in a daily or weekly major local newspaper of general circulation within the area affected by the facility or activity, at least once, and in accordance with the provisions of paragraph (b) of this subsection; and
 - (iii) For all permits, a radio announcement broadcast over two local radio stations serving the affected area at least once during the period two weeks prior to the public hearing. The announcement shall contain:
 - (A) A brief description of the nature and purpose of the hearing;
 - (B) The information described in items (i), (ii), (iii), (iv), and (vii) of subparagraph (d)(1) of this subsection;
 - (C) The date, time, and place of the hearing; and
 - (D) Any additional information considered necessary or proper; or
 - (3) Reserved.
 - (4) Any other method reasonably calculated to give actual notice of the action in question to the persons potentially affected by it, including press releases or any other forum or medium to elicit public participation.
- (d) (1) Each public notice issued under this Article shall contain the following minimum information:
 - (i) Name and address of the office processing the permit action for which notice is being given;
 - (ii) Name and address of the permittee or permit applicant and, if different, of the facility or activity regulated by such permit;
 - (iii) A brief description of the business conducted at the facility or activity described in the permit application;
 - (iv) Name, address and telephone number of a person from whom interested persons may obtain further information, including copies of the statement of basis or fact sheet;
 - (v) A brief description of the comment procedures required by §§ 124.11 and 124.12 and the time and place of any hearing that shall be held, including a statement of procedures to request a hearing (unless a hearing has already been scheduled) and other procedures by which the public may participate in the final permit decision;
 - (vi) The location of the administrative record required by § 124.9, the times at which the record will be open for public inspection, and a statement that all data submitted by the applicant (except for confidential information pursuant to A.R.S. § 49-928) is available as part of the administrative record;
 - (vii) The locations where a copy of the application and the draft permit may be inspected and the times at which these documents are available for public review; and
 - (viii) Reserved.
 - (ix) Any additional information considered necessary or proper.
- (2) Public notices for hearings. In addition to the general public notice described in paragraph (d)(1) of this subsection, the public notice of a hearing under § 124.12 shall contain the following information:
 - (i) Reference to the date of previous public notices relating to the permit;
 - (ii) Date, time, and place of the hearing; and
 - (iii) A brief description of the nature and purpose of the hearing, including the applicable rules and procedures.
 - (iv) Reserved.
 - (e) In addition to the general public notice described in paragraph (d)(1) of this subsection, all persons identified in paragraphs (c)(1)(i), (ii), and (iii) of this subsection shall be mailed a copy of the fact sheet or statement of basis, the permit application (if any), and the draft permit (if any).
- J.** § 124.11, titled "Public comments and requests for public hearings," is replaced by the following:

During the public comment period provided under § 124.10, any person may submit written comments on the draft permit and may request a public hearing, if no hearing has already been scheduled. A request for a public hearing shall be in writing and shall state the nature of the issues proposed to be raised in the hearing. All comments shall be considered in making the final decision and shall be answered as provided in § 124.17.
 - K.** § 124.12, titled "Public hearings," is replaced by the following:
 - [(a) (1) The Director shall hold a public hearing whenever the Director finds, on the basis of requests, a significant degree of public interest in a draft permit.
 - (2) The Director may also hold a public hearing at the Director's discretion whenever, for instance, such a hearing might clarify one or more issues involved in the permit decision.
 - (3) The Director shall hold a public hearing whenever written notice of opposition to a draft permit and a request for a hearing has been received within 45 days of public notice under § 124.10(b)(1). Whenever possible the Director shall schedule a hearing under this subsection at a location convenient to the nearest population center to the proposed facility.
 - (4) Public notice of the hearing shall be given as specified in § 124.10.
 - (b) Reserved.
 - (c) Any person may submit oral or written statements and data concerning the draft permit. Reasonable limits may

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be set upon the time allowed for oral statements, and the submission of statements in writing may be required. The public comment period under § 124.10 shall automatically be extended to the close of any public hearing under this subsection. The hearing officer may also extend the comment period by so stating at the hearing.

- (d) A tape recording or written transcript of the hearing shall be made available to the public.
- (e) Reserved.]

L. § 124.13, titled "Obligation to raise issues and provide information during the public comment period," is replaced by the following:

[All persons, including applicants, who believe any condition of a draft permit is inappropriate or that the Director's tentative decision to deny an application, terminate a permit, or prepare a draft permit is inappropriate, shall raise all reasonably ascertainable issues and submit all reasonably available arguments supporting their position by the close of the public comment period (including any public hearing) under § 124.10. Any supporting materials that a commenter submits shall be included in full and shall not be incorporated by reference, unless they are already part of the administrative record in the same proceeding or consist of state or federal statutes and regulations, EPA documents of general applicability, or other generally available reference materials. Commenters shall make supporting material not already included in the administrative record available to the DEQ as directed by the Director.]

M. § 124.14, titled "Reopening of the public comment period," is replaced by the following:

- (a) (1) The Director may order the public comment period reopened if the procedures of this paragraph could expedite the decision-making process. When the public comment period is reopened under this paragraph, all persons, including applicants, who believe any condition of a draft permit is inappropriate or that the Director's tentative decision to deny an application, terminate a permit, or prepare a draft permit is inappropriate, must submit all reasonably available factual grounds supporting their position, including all supporting material, by a date, not less than 60 days after public notice under paragraph (a)(2) of this subsection, set by the Director. Thereafter, any person may file a written response to the material filed by any other person, by a date, not less than 20 days after the date set for filing of the material, set by the Director.
- (2) Public notice of any comment period under this paragraph shall identify the issues to which the requirements of § 124.14(a) apply.
- (3) On the Director's own motion or on the request of any person, the Director may direct that the requirements of paragraph (a)(1) of this subsection shall apply during the initial comment period where it reasonably appears that issuance of the permit will be contested and that applying the requirements of paragraph (a)(1) of this subsection will substantially expedite the decision-making process. The notice of the draft permit shall state whenever this has been done.
- (4) A comment period of longer than 60 days will often be necessary in complicated proceedings to give commenters a reasonable opportunity to comply with the requirements of this subsection. Comment-

ers may request longer comment periods and they shall be granted under § 124.10 to the extent they appear necessary.

- (b) If any data, information, or arguments submitted during the public comment period, including information or arguments required under § 124.13, appear to raise substantial new questions concerning a permit, the Director may take one or more of the following actions:

- (1) Prepare a new draft permit, appropriately modified, under §§ 124.6;
- (2) Prepare a revised statement of basis under § 124.7, a fact sheet or revised fact sheet under this § 124.8, and reopen the comment period under this subsection; or,
- (3) Reopen or extend the comment period under § 124.10 to give interested persons an opportunity to comment on the information or arguments submitted.

- (c) Comments filed during the reopened comment period shall be limited to the substantial new questions that caused its reopening. The public notice under § 124.10 shall define the scope of the reopening.

- (d) Reserved.

- (e) Public notice of any of the above actions shall be issued under §§ 124.10.

N. § 124.15, titled "Issuance and effective date of permit," is replaced by the following:

- (a) After the close of the public comment period under § 124.10 on a draft permit, the Director shall issue a final permit decision or a decision to deny a permit for the active life of a RCRA hazardous waste management facility or unit under § 270.29. The Director shall notify the applicant and each person who has submitted written comments or requested notice of the final permit decision. This notice shall include reference to the procedures for appealing a decision on a permit or a decision to terminate a permit. For purposes of this subsection, a final permit decision means a final decision to issue, deny, modify, revoke and reissue, or terminate a permit.
- (b) A final permit decision or a decision to deny a permit for the active life of a RCRA hazardous waste management facility or unit under § 270.29 becomes effective on the date specified by the Director in the final permit notice.
 - (1) Reserved.
 - (2) Reserved.
 - (3) Reserved.

O. § 124.17, titled "Response to comments," is replaced by the following:

- (a) At the time that any final decision to issue a permit is made under § 124.15, the Director shall issue a response to comments. This response shall:
 - (1) Specify which provisions, if any, of the draft permit have been changed in the final permit decision, and the reasons for the change; and
 - (2) Briefly describe and respond to all significant comments on the draft permit raised during the public comment period, or during any hearing.
- (b) Any documents cited in the response to comments shall be included in the administrative record for the final permit decision as defined in § 124.18. If new points are raised or new material supplied during the public comment period, the DEQ may document its response to those matters by adding new materials to the administrative record.

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- (c) The response to comments shall be available to the public.
- P. § 124.18, titled “Administrative record for final permit” is replaced by the following:
- (a) The Director shall base final permit decisions under § 124.15 on the administrative record defined in this subsection.
 - (b) The administrative record for any final permit shall consist of the administrative record for the draft permit, and:
 - (1) All comments received during the public comment period provided under § 124.10, including any extension or reopening under § 124.14;
 - (2) The tape or transcript of any hearing(s) held under § 124.12;
 - (3) Any written materials submitted at such a hearing;
 - (4) The response to comments required by § 124.17 and any new material placed in the record under that subsection;
 - (5) Reserved.
 - (6) Other documents contained in the supporting file for the permit; and
 - (7) The final permit.
 - (c) The additional documents required under (b) of this subsection shall be added to the record as soon as possible after their receipt or publication by the DEQ. The record shall be complete on the date the final permit is issued.
 - (d) This subsection applies to all final permits when the draft permit was subject to the administrative record requirement of § 124.9.
 - (e) Material readily available at the DEQ, or published materials which are generally available and which are included in the administrative record under the standards of this subsection or of § 124.17, (“Response to comments”), need not be physically included in the same file as the rest of the record as long as the materials and their location are specifically identified in the statement of basis or fact sheet or in the response to comments.
- Q. § 124.19, titled “Appeal of RCRA, UIC, and PSD permits,” is replaced by the following:
- A final permit decision (or a decision under § 270.29 to deny a permit for the active life of a RCRA hazardous waste management facility or unit issued under § 124.15 is an appealable agency action as defined in A.R.S. § 41-1092 and is subject to appeal under A.R.S. Title 41, Ch. 6, Art. 10.
- R. § 124.31(a) titled “Pre-application public meeting and notice” is amended by deleting the following sentence:
- “For the purpose of this section only, ‘hazardous waste management units over which EPA has permit issuance authority’ refers to hazardous waste management units for which the State where the units are located has not been authorized to issue RCRA permits pursuant to 40 CFR 271.”
- S. § 124.32(a) titled “Public notice requirements at the application stage” is amended by deleting the following sentence:
- “For the purpose of this section only, ‘hazardous waste management units over which EPA has permit issuance authority’ refers to hazardous waste management units for which the State where the units are located has not been authorized to issue RCRA permits pursuant to 40 CFR 271.”
- T. § 124.33(a) titled “Information repository” is amended by deleting the following sentence:

“For the purpose of this section only, ‘hazardous waste management units over which EPA has permit issuance authority’ refers to hazardous waste management units for which the State where the units are located has not been authorized to issue RCRA permits pursuant to 40 CFR 271.”

Historical Note

Adopted effective July 24, 1984 (Supp. 84-4). Amended subsection (A) effective June 27, 1985 (Supp. 85-3). Amended subsection (A) effective August 5, 1986 (Supp. 86-4). Former Section R9-8-1871 renumbered as R18-8-271; subsections (A), (C), (E), (I), (L) and (M) amended effective May 29, 1987 (Supp. 87-2). Amended subsection (C) effective December 1, 1988 (Supp. 88-4). Amended effective October 11, 1989 (Supp. 89-4). Amended effective August 14, 1991 (Supp. 91-3). Amended effective October 6, 1992 (Supp. 92-4). Amended effective December 2, 1994 (Supp. 94-4). Amended effective December 7, 1995 (Supp. 95-4). Amended effective June 13, 1996 (Supp. 96-2). Amended effective August 8, 1997 (Supp. 97-3). Amended effective June 4, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 4625, effective November 15, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3093, effective July 24, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 816, effective April 15, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 4364, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5523, effective February 4, 2006 (Supp. 05-4). Amended by final rulemaking at 12 A.A.R. 3061, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 14 A.A.R. 409, effective March 8, 2008 (Supp. 08-1). Amended by final rulemaking at 21 A.A.R. 1246, effective September 5, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 435, effective February 5, 2019 (Supp. 19-1). Amended by final rulemaking at 26 A.A.R. 2949, with an immediate effective date of November 3, 2020 (Supp. 20-4).

R18-8-272. Reserved**R18-8-273. Standards for Universal Waste Management**

- A. All of 40 CFR 273, revised as of July 1, 2020 (and no future editions), is incorporated by reference, modified by the following subsections, and on file with the DEQ. Copies of 40 CFR 273 are available at <https://www.eCFR.gov>.
- B. § 273.13, titled “Waste management”, paragraphs (c)(2)(iii) and (c)(2)(iv) are amended as follows:
- (iii) Ensures that a mercury clean-up system is readily available to immediately transfer any mercury resulting from spills or leaks from broken ampules from that containment device to a container that meets the requirements of [40 CFR 262.15 and 40 CFR 262.16;]
 - (iv) Immediately transfers any mercury resulting from spills or leaks from broken ampules from the containment device to a container that meets the requirements of [40 CFR 262.15 and 40 CFR 262.16;]
- C. § 273.33, titled “Waste management”, paragraphs (c)(2)(iii) and (c)(2)(iv) are amended as follows:
- (iii) Ensures that a mercury clean-up system is readily available to immediately transfer any mercury resulting from spills or leaks [from] broken ampules from that containment device to a container that meets the requirements of [40 CFR 262.15 and 40 CFR 262.16;]

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- (iv) Immediately transfers any mercury resulting from spills or leaks from broken ampules from the containment device to a container that meets the requirements of [40 CFR 262.15 and 40 CFR 262.16;]

Historical Note

Adopted effective June 13, 1996 (Supp. 96-2). Amended effective August 8, 1997 (Supp. 97-3). Amended effective June 4, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 4625, effective November 15, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3093, effective July 24, 2000 (Supp. 00-3). Amended by final rulemaking at 9 A.A.R. 816, effective April 15, 2003 (Supp. 03-1). Amended by final rulemaking at 12 A.A.R. 3061, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 14 A.A.R. 409, effective March 8, 2008 (Supp. 08-1). Amended by final rulemaking at 21 A.A.R. 1246, effective September 5, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 435, effective February 5, 2019 (Supp. 19-1). Amended by final rulemaking at 26 A.A.R. 2949, with an immediate effective date of November 3, 2020 (Supp. 20-4).

R18-8-274. Reserved**R18-8-275. Reserved****R18-8-276. Reserved****R18-8-277. Reserved****R18-8-278. Reserved****R18-8-279. Reserved****R18-8-280. Compliance**

- A. Inspection and entry. For purposes of ensuring compliance with the provisions of HWMA, any person who generates, stores, treats, transports, disposes of, or otherwise handles hazardous wastes, including used oil that may be classified as hazardous waste pursuant to A.R.S. Title 49, Chapter 4, Article 7, and hazardous secondary materials, shall, upon request of any officer, employee, or representative of the DEQ duly designated by the Director, furnish information pertaining to such wastes and permit such person at reasonable times:
1. To enter any establishment or other place maintained by such person where such wastes are or have been generated, stored, treated, disposed, or transported from;
 2. To have access to, and to copy all records relating to such wastes;
 3. To inspect any facilities, equipment (including monitoring and control equipment), practices, and operations, relating to such wastes;
 4. To inspect, monitor, and obtain samples from such person of any such wastes and of any containers or labeling for such wastes; and
 5. To record any inspection by use of written, electronic, magnetic and photographic media.
- B. Penalties. A person who violates HWMA or any permit, rule, regulation, or order issued pursuant to HWMA is subject to civil and/or criminal penalties pursuant to A.R.S. §§ 49-923 through 49-925, as amended. Nothing in this Article shall be construed to limit the Director's or Attorney General's enforcement powers authorized by law including but not limited to the seeking or recovery of any civil or criminal penalties.

- C. A certification statement may be required on written submittals to the DEQ in response to Compliance Orders or in response to information requested pursuant to subsection (A) of this Section. In addition, the DEQ may request in writing that a certification statement appear in any written submittal to the DEQ. The certification statement shall be signed by a person authorized to act on behalf of the company or empowered to make decisions on behalf of the company on the matter contained in the document.

D. Site assessment plan.

1. The requirement to develop a site assessment plan shall be contained in a Compliance Order. The Director may require an owner or operator to develop a site assessment plan based on one or more of the following conditions:
 - a. Unauthorized disposal or discharges of hazardous waste or hazardous waste constituents which have not been remediated.
 - b. Results of environmental sampling by the DEQ that indicate the presence of a hazardous waste or hazardous waste constituents.
 - c. Visual observation of unauthorized disposal or discharges which cannot be verified pursuant to § 262.11, § 264.13, or § 265.13 as not containing a hazardous waste or hazardous waste constituents.
 - d. Other evidence of disposal or discharges of hazardous waste or hazardous waste constituents into the environment which have not been remediated.
2. The site assessment plan shall describe in detail the procedures to determine the nature, extent and degree of hazardous waste contamination in the environment.
3. The site assessment plan shall be approved by the DEQ before implementation.
4. The site assessment shall be conducted and the results shall be submitted to the DEQ within the time limitations established by the DEQ.
5. The DEQ may request in writing that a site assessment plan be conducted. The DEQ will review a voluntarily submitted site assessment plan if the plan satisfies the requirements listed in subsections (D)(2) through (4).

Historical Note

Adopted effective July 24, 1984 (Supp. 84-4). Amended subsection (B) effective June 27, 1985 (Supp. 85-3). Former Section R9-8-1880 renumbered as Section R18-8-280, and subsection (A) amended effective May 29, 1987 (Supp. 87-2). Amended subsection (B) effective December 1, 1988 (Supp. 88-4). Amended October 11, 1989 (Supp. 89-4). Amended effective October 6, 1992 (Supp. 92-4). Amended effective December 2, 1994 (Supp. 94-4). Amended effective June 13, 1996 (Supp. 96-2). Amended by final rulemaking at 25 A.A.R. 435, effective February 5, 2019 (Supp. 19-1). Amended by final rulemaking at 26 A.A.R. 2949, with an immediate effective date of November 3, 2020 (Supp. 20-4).

ARTICLE 3. RECODIFIED

Title 18, Chapter 8, Article 3, consisting of Sections R18-8-301 through R18-8-305, R18-8-307, Table A, Exhibit I, and Appendices A and B, recodified to Title 18, Chapter 13, Article 13, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-301. Recodified**Historical Note**

Adopted effective August 16, 1993 (Supp. 93-3). Amended effective March 24, 1994 (Supp. 94-1). Section

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recodified to A.A.C. R18-13-1301, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-302. Recodified**Historical Note**

Adopted effective August 16, 1993 (Supp. 93-3). Section recodified to A.A.C. R18-13-1303, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-303. Recodified**Historical Note**

Adopted effective August 16, 1993 (Supp. 93-3). Section recodified to A.A.C. R18-13-1303, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-304. Recodified**Historical Note**

Adopted effective August 16, 1993 (Supp. 93-3). Section recodified to A.A.C. R18-13-1304, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-305. Recodified**Historical Note**

Adopted effective August 16, 1993 (Supp. 93-3). Section recodified to A.A.C. R18-13-1305, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-306. Repealed**Historical Note**

Emergency rule adopted effective February 22, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-1). Emergency expired. Emergency rule adopted again effective May 26, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-2). Emergency expired. Emergency rule adopted again effective August 30, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 2, 1993 (Supp. 93-4). The permanent rule that was adopted effective December 2, 1993, was inadvertently published without the changes the agency made.

Those changes appear here. (Supp. 95-4). Section repealed by summary rulemaking with an interim effective date of July 16, 1999, filed in the Office of the Secretary of State June 25, 1999 (Supp. 99-2). Interim effective date of July 16, 1999 now the permanent effective date (Supp. 99-4).

R18-8-307. Recodified**Historical Note**

Emergency rule adopted effective December 21, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-4). Permanent rule adopted with changes effective March 24, 1994 (Supp. 94-1). Section recodified to A.A.C. R18-13-1307, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

Table A. Recodified**Historical Note**

Emergency rule adopted effective December 21, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-4). Permanent rule adopted with changes effective March 24, 1994 (Supp. 94-1). Table A recodified to 18 A.A.C. 13, Article 3, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

Exhibit 1. Recodified**Historical Note**

Emergency rule adopted effective December 21, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-4). Permanent rule adopted with changes effective March 24, 1994 (Supp. 94-1). Exhibit 1 recodified to 18 A.A.C. 13, Article 3, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

Appendix A. Recodified**Historical Note**

Adopted effective August 16, 1993 (Supp. 93-3). Appendix A recodified to 18 A.A.C. 13, Article 3, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

Appendix B. Recodified**Historical Note**

Adopted effective August 16, 1993 (Supp. 93-3). Appendix B recodified to 18 A.A.C. 13, Article 3, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

ARTICLE 4. RECODIFIED

Title 18, Chapter 8, Article 4, consisting of Section R18-8-402, recodified to Title 18, Chapter 13, Article 9, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-401. Expired**Historical Note**

Adopted effective December 21, 1977 (Supp. 77-6). Former Section R9-8-1711 renumbered without change as Section R18-8-401 (Supp. 87-3). Amended effective December 1, 1988 (Supp. 88-4). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 15, 2000 (Supp. 00-1).

R18-8-402. Recodified**Historical Note**

Adopted effective December 21, 1977 (Supp. 77-6). Former Section R9-8-1717 renumbered without change as Section R18-8-402 (Supp. 87-3). Section recodified to A.A.C. R18-13-902, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

ARTICLE 5. RECODIFIED

Title 18, Chapter 8, Article 5, consisting of Sections R18-8-502 through R18-8-512, recodified to Title 18, Chapter 13, Article 3, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-501. Expired**Historical Note**

Former Section R9-8-411 renumbered without change as Section R18-8-501 (Supp. 87-3). Amended effective December 1, 1988 (Supp. 88-4). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 15, 2000 (Supp. 00-1).

R18-8-502. Recodified**Historical Note**

Former Section R9-8-412 renumbered without change as Section R18-8-502 (Supp. 87-3). Section recodified to

TITLE 18. ENVIRONMENTAL QUALITY

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A.A.C. R18-13-302, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-503. Recodified**Historical Note**

Former Section R9-8-413 renumbered without change as Section R18-8-503 (Supp. 87-3). Section recodified to A.A.C. R18-13-303, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-504. Recodified**Historical Note**

Former Section R9-8-414 renumbered without change as Section R18-8-504 (Supp. 87-3). Section recodified to A.A.C. R18-13-304, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-505. Recodified**Historical Note**

Former Section R9-8-415 renumbered without change as Section R18-8-505 (Supp. 87-3). Section recodified to A.A.C. R18-13-305, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-506. Recodified**Historical Note**

Former Section R9-8-416 renumbered without change as Section R18-8-506 (Supp. 87-3). Section recodified to A.A.C. R18-13-306, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-507. Recodified**Historical Note**

Former Section R9-8-421 renumbered without change as Section R18-8-507 (Supp. 87-3). Section recodified to A.A.C. R18-13-307, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-508. Recodified**Historical Note**

Amended effective August 6, 1976 (Supp. 76-4). Former Section R9-8-426 renumbered without change as Section R18-8-508 (Supp. 87-3). Section recodified to A.A.C. R18-13-308, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-509. Recodified**Historical Note**

Former Section R9-8-427 renumbered without change as Section R18-8-509 (Supp. 87-3). Section recodified to A.A.C. R18-13-309, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-510. Recodified**Historical Note**

Former Section R9-8-428 renumbered without change as Section R18-8-510 (Supp. 87-3). Section recodified to A.A.C. R18-13-310, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-511. Recodified**Historical Note**

Former Section R9-8-431 renumbered without change as Section R18-8-511 (Supp. 87-3). Section recodified to

A.A.C. R18-13-311, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-512. Recodified**Historical Note**

Amended effective August 6, 1976 (Supp. 76-4). Correction in spelling, paragraph (5), "feeding"; former Section R9-8-432 renumbered without change as Section R18-8-512 (Supp. 87-3). Section recodified to A.A.C. R18-13-312, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-513. Expired**Historical Note**

Adopted effective March 14, 1979 (Supp. 79-2). Former Section R9-8-433 renumbered without change as Section R18-8-513 (Supp. 87-3). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 15, 2000 (Supp. 00-1).

ARTICLE 6. RECODIFIED

Existing Sections in Article 6 recodified to 18 A.A.C. 13, Article 11 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-601. Expired**Historical Note**

Former Section R9-8-1211 renumbered without change as Section R18-8-601 (Supp. 87-3). Amended effective December 1, 1988 (Supp. 88-4). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 15, 2000 (Supp. 00-1).

R18-8-602. Recodified**Historical Note**

Former Section R9-8-1212 renumbered without change as Section R18-8-602 (Supp. 87-3). Section R18-8-602 recodified to R18-13-1102 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-603. Recodified**Historical Note**

Former Section R9-8-1213 renumbered without change as Section R18-8-603 (Supp. 87-3). Section R18-8-603 recodified to R18-13-1103 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-604. Recodified**Historical Note**

Former Section R9-8-1214 renumbered without change as Section R18-8-604 (Supp. 87-3). Section R18-8-604 recodified to R18-13-1104 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-605. Expired**Historical Note**

Former Section R9-8-1215 renumbered without change as Section R18-8-605 (Supp. 87-3). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 15, 2000 (Supp. 00-1).

R18-8-606. Recodified**Historical Note**

Former Section R9-8-1216 renumbered without change as Section R18-8-606 (Supp. 87-3). Section R18-8-606

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recodified to R18-13-1106 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-607. Expired**Historical Note**

Former Section R9-8-1221 renumbered without change as Section R18-8-607 (Supp. 87-3). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 15, 2000 (Supp. 00-1).

R18-8-608. Recodified**Historical Note**

Former Section R9-8-1222 renumbered without change as Section R18-8-608 (Supp. 87-3). Section R18-8-608 recodified to R18-13-1108 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-609. Expired**Historical Note**

Former Section R9-8-1223 renumbered without change as Section R18-8-609 (Supp. 87-3). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 15, 2000 (Supp. 00-1).

R18-8-610. Expired**Historical Note**

Former Section R9-8-1224 renumbered without change as Section R18-8-610 (Supp. 87-3). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 15, 2000 (Supp. 00-1).

R18-8-611. Expired**Historical Note**

Former Section R9-8-1225 renumbered without change as Section R18-8-611 (Supp. 87-3). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 15, 2000 (Supp. 00-1).

R18-8-612. Recodified**Historical Note**

Former Section R9-8-1231 renumbered without change as Section R18-8-612 (Supp. 87-3). Section R18-8-612 recodified to R18-13-1112 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-613. Recodified**Historical Note**

Former Section R9-8-1232 renumbered without change as Section R18-8-613 (Supp. 87-3). Section R18-8-613 recodified to R18-13-1113 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-614. Recodified**Historical Note**

Former Section R9-8-1233 renumbered without change as Section R18-8-614 (Supp. 87-3). Section R18-8-614 recodified to R18-13-1114 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-615. Recodified**Historical Note**

Former Section R9-8-1234 renumbered without change as Section R18-8-615 (Supp. 87-3). Section R18-8-615

recodified to R18-13-1115 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-616. Recodified**Historical Note**

Former Section R9-8-1235 renumbered without change as Section R18-8-616 (Supp. 87-3). Section R18-8-616 recodified to R18-13-1116 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-617. Recodified**Historical Note**

Former Section R9-8-1236 renumbered without change as Section R18-8-617 (Supp. 87-3). Section R18-8-617 recodified to R18-13-1117 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-618. Recodified**Historical Note**

Former Section R9-8-1241 renumbered without change as Section R18-8-618 (Supp. 87-3). Section R18-8-618 recodified to R18-13-1118 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-619. Recodified**Historical Note**

Former Section R9-8-1242 renumbered without change as Section R18-8-619 (Supp. 87-3). Section R18-8-619 recodified to R18-13-1119 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-620. Recodified**Historical Note**

Former Section R9-8-1243 renumbered without change as Section R18-8-620 (Supp. 87-3). Section R18-8-620 recodified to R18-13-1120 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-621. Expired**Historical Note**

Former Section R9-8-1244 renumbered without change as Section R18-8-621 (Supp. 87-3). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 15, 2000 (Supp. 00-1).

ARTICLE 7. RECODIFIED

18 A.A.C. 8, Article 7, consisting of Sections R18-8-701 through R18-8-710, recodified to Title 18, Chapter 13, Article 12, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-701. Recodified**Historical Note**

Adopted effective July 6, 1993 (Supp. 93-3). Section recodified to A.A.C. R18-13-1201, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-702. Recodified**Historical Note**

Adopted effective July 6, 1993 (Supp. 93-3). Section recodified to A.A.C. R18-13-1202, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-703. Recodified

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Historical Note

Adopted effective July 6, 1993 (Supp. 93-3). Section recodified to A.A.C. R18-13-1203, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-704. Recodified**Historical Note**

Adopted effective July 6, 1993 (Supp. 93-3). Section recodified to A.A.C. R18-13-1204, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-705. Recodified**Historical Note**

Adopted effective July 6, 1993 (Supp. 93-3). Section recodified to A.A.C. R18-13-1205, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-706. Recodified**Historical Note**

Adopted effective July 6, 1993 (Supp. 93-3). Section recodified to A.A.C. R18-13-1206, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-707. Recodified**Historical Note**

Adopted effective July 6, 1993 (Supp. 93-3). Section recodified to A.A.C. R18-13-1207, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-708. Recodified**Historical Note**

Adopted effective July 6, 1993 (Supp. 93-3). Section recodified to A.A.C. R18-13-1208, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-709. Recodified**Historical Note**

Emergency rule adopted effective February 5, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-1). Emergency rule adopted again effective May 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-2). Emergency expired (Supp. 93-3). Emergency rule permanently adopted without change effective February 1, 1994 (Supp. 94-1). Section recodified to A.A.C. R18-13-1209, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

R18-8-710. Recodified**Historical Note**

Emergency rule adopted effective February 5, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-1). Emergency rule adopted again effective May 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-2). Emergency expired (Supp. 93-3). Emergency rule permanently adopted without change effective February 1, 1994 (Supp. 94-1). Section recodified to A.A.C. R18-13-1210, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

ARTICLE 8. RESERVED**ARTICLE 9. RESERVED****ARTICLE 10. RESERVED****ARTICLE 11. RESERVED****ARTICLE 12. RESERVED****ARTICLE 13. RESERVED****ARTICLE 14. RESERVED****ARTICLE 15. RESERVED****ARTICLE 16. RECODIFIED**

Article 16, consisting of Sections R18-8-1601 through R18-8-1614, recodified to 18 A.A.C. 13, Article 16 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-1601. Recodified**Historical Note**

Adopted effective May 30, 1995 (Supp. 95-2). Section recodified to R18-13-1601 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-1602. Recodified**Historical Note**

Adopted effective May 30, 1995 (Supp. 95-2). Section recodified to R18-13-1602 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-1603. Recodified**Historical Note**

Adopted effective May 30, 1995 (Supp. 95-2). Section recodified to R18-13-1603 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-1604. Recodified**Historical Note**

Adopted effective May 30, 1995 (Supp. 95-2). Section recodified to R18-13-1604 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-1605. Recodified**Historical Note**

Adopted effective May 30, 1995 (Supp. 95-2). Section recodified to R18-13-1605 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-1606. Recodified**Historical Note**

Adopted effective May 30, 1995 (Supp. 95-2). Section recodified to R18-13-1606 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-1607. Recodified**Historical Note**

Adopted effective May 30, 1995 (Supp. 95-2). Section recodified to R18-13-1607 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-1608. Recodified**Historical note**

Adopted effective May 30, 1995 (Supp. 95-2). Section recodified to R18-13-1608 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-1609. Recodified

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Historical Note

Adopted effective May 30, 1995 (Supp. 95-2). Section recodified to R18-13-1609 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-1610. Recodified**Historical Note**

Adopted effective May 30, 1995 (Supp. 95-2). Section recodified to R18-13-1610 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-1611. Recodified**Historical Note**

Adopted effective May 30, 1995 (Supp. 95-2). Section recodified to R18-13-1611 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-1612. Recodified**Historical Note**

Adopted effective May 30, 1995 (Supp. 95-2). Section recodified to R18-13-1612 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

R18-8-1613. Recodified**Historical Note**

Adopted effective May 30, 1995 (Supp. 95-2). Section recodified to R18-13-1613 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

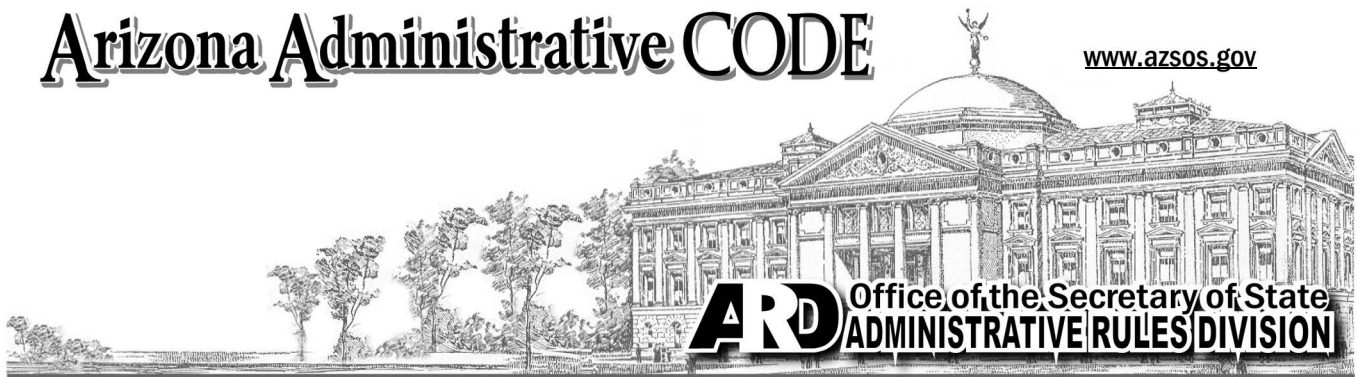
R18-8-1614. Recodified**Historical Note**

Adopted effective May 30, 1995 (Supp. 95-2). Section recodified to R18-13-1614 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

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20 A.A.C. 05

Supp. 23-1

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

The table of contents on page one contains links to the referenced page numbers in this Chapter.
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of
January 1, 2023 through March 31, 2023

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R20-5-504.	Safety Standard for Platform Lifts and Stairway Chairlifts	40	R20-5-511.	Repealed	42
R20-5-505.	Certificate of Inspection	41	R20-5-513.	Firefighters' Emergency Operation	42
R20-5-506.	Recordkeeping	41	R20-5-514.	Standard for Elevator Suspension, Compensation, and Governor Systems	43
R20-5-507.	Safety Code for Elevators, Escalators, Dumbwaiters, Moving Walks, Material Lifts, Special Purpose Personnel Elevators, and Dumbwaiters with Automatic Transfer Devices	41	R20-5-515.	Safety Requirements for Stage and Orchestra Lifts	43
R20-5-508.	Safety Standard for Manlifts	41	R20-5-1202.	Definitions	73
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			R20-5-1213.	Findings and Order Issued by the Department ...	78

Questions about these rules? Contact:

Commission: Industrial Commission of Arizona
Division of Occupational Safety and Health

Address: 800 W. Washington St., Suite 203
Phoenix, AZ 85007

Website: <https://www.azica.gov/>

Name: Jessie Atencio, Director

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The release of this Chapter in Supp. 23-1 replaces Supp. 22-4, 1-358 pages.

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, www.azsos.gov under Services-> Legislative Filings.

EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.

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Administrative Rules Division

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE**CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA**

Authority: A.R.S. §§ 23-107(A)(1) and 23-405(4)

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ARTICLE 2. REPEALED

Article 2, consisting of Sections R20-5-201 through R20-5-224, repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

Article 2, consisting of Sections R4-13-201 through R4-13-222, adopted effective July 6, 1993 (Supp. 93-3).

Article 2, consisting of Sections R4-13-201 through R4-13-224, repealed effective July 6, 1993 (Supp. 93-3).

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ARTICLE 7. REPEALED

Article 7, consisting of Sections R20-5-701 through R20-5-739, repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

Article 7, consisting of new Sections R20-5-701 through R20-5-739, adopted effective September 9, 1998 (Supp. 98-3).

R20-5-701 through R20-5-708 recodified from R4-13-701 through R4-13-708 (Supp. 95-1).

Article 7, consisting of Sections R4-13-701 through R4-13-708, transferred to the Department of Agriculture, Title 3, Chapter 8, Article 7, Sections R3-8-201 through R3-8-208, pursuant to Laws 1990, Ch. 374, Sec. 445 (Supp. 91-3).

New Article 7 adopted effective July 13, 1989. (Supp. 89-3)

Laws 1981, Ch. 149, effective January 1, 1982, provided for the transfer of the Office of Fire Marshal from the Industrial Commission to the Department of Emergency and Military Affairs, Division of Emergency Services (Supp. 82-2).

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ARTICLE 9. EXPIRED

Article 9, consisting of Sections R20-5-901 through R20-5-914, expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

Former Article 9 consisting of Sections R4-13-901 through R4-13-906 repealed effective May 27, 1977. R20-5-901 through R20-5-914 recodified from R4-13-901 through R4-13-914 (Supp. 95-1).

Article 9 consisting of Sections R4-13-901 through R4-13-914 adopted effective May 27, 1977.

Section

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APPENDIX A. ARIZONA PHYSICIANS' AND PHARMACEUTICAL FEE SCHEDULE 2022/2023

Appendix A, Arizona Physicians' and Pharmaceutical Fee Schedule repealed; new Appendix A, Arizona Physicians' and Pharmaceutical Fee Schedule made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

Appendix A, Arizona Physicians' and Pharmaceutical Fee Schedule repealed; new Appendix A, Arizona Physicians' and Pharmaceutical Fee Schedule made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3).

Appendix A, Arizona Physicians' and Pharmaceutical Fee Schedule repealed; new Appendix A, Arizona Physicians' and Pharmaceutical Fee Schedule made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3).

Appendix A, Arizona Physicians' and Pharmaceutical Fee Schedule made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A will remain in effect though Septem-

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ARTICLE 1. WORKERS' COMPENSATION PRACTICE AND PROCEDURE**R20-5-101. Application of the Article; Notice of Rules; Part of Record**

- A. This Article applies to all actions and proceedings before the Commission resulting from:
1. Injuries that occurred on or after January 1, 1969;
 2. Petitions to Reopen or Petitions for Readjustment or Rearrangement of Compensation filed on or after that date; and
 3. Requests for hearing under A.R.S. §§ 23-907(H), (I), and (J).
- B. This Article is part of the record in each action or proceeding without reference to the Article.
- C. The Commission deems all parties to have knowledge of this Article.
- D. The Commission shall provide a copy of this Article upon request to any person free of charge.

Historical Note

Former Rule 1. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-101 recodified from R4-13-101 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3). Amended by final rulemaking at 14 A.A.R. 4530, effective, December 2, 2008 (Supp. 08-4).

R20-5-102. Definitions

In this Article, unless the context otherwise requires:

“Act” means the Arizona Workers’ Compensation Act, A.R.S. Title 23, Ch. 6, Articles 1 through 11.

“Authorized representative” means an individual authorized by law to act on behalf of a party who files with the Commission a written instrument advising of the individual’s authority to act on behalf of the party.

“Carrier” or “insurance carrier” means the state compensation fund and every insurance carrier authorized by the Arizona Department of Insurance to underwrite workers’ compensation insurance in Arizona.

“Claimant” means an employee who files a claim for workers’ compensation.

“Filing” means actual receipt of a report, document, instrument, videotape, audiotape, or other written matter at a Commission office during office hours as set forth in R20-5-103.

“Physician” means a licensed physician or other licensed practitioner of the healing arts.

“Self-insured employer” means an employer or workers’ compensation pool granted authority by the Commission to self-insure for workers’ compensation.

“Uninsured employer” or “noncomplying employer” means an employer that is subject to and fails to comply with A.R.S. §§ 23-961 or 23-962.

“Working days” means all days except Saturdays, Sundays, and state legal holidays.

Historical Note

Former Rule 2. R20-5-102 recodified from R4-13-102 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-103. Location of Industrial Commission Offices and Office Hours

The main office of the Industrial Commission of Arizona is located in Phoenix, Arizona. An office is also located in Tucson, Arizona. The offices are open for business from 8:00 a.m. until 5:00 p.m. every day except Saturdays, Sundays, and state legal holidays.

Historical Note

Former Rule 3. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-103 recodified from R4-13-103 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-104. Address of Claimant and Uninsured Employer

- A. A claimant shall advise the Commission and carrier or self-insured employer of the claimant’s current mailing address and place of residence. If a claimant files a workers’ compensation claim against an uninsured employer, the claimant shall advise the special fund division of the claimant’s current mailing address and place of residence.
- B. An uninsured employer against whom a claimant files a workers’ compensation claim shall advise the special fund division of the uninsured employer’s current mailing address and place or places of residence.
- C. Providing the address of a claimant’s or uninsured employer’s attorney or authorized representative is not sufficient to meet the requirements of this Section.

Historical Note

Former Rule 4. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-104 recodified from R4-13-104 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-105. Filing Requirements; Time for Filing; Computation of Time; Response to Motion

- A. A report, document, instrument, videotape, audiotape, or other written matter required to be filed with the Commission under A.R.S. § 23-901 et seq. and this Article shall be filed at a Commission office within the time required by law and this Article.
- B. For purposes of computing time under this Article, the following applies:
1. The Commission shall not include in the computation of time the day of the act or event from which the designated period begins to run.
 2. The Commission shall include in the computation of time the last day of the designated period, unless the last day is a Saturday, Sunday, or state legal holiday, in which event the period runs until the end of the next day that is not a Saturday, Sunday, or state legal holiday.
 3. If this Article or other law requires that a report, document, instrument, videotape, audiotape, or other written matter be filed within a designated period of time before hearing, the Commission shall not include the day of the act or event from which the designated period of time begins to run. The Commission shall include the last day of the designated period unless that day is a Saturday, Sunday, or state legal holiday, in which event the period runs to the end of the next day that is not a Saturday, Sunday, or state legal holiday.
 4. If the period of time prescribed is less than 11 days, the Commission shall not include intermediate Saturdays, Sundays, or state legal holidays in the computation of time.

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- C. The Commission shall deem a report, document, instrument, videotape, audiotape, or other written matter filed at the Tucson office as filed at the main office for purposes of computing time.
 - D. A person upon whom a motion to join is filed under this Article may file a response to the motion within 10 days after the motion is filed.
 - E. The Commission shall not consider a discovery motion unless the moving party attaches a separate statement to the discovery motion certifying that after good faith efforts to do so, the moving party has been unable to satisfactorily resolve the matter giving rise to the discovery motion with the opposing party.
- b. Effective date of the suspension;
 - c. Reasons for the suspension;
 - d. Date the notice is mailed;
 - e. Name and telephone number of the individual issuing the notice; and
 - f. Statement of a party's hearing and appeal rights including filing requirements.
- 6. Notice of permanent disability or death benefits (form 106) shall contain:
 - a. Employee, employer, insurance carrier, and claim identification;
 - b. Applicable statutory authority under which compensation is paid;
 - c. Disability and compensation information;
 - d. Date the notice is mailed;
 - e. Name and telephone number of the individual issuing the notice; and
 - f. Statement regarding hearing and appeal rights including filing requirements.

Historical Note

Former Rule 5. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-105 recodified from R4-13-105 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-106. Commission Forms

- A. The following forms shall be used when applicable:
 - 1. Employer's report of industrial injury (form 101) shall contain:
 - a. Employee, employer, and carrier identification;
 - b. Description of employment;
 - c. Description of accident and injury;
 - d. Description of medical treatment received by employee;
 - e. Employee's wage data;
 - f. Date, signature, and title of employer or the employer's representative; and
 - g. Statement doubting the validity of the claim, if the employer doubts the validity of the claim.
 - 2. The physician's portion of the worker's and physician's report of injury (form 102) shall contain:
 - a. Name and address of physician;
 - b. Information regarding preexisting conditions;
 - c. Information regarding the industrial injury, treatment, and prognosis;
 - d. Statement authorizing the attachment of a medical report that contains the information required in form 102; and
 - e. Physician's signature and date.
 - 3. Notice of supportive medical benefits (form 103) shall contain:
 - a. Employee, employer, insurance carrier, and claim identification;
 - b. Description of authorized medical benefits;
 - c. Date the notice is mailed;
 - d. Name and telephone number of the individual issuing the notice; and
 - e. Statement regarding reopening and appeal rights including filing requirements.
 - 4. Notice of claim status (form 104) shall contain:
 - a. Employee, employer, insurance carrier, and claim identification;
 - b. Status of the claim;
 - c. Date the notice is mailed;
 - d. Name and telephone number of the individual issuing the notice; and
 - e. Statement of a party's hearing and appeal rights including filing requirements.
 - 5. Notice of suspension of benefits (form 105) shall contain:
 - a. Employee, employer, insurance carrier, and claim identification;
- 7. Notice of permanent disability and request for determination of benefits (form 107) shall contain:
 - a. Employee, employer, insurance carrier, and claim identification;
 - b. Type of disability;
 - c. Applicable statutory authority for designated disability;
 - d. Designation of dependents where death is involved;
 - e. Designation of advanced payments and amount of the advance;
 - f. Date the notice is mailed; and
 - g. Name and telephone number of the individual issuing the notice.
 - 8. Carrier's recommended average monthly wage calculation (form 108) shall contain:
 - a. Employee, employer, insurance carrier, and claim identification;
 - b. Employment and wage history;
 - c. Designation of dependents; and
 - d. Carrier's calculations for the recommended average monthly wage and the basis for the calculation.
 - 9. Notice of permanent compensation payment plan (form 111) shall contain:
 - a. Employee, employer, and carrier identification;
 - b. Amount of permanent compensation and description of payment plan;
 - c. Name of the responsible entity contracted by the carrier to administer the payment plan;
 - d. Statement that the carrier remains the responsible party for payment;
 - e. Statement regarding supportive care and reopening rights;
 - f. Date the notice is mailed; and
 - g. Name and telephone number of the individual issuing the notice.
 - 10. Report of insurance coverage (form 0006) shall contain:
 - a. Name and address of the carrier;
 - b. Legal name of entity that the carrier insures;
 - c. All other insured names or subsidiary entities under which the carrier's insured does business in Arizona;
 - d. Address of all insured entities with insurance policy information for each address; and
 - e. Employer Identification Number (EIN), Taxpayer Identification Number (TIN), or Federal Identification Number (FIN) assigned to each insured person or entity.

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11. Report of significant work exposure to bodily fluids or other infectious material shall contain:
 - a. The requirements set forth in A.R.S. §§ 23-1043.02(B), 23-1043.03(B), and 23-1043.04(B);
 - b. Employee identification,
 - c. Employer identification,
 - d. Source of exposure person identification (if known),
 - e. Details of the exposure including:
 - i. Date of exposure,
 - ii. Time of exposure,
 - iii. Place of exposure,
 - iv. How exposure occurred,
 - v. Type of bodily fluid or fluids,
 - vi. Source of bodily fluid or fluids,
 - vii. Part or parts of body exposed to bodily fluid or fluids,
 - viii. Presence of break or rupture in skin or mucous membrane, and
 - ix. Witnesses (if known), and
 - f. Dated signature of employee or the employee's authorized representative.
 12. The medical treatment preauthorization form (MRO-1.1) shall contain five sections, as follows:
 - a. Section I (Provider Request for Preauthorization) shall contain:
 - i. Injured employee identification, including name, date of injury, date of birth, and payer claim number (if known);
 - ii. Provider identification, including name, phone number, provider medical specialty, preferred method of contact, and contact information;
 - iii. Payer identification, including name and contact information (i.e., mailing address, fax number, or e-mail address);
 - iv. Information regarding requested medical treatment and/or services, including:
 - (1) Applicable diagnosis and/or ICD codes;
 - (2) A detailed statement of the treatment or services requested;
 - (3) Applicable Current Procedural Terminology (CPT) codes and/or National Drug Codes (NDC);
 - (4) Type of request (i.e., routine or urgent); and
 - (5) An indication as to whether the provider has attached documentation to support the medical necessity and appropriateness of the requested treatment and/or services; and
 - v. Dated signature or electronic signature of provider or provider's authorized representative.
 - b. Section II (Payer Decision on Request for Preauthorization) shall contain:
 - i. Payer's preferred method of contact and contact information;
 - ii. Date request for preauthorization is received;
 - iii. The Commission claim number;
 - iv. The payer's decision (i.e., approved, partial denial, denied, request for preauthorization incomplete, or IME requested);
 - v. An indication as to whether the payer has attached a statement of what treatment and/or services have been authorized, including, if applicable, a partial authorization, and, if the request for preauthorization is denied, in whole or in part, a statement of explanation that includes the medical reason supporting the payer's decision; and
 - c. Section III (Provider or Employee Request for Reconsideration of Payer Decision) shall contain:
 - i. An indication as to whether the provider or injured employee has attached a statement of the specific reasons and justifications to support the request for reconsideration;
 - ii. An indication as to whether the provider or injured employee has attached documentation to support the medical necessity and appropriateness of the requested treatment and/or services, if not previously provided; and
 - iii. Dated signature or electronic signature of provider, provider's authorized representative, injured employee, or injured employee's authorized representative.
 - d. Section IV (Payer Decision on Request for Reconsideration) shall contain:
 - i. Date request for reconsideration received;
 - ii. The payer's decision (e.g., approved, partial denial, denied, or IME requested);
 - iii. An indication as to whether the payer has attached a statement of what has been authorized, including if applicable, a partial authorization, and, if the request for preauthorization is denied, in whole or in part, a statement of explanation that includes the medical reason supporting the payer's decision; and
 - iv. Dated signature or electronic signature of payer or payer's authorized representative.
 - e. Section V (Provider or Employee Request for Administrative Peer Review) shall contain:
 - i. An indication of the basis for the request for administrative peer review (e.g., payer non-response, denial (in whole or in part) of requested treatment or services, the payer's decision on the request for preauthorization denied treatment or services that are subject to R20-5-1304(B));
 - ii. An indication as to whether the provider or injured employee has attached copies of relevant medical records and, if applicable, documentation related to the payer's non-response;
 - iii. An indication as to whether the provider or injured employee has attached all documentation and statements previously attached to Sections I-IV; and
 - iv. Dated signature or electronic signature of provider, provider's authorized representative, injured employee, or injured employee's authorized representative.
- B.** The following forms may be used:
1. The workers' portion of the worker's and physician's report of injury (form 102) requests:
 - a. Employee, employer, insurance carrier, and physician identification;
 - b. Description of the accident, including date of injury; and
 - c. Date and signature of the employee or the employee's authorized representative.
 2. Worker's report of injury (form 407) requests:

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- a. Employee and employer identification,
 - b. Job title,
 - c. Employment description,
 - d. Employee's wage data,
 - e. Date of injury,
 - f. Accident and injury descriptions,
 - g. Medical treatment information,
 - h. Information concerning prior injuries of the employee,
 - i. Disability income, and
 - j. Date and signature of the employee or the employee's authorized representative.
3. Worker's annual report of income (form 110-A) requests:
- a. Employee, employer, insurance carrier, and claim identification;
 - b. Employment and wage history for the preceding 12 months;
 - c. Date and signature of the employee or the employee's authorized representative attesting to the truthfulness of the employment and wage information; and
 - d. Statement that failure to submit an annual report of income may result in a suspension of benefits by the carrier or self-insured employer.
4. Notice of intent to suspend (form 110-B) requests:
- a. Employee, employer, insurance carrier, and claim identification;
 - b. Employment and wage history for the preceding 12 months;
 - c. Date and signature of the employee or the employee's authorized representative attesting to the truthfulness of the employment and wage information;
 - d. Statement that failure to submit an annual report within 30 days of the date of the notice shall result in a suspension of benefits by the carrier or self-insured employer.
5. Request for hearing requests:
- a. Names of the employee, employer, and insurance carrier;
 - b. Claim identification;
 - c. Identification of the award, notice, order, or determination protested and reason(s) for the protest;
 - d. Estimated length of time for hearing and city or town in which hearing is requested;
 - e. Name and address of any witness for whom a subpoena is requested; and
 - f. Date and signature of party or the party's authorized representative.
6. Petition to reopen requests:
- a. Names of the employee, employer, and insurance carrier;
 - b. Claim identification;
 - c. Identification or description of the new, additional, or previously undiscovered temporary or permanent disability or medical condition justifying the reopening of the claim; and
 - d. Employee's medical and employment history.
7. Petition for rearrangement or readjustment of compensation requests:
- a. Names of the employee, employer, and insurance carrier;
 - b. Claim identification;
 - c. Income and employment history;
 - d. Medical history; and
 - e. Statement of the basis for the increase or decrease in earning capacity.
8. Claim for dependent's benefits-fatality form requests:
- a. Identification of dependent filing claim;
 - b. Identification of deceased;
 - c. Date of death;
 - d. Date of injury, if different than date of death;
 - e. Name and address of employer at time of deceased's death;
 - f. Statement of cause of death;
 - g. Names and addresses of health care providers rendering treatment to deceased in two years before death;
 - h. Conditions treated by health care providers in the two years before deceased's death;
 - i. If claim is for spousal benefits, the form requests:
 - i. Name, address, and date of birth of spouse;
 - ii. Copy of marriage certificate;
 - iii. Date and place of marriage to deceased;
 - iv. History of prior marriages of deceased and deceased's spouse, including copies of divorce decrees; and
 - v. Statement of living arrangements at time of deceased's death, including reason for living apart at time of death, if applicable;
 - j. If claim is for a dependent child, the form requests:
 - i. Name, date of birth, and address of child at time of deceased's death;
 - ii. List of children in care and custody of current spouse; and
 - iii. Statement of whether unborn child is expected and date expected;
 - k. If claim is for dependent other than a child, the form requests:
 - i. Name and address of other dependent,
 - ii. Relationship of other dependent to deceased, and
 - iii. Statement of the nature and extent of dependency; and
 - l. Date, telephone number, and signature of dependent or authorized representative of dependent.
9. Request to leave the state form requests:
- a. Employee, insurance carrier, and claim identification;
 - b. Reason for requesting to leave Arizona;
 - c. Dates leaving and returning to Arizona;
 - d. Out-of-state address;
 - e. Name and telephone number of attending physician; and
 - f. Date and signature of the employee or the employee's authorized representative.
10. Request to change doctors form requests:
- a. Employee, insurance carrier, and claim identification;
 - b. Reason for requesting change of doctor;
 - c. Name and phone number of claimant's current doctor;
 - d. Name and phone number of doctor claimant requests to change to; and
 - e. Date and signature of the employee or the employee's authorized representative.
11. Complaint of bad faith and unfair claim processing practices requests:
- a. Employee, employer, and insurance carrier identification;

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- b. Description of the alleged bad faith or unfair claim processing practices;
 - c. Date of the complaint; and
 - d. Name, address, and telephone number of the person signing the complaint.
12. Certification of employer's drug and alcohol testing policy requests:
- a. Employer's certification as described under A.R.S. § 23-1021(F),
 - b. Name and federal identification number of the employer, and
 - c. Name of all subsidiaries and locations of the employer.
- C. Optional use of a form described in subsection (B) does not affect any requirement under the Act or this Article.
- D. Forms or format for the forms described in this Section are available from the Commission.
- E. Forms prescribed under this Section shall not be changed, amended, or otherwise altered without the prior written approval of the Commission.

Historical Note

Former Rule 6. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-106 recodified from R4-13-106 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3). Amended by final rulemaking at 15 A.A.R. 991, effective June 2, 2009 (Supp. 09-2). Amended by final rulemaking at 24 A.A.R. 2069, effective October 1, 2018 (Supp. 18-3).

R20-5-107. Manner of Completion of Forms and Documents

- A. An individual completing a form or document shall fill out the form or document legibly in ink or by typewriter.
- B. A party or a party's authorized representative shall sign any form or document that is required by the Act, this Article, or other law to be signed.
- C. Unless otherwise provided in this Article, if a party is required to sign a form or document, the Commission shall not accept a typewritten name or stamped signature.
- D. If, within the time period prescribed by law, a party files an incomplete form or document, or files an instrument other than a form or document when a form or document is required, the Commission shall serve notice to the party that the form or document fails to comply with this Section. The Commission deems the report or document timely filed if the party files a properly completed and signed form or document within 14 days after the Commission serves the notice described in this subsection.

Historical Note

Former Rule 7. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-107 recodified from R4-13-107 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-108. Confidentiality of a Commission Claims File; Reproduction and Inspection of a Commission Claims File

- A. Except as provided in this Section, a claims file maintained by the Commission is private and confidential and the Commission shall not make the claims file available for inspection and copying. For purposes of this Section, "claims file" means the official record maintained by the Commission for a claimant's industrial injury including the worker's report of injury, employer's report of injury, worker and physician's report of

injury, and all other reports, records, instruments, videotapes, audiotapes, transcripts, and other matters scanned or otherwise placed into the file.

- B. Except as provided in subsections (D) and (E), the Commission shall make a Commission claims file relating to a current or prior claim of a claimant available for inspection and copying by any party to any proceeding currently or previously before the Commission involving the same claimant.
- C. Except as provided in subsections (D) and (E), the Commission shall not make a Commission claims file available to a non-party for inspection and copying unless the Commission receives a court order or written authorization signed by the affected claimant or the affected claimant's authorized representative.
- D. The Commission shall make a transcript contained in a Commission claims file available for inspection and copying if:
 1. The person requesting to inspect and copy the transcript is a person authorized under subsections (B) or (C); and
 2. The transcript concerns a hearing related to a claim that is not in litigation.
- E. The Commission shall make a transcript contained in a Commission claims file available only for inspection if:
 1. The person requesting to inspect and copy the transcript is a person authorized under subsections (B) or (C); and
 2. The transcript concerns a hearing related to a claim currently in litigation.
- F. The Commission shall provide copies at a charge of \$.25 per page.
- G. A Commission claims file shall not be removed from a Commission office unless in the custody of an authorized representative of the Commission.

Historical Note

Former Rule 8. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-108 recodified from R4-13-108 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-109. Admission into Evidence of Documents Contained in a Commission Claims File

- A. If a party or an administrative law judge considers a document contained in a Commission claims file, including a transcript of a prior proceeding, necessary or appropriate for hearing purposes, the administrative law judge shall receive a copy of the document into evidence if the document is otherwise admissible.
- B. With the permission of the administrative law judge, instead of submitting a copy of the document into evidence, a party may refer to the document's location on the Commission's optical disk imaging system by providing an accurate description of the document that includes the claimant's claim number and image document identification number the Commission assigns to the document.

Historical Note

Former Rule 9. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-109 recodified from R4-13-109 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-110. Employer Duty to Report Fatality

If an employee dies as a result of an injury by accident arising out of and in the course of employment, the employer shall report the death to the Commission's claims division by telephone, telegram,

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or electronic filing, no later than the next business day following the death. The report shall state the name of the employee, when, how, and where the accident occurred, and the nature of the condition causing the accident. This Section does not limit or affect an employer's duty to report a death to the Arizona Occupational Safety and Health Division of the Commission as required under R20-5-637.

Historical Note

Former Rule 10. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-110 recodified from R4-13-110 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-111. Request for Autopsy

If a claim is filed for compensation for death from an industrial injury and an autopsy is requested, the expense of the autopsy shall be borne by the requesting party.

Historical Note

Former Rule 11. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-111 recodified from R4-13-111 (Supp. 95-1).

R20-5-112. Physician's Initial Report of Injury

- A. A physician shall complete and file with the Commission a physician's initial report of injury under A.R.S. § 23-908(A) within eight days after first providing treatment to an injured worker. The physician shall report the injury:
 1. Using Commission form 102 (worker's and physician's report of injury), or
 2. Attaching to form 102 a medical report that contains the information required in form 102.
- B. The physician shall sign and date form 102 or the medical report attached to form 102. The signature of the physician may be typewritten or stamped on this form.
- C. If a claimant uses form 102 to initiate a claim, either the injured worker or the injured worker's authorized representative shall sign the worker's portion of form 102.

Historical Note

Former Rule 12. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-112 recodified from R4-13-112 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-113. Physician's Duty to Provide Signed Reports; Rating of Impairment of Function; Restriction Against Interruption or Suspension of Benefits; Change of Physician

- A. If a claimant's disability extends beyond seven days, every physician who attends, treats, or examines the claimant shall provide to the insurance carrier, self-insured employer, or special fund division, at least once every 30 days while the claimant's disability continues, a personally signed report describing the:
 1. Claimant's condition,
 2. Nature of treatment,
 3. Expected duration of disability, and
 4. Claimant's prognosis.
- B. When a physician discharges a claimant from treatment, the physician:
 1. Shall determine whether the claimant has sustained any impairment of function resulting from the industrial injury. The physician should rate the percentage of impairment using the standards for the evaluation of per-

manent impairment as published by the most recent edition of the American Medical Association in Guides to the Evaluation of Permanent Impairment, if applicable; and

2. Shall provide a final signed report to the insurance carrier, self-insured employer, or special fund division that details the rating of impairment and the clinical findings that support the rating.
- C. A carrier, self-insured employer, and special fund division shall not interrupt or suspend a claimant's temporary disability compensation benefits because a physician fails to comply with any requirement of subsection (A).
- D. A carrier, self-insured employer, and special fund division may withhold payment to a physician for services rendered to a claimant until the physician complies with subsection (A).
- E. Upon application of a party, the Commission shall authorize a change of physician if:
 1. The Commission determines that the health, life, or recovery of a claimant is retarded, endangered, or impaired;
 2. The attending physician agrees to the change or is unavailable to continue treatment;
 3. The Commission determines that the relationship between the attending physician and claimant renders further progress or improvement unlikely;
 4. The Commission determines that the claimant's recovery may be expedited by a change of physician or conditions of treatment; or
 5. The insurance carrier agrees to the change.
- F. Except as provided in A.R.S. § 23-1070 and this subsection, a claimant who is examined by a physician under A.R.S. § 23-908(E) is not required to obtain written authorization to change to another physician. If, however, the claimant continues to see, or treat with, a physician who the claimant initially saw or treated with under A.R.S. § 23-908(E), then that physician is an attending physician and the claimant shall obtain written authorization to change under A.R.S. § 23-1071(B) if the claimant seeks to change to another physician.

Historical Note

Former Rule 13. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-113 recodified from R4-13-113 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-114. Examination at Request of Commission, Carrier or Employer; Motion for Relief

- A. If the Commission or a party requests an examination of a claimant by a physician, the party requesting the examination shall serve the claimant, or if represented, the claimant's attorney, with notice of the time, date, place, and physician conducting the examination at least 15 days before the scheduled date of the examination.
- B. If a claimant unreasonably fails to attend or promptly advise of the claimant's inability to attend an examination under this Section, the party requesting the examination may charge the claimant or deduct from the claimant's entitlement to present or future temporary or permanent disability compensation, any reasonable expense of the missed appointment.
- C. A party adverse to a party who schedules a medical examination may offer into evidence the report of any medical examination as provided in R20-5-155 or within five days after the adverse party receives the report, subject to the right of cross-examination by the party who scheduled the examination.

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- D. If a carrier, self-insured employer, or special fund division requests an examination of a claimant's mental or physical condition under A.R.S. § 23-1026, the carrier, self-insured employer, or special fund division shall immediately, upon receipt of the report of the examination, provide a copy of the report to the claimant or the claimant's authorized representative. If the mental condition of an unrepresented claimant is examined under A.R.S. § 23-1026, the carrier, self-insured employer, or special fund division may, in its discretion, provide the report to the claimant's treating physician rather than to the claimant.
- E. To protect a claimant from annoyance, embarrassment, oppression, or undue burden or expense, the Commission may order, upon good cause shown, one or both of the following:
1. That the examination not be held; or
 2. That the examination may be conducted only on specified terms and conditions, including a designation of the time, place, and examining physician.
- F. A claimant requesting protection under subsection (E) shall file a motion with the presiding administrative law judge or chief administrative law judge if a judge has not been assigned to the case, within three days after the claimant receives notice of the examination. The claimant shall serve a copy of the motion on all parties. The party requesting the examination shall have three days after receiving the motion to file a response. The party shall serve the response on the claimant or, if represented, the claimant's attorney of record.

Historical Note

Former Rule 14. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-114 recodified from R4-13-114 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-115. Request to Leave the State

- A. The effective date of an order granting or denying a request to leave the state under A.R.S. § 23-1071(A) is the date a claimant files a request to leave the state with the Commission.
- B. For purposes of A.R.S. § 23-1071(A):
1. "While the necessity of having medical treatment continues" means the period of time in which a claimant asserts an entitlement to temporary compensation, or active medical, surgical, or hospital benefits;
 2. "Leave the state" means to travel across the state border, except when the logical or nearest medical facility is situated across the state border; and
 3. "From the date the employee first requested the written approval" means from the date the claimant's request is filed with the Commission.

Historical Note

Former Rule 15. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-115 recodified from R4-13-115 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-116. Payment of Claimant's Travel Expenses When Directed to Report for Medical Examination or Treatment

- A. If a claimant is directed by a carrier, self-insured employer, or special fund division to report for a medical examination or treatment in a locality other than either the claimant's current place of residence or employment, the carrier, self-insured employer, or special fund division shall pay, in advance, the claimant's travel expenses from either the claimant's current

place of residence or employment, whichever route of travel is required.

- B. For purposes of this Section, "travel expenses" means those expenses required to be paid under A.R.S. § 23-1026.
- C. The carrier, self-insured employer, or special fund division shall calculate travel expenses using the current rates applicable to state employees.

Historical Note

Former Rule 16. Amended subsections (A) and (B) effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Correction to subsection (A) as certified effective March 1, 1987 (Supp. 88-4). R20-5-116 recodified from R4-13-116 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-117. Medical, Surgical, Hospital, and Burial Expenses

- A. A carrier, self-insured employer, or special fund division, shall pay bills for medical, surgical, and hospital benefits provided under A.R.S. § 23-901 et seq. according to applicable medical and surgical fee schedules adopted by the Commission and in effect at the time the services are rendered. A physician or provider of nursing, hospital, drug or other medical services shall itemize and submit a bill for payment only to the responsible carrier, self-insured employer, or special fund division.
- B. A claimant shall not be responsible to pay any disputed amounts between the medical provider and the carrier, self-insured employer, or special fund division.
- C. If a claimant pays a bill described in subsection (A), the responsible carrier, self-insured employer, or special fund division shall reimburse the claimant the amount allowed by the fee schedules, provided that the claimant presents receipted vouchers or other proof of payment to support the claim for reimbursement.
- D. If an insured employer pays a bill described in subsection (A), the responsible carrier or self-insured employer shall reimburse the employer the amount allowed by the fee schedules, provided that the employer presents receipted vouchers or other proof of payment to support the claim for reimbursement.
- E. An insurance carrier, self-insured employer, or special fund division may pay any authorized burial expenses directly to the funeral service professional.
- F. If an employee's dependent pays burial expenses, the responsible carrier, self-insured employer, or special fund division shall reimburse the dependent the amount authorized by A.R.S. § 23-1046 provided that the dependent presents proof of payment to support the claim for reimbursement.
- G. If an insured employer pays burial expenses, the responsible carrier or self-insured employer shall reimburse the employer to the extent authorized by A.R.S. § 23-1046 provided that the employer presents proof of payment to support the claim for reimbursement.

Historical Note

Former Rule 17. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-117 recodified from R4-13-117 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-118. Effective Date of Notices of Claim Status and Other Determinations; Attachments to Notices of Claim Status; Form of Notices of Claim Status

- A. If a notice of claim status accepting a claim for benefits is final, any subsequent notice of claim status that changes a

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claimant's amount of, or entitlement to, compensation or medical, surgical, or hospital benefits shall not have a retroactive effect for more than 30 days from the date a carrier or self-insured employer issues the subsequent notice of claim status. This subsection does not apply to a subsequent notice that affects the entitlement to or amount of death benefits. The Commission may for good cause relieve a carrier or self-insured employer of the effect of this subsection.

- B.** If a notice of claim status or other determination issued by a carrier, self-insured employer, or special fund division, is based upon a physician's report:
1. The carrier or self-insured employer shall attach a copy of the physician's complete report to the notice of claim status or other determination sent to the Commission; and
 2. The carrier, self-insured employer, or special fund division shall attach a copy of the physician's complete report to the notice of claim status or other determination served on a party, except as provided in R20-5-114(D).
- C.** If a carrier, self-insured employer, or special fund division pays compensation to a claimant:
1. The carrier or self-insured employer shall close the claim by issuing a notice of claim status; and
 2. The special fund division shall close the claim by issuing a notice of determination.
- D.** The inadvertent failure of a carrier, self-insured employer, or special fund division to comply with subsection (B) shall not affect the validity of a notice or determination if the carrier, self-insured employer, or special fund division issuing the notice or determination had in its possession at the time the notice or determination is issued a medical report consistent with the notice or determination.

Historical Note

Former Rule 18. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-118 recodified from R4-13-118 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-119. Notice of Third-party Settlement

- A.** Except as otherwise provided by law, if an employer is insured for workers' compensation insurance and a claimant, or in the event of death, the claimant's dependent, elects to proceed against a third party, the claimant shall notify the appropriate workers' compensation carrier, or self-insured employer, of any settlement or judgment in the third party suit and the basis upon which the claimant and third party agree to disburse the proceeds of the settlement or judgment.
- B.** If an employer is uninsured for workers' compensation insurance and a claimant, or in the event of death, the claimant's dependent, elects to proceed against a third party, the claimant shall notify the special fund division of any settlement or judgment in the third party suit and the basis upon which the claimant and third party agree to disburse the proceeds of the settlement or judgment.
- C.** If a lawsuit is filed against a third party, the claimant or the claimant's attorney shall provide copies of pleadings and all offers of settlement to the workers' compensation carrier, self-insured employer, or special fund division to whom notice is required under subsections (A) and (B).

Historical Note

Former Rule 19. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-119 recodified from R4-13-119 (Supp. 95-1). Amended by final

rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-120. Settlement Agreements, Compromises and Releases

- A.** No settlement agreement, compromise, or waiver of rights of a workers' compensation claim, will be valid unless approved by the Commission.
- B.** The acceptance of any payments or the signing of a settlement agreement, compromise, release or waiver of rights, unless approved by the Commission, shall not release the employer or his insurance carrier from any obligation imposed by the Workers' Compensation Law.
- C.** The carrier or employer shall not be entitled to a credit for any sums paid to an employee under a settlement agreement which has not been approved by the Commission.

Historical Note

Former Rule 20. Amended subsections (A) and (B) effective March 1, 1987, filed February 26, 1987 (Supp. 87-1).

R20-5-120 recodified from R4-13-120 (Supp. 95-1).

R20-5-121. Present Value and Basis of Calculation of Lump Sum Commutation Awards

- A.** The Commission shall calculate the present value of an award that is commuted to a lump sum under R20-5-122. The Commission shall not include in the present value calculation compensation paid before the filing of a lump sum commutation petition. The Commission shall use the filing date of a lump sum commutation petition to compute the present value of an award.
- B.** The Commission shall calculate the present value of an award at least annually, whether payable for a period of months or based upon the life of the employee, using the United States Life Tables, 2003, National Vital Statistics Reports, Vol. 54, Number 14, April 19, 2006, revised March 28, 2007, Table 1 incorporated by reference, and discounted at the rate established by the Commission. This incorporation does not include any later amendments or editions of the incorporated matter. A copy of this referenced material is available for review at the Commission and may be obtained from the U.S. Department of Health and Human Services, Centers for Disease Control. The rate established by the Commission is based on the following formula: The mean average of the three-month Treasury Bill rate on December 31 of each of the five years prior to July 1 of the current year. The rate, once calculated, is effective until the Commission calculates a new rate under this subsection. The discount rate is published in the minutes of the Commission meeting establishing the rate and is available upon request from the Commission.

Historical Note

Former Rule 21. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-121 recodified from R4-13-121 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3). Amended by final rulemaking at 10 A.A.R. 724, effective February 3, 2004 (Supp. 04-1). Amended by final rulemaking at 11 A.A.R. 2973, effective July 12, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 4139, effective November 6, 2007 (Supp. 07-4).

R20-5-122. Lump Sum Commutation

- A.** A petition for a lump sum commutation in an unscheduled case shall not be approved unless the carrier approves of such petition.

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- B.** If the lump sum commutation petition is approved by the carrier, the Commission's primary consideration in passing upon the petition will be whether more net income per month will be generated after receipt of the lump sum than the applicant is presently receiving. The granting of a lump sum petition will only be granted if the facts demonstrate a reasonable basis for financial betterment or rehabilitation of the claimant.
- C.** The burden of proving that the commutation of compensation satisfies the criteria in (B) is on the applicant.

Historical Note

Former Rule 22. Amended subsections (A) and (B) effective March 1, 1987, filed February 26, 1987 (Supp. 87-1).
R20-5-122 recodified from R4-13-122 (Supp. 95-1).

R20-5-123. Rejection of the Act

If an employee serves upon an employer written notice under A.R.S. § 23-906, rejecting the provisions of the Act, the employer shall keep one copy of the rejection in the employer's business records.

Historical Note

Former Rule 23. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-123 recodified from R4-13-123 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-124. Rejection Not Applicable to New Employment

- A.** An election by an employee to reject the Act is not binding upon the employee in a new employment by another employer or following re-employment by the same employer.
- B.** If an employee is continuously employed and the employer changes workers' compensation insurance carriers, or form of doing business, the prior rejection is valid and remains in full force and effect.

Historical Note

Former Rule 24. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-124 recodified from R4-13-124 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-125. Rejection Before an Employer Complies with A.R.S. §§ 23-961(A) and 23-906(D)

An employee's rejection of the Act received by an employer before the employer complies with the requirements of A.R.S. §§ 23-961(A) or 23-906(D) is valid and continues in full force and effect whether the employer subsequently obtains workers' compensation coverage under A.R.S. § 23-961(A), posts the notice required under A.R.S. § 23-906(D), or makes available the forms required under A.R.S. § 23-906(D).

Historical Note

Former Rule 25. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-125 recodified from R4-13-125 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-126. Revocation of Rejection

- A.** An employee who rejects the Act may revoke that rejection by serving upon the employee's employer an original and one copy of a written notice of revocation. The written revocation shall state that the employee revokes the employee's prior rejection of the Act.
- B.** Within five days after receiving a written notice of revocation, an insured employer shall file with the employer's carrier, or

workers' compensation pool, a copy of the notice of revocation. The employee has all rights to compensation and benefits provided by the Act for any injury that occurs after the employee serves the revocation notice upon the employer.

Historical Note

Former Rule 26. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-126 recodified from R4-13-126 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-127. Insurance Carrier Notification to Commission of Coverage

- A.** Every insurance carrier authorized to underwrite workers' compensation insurance in Arizona shall, within five days after undertaking to insure an employer, report that information to the Commission. The carrier shall provide the information on or in the same format as Commission form 0006. Form 0006 is available upon request from the Commission.
- B.** Failure to comply with this Section does not affect the validity of coverage.

Historical Note

Former Rule 27. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-127 recodified from R4-13-127 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-128. Medical Information Reproduction Cost Limitation; Definition of Medical Information

- A.** A health care provider shall not charge more than \$.25 per page plus \$10 per hour in associated clerical costs for reproduction of medical information when a party, an authorized representative of a party, or an entity that is authorized by a claimant in a workers' compensation matter makes a request for that information under A.R.S. § 23-908(C).
- B.** This Section applies to all A.R.S. § 23-908(B) health care providers providing medical services to injured claimants including health care providers that contract with copying services, recordkeeping services, or other similar services for the reproduction of medical information. For purposes of this Section, fees for reproduction of medical information charged by these services are considered the same as if the reproduction fees are charged by a health care provider.
- C.** For purposes of this Section, "medical information" means:
1. A communication recorded in any form or medium and maintained for the purpose of patient care, diagnosis, or treatment, including a report, note, order, test result, photograph, videotape, X-ray, and billing record;
 2. A report of an independent medical examination that describes patient care or treatment;
 3. A psychological record;
 4. A medical record held by a health care provider including a medical record prepared by another provider; and
 5. A recorded communication between emergency medical personnel and medical personnel concerning the care or treatment of a person.
- D.** For purposes of this Section, "medical information" does not include:
1. Materials that are prepared in connection with utilization review, peer review, or quality assurance activities, including records that a health care provider prepares under A.R.S. §§ 36-441, 36-445 or 36-2402; and

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2. Recorded telephone and radio calls to and from a publicly operated emergency dispatch office relating to requests for emergency services or reports of suspected criminal activity.

Historical Note

Former Rule 28. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-128 recodified from R4-13-128 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-129. Carrier or Workers' Compensation Pool Determinations Binding upon its Insured or Member; Self-Rater Exception

- A. The Commission deems an insurance carrier or workers' compensation pool the agent of an employer insured by the carrier or workers' compensation pool.
- B. The Commission also deems any action or determination taken or made by the insurance carrier or workers' compensation pool binding upon the employer. The employer may not protest or petition the Commission for relief concerning an action or determination taken by the employer's insurance carrier or workers' compensation pool unless the employer notifies the carrier or workers' compensation pool, and the Commission in writing that the employer disagrees with the carrier's or worker's compensation pool's action or determination within the time described in A.R.S. § 23-947.
- C. This Section does not apply to employers insured under a Self-Rating Insurance Plan.

Historical Note

Former Rule 29. Amended subsection (A) effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-129 recodified from R4-13-129 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-130. Claims Office Location and Function; Requirements of Maintaining an Out-of-State Claims Office

- A. Except as provided in subsection (B), each carrier that has or is underwriting workers' compensation insurance in Arizona, and each employer and workers' compensation pool that has been granted authority to act as a self-insurer by the Commission, shall maintain a workers' compensation claims office in Arizona. A carrier, self-insured employer, and self-insured workers' compensation pool shall process and pay workers' compensation claims and maintain the workers' compensation claims files described in R20-5-131 in its Arizona office. A carrier, self-insured employer, and self-insured workers' compensation pool shall notify the claims division of the Commission of the address of the Arizona claims office.
- B. Except as provided in subsections (C) and (D), a carrier or self-insured employer may request authorization from the Commission to maintain an out-of-state claims office. The Commission shall grant a carrier or self-insured employer authorization to maintain an out-of-state claims office no later than 20 days after the carrier or self-insured employer provides satisfactory evidence of the following:
 1. Existence of a toll-free telephone line to the out-of-state claims office;
 2. Completion of Commission claims division's training by the individuals responsible for claims processing at the out-of-state office; and
 3. Designation of a financial institution located in Arizona that will cash on demand checks issued by the out-of-state claims office.

- C. The Commission shall not permit a self-insured workers' compensation pool to maintain a claims office out-of-state.
- D. The Commission shall rescind its authorization to maintain an out-of-state claims office if a carrier or self-insured employer no longer meets the requirements of subsection (B) or fails to process and pay claims as required under the Act and this Article.
- E. A carrier or self-insured employer maintaining an out-of-state claims office shall print the carrier's or self-insured employer's toll-free telephone number to the out-of-state claims office on all notices of claim status or other determinations issued by the out-of-state claims office. Failure to print the toll-free telephone number on a notice or other determination as required by this subsection does not affect the validity of the notice or determination.
- F. For claims processing purposes, a carrier, self-insured employer, or self-insured workers' compensation pool may have more than one designated representative provided the carrier, self-insured employer, or self-insured workers' compensation pool:
 1. Notifies the Commission at the time an insurance policy is issued or authorization to self-insure is granted; and
 2. Notifies the Commission each time that the insurance policy or authorization to self-insure is renewed.

Historical Note

Former Rule 30. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-130 recodified from R4-13-130 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-131. Maintenance of Carrier and Self-insured Employer Claims Files; Contents; Inspection and Copying; Exchange of Medical Reports; Authorization to Obtain Medical Records

- A. A carrier and self-insured employer shall maintain a workers' compensation claims file for each claimant. A carrier and self-insured employer shall include in a workers' compensation claims file all employer's reports, medical and hospital reports, awards, orders, notices of claims status, wage data, and all other items affecting the claim required by law to be maintained by a carrier or self-insured employer.
- B. Subject to subsection (C), all parties, authorized representatives of parties, and authorized representatives of the Commission may inspect and copy items contained in a carrier's or self-insured employer's claims file within five days from the date the item is filed in the claims file.
- C. If a carrier or self-insured employer maintains a claims file at an out-of-state claims office, the carrier or self-insured employer shall make the claims file available for copying and inspection to the persons listed in subsection (B) within 10 days after receiving a request for the file at a location in Arizona designated by the carrier or self-insured employer.
- D. A carrier or self-insured employer shall furnish copies of a claims file within 10 days after receiving a request from any party, authorized representative of a party, and authorized representative of the Commission at a charge not to exceed \$.25 per page. A carrier or self-insured employer may require prepayment of the copying charges if the requester or authorized representative has an account with the carrier or self-insured employer that is more than 30 days overdue.
- E. A carrier or self-insured employer is not required to maintain in a claims file, or produce for inspection and copying:
 1. Documents or matters representing the work product of the carrier or self-insured employer;

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2. Documents or matters representing the work product of a carrier's or self-insured's attorney; or
 3. Investigation and rehabilitation reports.
- F.** All medical records concerning a claimant's mental or physical condition that are in a party's possession shall be furnished, upon request, to another party in the same Commission proceeding.
- G.** Within 10 days of a request, a claimant shall provide to a party in a Commission proceeding involving the claimant, a release of information authorizing any attending, treating, or examining physician to provide records described in A.R.S. § 23-908(C).

Historical Note

Former Rule 31. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-131 recodified from R4-13-131 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-132. Parties' Notice to Commission of Intention to Impose Liability upon A.R.S. § 23-1065 Special Fund

If the notices required by A.R.S. § 23-1065 are not given to the Commission, the Commission shall not be bound by the testimony and evidence presented at a hearing as it relates to the imposition of liability upon the special fund.

Historical Note

Former Rule 32. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-132 recodified from R4-13-132 (Supp. 95-1).

R20-5-133. Claimant's Petition to Reopen Claim

- A.** A petition to reopen filed with the Commission under A.R.S. § 23-1061(H) shall be in writing, signed, and dated by the claimant or the claimant's authorized representative. A petition to reopen form is available from the Commission upon request.
- B.** A claimant shall provide to the Commission a copy of a medical report supporting the disability or condition justifying the reopening of the claim.
- C.** If the Commission does not receive the medical report described in subsection (B) within 14 days of receipt of a petition to reopen, the Commission shall notify all parties, in writing, that it has received a petition to reopen without the required medical report. A carrier or self-insured employer is not required to act on a petition to reopen that is received without the required medical report.
- D.** If the Commission receives a medical report in support of a petition to reopen and a claimant does not file a petition to reopen within 14 days of receipt of the medical report, the Commission shall forward the medical report to the carrier or self-insured employer for information purposes only. A carrier or self-insured employer is not required to take any action upon receipt of the medical report.
- E.** If the Commission receives a medical report in support of a petition to reopen from an out-of-state physician and a party objects to the report at least 20 days before a scheduled hearing, the Commission shall not consider the report or place the report in evidence unless the party submitting the report produces the author of the report for cross-examination either at the hearing or at a deposition. The party submitting into evidence the medical report prepared by an out-of-state physician shall pay the expenses of a deposition under this subsection.

Historical Note

Former Rule 33. Amended subsections (A), (C), (D) and (E) effective March 1, 1987, filed February 26, 1987

(Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-133 recodified from R4-13-133 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-134. Petition for Rearrangement or Readjustment of Compensation Based Upon Increase or Reduction of Earning Capacity

- A.** A petition for rearrangement or readjustment of compensation filed with the Commission under A.R.S. § 23-1044(F) shall be in writing. A form is available from the Commission upon request.
- B.** A party or a party's authorized representative shall sign a petition for rearrangement or readjustment and include in the petition:
 1. A statement of the basis upon which the rearrangement or readjustment of compensation is sought, and
 2. Documentation in support of the petition.
- C.** The petition shall be signed by the employee or the employee's authorized representative, the employer, or, in the case of an insurance carrier, by its authorized representative, and shall include a statement of the basis upon which the rearrangement of compensation is sought accompanied by supportive documentary evidence.
- D.** If a self-insured employer, carrier, special fund division, or uninsured employer requests a hearing protesting the Commission's determination under A.R.S. § 23-1044(F) and the claimant resides outside of Arizona, the Commission may order the self-insured employer, carrier, special fund division, or uninsured employer to pay the claimant's transportation and living expenses to attend any scheduled hearing.

Historical Note

Former Rule 34. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-134 recodified from R4-13-134 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-135. Requests for Hearing; Form

- A.** Any interested party or the party's authorized representative, except as otherwise provided by law or this Article, may request a hearing on a claim. A request for hearing shall be in writing.
- B.** A Request for Hearing form is available upon request from the Commission and requests the following:
 1. Employee, employer, insurance carrier, authorized representative, and claim identification;
 2. Issue upon which the request for hearing is filed;
 3. Requests for subpoenas of witnesses;
 4. Desired location and length of time for the hearing;
 5. Signature and address of requesting party.

Historical Note

Former Rule 35. Amended subsections (A) and (B) effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). Amended effective August 28, 1992 (Supp. 92-3). R20-5-135 recodified from R4-13-135 (Supp. 95-1).

R20-5-136. Expired**Historical Note**

Former Rule 36. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-136 recodified from R4-13-136 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3). Section expired under

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A.R.S. § 41-1056(J) at 22 A.A.R. 3475, effective November 8, 2016 (Supp. 16-4).

R20-5-137. Service of a Request for Hearing

A party filing a request for hearing shall serve a copy of the party's request for hearing upon all other parties at the same time that the party files the request for hearing with the Commission. The failure to serve a copy of a request for hearing upon other parties does not affect the validity of the hearing request.

Historical Note

Former Rule 37. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-137 recodified from R4-13-137 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-138. Hearing Calendar and Assignment to Administrative Law Judge; Notification of Hearing

- A. The chief administrative law judge shall maintain a hearing calendar. The chief administrative law judge shall ensure that a request for hearing filed in accordance with this Article is:
 1. Placed on the hearing calendar, and
 2. Assigned to an administrative law judge who is designated as the presiding administrative law judge.
- B. A presiding administrative law judge may hold a hearing at an earlier date than required under A.R.S. § 23-941(D), if all parties to the proceeding agree.

Historical Note

Former Rule 38. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-138 recodified from R4-13-138 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-139. Administrative Resolution of Issues by Stipulation Before Filing a Request for Hearing

- A. At any time before the filing of a request for hearing, parties may resolve issues by written stipulation. The parties shall file the stipulation with the Commission for approval or other action as may be appropriate.
- B. If the Commission determines that a written stipulation is reasonably supported by the facts, the Commission may approve the stipulation or enter an appropriate award without a request for hearing or hearing.

Historical Note

Former Rule 39. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-139 recodified from R4-13-139 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-140. Informal Conferences

- A. A presiding administrative law judge may hold an informal conference to:
 1. Resolve and dispose of disputed issues;
 2. Narrow or limit the scope of the issues to be considered at a subsequent hearing;
 3. Simplify the method of proof at a hearing; or
 4. Eliminate the need for hearing if the facts appear to be uncontested.
- B. A party may request that a pending hearing be disposed of by an informal conference, by filing a written request that:
 1. Specifies the purpose for the conference consistent with subsection (A), and

2. Does not contain any argument regarding the merits of the case.

- C. If the presiding administrative law judge determines that an informal conference is appropriate, the judge shall give notice to the parties of the time and place of the conference. The presiding administrative law judge may, without a request from a party, schedule an informal conference by giving five days notice to the parties of the time, place, and subject matter of the informal conference. The parties may waive the five day notice requirement of this subsection.
- D. If a presiding administrative law judge disposes of issues in controversy at an informal conference, the presiding administrative law judge may enter an award without convening a hearing.
- E. If a presiding administrative law judge disposes of, narrows, or limits some, but not all issues in controversy, the presiding administrative law judge shall prepare and mail to the parties a statement setting forth the issues to be resolved at a hearing. The presiding administrative law judge shall limit the hearing to the issues contained in the statement unless at the hearing all parties and, the presiding administrative law judge agree that the judge may consider issues beyond the scope of the statement.
- F. Upon request by a party or upon a presiding administrative law judge's own motion, the presiding administrative law judge may order the parties to file a joint statement listing the disputed issues to be considered at formal hearing. The presiding administrative law judge shall give the parties at least 10 days to file the statement and shall order the parties to file the statement three to 10 days before the first scheduled hearing.

Historical Note

Former Rule 40. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-140 recodified from R4-13-140 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-141. Subpoena Requests for Witnesses; Objection to Documents or Reports Prepared by Out-of-State Witness

- A. Subpoena requests for witnesses.
 1. Subpoena request for non-medical witness. A party may request a presiding administrative law judge to issue a subpoena to compel the appearance of a non-medical witness by filing a written request with the presiding administrative law judge at least 10 days before the date of the first scheduled hearing.
 2. Subpoena request for expert medical witness. A party may request a presiding administrative law judge to issue a subpoena to compel the appearance of an expert medical witness by filing a written request with the presiding administrative law judge at least 20 days before the date of the first scheduled hearing.
 3. Statement of expected testimony. In the discretion of the presiding administrative law judge, the judge may order the party requesting a subpoena to file within five days of the order a written statement summarizing the substance of the testimony expected of the witness.
 4. Issuance of Subpoena. A presiding administrative law judge shall issue a subpoena requested under this Section if the judge determines that the testimony of the witness is material and necessary and, if applicable:
 - a. The party files a timely statement under subsection (A)(3); or
 - b. The party shows at or before the first scheduled hearing that good cause exists for the party's failure

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to respond timely to the judge's order under subsection (A)(3).

5. Service of a subpoena. The Commission may serve a subpoena by mail unless the party requesting the subpoena requests personal service. If a party requests personal service of a subpoena, the Commission shall prepare the subpoena and the party requesting personal service shall:
 - a. Ensure that the subpoena is served in the same manner as in a civil action; and
 - b. Pay all expenses of the service.
- B. A presiding administrative law judge shall not grant a party a continued hearing because a subpoenaed witness fails to appear at hearing unless the party filed a timely request for subpoena as required by subsection (A). If a party timely requested a subpoena for a witness who fails to appear at a scheduled hearing, the presiding administrative law judge may grant a continued hearing if the party requesting the subpoena demonstrates that:
 1. The testimony of the witness is material and necessary, and
 2. Good cause is shown as to why the witness failed to appear.
- C. Witness Fees.
 1. If a non-medical witness requests a witness fee, the party requesting the subpoena shall pay the non-medical witness fees and mileage provided for witnesses in civil actions in the Superior Court. If more than one party subpoenas the same witness, the parties shall divide the witness fee equally.
 2. The Commission shall pay the witness fee to a medical witness under the Commission's medical fee schedule after the presiding administrative law judge approves the fee.
- D. Objection to an out-of-state physician's report.
 1. A presiding administrative law judge shall not consider or place into evidence a timely filed physician's report authored by a physician residing outside Arizona if a party files an objection to that report at least 20 days before the scheduled hearing, unless the party submitting the report produces the author for cross-examination either at the hearing or at a deposition.
 2. Nothing in R20-5-143(G) precludes a party from taking or submitting into evidence a deposition of a physician taken under this subsection.
 3. The party submitting into evidence a report of an out-of-state physician shall pay the expenses of a deposition taken under this subsection.
- E. Objection to document prepared by out-of-state non-medical witness.
 1. A presiding administrative law judge shall not consider or place into evidence a timely filed document prepared by a non-medical witness who resides outside Arizona if a party files an objection to that document at least seven days before the scheduled hearing unless the party submitting the document produces the author for cross-examination either at the hearing or at a deposition.
 2. Nothing in R20-5-143 precludes a party from taking or submitting into evidence a deposition within the time limits set by a presiding administrative law judge.
 3. The party submitting into evidence a document prepared by an out-of-state non-medical witness shall pay the expenses of a deposition taken under this subsection.
- F. If a presiding administrative law judge approves, the testimony of a party's out-of-state non-medical or expert medical witness may be taken telephonically.

Historical Note

Former Rule 41. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-141 recodified from R4-13-141 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-142. In-State Oral Depositions

- A. A party may take the oral deposition of another party or a witness residing in Arizona by serving a Notice of Deposition by Oral Examination upon the deponent and every party at least 10 days before the date of the oral deposition and at least 40 days before the first scheduled hearing.
- B. A party may file with the presiding administrative law judge a written objection to the taking of an oral deposition within five days after service of the Notice of Deposition. If no request for hearing has been filed, a party shall file the written objection with the chief administrative law judge. The party objecting to the deposition shall:
 1. State the basis for objecting to the deposition; and
 2. Serve a copy of the party's objections on all parties.
- C. The oral deposition shall not commence until the presiding administrative law judge rules on the written objection. The presiding administrative law judge shall rule on the written objection to the taking of an oral deposition within seven days after a party files a written objection by:
 1. Ordering the deposition to proceed;
 2. Ordering the deposition not be taken; or
 3. Entering any other appropriate protective order.
- D. The party taking the deposition shall comply with the Arizona Rules of Civil Procedure governing the taking of depositions.
- E. The expense of any deposition shall be borne by the party taking the deposition but shall not include the expense of any other interested party.
- F. A presiding administrative law judge shall not cancel or continue a hearing because a party fails to take or complete a deposition under this Section.
- G. A deposition taken under this Section shall only be used to impeach a witness during a hearing, except that, in the exercise of discretion, the presiding administrative law judge may admit a deposition into evidence for another purpose if:
 1. The deponent is deceased at the time of the hearing, or
 2. All parties agree.
- H. A party may take a telephonic deposition under this Section either by agreement of the parties or by order of the presiding administrative law judge in the exercise of the judge's discretion.

Historical Note

Former Rule 42. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-142 recodified from R4-13-142 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-143. Out-of-State Oral Depositions

- A. A party shall obtain permission from a presiding administrative law judge before taking an out-of-state oral deposition of another party or a witness by filing a written request with the presiding administrative law judge that contains:
 1. The name and address of the party or witness to be deposed, and
 2. Each reason why the party's or witness' testimony is necessary.
- B. The party requesting permission to take the out-of-state deposition shall serve a copy of the request upon each party.

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- C. If no objection to the request for permission to take the deposition is filed under subsection (D) the presiding administrative law judge shall, within seven days from the date of the request, grant or deny permission to take the deposition.
- D. A party may file with the presiding administrative law judge a written objection to the taking of an out-of-state oral deposition within five days after being served with a request to take the out-of-state deposition. The party objecting to the out-of-state deposition shall:
 - 1. State the basis for objecting to the deposition; and
 - 2. Serve a copy of the party's objections on each party.
- E. The oral deposition shall not commence until the presiding administrative law judge rules on the written objection. The presiding administrative law judge shall rule on the written objection to the taking of an out-of-state oral deposition within seven days after a party files the written objection by:
 - 1. Ordering the deposition to proceed,
 - 2. Ordering the deposition not be taken, or
 - 3. Entering any other appropriate protective order.
- F. A party shall not take more than two depositions per hearing under this Section unless a presiding administrative law judge, upon a showing of good cause, approves the taking of additional depositions.
- G. In the exercise of discretion, the presiding administrative law judge may admit into evidence a deposition taken under this Section if the transcript of the deposition is filed with the Commission at least five days before any scheduled hearing or as otherwise directed by the presiding administrative law judge. If the transcript of the deposition is not timely filed under this subsection, the administrative law judge shall not consider the deposition for any purpose unless the parties and the administrative law judge agree that the deposition may be considered.
- H. Parties may take telephonic depositions under this Section either by agreement of the parties or by order of a presiding administrative law judge in the exercise of the administrative law judge's discretion.
- I. A party taking a deposition taken under this Section shall comply with R20-5-142(A), (D), (E) and (F).

Historical Note

Former Rule 43. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-143 recodified from R4-13-143 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-144. Written Interrogatories

- A. After a party files a request for hearing with the Commission, any party may serve written interrogatories upon another party. A party shall serve written interrogatories at least 40 days before the scheduled hearing.
- B. A party shall not serve more than 25 interrogatories, including subsections.
- C. A party shall serve answers to the interrogatories upon all parties within 10 days after service of the interrogatories. A party shall not file answers to the interrogatories with the Commission.
- D. A presiding administrative law judge shall not cancel or continue a hearing because a party fails to answer interrogatories under this Section.
- E. A party shall only use written interrogatories served under this Section to impeach a witness during a hearing, except that, in the exercise of discretion, the presiding administrative law judge may admit the interrogatory answers into evidence for

another purpose if the party answering the interrogatories is deceased at the time of the scheduled hearing.

Historical Note

Former Rule 44. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-144 recodified from R4-13-144 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-145. Refusal to Answer or Attend; Motion to Compel; Sanctions Imposed

- A. If a party or deponent refuses to answer any question asked at a deposition under R20-5-142 or R20-5-143, the party asking the question shall either complete the deposition in other matters or adjourn the deposition. With notice to all persons affected by the deponent's refusal to answer a question, the party asking the question may apply to the presiding administrative law judge for an order compelling the deponent to answer the question.
- B. If a party refuses to answer an interrogatory served under R20-5-144, the party serving the interrogatory may submit the interrogatory to the presiding administrative law judge and apply for an order compelling the answer.
- C. If a presiding administrative law judge issues an order compelling an answer under subsection (A) or (B) and finds that a refusal to answer is without substantial justification, the presiding administrative law judge shall require the party or witness refusing to answer or the authorized representative advising that party or witness not to answer, or both of them, to pay to the party asking the question:
 - 1. Reasonable attorney's fees incurred to obtain the order compelling the answer, and
 - 2. Reasonable expenses that will be incurred to obtain the requested answer.
- D. If a presiding administrative law judge denies a motion to compel an answer under subsection (A) or (B), and finds that the motion was made without substantial justification, the presiding administrative law judge shall require the party filing the motion, or the parties' authorized representative advising that party to make the motion, or both of them, to pay to the party or witness refusing to answer, reasonable attorney's fees incurred in opposing the motion.
- E. In addition to the sanctions authorized under R20-5-157, a presiding administrative law judge may, upon a party's motion, impose the following sanctions upon a party if the party, or an officer or managing agent of that party, willfully fails to appear for a deposition after being served with proper notice of the deposition, or fails to serve answers to interrogatories after proper service of the interrogatories:
 - 1. Strike out all or any part of a document filed by the party;
 - 2. Dismiss the action or proceeding, or any part of the action or proceeding;
 - 3. Order the suspension or forfeiture of compensation; or
 - 4. Preclude the introduction of evidence.
- F. The party filing a motion under subsections (A), (B), or (E) shall attach to the motion:
 - 1. The statement required under R20-5-105(E) and
 - 2. A proposed order that includes the relief requested and a service page with the names and addresses of all parties served.

Historical Note

Former Rule 45. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-145 recodified from R4-13-145 (Supp. 95-1). Amended by final

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rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-146. Repealed**Historical Note**

Former Rule 46. R20-5-146 recodified from R4-13-146 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-147. Videotape Recordings and Motion Pictures

- A. A party proposing to offer a videotape recording or motion picture into evidence at a Commission hearing shall provide written notice to the Commission and all parties at least 40 days before the first scheduled hearing.
- B. If a party serves a written request to view a videotape recording or motion picture upon the party proposing to submit the videotape recording or motion picture into evidence, the party proposing to offer the videotape recording or motion picture into evidence shall provide the necessary facilities and equipment to allow the other party to view the videotape recording or motion picture no later than 25 days before the first scheduled hearing.
- C. A presiding administrative law judge may admit into evidence a videotape recording or motion picture if the videotape recording or motion picture:
 1. Is a reasonable and accurate representation of the scene, person, object, or action portrayed; and
 2. Will aid in the understanding of the issues before the presiding administrative law judge.
- D. The party submitting the videotape recording or motion picture into evidence shall ensure that commentary, interrogation, dialogue, or testimony are not a part of the videotape recording or motion picture.
- E. A presiding administrative law judge shall not cancel or continue a hearing because a party fails to view a videotape recording or motion picture as provided in this Section.
- F. This Section does not apply to:
 1. Videotape recordings or motion pictures obtained by surveillance, or
 2. Videotape recordings or motion pictures of medical procedures performed by a physician.

Historical Note

Former Rule 47. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-147 recodified from R4-13-147 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-148. Burden of Presentation of Evidence; Offer of Proof

- A. A party shall rest at the conclusion of the presentation of the party's evidence. If there is a dispute as to which party has the burden of proof, the presiding administrative law judge shall direct who has the burden of proof.
- B. If a presiding administrative law judge prohibits a witness from answering a question, the presiding administrative law judge shall permit an offer of proof in the form of an avowal or in writing.

Historical Note

Former Rule 48. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-148 recodified from R4-13-148 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-149. Presence of Claimant at Hearing; Notice of a Parties' Non-Appeal at Hearing; Assessment of Hearing Costs for Non-Appeal

- A. A claimant, whether or not represented by an attorney, shall appear personally at any hearing without the necessity of subpoena unless excused by the presiding administrative law judge.
- B. Subject to subsection (A), at least three days before a scheduled hearing a party shall notify the presiding administrative law judge of any non-appearance by a party or party's authorized representative that requires the judge to cancel or reschedule the hearing.
- C. If a party fails to notify the presiding administrative law judge as required under subsection (B), the presiding administrative law judge may order the party or the party's authorized representative to reimburse the Commission for hearing expenses and costs incurred by the Commission including fees of expert medical witnesses and other witness fees.

Historical Note

Former Rule 49. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-149 recodified from R4-13-149 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-150. Joinder of a Party

- A. An administrative law judge may join as a party any person, firm, corporation, or other entity in favor of whom or against whom a right to relief may exist and over whom the Commission may acquire jurisdiction.
- B. Joinder may be made upon application of any party or upon the presiding administrative law judge's own motion.
- C. A party seeking to join another person, firm, corporation, or other entity shall file a motion requesting joinder with the presiding administrative law judge at least 30 days before hearing. The moving party shall serve a copy of the motion upon the person, firm, corporation, or other entity for whom joinder is requested, and upon all other parties.
- D. If the requirements of this Section are met, the presiding administrative law judge shall join as a party the person, firm, corporation, or other entity for whom joinder is requested and shall issue a notice advising the parties of the joinder.

Historical Note

Former Rule 50. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-150 recodified from R4-13-150 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-151. Special Appearance

Any party against whom a claim may exist under the Act, or against whom a contingent liability may exist under the Act, and over whom the Commission has not acquired jurisdiction, may enter a special appearance. A special appearance made under this Section does not invoke the jurisdiction of the Commission.

Historical Note

Former Rule 51. R20-5-151 recodified from R4-13-151 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-152. Resolution of Issues by Stipulation After the Filing of a Request for Hearing; Notice of Resolution; Assessment

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of Hearing Costs

- A. Subject to the requirement of subsection (D), parties may stipulate to any fact or issue after a party files a request for hearing. The stipulation may be in writing or made orally at the time of hearing.
- B. A stipulation is binding upon the parties unless a presiding administrative law judge or the Commission grants the parties permission to withdraw the stipulation.
- C. If a stipulation is not reasonably supported by the evidence, a presiding administrative law judge or the Commission, may set aside or refuse to accept the stipulation and proceed to determine the true facts.
- D. A party shall notify a presiding administrative law judge of any stipulation, compromise or settlement agreement, or withdrawal of a hearing request that makes a hearing unnecessary at least three days before a scheduled hearing.
- E. The presiding administrative law judge may order a party or parties to reimburse the Commission for hearing expenses and costs incurred by the Commission including fees of expert medical witnesses and other witness fees if a party fails to notify the presiding administrative law judge as required under subsection (D).

Historical Note

Former Rule 52. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-152 recodified from R4-13-152 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-153. Exclusion of Witnesses

Any party may request that all other witnesses except the parties be excluded from the hearing until called to testify. The presiding administrative law judge may, in the judge's discretion, grant or deny the request. If the request is granted, the presiding administrative law judge shall admonish each witness not to discuss the witness's testimony with anyone other than attorneys on the case.

Historical Note

Former Rule 53. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-153 recodified from R4-13-153 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-154. Correspondence to Administrative Law Judge

A person submitting correspondence, including subpoena requests, to an administrative law judge concerning a matter pending before the administrative law judge, shall contemporaneously serve a copy of the correspondence upon all other parties, or if represented, the parties' authorized representatives. The administrative law judge shall not consider correspondence or subpoena requests to be evidence except by agreement of all parties to the matter.

Historical Note

Former Rule 54. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-154 recodified from R4-13-154 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-155. Filing of Medical and Non-Medical Reports Into Evidence; Request for Subpoena to Cross-examine Author of Report Submitted into Evidence; Failure to Timely Request Subpoena for Author

- A. Except as provided in R20-5-114(C), a party filing a medical report or hospital record into evidence ("medical report") that is not already contained in the Commission's claims file, shall

file the medical report with the presiding administrative law judge at least 25 days before the first scheduled hearing.

- B. A party filing into evidence a document, report, instrument, or other written matter not described in subsection (A) ("non-medical report") that is not already contained in the Commission's claims file, shall file the non-medical report with the presiding administrative law judge at least 15 days before the first scheduled hearing.
- C. The party filing a medical or non-medical report into evidence shall serve a copy of the report to all other parties.
- D. A presiding administrative law judge shall not receive into evidence any medical or non-medical report that is not filed as required under this Section. If the report has been placed in the Commission's claims file, the presiding administrative law judge shall remove the report from the Commission's claims file and return the report to the filing party.
- E. The presiding administrative law judge may suspend the requirements of this Section;
 1. Upon a showing of good cause; or
 2. If the parties agree that the judge may accept the medical or non-medical report into evidence.
- F. The party filing a medical or non-medical report under this Section shall file a cover letter with the report stating:
 1. The party's identity;
 2. The reports filed; and
 3. Proof of service of the reports upon the other parties.
- G. A party seeking to cross-examine the author of any medical or non-medical report filed into evidence shall request a subpoena under R20-5-141.
- H. If a party fails to timely request a subpoena under this Section and R20-5-141, the party waives the right to cross-examine the author of any medical or non-medical report filed into evidence and the presiding administrative law judge shall admit the medical or non-medical report in evidence.

Historical Note

Former Rule 55. Amended subsections (A) and (D) effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-155 recodified from R4-13-155 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-156. Continuance of Hearing

- A. A party may request a continuance of a scheduled hearing. If a party shows good cause, a presiding administrative law judge may grant a request that a hearing be continued.
- B. If at the conclusion of a hearing a party seeks to continue the hearing to introduce additional evidence, the party shall state specifically and in detail:
 1. The nature and substance of the additional evidence,
 2. The names and addresses of additional witnesses, and
 3. The reason the party was unable to produce the evidence or witnesses at the hearing.
- C. A presiding administrative law judge may deny a request for a continuance under subsection (B) if the presiding administrative law judge determines that, with the exercise of due diligence, the evidence or testimony could have been produced or the evidence or testimony would be cumulative, immaterial, or unnecessary.
- D. A presiding administrative law judge may, on the judge's own motion, continue a hearing and order further examinations or investigations that the judge determines are warranted.
- E. If more than 40 days before the first scheduled hearing, a presiding administrative law judge reschedules the hearing discovery and filing deadlines under this Article shall be calculated with respect to the new hearing date.

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- F. If less than 40 days before the first scheduled hearing, a presiding administrative law judge reschedules the hearing discovery and filing deadlines under this Article shall be calculated with respect to the original hearing date.

Historical Note

Former Rule 56. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-156 recodified from R4-13-156 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-157. Sanctions

- A. A presiding administrative law judge may impose the following sanctions against any party or authorized representative of a party who fails to comply with this Article or fails to comply with an order of the presiding administrative law judge or Commission:
1. Dismissal of the party's request for hearing;
 2. Refusal to permit the introduction of evidence by the party; or
 3. Assessment of reasonable attorney's fees and costs against the sanctioned party or authorized representative of a party.
- B. If a party shows good cause, a presiding administrative law judge or the Commission may relieve a party of sanctions imposed under subsection (A).

Historical Note

Former Rule 57. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-157 recodified from R4-13-157 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-158. Service of Awards and Other Matters

- A. An award, decision, order, subpoena, notice, document, or other matter required by the Act, this Article, or other law to be served shall be made upon a party or, if represented, the party's authorized representative. Service upon the authorized representative is service upon the party.
- B. Service may be made and is deemed complete by:
1. Depositing the document or matter in the United States mail, with postage prepaid, addressed to the party served at the address as shown by the records of the Commission; or
 2. Personal service in the same manner as a summons is served in a civil action.
- C. Proof of service may be made by an affidavit or oral testimony of the person making such service.

Historical Note

Former Rule 58. Amended subsection (C) effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-158 recodified from R4-13-158 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-159. Record for Award or Decision on Review

A presiding administrative law judge's award or decision under A.R.S. § 23-942 or award or decision upon review under A.R.S. § 23-943 shall be based upon:

1. The record as it exists at the conclusion of the hearings, and
2. Any memoranda provided under A.R.S. § 23-943(E) or requested by the presiding administrative law judge.

Historical Note

Former Rule 59. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-159 recodified from R4-13-159 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-160. Application to Set Attorney Fees Under A.R.S. § 23-1069

- A. For purposes of A.R.S. § 23-1069, "final disposition of a case" occurs when all compensation benefits have been released to a claimant.
- B. A claimant or attorney filing an application for attorney's fees under A.R.S. § 23-1069 shall serve notice of the application to all parties, including if applicable, the insurance carrier, self-insured employer, or special fund division.
- C. Upon the filing of an application, the attorney and claimant shall, provide information to the Commission to enable the Commission to award reasonable attorney's fees.
- D. Attorney's fees awarded under this Section shall be set by the Commission, an administrative law judge, or other authorized representative of the Commission.

Historical Note

Former Rule 60. Amended effective March 1, 1987, filed February 26, 1987 (Supp. 87-1). R20-5-160 recodified from R4-13-160 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-161. Stipulations for Extensions of Time

Stipulations for extensions of time in which to file papers or briefs in the various courts shall be received and signed by the Chief Counsel or other members of the Legal Department.

Historical Note

Former Rule 61. R20-5-161 recodified from R4-13-161 (Supp. 95-1).

R20-5-162. Legal Division Participation

The chief counsel and other members of the legal staff of the Commission who participate in proceedings or matters under the Act and this Article do so on behalf of the Commission.

Historical Note

Former Rule 62. R20-5-162 recodified from R4-13-162 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-163. Bad Faith and Unfair Claim Processing Practices

- A. For purposes of A.R.S. § 23-930, an employer, self-insured employer, insurance carrier, or claims processing representative commits "bad faith" if the employer, self-insured employer, insurance carrier, or claims processing representative:
1. Institutes a proceeding or interposes a defense that is not:
 - a. Well-grounded in fact;
 - b. Warranted by existing law; or
 - c. A good faith argument for the extension, modification, or reversal of existing law;
 2. Unreasonably delays:
 - a. Payment of benefits; or
 - b. Authorization for, or receipt of, medical benefits or treatment;
 3. Unreasonably underpays benefits;
 4. Unreasonably terminates benefits;

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5. Intentionally misleads a claimant as to applicable statutes of limitation, benefits, or remedies available to the claimant under the Act or under this Article; or
 6. Unreasonably interferes with or obstructs the claimant's right to choose the claimant's attending physician, except in cases involving a self-insured employer under A.R.S. § 23-1070.
- B.** For purposes of A.R.S. § 23-930, an employer, self-insured employer, insurance carrier, or claims processing representative commits "unfair claim processing practices" if the employer, self-insured employer, insurance carrier, or claims processing representative:
1. Unreasonably issues a notice of claim status without adequate supporting information in its possession or available to it;
 2. Unreasonably fails to acknowledge communications from the Commission, an unrepresented claimant, or a claimant's attorney with respect to a claim;
 3. Fails to act reasonably and promptly upon communications from the Commission, an unrepresented claimant, or a claimant's attorney with respect to a claim;
 4. Directly advises a claimant not to consult or obtain the services of an attorney; or
 5. Communicates directly, for an improper purpose, with a claimant represented by an attorney.
- C.** A person alleging bad faith or unfair claim processing practices ("complainant") shall file a written complaint with the claims manager of the Commission. The complainant, or the complainant's authorized representative, shall sign the complaint.
- D.** The complaint shall describe the specific actions of the employer, self-insured employer, insurance carrier, or claims processing representative, that are alleged to constitute bad faith or unfair claim processing practices. A complaint form is available upon request from the Commission.
- E.** Upon receipt of a complaint under this subsection, the claims manager of the Commission shall serve the complaint upon all parties.
- F.** If the Commission acts on its own motion under A.R.S. § 23-930(A), the claims manager shall mail a notice of alleged bad faith or unfair claim processing practices to the claimant or the claimant's authorized representative and the:
1. Employer;
 2. Self-insured employer;
 3. Insurance carrier; or
 4. Claims processing representative.
- G.** The person or entity named in a complaint or notice served under A.R.S. § 23-930 and this Section shall file with the claims manager a written response to the complaint or notice, within 30 days after service by the Commission of the complaint or notice.
- H.** The person or entity filing a written response shall serve a copy of the response upon the complainant, or the complainant's authorized representative, if represented.
- I.** If the person or entity named in a complaint or notice served under A.R.S. § 23-930 and this Section fails to file a written response, the Commission shall consider the absence of a response a denial of the allegations of the complaint or notice.
- J.** Upon receipt of a written response, or upon the expiration of 30 days if no response is filed, the Commission shall enter an award as it deems, in its discretion, appropriate under A.R.S. §§ 23-930(B) or (C).

Historical Note

Adopted as an emergency effective February 1, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days

(Supp. 88-1). Emergency expired. Amended and readopted as an emergency effective April 29, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-2). Readopted without change as an emergency effective August 1, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Readopted without change as an emergency effective November 9, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Amended and readopted as an emergency effective July 11, 1989 (Supp. 89-3). Adopted as a permanent rule effective October 4, 1989 (Supp. 89-4). R20-5-163 recodified from R4-13-163 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3).

R20-5-164. Human Immunodeficiency Virus, Hepatitis C, Methicillin-resistant *Staphylococcus Aureus*, Spinal Meningitis and Tuberculosis; Significant Exposure; Employee Notification; Reporting; Documentation; Forms

- A.** An employer subject to the Act shall notify its employees of the requirements of A.R.S. §§ 23-1043.02, 23-1043.03, and 23-1043.04 by posting the Commission notices titled "Work Exposure to Bodily Fluids" and "Work Exposure to methicillin-resistant *Staphylococcus Aureus* (MRSA), Spinal Meningitis, or Tuberculosis (TB)" in a conspicuous place immediately next to the "Notice to Employees" notice required under A.R.S. § 23-906(D).
- B.** Properly posted "Work Exposure to Bodily Fluids" and "Work Exposure to Methicillin-resistant *Staphylococcus Aureus* (MRSA), Spinal Meningitis, or Tuberculosis (TB)" notices constitute sufficient notice to employees of the requirements of a prima facie case under A.R.S. §§ 1043.02(B), 23-1043.03(B), and 23-1043.04(B).
- C.** An employer's insurance carrier, claims processor, or workers' compensation pool shall provide the notices specified in subsection (A) to the employer. These notices are also available from the Commission upon request.
- D.** An employer shall make readily available to its employees the Commission form described in R20-5-106 titled "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material." An employer's insurance carrier, claims processor, or workers' compensation pool shall provide the "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material" to the employer. This form is also available from the Commission upon request.
- E.** If an employee sustains a significant exposure as defined in A.R.S. §§ 23-1043.02(G), 23-1043.03(G), or 23-1043.04(H)(2), the employee shall complete, date, and sign a "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material" form. The employee or employee's authorized representative shall give to the employer the completed, dated, and signed form. The employer shall return one copy of the completed form to the employee or to the employee's authorized representative. Nothing in this subsection limits the requirements to report an injury or file a claim under the Act.
- F.** If an employee submits a written report of a significant exposure to an employer, but does not use the Commission form titled "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material," the employer shall provide the employee the Commission form within five calendar days after receiving the employee's initial written report.
- G.** The date of the receipt by the employer or its authorized representative of the employee's initial report is the date used to

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compute the time period prescribed in A.R.S. §§ 23-1043.02(B)(2), 23-1043.03(B)(2), and 23-1043.04(B)(2) if:

1. The initial report contains the information required in the "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material" form, or
2. The employee gives to the employer the completed Commission form within 10 calendar days after the employee's receipt of the Commission form.

H. Failure or refusal by the employer to provide the Commission form to the employee shall not be a defense to a prima facie claim under A.R.S. §§ 23-1043.02(B), 23-1043.03(B), and 23-1043.04(B).

I. In investigating the circumstances and facts surrounding an employee's report to an employer of a significant exposure under A.R.S. §§ 23-1043.02(C), 23-1043.03(C), and 23-1043.04(C), the employer, or its carrier, or any employees, agents or contractors of either the employer or carrier, shall not disclose to any person, except as authorized or required by law, that the reporting employee, or any witness or alleged source of exposure, may have or did contract the human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, methicillin-resistant *Staphylococcus aureus*, spinal meningitis, or tuberculosis. However, an employer, its carrier or their respective attorneys, may:

1. Direct an agent to investigate the employee's report of significant exposure, and
2. Communicate with the investigating agent about the conduct and results of the investigation.

J. As required under the federal Occupational Safety and Health Standard for Bloodborne Pathogens, 29 CFR 1910.1030, an employer shall pay for the testing required by A.R.S. § 23-1043.02.

Historical Note

Adopted effective April 9, 1992 (Supp. 92-2). R20-5-163 recodified from R4-13-163 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 3966 and 7 A.A.R. 4995, effective August 17, 2001 (Supp. 01-3). Amended by final rulemaking at 15 A.A.R. 991, effective June 2, 2009 (Supp. 09-2).

R20-5-165. Calculation of Maximum Average Monthly Wage
In using the Bureau of Labor Statistics Employment Cost Index to adopt the amount of an increase to the maximum average monthly wage under A.R.S. § 23-1041(E), the Commission shall use the *Bureau of Labor Statistics, Employment Cost Index for Wages and Salaries, for Civilian Workers, by Occupational Group and Industry, All Workers*, available at <http://www.bls.gov/>.

Historical Note

New Section made by final rulemaking at 19 A.A.R. 1925, effective July 10, 2013 (Supp. 13-3).

ARTICLE 2. REPEALED**R20-5-201. Repealed****Historical Note**

Former Rule I. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-201 recodified from R4-13-201 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-202. Repealed**Historical Note**

Former Rule II. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-202 recodified from R4-13-202 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-203. Repealed**Historical Note**

Former Rule III. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-203 recodified from R4-13-203 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-204. Repealed**Historical Note**

Former Rule IV. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-204 recodified from R4-13-204 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-205. Repealed**Historical Note**

Former Rule V. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-205 recodified from R4-13-205 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-206. Repealed**Historical Note**

Former Rule VI; Amended effective February 27, 1975 (Supp. 75-1). Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-206 recodified from R4-13-206 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-207. Repealed**Historical Note**

Former Rule VII. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-207 recodified from R4-13-207 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-208. Repealed**Historical Note**

Former Rule VIII. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-208 recodified from R4-13-208 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

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R20-5-209. Repealed**Historical Note**

Former Rule IX. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-209 recodified from R4-13-209 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-210. Repealed**Historical Note**

Former Rule X. R20-5-210 recodified from R4-13-210 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-211. Repealed**Historical Note**

Former Rule XI. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-211 recodified from R4-13-211 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-212. Repealed**Historical Note**

Former Rule XII. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-212 recodified from R4-13-212 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-213. Repealed**Historical Note**

Former Rule XIII. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-213 recodified from R4-13-213 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-214. Repealed**Historical Note**

Former Rule XIV. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-214 recodified from R4-13-214 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-215. Repealed**Historical Note**

Former Rule XV. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-215 recodified from R4-13-215 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-216. Repealed**Historical Note**

Former Rule XVI. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-216 recodified from R4-13-216 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-217. Repealed**Historical Note**

Former Rule XVII. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-217 recodified from R4-13-217 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-218. Repealed**Historical Note**

Former Rule XVIII. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-218 recodified from R4-13-218 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-219. Repealed**Historical Note**

Former Rule XIX. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-219 recodified from R4-13-219 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-220. Repealed**Historical Note**

Former Rule XX. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-220 recodified from R4-13-220 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-221. Repealed**Historical Note**

Former Rule XXI. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-221 recodified from R4-13-221 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-222. Repealed**Historical Note**

Former Rule XXII. Section repealed, new Section adopted effective July 6, 1993 (Supp. 93-3). R20-5-222 recodified from R4-13-222 (Supp. 95-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-223. Repealed**Historical Note**

Former Rule XXIII. Section repealed effective July 6,

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1993 (Supp. 93-3). R20-5-223 recodified from R4-13-223 (Supp. 95-1). New Section adopted October 9, 1998 (Supp. 98-4). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-224. Repealed**Historical Note**

Former Rule XXIV. Section repealed effective July 6, 1993 (Supp. 93-3). R20-5-224 recodified from R4-13-224 (Supp. 95-1). New Section adopted effective October 9, 1998 (Supp. 98-4). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

ARTICLE 3. EXPIRED**R20-5-301. Expired****Historical Note**

Former Rule I. R20-5-301 recodified from R4-13-301 (Supp. 95-1). Section R20-5-301 repealed; new Section R20-5-301 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-302. Expired**Historical Note**

Former Rule II; Amended effective March 9, 1981 (Supp. 81-2). R20-5-302 recodified from R4-13-302 (Supp. 95-1). Section R20-5-302 repealed; new Section R20-5-302 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-303. Expired**Historical Note**

Former Rule III; Amended effective March 9, 1981 (Supp. 81-2). R20-5-303 recodified from R4-13-303 (Supp. 95-1). Section R20-5-303 repealed; new Section R20-5-303 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-304. Expired**Historical Note**

Former Rule IV; Amended effective March 9, 1981 (Supp. 81-2). R20-5-304 recodified from R4-13-304 (Supp. 95-1). Section R20-5-304 repealed; new Section R20-5-304 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-305. Expired**Historical Note**

Former Rule V; Former Section R4-13-305 renumbered and amended as Section R4-13-306, new Section R20-5-305 adopted effective March 9, 1981 (Supp. 81-2). R20-5-305 recodified from R4-13-305 (Supp. 95-1). Section R20-5-305 repealed; new Section R20-5-305 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-306. Expired**Historical Note**

Former Rule VI. Former Section R4-13-306 renumbered and amended as Section R4-13-307, former Section R4-13-305 renumbered and amended as Section R4-13-306 effective March 9, 1981 (Supp. 81-2). R20-5-306 recodified from R4-13-306 (Supp. 95-1). Section R20-5-306 repealed; new Section R20-5-306 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-307. Expired**Historical Note**

Former Rule VII. Former Section R4-13-307 renumbered as Section R4-13-309, former Section R4-13-306 renumbered and amended as Section R4-13-307 effective March 9, 1981 (Supp. 81-2). R20-5-307 recodified from R4-13-307 (Supp. 95-1). Section R20-5-307 repealed; new Section R20-5-307 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-308. Expired**Historical Note**

Former Rule VIII. Former Section R4-13-308 renumbered as Section R4-13-310, new Section R4-13-308 adopted effective March 9, 1981 (Supp. 81-2). R20-5-308 recodified from R4-13-308 (Supp. 95-1). Section R20-5-308 repealed; new Section R20-5-308 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-309. Expired**Historical Note**

Former Rule IX. Former Section R4-13-309 repealed, former Section R4-13-307 renumbered as Section R4-13-309 effective March 9, 1981 (Supp. 81-2). R20-5-309 recodified from R4-13-309 (Supp. 95-1). Section R20-5-309 repealed; new Section R20-5-309 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-310. Expired**Historical Note**

Former Rule X. Former Section R4-13-310 renumbered and amended as Section R4-13-312, former Section R4-13-308 renumbered as Section R4-13-310 effective March 9, 1981 (Supp. 81-2). R20-5-310 recodified from R4-13-310 (Supp. 95-1). Section R20-5-310 repealed; new Section R20-5-310 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-311. Expired**Historical Note**

Former Rule XI. Former Section R4-13-311 repealed, new Section R4-13-311 adopted effective March 9, 1981 (Supp. 81-2). R20-5-311 recodified from R4-13-311 (Supp. 95-1). Section R20-5-311 repealed; new Section

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R20-5-311 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-312. Expired**Historical Note**

Former Rule XII. Former Section R4-13-312 renumbered as Section R4-13-314, former Section R4-13-310 renumbered and amended as Section R4-13-312 effective March 9, 1981 (Supp. 81-2). R20-5-312 recodified from R4-13-312 (Supp. 95-1). Section R20-5-312 repealed; new Section R20-5-312 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-313. Expired**Historical Note**

Former Rule XIII. Former Section R4-13-313 renumbered and amended as Section R4-13-318 effective March 9, 1981 (Supp. 81-2). R20-5-313 recodified from R4-13-313 (Supp. 95-1). New Section adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-314. Expired**Historical Note**

Former Section R4-13-312 renumbered as Section R4-13-314 effective March 9, 1981 (Supp. 81-2). R20-5-314 recodified from R4-13-314 (Supp. 95-1). Section R20-5-314 repealed; new Section R20-5-314 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-315. Expired**Historical Note**

Adopted effective March 9, 1981 (Supp. 81-2). R20-5-315 recodified from R4-13-315 (Supp. 95-1). Section R20-5-315 repealed; new Section R20-5-315 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-316. Expired**Historical Note**

Adopted effective March 9, 1981 (Supp. 81-2). R20-5-316 recodified from R4-13-316 (Supp. 95-1). Section R20-5-316 repealed; new Section R20-5-316 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-317. Expired**Historical Note**

Adopted effective March 9, 1981 (Supp. 81-2). R20-5-317 recodified from R4-13-317 (Supp. 95-1). Section R20-5-317 repealed; new Section R20-5-317 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-318. Expired**Historical Note**

Former Section R4-13-313 renumbered and amended as Section R4-13-318 effective March 9, 1981 (Supp. 81-2). R20-5-318 recodified from R4-13-318 (Supp. 95-1). Section R20-5-318 repealed; new Section R20-5-318 adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-319. Expired**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-320. Expired**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-321. Expired**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-322. Expired**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-323. Expired**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-324. Expired**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-325. Expired**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-326. Expired**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-327. Expired**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

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R20-5-328. Expired**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

R20-5-329. Expired**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 297, effective January 3, 2017 (Supp. 17-1).

ARTICLE 4. ARIZONA BOILERS AND LINED HOT WATER HEATERS**R20-5-401. Applicability**

This Article applies to all Boilers, Lined Hot Water Heaters, and Pressure Vessels operated in Arizona, except the following:

1. Boilers, Lined Hot Water Heaters, and Pressure Vessels regulated by the United States Government;
2. Boilers, Lined Hot Water Heaters, and Pressure Vessels operated in private residences or Apartment Complexes of not more than six units; and
3. Boilers, Lined Hot Water Heaters, and Pressure Vessels operated on Indian reservations.
4. A Lined Hot Water Heater that does not exceed any of the following:
 - a. Heat input of 200,000 BTU/hr;
 - b. Water temperature of 210° F; or
 - c. Nominal water containing capacity of 120 gallons.
5. An electric Boiler that does not exceed either of the following:
 - a. Tank volume of one-and-a-half cubic feet; or
 - b. MAWP of 100 pounds per square inch or less, with a pressure relief system to prevent excess pressure.

Historical Note

Former Rules B-1.1 and B-1.2. Former Section R4-13-401 repealed, new Section R4-13-401 adopted effective April 12, 1979 (Supp. 79-2). Section R4-13-401 repealed, new Section adopted effective April 9, 1992 (Supp. 92-2).

R20-5-401 recodified from R4-13-401 (Supp. 95-1).

Amended effective October 9, 1998 (Supp. 98-4).

Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-402. Definitions

In addition to the definitions provided in A.R.S. § 23-471, the following definitions apply to this Article:

“Act” means A.R.S. Title 23, Chapter 2, Article 11.

“Alteration” means any change in the item described on the original manufacturer’s data report which affects the pressure-containing capability of the Boiler or Pressure Vessel, including but not limited to:

Nonphysical changes such as an increase in the MAWP either internal or external, or
A reduction in minimum design temperature of a Boiler or Pressure Vessel requiring additional mechanical tests.

“ANSI” means American National Standards Institute, Inc.

“Apartment Complex” means a building with multiple family dwelling units, not used for commercial purposes,

including condominiums and townhouses, where Boilers are located in a common area outside of the individual dwelling units, such as a Boiler room.

“Applicant” means an individual requesting permission to act as a Special Inspector under A.R.S. § 23-485.

“ASME” means the American Society of Mechanical Engineers.

“Authorized Inspector” means an Authorized Representative under A.R.S. § 23-471(1) or a Special Inspector under A.R.S. § 23-485.

“Blowdown Tank” or “Blowdown Separator” means an ASME-stamped vessel designed to receive discharged steam or hot water from a Boiler blowoff or blowdown piping system.

“BTU” means British thermal units.

“Condemned” means a Boiler or Lined Hot Water Heater that has been inspected and found to be unsafe by an Authorized Inspector and has been stamped or tagged with the code XXX AZ8 XXX.

“CSD-1” means Controls and Safety Devices for Automatically Fired Boilers, published by ASME, incorporated by reference in R20-5-404(A)(4).

“Direct Fired Jacketed Steam Kettle” means a jacketed steam kettle having its own source of energy, such as gas or electricity for generating steam within the jacket’s walls.

“External Inspection” means an examination of a Boiler or Lined Hot Water Heater performed by an Authorized Inspector when the Boiler or Lined Hot Water Heater is in operation.

“Forced Circulation Lined Hot Water Heater” means a Lined Hot Water Heater used for potable water, a Lined Hot Water Heater requiring movement of water to prevent overheating and failure of the tubes or coils, and has no definitive waterline.

“Fully Attended Power Boiler” means a Power Boiler that is operated by an individual who meets the requirements of R20-5-408(D), and whose primary function is the care, maintenance, and operation of the Boiler and the equipment associated with the Boiler system.

“Historical Boilers” means steam Boilers preserved, restored, or maintained for hobby or demonstration use.

“HS” means heating surface.

“Inspection Certificate” means a document issued by the Division for the operation of a Boiler, Lined Hot Water Heater, or Direct Fired Jacketed Steam Kettle when a Certificate Inspection has been successfully completed.

“Internal Inspection” means a complete examination of the internal and external surfaces of a Boiler or Lined Hot Water Heater by an Authorized Inspector after the Boiler or Lined Hot Water Heater is shut down.

“Kw” means kilowatt.

“MAWP” means maximum allowable working pressure.

“National Board Commissioned Inspector” means an individual who holds a valid and current National Board Commission issued by the National Board of Boiler and Pressure Vessel Inspectors.

“National Board Registration Number” means a unique number issued to a Boiler, Lined Hot Water Heater, or Pressure Vessel by the manufacturer and recorded with the National Board of Boiler and Pressure Vessel Inspectors.

“NFPA” means National Fire Protection Association.

“Non-Standard Boiler” means any Boiler, Lined Hot Water Heater, or Pressure Vessel that is not constructed or

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maintained to the standards incorporated by reference of this Article.

“Out of Service” means to either: (1) physically sever or disconnect all sources of energy (water, gas, fuel, electricity, etc.); cap all fuel lines; and disconnect or remove all electrical lines from the Boiler, Lined Hot Water Heater, or Pressure Vessel; or (2) to lock out and tag out the Boiler, Hot Water Heater, or Pressure Vessel per 29 C.F.R. §1910.147, OSHA, General Industry Regulations. “Portable Boiler” means a Boiler permanently affixed to a trailer with wheels, that is totally self-contained while operating, and not attached to any other object either by pipe, hose, or wire.

“PVHO” means Pressure Vessels for Human Occupancy.

“Relief Valve” means an ASME-stamped automatic pressure relieving device designed for liquid service which is actuated by the pressure upstream of the valve and opens further with an increase in pressure above the stamped pressure.

“Repairs” means work necessary to restore a Boiler, Lined Hot Water Heater, or Pressure Vessel to operating condition that complies with this Article.

“Safety Relief Valve” means an ASME-stamped automatically pressure-actuated relieving device designed for use either as a Safety Valve or as a Relief Valve.

“Safety Valve” means an ASME-stamped automatic pressure relieving device designed for steam or vapor service which is actuated by the pressure upstream of the valve and characterized by full opening pop-action.

“Secondhand” means a Boiler, Lined Hot Water Heater, or Pressure Vessel that has changed both location and ownership since original installation.

“Serves” means either mailing to the last known address of the receiving party, or transmitting by other means, including electronic transmission, with the written consent of the receiving party.

“Shelter” means a permanent structure that provides protection from the weather.

“Special Inspector” means an inspector who is issued a Special Inspector Certificate under R20-5-420.

“State Identification Number” means a unique number assigned by the Division to a Boiler, Lined Hot Water Heater, or Pressure Vessel installed in Arizona.

“User” means a person or entity that does not have legal title to a Boiler, Lined Hot Water Heater, or Pressure Vessel, but has control and responsibility for the operation of a Boiler, Lined Hot Water Heater, or Pressure Vessel.

Historical Note

Former Rules B-2.1 through B-2.6. Former Section R4-13-402 repealed, new Section R4-13-402 adopted effective April 12, 1979 (Supp. 79-2). Amended effective March 31, 1981 (Supp. 81-2). Amended effective May 11, 1981 (Supp. 81-3). Amended effective May 31, 1985 (Supp. 85-3). Section R4-1-402 repealed, new Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-402 recodified from R4-13-402 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-403. Repealed**Historical Note**

Former Rules B-3.1 through B-3.3. Former Section R4-13-403 repealed, new Section R4-13-403 adopted effective April 12, 1978 (Supp. 79-2). Section R4-13-403 repealed, new Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-403 recodified from R4-13-403 (Supp. 95-1). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Repealed by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-404. Standards for Boilers, Lined Hot Water Heaters and Pressure Vessels**A. The following apply to this Article:**

1. An Owner, Operator, or User, of a Boiler, Lined Hot Water Heater or Pressure Vessel installed, repaired, replaced, or reinstalled in Arizona, six months after the effective date of this Article shall comply with the 2019 ASME Boiler and Pressure Vessel Code, Sections I, II, IV, V, VI, VII, VIII Division 1, 2, 3, IX, X, ASME 2020 Code for Pressure Piping B31.1, and 2019 ASME PVHO-1 Safety Standard for Pressure Vessels for Human Occupancy incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from the ASME at Three Park Avenue, New York, NY 10016-5990 or at <http://www.asme.org/>.
2. An Owner, Operator, or User, of a Boiler, Lined Hot Water Heater, or Pressure Vessel installed, repaired, replaced, or reinstalled in Arizona, before the effective date of this Article shall comply with subsection (A)(1), or the ASME Boiler and Pressure Vessel Code in effect at the time of the last installation, repair, replacement, or reinstallation of the boiler Boiler, Lined Hot Water Heater, or Pressure Vessel in Arizona.
3. An Owner, Operator, or User of a gas-fired Lined Hot Water Heater installed, operated, repaired, replaced, or reinstalled in Arizona shall comply with the American National Standard for Gas Water Heaters, ANSI Z21.10.3 2017, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from ANSI, Customer Service Department, 25 W. 43rd Street, 4th Floor, New York, NY 10036 or at <http://www.ansi.org/>.
4. An Owner, Operator, or User, of a Boiler installed, repaired, replaced, or reinstalled in Arizona after the effective date of this Article shall comply with the American National Standard for Controls and Safety Devices for Automatically Fired Boilers, ANSI/ASME CSD-1-2018, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated matter. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from the ASME, Three Park Avenue, New York, NY 10016-5990 or at <http://www.asme.org/>.
5. An Owner, Operator, or User, of a Boiler installed, repaired, replaced, or reinstalled in Arizona before the

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effective date of this Article shall comply with the American National Standard for Controls and Safety Devices for Automatically Fired Boilers in effect at the time of the last installation, repair, replacement or reinstallation of a Boiler in Arizona. As an alternative, an Owner, Operator, or User, of a Boiler described in this subsection may comply with subsection (A)(4).

6. A permanent source of outside air shall be provided for each Boiler and Lined Hot Water Heater room to assure complete combustion of the fuel as required by ANSI Z223.1- 2018, NFPA 54, National Fuel Gas Code incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated matter. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from ANSI, at Customer Service Department, 25 W. 43rd Street, 4th Floor, New York, NY 10036 or at <http://www.ansi.org/>.
 7. All new Power Boilers installed after the effective date of this subsection, having power piping, welded or mechanically assembled, (pipe, valves, and fittings) falling within the scope of ASME Code, Section I, shall be designed, constructed and listed on the appropriate ASME Code, Section I, manufacturer's data report, P-2A, P-4A, P-4B, P-6 as applicable, incorporated by reference in R20-5-404(A)(1).
 8. An Owner, Operator, or User, of a Boiler installed, repaired, replaced, or reinstalled in Arizona having a capacity equal to or greater than 12,500,000 BTU/hr input after the effective date of this subsection shall comply with ANSI NFPA 85, Boiler and Combustion Systems Hazards Code, 2019 edition, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated matter. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from ANSI, at Customer Service Department, 25 W. 43rd Street, 4th Floor, New York, NY 10036 or at <http://www.ansi.org/>.
- B.** The following registration requirements apply to this Article;
1. All Boilers, Lined Hot Water Heaters, and Pressure Vessels, including reinstalled and Secondhand Boilers, shall be registered with the National Board of Boiler and Pressure Vessel Inspectors except for:
 - a. Non-Standard Boilers installed up to six months after the effective date of this Section,
 - b. Cast iron Boilers, and
 - c. Cast aluminum Boilers.
 2. All fired and unfired Pressure Vessels installed or reinstalled on or after July 1, 2009, shall be registered with the National Board of Boiler and Pressure Vessel Inspectors.
- C.** The following installation, maintenance, and repair requirements apply to this Article.
1. An Owner, Operator, or User shall maintain a signed copy of the Manufacturer's Data Report, and Manufacturer's/Installing Contractors Report for ASME CSD-1, if applicable for a Boiler, Lined Hot Water Heater, or Pressure Vessel at the location of the Boiler Lined Hot Water Heater, or Pressure Vessel and make the reports available for review upon request from an Authorized Inspector.
 2. A Boiler shall have masonry or structural supports of sufficient strength and rigidity to safely support the Boiler and its contents without any vibration in the Boiler or its connecting piping.
 3. There shall be at least 36 in. (915 mm) of clearance on each side of the Boiler or Lined Hot Water Heater. Alternative clearances according to the manufacturer's recommendations are subject to approval by an Authorized Inspector prior to installation of a Boiler, Lined Hot Water Heater or Pressure Vessel.
 4. A Boiler with a manhole shall have at least five feet clearance between the Boiler manhole and any wall, ceiling, or piping.
 5. A newly constructed Boiler room in excess of 500 square feet of floor area and containing one or more Boilers with a fuel capacity of 1,000,000 BTU /hr or a heating capacity greater than 285 Kw (electric), shall have at least two exits on each level of the Boiler or Boilers. The Owner, Operator, or User shall ensure each exit is remotely located from other exits.
 6. An Owner, Operator, or User shall keep a Boiler, Lined Hot Water Heater, or Pressure Vessel room clean and with no obstructions to the Boiler, Lined Hot Water Heater, or Pressure Vessel.
 7. An Owner, Operator, or User shall not store flammable or explosive materials in a Boiler or Lined Hot Water Heater room.
 8. An Owner, Operator, or User shall not store combustibles any less than three feet from any part of a Boiler, Lined Hot Water Heater, or Pressure Vessel.
 9. If a Boiler, Lined Hot Water Heater, or Pressure Vessel is moved outside Arizona for temporary use or Repairs, the Owner, Operator, or User shall not reinstall the Boiler, Lined Hot Water Heater, or Pressure Vessel in Arizona until receiving verbal or written approval from the Division under R20-5-419. If the Division grants approval the Owner, Operator, or User shall not operate the reinstalled Boiler, Lined Hot Water Heater, or Pressure Vessel until receiving an Inspection Certificate under this Article.
 10. Before a new Power Boiler or Secondhand Boiler or Pressure Vessel is installed, an inspection in accordance with R20-5-408 shall be made by an Authorized Inspector or by a National Board Commissioned Inspector. This inspection is to assess the integrity of the vessel and evaluate the original design specification. Prior to installation, an application shall be filed by the Owner, Operator, or User of the Boiler or Pressure Vessel with the Division for approval. This application shall contain the following information:
 - a. Name of the Owner, Operator, or User;
 - b. Mailing address of Owner, Operator, or User;
 - c. Business telephone number of Owner, Operator, or User;
 - d. Installation name and address;
 - e. Installation date;
 - f. Start up date;
 - g. Name and address of Boiler or Pressure Vessel insurance company;
 - h. Arizona serial number of the Boiler or Pressure Vessel being replaced, if applicable;
 - i. Description of the new, or Secondhand Power Boiler or Pressure Vessel to include:
 - i. Manufacture's name,
 - ii. Date manufactured,
 - iii. MAWP or temperature of Boiler or Pressure Vessel, and
 - iv. National Board registration number;

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- j. Name, address, business phone number, cell phone number, fax number and state contractor's license number of company or individual that will be installing the Boiler or Pressure Vessel;
 - k. Name, title, and phone number of the contact person on the site of installation; and
 - l. Signature, title, and date of the person submitting the application.
11. Before the Owner, Operator, or User installing a Second-hand Boiler or Pressure Vessel, the Boiler or Pressure Vessel shall pass a hydrostatic test that is witnessed by an Authorized Inspector or by any National Board Commissioned inspector in accordance with R20-5-411.
 12. An Owner, Operator, or User of a Portable Boiler shall notify an Authorized Inspector before installing the Portable Boiler and shall not operate the Portable Boiler until the Owner, Operator, or User receives an Inspection Certificate from the Division.

Historical Note

Former Rules B-4.1 through B-4.3. Former Section R4-13-404 repealed, new Section R4-13-404 adopted effective April 12, 1979 (Supp. 79-2). Amended subsection (P) by adding paragraph (7) and amended subsection (Q) effective October 3, 1980 (Supp. 80-5). Section R4-13-404 repealed, new Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-404 recodified from R4-13-404 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-405. Repealed**Historical Note**

Former Section R4-13-405 repealed effective April 12, 1979 (Supp. 79-2). New Section R4-13-405 adopted effective June 13, 1980 (Supp. 80-3). Section R4-13-405 repealed, new Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-405 recodified from R4-13-405 (Supp. 95-1). Repealed by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-406. Repairs and Alterations

- A. If Repairs or Alterations may affect the working pressure or safety of a Boiler, Lined Hot Water Heater, or Pressure Vessel, an Owner, Operator, or User shall consult with an Authorized Inspector before having the Repairs or Alterations made. The Authorized Inspector shall provide the Owner, Operator, or User information regarding the best method to repair or alter the Boiler, Lined Hot Water Heater, or Pressure Vessel. The Owner, Operator, or User shall ensure that an Authorized Inspector inspects and approves the Repairs and Alterations after the Repairs or Alterations are made.
- B. Repairs and Alterations to Boilers, Lined Hot Water Heaters, or Pressure Vessels shall conform to the applicable provisions of the National Board Inspection Code, ANSI/NB-23-2019, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007, and may be obtained from the National Board of Boiler and Pressure Vessel Inspectors, at 1055 Crupper Avenue, Columbus, OH 43229-1183 or at <http://www.nationalboard.org/>.

- C. An Owner, Operator, or User shall not permit an individual to remove or repair a safety appliance of a Boiler, Lined Hot Water Heater, or Pressure Vessel in operation. An Owner, Operator, or User shall not permit a person to remove or repair a safety appliance of a Boiler, Lined Hot Water Heater, or Pressure Vessel not in operation except as provided under the ASME Code. If an Owner, Operator, or User permits a person to remove a safety appliance from a Boiler, Lined Hot Water Heater, or Pressure Vessel as provided under the ASME Code, then the Owner, Operator, or User shall ensure that the safety appliance is reinstalled in proper working order before the Boiler, Hot Water Heater, or Pressure Vessel is placed back into operation.
- D. No person shall alter in any manner a Safety Valve, Relief Valve, or Safety Relief Valve, except by an organization qualified in accordance with The National Board Inspection Code, ANSI/NB-23-2019 Edition, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007, and may be obtained from the National Board of Boiler and Pressure Vessel Inspectors at 1055 Crupper Avenue, Columbus, OH 43229-1183 or at <http://www.nationalboard.org/>.
- E. Repairs of fittings or appliances shall comply with the requirements of the National Board Inspection Code, ANSI/NB-23 2019 Edition, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from the National Board of Boiler and Pressure Vessel Inspectors, at 1055 Crupper Avenue, Columbus, OH 43229-1183 or at <http://www.nationalboard.org/>.
- F. On or after the effective date of this subsection, replacement of fittings or appliances shall comply with the requirements of the 2019 ASME Boiler and Pressure Vessel Code, Sections I, II, IV, V, VI, VII, VIII, Division 1, 2, 3, IX, X and 2018 ASME Code for Pressure Piping B31.1, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007. A copy of the incorporated material may also be obtained from ASME, Three Park Avenue, New York, NY 10016-5990 or at <http://www.asme.org>.

Historical Note

Former Section R4-13-406 repealed effective April 12, 1979 (Supp. 79-2). New Section R4-13-406 adopted effective June 13, 1980 (Supp. 80-3). Section R4-13-406 repealed, new Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-406 recodified from R4-13-406 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-407. Inspection of Boilers, Lined Hot Water Heaters, Direct Fired Jacketed Steam Kettles and Issuance of Inspection Certificates

- A. An Authorized Inspector shall comply with the guidelines set forth in The National Board Inspection Code, ANSI/NB-23-2019 Edition, incorporated by reference. This incorporation

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does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from the National Board of Boiler and Pressure Vessel Inspectors, 1055 Crupper Avenue, Columbus, OH 43229-1183 or at <http://www.nationalboard.org/>.

- B. If an Owner, Operator, or User fails to comply with the requirements for an inspection or pressure test under this Article, the Division shall withhold the Inspection Certificate until the Owner, Operator, or User complies with the requirements.
- C. An Authorized Inspector shall not engage in the sale of any object or device relating to, or equipment associated with, Boilers, Lined Hot Water Heaters, or Direct Fired Jacketed Steam Kettles.
- D. Under A.R.S. § 23-485(D), the Special Inspector shall file an inspection report within 30 days of an inspection by entering data into the Division's Web-based inspection entry form, by submitting a paper inspection report issued by the Division, or by electronic transfer of data. Whatever form of data transfer a Special Inspector chooses, there shall be no cost to the Division. The inspection report shall contain the following:
 - 1. Whether it is a Certificate or non-Certificate Inspection;
 - 2. Whether it is an Internal Inspection, External Inspection, or both;
 - 3. Name of location, address and phone number of the object;
 - 4. Name, address and phone number of owner or responsible party;
 - 5. Contact person's name and phone number at the inspection location;
 - 6. State Identification Number;
 - 7. Inspection Certificate due date;
 - 8. Inspection Certificate duration;
 - 9. Install/reinstall date, if known;
 - 10. Whether the object is active, inactive, Out-of-Service, standby, or scrapped;
 - 11. MAWP permitted or allowed;
 - 12. National Board registration number;
 - 13. Name of the manufacturer and the year the object was built;
 - 14. Special location in plant, if applicable;
 - 15. Boiler type;
 - 16. Purpose of the Boiler;
 - 17. Specify type of fuel used;
 - 18. Whether the firing method is automatic, manual, or unknown;
 - 19. Whether the fuel train is in compliance with CSD-1, NFPA 85, Z21.10.3 or other;
 - 20. Whether the Boiler is fully attended as per R20-5-408(C);
 - 21. Size/input rate, as applicable;
 - 22. Size classification (HS/BTU/Kw);
 - 23. Whether the heating surface type is stamped, computed, or unknown;
 - 24. Minimum Safety Valve relief capacity required;
 - 25. Whether the minimum Safety Valve relief capacity type is BTU/Hr, lbs/Hr or unknown;
 - 26. Number of temperature/pressure controls, as applicable;
 - 27. Owner number assigned by the Owner to specifically identify object's location;
 - 28. Inspection date;
 - 29. Whether the Inspection Certificate is posted;
 - 30. Safety Valve total capacity;
 - 31. Safety Valve total capacity type (PPH/Hr or BTU/Hr);
 - 32. Safety Valve #1 set pressure;
 - 33. Safety Valve #2 set pressure;
 - 34. Safety Valve #3 set pressure;
 - 35. Safety Valve code stamping (Example: V, HV, UV, UV3.TV, TD, OR NV);
 - 36. Whether the object has been hydro tested;
 - 37. Hydro Test (psi), if applicable;
 - 38. Whether Pressure/Altitude Gage was tested;
 - 39. Whether the condition of the object is okay to issue an Inspection Certificate;
 - 40. Inspection comments, condition of Boiler;
 - 41. Violations noted;
 - 42. Inspector name and Special Inspector number; and
 - 43. National Board Commission number.
- E. The Division shall issue to an Owner, Operator, or User an Inspection Certificate within 30 calendar days of receipt of an inspection report that documents a Boiler, Lined Hot Water Heater, or Direct Fired Jacketed Steam Kettle that complies with the Act and this Article. An Owner, Operator, or User of a Boiler, Lined Hot Water Heater, or Direct Fired Jacketed Steam Kettle shall post the Inspection Certificate in the establishment where the Boiler, Lined Hot Water Heater, or Direct Fired Jacketed Steam Kettle is located.
- F. An Owner, Operator, or User shall ensure that an Authorized Inspector tags or stamps a steam Boiler with an identification number immediately after installing, but before operating, a new steam Boiler, or when an Authorized Inspector performs an initial Certificate Inspection of an existing steam Boiler. The identification number shall be at least 5/16" in height and in the following format: AZ-# # # #.
- G. The Division shall mark with a metal dye stamp a Boiler or Lined Hot Water Heater identified by the Division as not safe for further service, with the code "XXX AZ8 XXX" which shall designate that the Boiler or Lined Hot Water Heater is Condemned.
- H. For any conditions not covered by this Article, the applicable provisions of the ASME Code that was in effect in Arizona at the time of the installation of the Boiler or Lined Hot Water Heater shall apply.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-407 recodified from R4-13-407 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-408. Frequency of Inspection

- A. An Owner, Operator, or User, of an existing Power Boiler or High Temperature Water Boiler shall ensure that an Authorized Inspector performs a Certificate Inspection and/or an External Inspection prior to operating the Power Boiler or High Temperature Water Boiler. A Certificate Inspection shall also be performed every 12 months thereafter and an External Inspection of the Power Boiler or High Temperature Water Boiler shall be performed every 12 months thereafter. An Authorized Inspector shall perform the External Inspection while the Power Boiler or High Temperature Water Boiler is in operation to ensure that safety devices are operating properly.
- B. An Authorized Inspector shall perform an Internal Inspection and pressure test on a Boiler, Lined Hot Water Heater, or Pressure Vessel if the Authorized Inspector determines from an External Inspection of the Boiler, Lined Hot Water Heater, or

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Pressure Vessel that continued operation is a danger to the public or worker safety.

- C. The Division shall issue a 12-month Inspection Certificate to an Owner, Operator, or User to operate a Fully Attended Power Boiler if:
1. An Owner, Operator, or User ensures that an Authorized Inspector performs an External Inspection and audit of the operational methods and logs of the Fully Attended Power Boiler at least every 12 months and performs an Internal Inspection of the Fully Attended Power Boiler at least every 36 months; and
 2. Continuous boiler water treatment is under the direct supervision of persons trained and experienced in water treatment for the purpose of controlling and limiting corrosion and deposits; and
 3. Records are available for review, that indicate:
 - a. The date, time, and reason the Boiler is Out of Service; and
 - b. Daily analysis of water samples that adequately show the conditions of the water and elements or characteristics that are capable of producing corrosion or other deterioration to the Boiler or its parts; and
 4. Controls, safety devices, instrumentation, and other equipment necessary for safe operation are current, in service, calibrated, and meet the requirements of an appropriate safety code for the size Boilers, such as NFPA 85, ASME CSD-1 Controls and Safety Devices for Automatically Fired Boilers, National Board Inspection Code ANSI/NB-23, and state requirements; and
 5. Inspection reports of an Authorized Inspector document that the Fully Attended Power Boiler complies with the Act and this Article.
- D. An Owner, Operator, or User of a Direct-Fired Jacketed Steam Kettle shall ensure that an Authorized Inspector performs a Certificate Inspection at the time of installation, and every 24 months thereafter.
- E. An Owner, Operator, or User of a steam heating or process Boiler, not exceeding 15 p.s.i. MAWP, steam or vapor, shall ensure that an Authorized Inspector performs a Certificate Inspection and an External Inspection of the heating or process boiler every 24 months.
- F. An Owner, Operator, or User of a hot water heating, hot water supply Boiler, or Lined Hot Water Heater shall ensure that an Authorized Inspector performs a Certificate Inspection and External Inspection of the hot water heating or hot water supply Boiler or Lined Hot Water Heater at installation. An inspection certificate issued by the Division following an inspection under this subsection shall not state an expiration date.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-408 recodified from R4-13-408 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-409. Notification and Preparation for Inspection

- A. An Authorized Inspector shall perform a Certificate Inspection at a time mutually agreeable to the Authorized Inspector and the Owner, Operator, or User.

- B. Before an Authorized Inspector performs an Internal Inspection of a Boiler, an Owner, Operator, or User shall:
1. Cool the furnace and combustion chambers;
 2. Drain the water from the Boiler;
 3. Remove the manhole and handhole plates, wash-out plugs, inspection plugs in water column connections, and disassemble all low-water fuel cutoff float chambers or bowls;
 4. Remove insulation or brickwork if necessary to determine the condition of the Boiler, headers, furnace, supports, and other parts;
 5. Remove the pressure gauge for testing;
 6. Prevent any leakage of steam or hot water into the boiler by disconnecting the involved pipe or valve;
 7. Close, tag, and padlock the non-return and steam stop valves before opening the manhole or handhole covers and entering any part of the steam generating unit that is connected to a common header with other Boilers. Open the free blow drain or cock between the non-return and steam stop valves;
 8. Close, tag, and padlock the blowoff valves after draining the Boiler; and
 9. Open all drains and vent lines.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-409 recodified from R4-13-409 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-410. Report of Accident

An Owner, Operator, or User shall notify the Division within 24 hours of an explosion, severe overheating, or personal injury involving a Boiler, Lined Hot Water Heater, or Direct Fired Jacketed Steam Kettle. A person shall not remove or disturb the involved Boiler, Lined Hot Water Heater, or Direct Fired Jacketed Steam Kettle or parts of the Boiler, Lined Hot Water Heater, or Direct Fired Jacketed Steam Kettle before an investigation by an Authorized Inspector, except for the purpose of preventing personal injury or limiting consequential damage.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-410 recodified from R4-13-410 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-411. Hydrostatic Tests

The Owner, Operator, or User of a Boiler shall perform a hydrostatic or pneumatic pressure test in accordance with the code incorporated by reference in R20-5-404(A) and R20-5-406(B).

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-411 recodified from R4-13-411 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final

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rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-412. Automatic Low-water Fuel Cutoff Devices or Combined Water Feeding and Fuel Cutoff Devices

- A. An Owner, Operator, or User shall ensure that low-water fuel cutoff devices or combined water feeding and fuel cutoff devices do not interfere with an Operator's or Authorized Inspector's ability to safely clean, repair, or inspect a Boiler, Lined Hot Water Heater, or Pressure Vessel.
- B. A low-water fuel cutoff device shall have a pressure rating not less than the set pressure of the Safety Valve or Safety Relief Valve.
- C. In addition to the requirements of subsections (A) and (B), all low-water fuel cutoffs and flow sensing devices shall be constructed and installed in accordance with applicable ASME Code and standards for Boilers and Direct Fired Jacketed Steam Kettle in R20-5-404(A).

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-412 recodified from R4-13-412 (Supp. 95-1). Amended effective October 9, 1998 (98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-413. Safety and Safety Relief Valves

- A. A valve shall not be placed between a Safety Valve, Relief Valve, or a Safety Relief Valve and the Boiler, Lined Hot Water Heater, or Pressure Vessel, or between a Safety Valve, Relief Valve, or a Safety Relief Valve and the discharge pipe attached to the Boiler, Lined Hot Water Heater, or Pressure Vessel.
- B. When a Power Boiler is supplied with feed-water directly from a water main without the use of a feeding apparatus, Safety Valves shall not be set at a pressure greater than 94% of the lowest pressure obtained in the water main feeding the Boiler;
- C. Safety Valves, Safety Relief Valves, and Relief Valves shall conform to the requirements of the 2019 ASME Boiler and Pressure Vessel Code, Section I, IV or VIII, July, incorporated by reference as applicable. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ and may be obtained from ASME, Three Park Avenue, New York, NY 10016-5990 or at <http://www.asme.org/>.
- D. The resetting, repairing, and restamping of Safety Valves, Relief Valves, and Safety Relief Valves shall be done by a qualified valve repair organization holding a valid "VR" Certificate of Authorization issued by the National Board of Boiler and Pressure Vessel Inspectors. ASME valve manufacturers holding a valid "V," "HV," and "UV" Certificate or Certificates of Authorization may also do this work provided they also have a valid "VR" Certificate of Authorization issued by the National Board of Boiler and Pressure Vessel Inspectors.
- E. With jurisdictional approval, Owner, Operators, and Users of Boilers, Lined Hot Water Heaters, and Pressure Vessels may authorize external adjustments to bring installed Safety Valves, Relief Valves, and Safety Relief Valves back to the stamped set pressure when performed by the Owner's, Operator's, or User's trained, qualified, regular, and full-time

employees. Refer to Supplement 7.10 of the National Board Inspection Code for guidelines regarding training, documentation, and the implementation of a quality system for the Owner, Operator, or User employees. All such external adjustments shall be resealed with a metal tag showing the identification of the organization making the adjustments and the date. If any valve repairs are required, they shall be done by a qualified "VR" certificate holder.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-413 recodified from R4-13-413 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-414. Repealed**Historical Note**

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-414 recodified from R4-13-414 (Supp. 95-1). Repealed by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3).

R20-5-415. Boiler Blowdown, Blowoff Equipment and Drains

- A. Except as provided in this Section, an Owner, Operator, or User of blowdown and blowoff equipment shall comply with the National Board of Boiler and Pressure Vessel Inspectors, A Guide for Blowoff Vessels, NB-27, Revision 1 (1/13), 2012 Edition, incorporated by reference. This incorporation does not include any later amendments or editions of the incorporated material. A copy of this referenced material is available for review at the Industrial Commission of Arizona, 800 W. Washington Street, Phoenix, AZ 85007 and may be obtained from the National Board of Boiler and Pressure Vessel Inspectors, 1055 Crupper Avenue, Columbus, OH 43229-1183 or at <http://www.nationalboard.org/>.
- B. Blowdown from a Boiler is a hazard to life and property.
- C. Blowdown from a Boiler shall pass through blowdown equipment that reduces pressure and temperature to levels not exceeding 5 p.s.i.g. and 140° F.
- D. The thickness of a blowdown vessel shall be at least 3/16".
- E. All blowdown equipment shall be fitted with openings that allow cleaning and inspection of the equipment.
- F. Blowdown Separators may be used with Boilers instead of Boiler Blowdown Tanks, provided that Blowdown Separators are operated with a temperature gauge and water cooler to prevent drain water temperature from exceeding 140° F.
- G. In addition to the requirements of subsections (A) through (F), the following requirements apply to blowdown piping, valves and drains for Power Boilers: Each Power Boiler and High Temperature Water Boiler shall be installed and maintained according to ASME Code, Section 1 and B31.1, incorporated by reference in R20-5-404, at the time of installation.
- H. In addition to the requirements of subsections (A) through (F), the following requirements apply to bottom blowdown or drain valves for heating Boilers and Lined Hot Water Heaters:
 1. A hot water heating Boiler or Lined Hot Water Heater shall have a bottom blowdown or drain pipe connection fitted with a valve or cock connected with the lowest available water space with the minimum size of blow-

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down piping and valves as required by ASME Code, Section IV, incorporated by reference, in R20-5-404(A).

2. Discharge outlets of blowdown pipes, Safety Valves, Relief Valves, or Safety Relief Valves, and other piping shall be located and structurally supported to prevent injury to individuals.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-415 recodified from R4-13-415 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-416. Maximum Allowable Working Pressure

- A. The ASME Code under which a Boiler, Lined Hot Water Heater, or Pressure Vessel was constructed and stamped shall determine the MAWP.
- B. If components in the Boiler, or hot water system such as valves, pumps, expansion tanks, storage tanks or piping have a lesser working pressure rating than the Boiler or Lined Hot Water Heater, the pressure setting for the Safety Valve Relief Valve, or Safety Relief Valve on the Boiler or Lined Hot Water Heater shall be based upon the component with the lowest MAWP rating.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-416 recodified from R4-13-416 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-417. Maintenance and Operation of Boilers, Lined Hot Water Heaters and Direct Fired Jacketed Steam Kettles

- A. An Owner, Operator, or User of a lined Boiler, Lined Hot Water Heater, or Direct Fired Jacketed Steam Kettle constructed under the ASME Code, Sections I, IV or VIII Division 1, incorporated by reference in R20-5-404(A) shall comply with the manufacturer's maintenance and operation instructions.
- B. In addition to the requirements of subsection (A), an Owner, Operator, or User of a Boiler constructed under the ASME Code, Sections I, or IV shall comply with the following preventive maintenance schedule if the boiler contains the component or system listed.
 1. On a daily basis, the Owner, Operator, or User shall:
 - a. Test the low-water fuel cutoff and alarm, and
 - b. Check the burner flame for proper combustion.
 2. On a weekly basis, the Owner, Operator, or User shall:
 - a. Check for proper ignition, and
 - b. Check the flame failure detection system.
 3. On a monthly basis, the Owner, Operator, or User shall:
 - a. Test all fan and air pressure interlocks,
 - b. Check the main burner safety shutoff valve,
 - c. Check the low fire start switch,
 - d. Test fuel pressure and temperature interlocks of oil-fired units, and

- e. Test the high and low fuel pressure switch of gas-fired units.

4. Every six months, the Owner, Operator, or User shall:
 - a. Inspect burner components;
 - b. Check flame failure system components, such as vacuum tubes, amplifier and relays;
 - c. Check wiring of all interlocks and shutoff valves; and
 - d. Check steam and blowdown piping and valves.
5. Annually, the Owner, Operator, or User shall:
 - a. Replace vacuum tubes, scanners, or flame rods in the flame failure system according to the manufacturer's instructions;
 - b. Check all coils and diaphragms; and
 - c. Test operating parts of all safety shutoff and control valves.
 - d. Unless there is other information to assess their accuracy or reliability, all pressure gages shall be removed, tested, and their readings compared to the readings of a calibrated standard test gage or a dead weight tester.

- C. An Owner, Operator, or User of a Power Boiler or High Temperature Water Boiler shall designate an individual who meets the requirements of subsection (D) to operate the Boiler. An Owner, Operator, or User may operate the Boiler if the Owner, Operator, or User meets the requirements of subsection (D).

- D. An Operator or User of a Power Boiler or High Temperature Water Boiler shall meet the following minimum requirements:
 1. Knowledge of and an ability to explain the function and operation of all safety controls of the Boiler,
 2. Ability to start the Boiler in a safe manner,
 3. Knowledge of all safe methods of feeding water to the Boiler,
 4. Knowledge of and the ability to blow down the Boiler in a safe manner,
 5. Knowledge of safety procedures to follow if water exceeds or drops below permissible safety levels, and
 6. Knowledge of and the ability to safely shut down the Boiler.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-417 recodified from R4-13-417 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-418. Non-standard Boilers

An Owner, Operator, or User shall remove from service a Boiler, Lined Hot Water Heater, or Pressure Vessel that does not bear an ASME stamp unless a variance is requested under R20-5-429.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). New Section adopted effective April 9, 1992 (Supp. 92-2). R20-5-418 recodified from R4-13-418 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

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R20-5-419. Request to Reinstall Boiler or Lined Hot Water Heater

- A. The Division shall grant or deny approval to reinstall a Boiler or Lined Hot Water Heater within three business days after an Owner, Operator, or User requests approval. The order of the Division granting or denying approval shall be in writing.
- B. The Division shall grant approval if the Boiler or Lined Hot Water Heater complies with the Act and this Article. The Division shall deny approval if the Boiler or Lined Hot Water Heater does not comply with the Act and this Article.
- C. An order of the Division denying approval shall be final unless an Owner, Operator, or User requests a hearing under A.R.S. § 23-479 within 15 days after the Division Serves the order. The Owner, Operator, or User requesting a hearing shall have the burden to prove that a Boiler or Lined Hot Water Heater meets the requirements of the Act and this Article.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-419 recodified from R4-13-419 (Supp. 95-1). New Section adopted effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-420. Special Inspector Certificate under A.R.S. § 23-485

- A. The Division shall administratively review an Applicant's application for a Special Inspector Certificate under A.R.S. § 23-485 within seven days of receipt of the application to determine if the application is complete. If the application is incomplete, the Division shall notify the Applicant in writing of the missing documentation or information necessary to comply with this Article.
- B. The Division shall deem an application withdrawn if the Applicant fails to file a complete application within ten days of being notified by the Division that the application is incomplete pursuant to subsection A, unless the Applicant obtains an extension to provide the missing information. An Applicant may obtain an extension to submit the missing information by filing a written request with the Division no later than ten days after the Division Serves notice that the application is incomplete, stating the reasons why the Applicant is unable to meet the ten-day deadline.
- C. An application for a Special Inspector Certificate under A.R.S. § 23-485 is deemed complete under subsection (A) when the following is filed with the Division:
 - 1. Written documentation demonstrating that the Applicant holds a current commission issued by the National Board of Boiler and Pressure Vessel Inspectors; and
 - 2. Proof of employment as a full-time inspector for a company conducting business in Arizona with a certificate of accreditation as outlined in A.R.S. § 23-485 and whose duties as an inspector include making inspections of Boilers or Lined Hot Water Heaters to be used or insured by such company and not for resale.
- D. If an Applicant meets the criteria of A.R.S. § 23-485 and subsection (C) of this Section, the Division shall issue a Special Inspector Certificate to the Applicant within 15 calendar days. If an Applicant fails to meet the criteria of A.R.S. § 23-485 and subsection (C) of this Section, the Division shall issue a written notice denying eligibility to the Applicant. The Commission shall deem the notice denying eligibility final if an

Applicant does not request a hearing within 15 calendar days after the Division Serves the notice.

- E. A Hearing on the denial of eligibility for a Special Inspector Certificate shall be governed by the following provisions:
 - 1. A request for hearing protesting a denial of eligibility shall be in writing and signed by the Applicant or the Applicant's legal representative and filed with the Division.
 - 2. The Commission shall hold a hearing under A.R.S. § 41-1065. The hearing shall be recorded.
 - 3. The chair of the Commission or designee shall preside over hearings held under this Section. The chair shall apply the provisions of A.R.S. § 41-1062 et seq. to hearings held under this Section and shall have the authority and power of a presiding officer as described in A.R.S. § 41-1062.
 - 4. A decision of the Commission to deny or grant eligibility for a Special Inspector Certificate shall be based upon the criteria set forth in A.R.S. § 23-485 and this Section and shall be made by a majority vote of the quorum of Commission members present when the decision is rendered at a public meeting. After a decision is rendered at a public meeting, the Commission shall issue a written decision upon hearing which shall include findings of fact and conclusions of law, separately stated. An order of the Commission denying a Special Inspector Certificate is final unless an applicant files a request for review within 15 days after the Commission Serves its order.
 - 5. A request for review shall be based upon one or more of the following grounds which have materially affected the rights of an Applicant:
 - a. Irregularities in the hearing proceedings or any order or abuse of discretion whereby the Applicant seeking review was deprived of a fair hearing;
 - b. Misconduct by the Division;
 - c. Accident or surprise which could not have been prevented by ordinary prudence;
 - d. Newly discovered material evidence that could not have been discovered with reasonable diligence and produced at the hearing;
 - e. Excessive or insufficient sanctions or penalties imposed at hearing;
 - f. Error in the admission or rejection of evidence, or errors of law occurring at, or during the course of, the hearing;
 - g. Bias or prejudice of the Division; and
 - h. The order, decision, or findings of fact are not justified by the evidence or are contrary to law.
 - 6. The Commission shall issue a decision upon review no later than 30 days after receiving a request for review.
 - 7. The Commission's decision upon review is final unless an Applicant seeks judicial review as provided in A.R.S. § 23-483.

Historical Note

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-420 recodified from R4-13-420 (Supp. 95-1). New Section adopted effective October 9, 1998 (Supp. 98-4). Amended by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

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R20-5-421. Repealed**Historical Note**

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-421 recodified from R4-13-421 (Supp. 95-1).

R20-5-422. Repealed**Historical Note**

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-422 recodified from R4-13-422 (Supp. 95-1).

R20-5-423. Repealed**Historical Note**

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-423 recodified from R4-13-423 (Supp. 95-1).

R20-5-424. Repealed**Historical Note**

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-424 recodified from R4-13-424 (Supp. 95-1).

R20-5-425. Repealed**Historical Note**

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-425 recodified from R4-13-425 (Supp. 95-1).

R20-5-426. Repealed**Historical Note**

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-426 recodified from R4-13-426 (Supp. 95-1).

R20-5-427. Repealed**Historical Note**

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-427 recodified from R4-13-427 (Supp. 95-1).

R20-5-428. Repealed**Historical Note**

Repealed effective April 12, 1979 (Supp. 79-2). R20-5-428 recodified from R4-13-428 (Supp. 95-1).

R20-5-429. Variance

- A. Any Owner, Operator, or User may apply to the Director for a variance from the requirements of this Article, upon demonstrating the construction, installation, and operation of the Boiler, Lined Hot Water Heater, or Pressure Vessel will maintain the same level of safety as prescribed by this Article. The Director shall issue a variance if the Director determines that the proponent of the variance has demonstrated the construction, installation, and operation of the Boiler, Lined Hot Water Heater, or Pressure Vessel will maintain the same level of safety as prescribed by this Article. The variance issued shall prescribe the construction, installation, operation, maintenance, and repair conditions that the Owner, Operator, or User shall maintain.
- B. A variance may be modified or revoked upon application by an Owner, Operator, or User or the Director, on the Director's own motion at any time after six months from issuance if the owner or user Owner, Operator, or User has not complied with the variance or if the variance does not protect the health and safety of employees or general public.
- C. The application for a variance shall be made on the form issued by the Division and contains the following information:
 1. Owner, Operator, or User name and company name;
 2. Mailing address;

3. Telephone number;
 4. Fax number;
 5. Contact person;
 6. Contact person's telephone number;
 7. Address or location of proposed variance;
 8. Type of facility to include;
 - a. Variance description,
 - b. Justification for variance,
 - c. Component or system involved,
 - d. Supporting documentation for variance,
 - e. Identify the statute, rule, code or standard to justify the variance; and
 9. Printed name and title of Owner, Operator, or User, signature of Owner, Operator, or User, and date.
- D. If an Owner, Operator, or User does not agree with the variance issued or revoked by the Director, a request for a hearing under A.R.S. § 23-479 can be made with the Commission.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-430. Forced Circulation Lined Hot Water Heaters

- A. All water tube or coil-type Lined Hot Water Heaters that require forced circulation to prevent overheating and failure of the tubes or coils shall have a safety control, to prevent burner operation at a flow rate inadequate to protect the Lined Hot Water Heater unit against overheating, at all allowable firing rates. The safety control shall shut down the burner and prevent restarting until an adequate flow is restored. The flow sensing device shall be labeled and listed by a nationally recognized testing agency as a standard for limit controls complying with UL 353. This safety control shall be independent of any other operating controls.
- B. All water tube or coil-type Lined Hot Water Heaters that require forced circulation to prevent overheating and failure of the tubes or coils, shall have a manually operated remote shutdown switch or circuit breaker and shall be located just outside the Lined Hot Water Heater's room door and marked for easy identification. The shutdown switch shall be installed in a manner to safeguard against tampering. If a Lined Hot Water Heater's room door is on the building exterior, the switch shall be located just inside the door. If there is more than one door to the Lined Hot Water Heater's room, there shall be a switch located at each door. The remote shutdown switch or circuit breaker shall disconnect all power to the burner controls.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-431. Code Cases

Code cases approved for use by ASME are allowed to be used in the design, fabrication and testing of Boilers, Lined Hot Water Heaters, and Pressure Vessels provided approval from the boiler chief is obtained prior to use.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30,

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2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

R20-5-432. Historical Boilers

Historical boilers shall require an initial Certificate Inspection by an Authorized Inspector in accordance with The National Board Inspection Code, followed by a Certificate Inspection every three years thereafter if stored inside a shelter, or annually if stored outdoors. The initial Certificate Inspection shall include ultrasonic thickness testing of all pressure boundaries. Thinning of the pressure retaining boundary shall be monitored and recorded on the inspection report.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 1496, effective August 18, 2009 (Supp. 09-3). Amended by final rulemaking at 28 A.A.R. 3952 (December 30, 2022), with an immediate effective date of December 7, 2022 (Supp. 22-4).

ARTICLE 5. ELEVATOR AND CONVEYANCE SAFETY**R20-5-501. Repealed****Historical Note**

Former Rule E-1. Amended effective November 9, 1979 (Supp. 79-6). R20-5-501 recodified from R4-13-501 (Supp. 95-1). Section repealed by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1).

R20-5-502. Definitions

In addition to the definitions provided in A.R.S. § 23-491, the following definitions apply to this Article:

“Alteration” or “altered” means work performed to any conveyance that is not routine maintenance or repair.

“ASME” means American Society of Mechanical Engineers.

“ANSI” means American National Standard Institute.

“AZFS key” means Arizona Firefighters Service Key, a universal key used by a firefighter to operate a conveyance during an emergency.

“Chief” means the head inspector of the Elevator Safety Section of the Division of Occupational Safety and Health.

“Conveyance” defined in A.R.S. § 23-491, also includes employee elevators for construction and demolition operations, material lifts, platform lifts, orchestra lifts and stairway chairlifts.

“Elevator Safety Section” means the Elevator Safety Section of the Division of Occupational Safety and Health of the Commission.

“Employee elevator for construction and demolition operations” means an elevator that is not an integral part of a building, is installed inside or outside buildings or structures during construction, alteration, or demolition operations, and is used to raise and lower workers and other personnel.

“Inspection” means the official determination by an inspector of the condition of all parts of the equipment on which the safe operation of a conveyance depends.

“Orchestra lift” means a lift operating at a speed of 15 (4.6 meters) per minute or less, not designed for passenger use, not for moving during performances, providing

an extension of the stage, and providing an extension of the auditorium floor.

“Platform lift” means a powered hoisting and lowering mechanism designed to transport mobility-impaired persons on a guided platform that travels on an incline or vertically.

“Stairway chairlift” means a powered hoisting and lowering mechanism that is guided and equipped with a seat to transport seated passengers along stairways.

“State Serial Number” is a unique number assigned by the Chief Elevator Inspector to a conveyance.

Historical Note

Former Rule E-2. R20-5-502 recodified from R4-13-502 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2). Amended by final rulemaking at 29 A.A.R. 512 (February 3, 2023), within an immediate effective date of January 9, 2023 (Supp. 23-1).

R20-5-503. Repealed**Historical Note**

Former Rule E-3. R20-5-503 recodified from R4-13-503 (Supp. 95-1). Section repealed by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1).

R20-5-504. Safety Standard for Platform Lifts and Stairway Chairlifts

- A. Every owner or operator of a platform lift or stairway chairlift installed, repaired, or altered on or after January 1, 2023, shall comply with ASME A18.1-2020 (Safety Standard for Platform Lifts and Stairway Chairlifts), with amendments as of November 29, 2020, which is incorporated by reference. For purposes of a repair or alteration, compliance with the specified standard shall apply, to the extent possible, to the scope of the repair or alteration. This incorporation by reference does not include any later amendments or editions of the incorporated matter.
- B. Every owner or operator of a platform lift or stairway chairlift installed, repaired, or altered prior to January 1, 2023, shall comply with either: (1) ASME A18.1-2005 (Safety Standard for Platform Lifts and Stairway Chairlifts), with amendments as of November 29, 2005; or (2) ASME A18.1-2020 (Safety Standard for Platform Lifts and Stairway Chairlift), with amendments as of November 29, 2020, which are incorporated by reference. For purposes of a repair or alteration, compliance with the specified standard shall apply, to the extent possible, to the scope of the repair or alteration. These incorporations by reference do not include any later amendments or editions of the incorporated matter.
- C. A copy of the referenced material is available for review at the Industrial Commission of Arizona, 800 West Washington Street, Phoenix, Arizona 85007, and ASME at Three Park Avenue, New York, New York 10016-5990 or at <http://www.asme.org>.

Historical Note

Former Rule E-4. R20-5-504 recodified from R4-13-504 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2). Amended by final rulemaking at 29 A.A.R. 512 (February 3, 2023), within an immediate effective date of January 9, 2023 (Supp. 23-1).

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R20-5-505. Certificate of Inspection

The owner or operator of a conveyance shall maintain the Commission's certificate at the same location as the conveyance or related equipment and make the certificate available for inspection and copying upon request. The State Serial Number or certificate shall be posted or displayed in or within close proximity to the conveyance in a location that is easily accessible.

Historical Note

Former Rule E-5. R20-5-505 recodified from R4-13-505 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2). Amended by final rulemaking at 29 A.A.R. 512 (February 3, 2023), within an immediate effective date of January 9, 2023 (Supp. 23-1).

R20-5-506. Recordkeeping

- A. The Elevator Safety Section shall assign a State Serial Number to every conveyance for recordkeeping purposes. The State Serial Number shall be on a tag that is affixed to the controller or mainline disconnect of the conveyance.
- B. The owner or operator of a conveyance shall notify the Elevator Safety Section at least 90 days before installation, relocation, or alteration of a conveyance.
- C. The owner or operator of a conveyance shall notify the Elevator Safety Section within 24 hours of every accident resulting in injury to a person or disabling damage to a conveyance. For purposes of this subsection, disabling damage means any damage to a conveyance that impairs normal operations.

Historical Note

Former Rule E-6. Amended effective November 9, 1979 (Supp. 79-6). R20-5-506 recodified from R4-13-506 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2). Amended by final rulemaking at 29 A.A.R. 512 (February 3, 2023), within an immediate effective date of January 9, 2023 (Supp. 23-1).

R20-5-507. Safety Code for Elevators, Escalators, Dumbwaiters, Moving Walks, Material Lifts, Special Purpose Personnel Elevators, and Dumbwaiters with Automatic Transfer Devices

- A. Every owner or operator of an elevator, escalator, dumbwaiter, moving walk, material lift, special purpose personnel elevator, or dumbwaiter with automatic transfer device installed, repaired, or altered on or after January 1, 2023, shall comply with the ASME A17.1-2019 (Safety Code for Elevators and Escalators) or ASME A17.7-2007 (Performance-Based Safety Code for Elevators and Escalators) as referenced in ASME A17.1-2019, which are incorporated by reference. For purposes of a repair or alteration, compliance with the specified standard shall apply, to the extent possible, to the scope of the repair or alteration. These incorporations by reference do not include any later amendments or editions of the incorporated matter.
- B. Every owner or operator of an elevator, escalator, dumbwaiter, moving walk, material lift, special purpose personnel elevator, or dumbwaiter with automatic transfer device installed, repaired, or altered between May 5, 2009, and December 31, 2022, shall comply with either: (1) ASME A17.1-2019 (Safety Code for Elevators and Escalators); (2) ASME A17.1-2007 (Safety Code for Elevators and Escalators); or (3) ASME

A17.7-2007 (Performance-Based Safety Code for Elevators and Escalators), as referenced in ASME A17.1-2019 and ASME A17.1-2007, which are incorporated by reference. For purposes of a repair or alteration, compliance with the specified standard shall apply, to the extent possible, to the scope of the repair or alteration. These incorporations by reference do not include any later amendments or editions of the incorporated matter.

- C. Every owner or operator of an elevator, escalator, dumbwaiter, moving walk, material lift, special purpose personnel elevator, or dumbwaiter with automatic transfer device installed, repaired, or altered before May 5, 2009, shall comply with either: (1) ASME A17.1-2019 (Safety Code for Elevators and Escalators); (2) ASME A17.1-2007 (Safety Code for Elevators and Escalators); (3) ASME A17.7-2007 (Performance-Based Safety Code for Elevators and Escalators), as referenced in ASME A17.1-2019 and A17.1-2007; or (4) the version of ASME A17.1 (Safety Code for Elevators and Escalators) in effect at the time of installation, which are incorporated by reference. For purposes of a repair or alteration, compliance with the specified standard shall apply, to the extent possible, to the scope of the repair or alteration. These incorporations by reference do not include any later amendments or editions of the incorporated matter.
- D. For installations of a residential elevator, escalator, dumbwaiter, moving walk, material lift, or dumbwaiter with an automatic transfer device, installed after February 6, 2020, the distance between the hoistway face of the hoistway doors and the hoistway edge of the landing sill shall not exceed 19 mm (0.75 in.) for swinging doors and 57 mm (2.25 in.) for sliding doors.
- E. A copy of the referenced material is available for review at the Industrial Commission of Arizona, 800 West Washington Street, Phoenix, Arizona 85007, and may be obtained from ASME at Three Park Avenue, New York, New York 10016-5990 or at <http://www.asme.org>.

Historical Note

Former Rule R4-13-507 repealed, new Section R4-13-507 adopted effective November 9, 1979 (Supp. 79-6). Amended effective March 30, 1981 (Supp. 81-2). Amended effective June 23, 1983 (Supp. 83-3). Amended effective July 24, 1985 (Supp. 85-4). Amended effective September 5, 1989 (Supp. 89-3). Amended effective March 20, 1992 (Supp. 91-2). R20-5-507 recodified from R4-13-507 (Supp. 95-1). Amended effective October 8, 1996 (Supp. 96-4). Amended by final rulemaking at 5 A.A.R. 2935, effective August 4, 1999 (Supp. 99-3). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2). Amended by final rulemaking at 25 A.A.R. 2182, with an immediate effective date of August 6, 2019 (Supp. 19-3). Amended by final rulemaking at 26 A.A.R. 311, with an immediate effective date of February 6, 2020 (Supp. 20-1). Amended by final rulemaking at 29 A.A.R. 512 (February 3, 2023), within an immediate effective date of January 9, 2023 (Supp. 23-1).

R20-5-508. Safety Standard for Manlifts

- A. Every owner or operator of a manlift installed, repaired, or altered on or after January 1, 2023, shall comply with ASME A90.1-2015 (Safety Standard for Belt Manlifts), which is incorporated by reference. For purposes of a repair or alteration, compliance with the specified standard shall apply, to the extent possible, to the scope of the repair or alteration. This

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incorporation by reference does not include any later amendments or editions of the incorporated matter.

- B. Every owner or operator of a manlift installed, repaired, or altered prior to January 1, 2023, shall comply with either: (1) ASME A90.1-2015 (Safety Standard for Belt Manlifts); or (2) ASME A90.1-2003 (Safety Standard for Belt Manlifts), which are incorporated by reference. For purposes of a repair or alteration, compliance with the specified standard shall apply, to the extent possible, to the scope of the repair or alteration. These incorporations by reference do not include any later amendments or editions of the incorporated matter.
- C. A copy of the referenced material is available for review at the Industrial Commission of Arizona, 800 West Washington Street, Phoenix, Arizona 85007, and ASME at Three Park Avenue, New York, New York 10016-5990 or at <http://www.asme.org>.

Historical Note

Adopted effective November 9, 1979 (Supp. 79-6). R20-5-508 recodified from R4-13-508 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15

A.A.R. 872, effective May 5, 2009 (Supp. 09-2).

Amended by final rulemaking at 29 A.A.R. 512 (February 3, 2023), within an immediate effective date of January 9, 2023 (Supp. 23-1).

R20-5-509. Safety Requirements for Personnel Hoists and Employee Elevators for Construction and Demolition Operations

- A. Every owner or operator of a personnel hoist or employee elevator for construction and demolition operation installed, repaired, or altered on or after January 1, 2023, shall comply with ANSI A10.4-2016 (Safety Requirements for Personnel Hoists and Employee Elevators for Construction and Demolition Sites), which is incorporated by reference. For purposes of a repair or alteration, compliance with the specified standard shall apply, to the extent possible, to the scope of the repair or alteration. This incorporation by reference does not include any later amendments or editions of the incorporated matter.
- B. Every owner or operator of a personnel hoist or employee elevator for construction and demolition operation installed prior to January 1, 2023, shall comply with either: (1) ANSI A10.4-2016 (Safety Requirements for Personnel Hoists and Employee Elevators for Construction and Demolition Sites); or (2) ANSI A10.4-2007 (Safety Requirements for Personnel Hoists and Employee Elevators for Construction and Demolition Sites), which are incorporated by reference. For purposes of a repair or alteration, compliance with the specified standard shall apply, to the extent possible, to the scope of the repair or alteration. These incorporations by reference do not include any later amendments or editions of the incorporated matter.
- C. A copy of the referenced material is available for review at the Industrial Commission of Arizona, 800 West Washington Street, Phoenix, Arizona 85007, and ANSI at 25 West 43rd Street, 4th Floor, New York, New York, 10036 or at <http://www.ansi.org>.

Historical Note

Adopted effective November 9, 1979 (Supp. 79-6). Amended effective June 23, 1983 (Supp. 83-3). R20-5-509 recodified from R4-13-509 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2).

Amended by final rulemaking at 29 A.A.R. 512 (February 3, 2023), within an immediate effective date of January 9, 2023 (Supp. 23-1).

R20-5-510. Safety Requirements for Material Hoists

- A. Every owner or operator of a material hoist installed, repaired, or altered on or after January 1, 2023, shall comply with ANSI A10.5-2020 (Safety Requirements for Material Hoists), which is incorporated by reference. For purposes of a repair or alteration, compliance with the specified standard shall apply, to the extent possible, to the scope of the repair or alteration. This incorporation by reference does not include any later amendments or editions of the incorporated matter.
- B. Every owner or operator of a material hoist installed, repaired, or altered prior to January 1, 2023, shall comply with either: (1) ANSI A10.5-2020 (Safety Requirements for Material Hoists); or (2) ANSI A10.5-2006 (Safety Requirements for Material Hoists), which are incorporated by reference. For purposes of a repair or alteration, compliance with the specified standard shall apply, to the extent possible, to the scope of the repair or alteration. These incorporations by reference do not include any later amendments or editions of the incorporated matter.
- C. A copy of the referenced material is available for review at the Industrial Commission of Arizona, 800 West Washington Street, Phoenix, Arizona 85007, and ANSI at 25 West 43rd Street, 4th Floor, New York, New York, 10036 or at <http://www.ansi.org>.

Historical Note

Adopted effective November 9, 1979 (Supp. 79-6). Amended effective June 23, 1983 (Supp. 83-3). R20-5-510 recodified from R4-13-510 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2). Amended by final rulemaking at 29 A.A.R. 512 (February 3, 2023), within an immediate effective date of January 9, 2023 (Supp. 23-1).

R20-5-511. Repealed**Historical Note**

Adopted effective March 30, 1981 (Supp. 81-2). R20-5-511 recodified from R4-13-511 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 381, effective March 15, 2003 (Supp. 03-1). Amended by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2). Repealed by final rulemaking at 29 A.A.R. 512 (February 3, 2023), within an immediate effective date of January 9, 2023 (Supp. 23-1).

R20-5-512. Expired**Historical Note**

Adopted effective March 30, 1981 (Supp. 81-2). R20-5-512 recodified from R4-13-512 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 11 A.A.R. 2320, effective May 19, 2005 (Supp. 05-2).

R20-5-513. Firefighters' Emergency Operation

All conveyances equipped with firefighters' emergency operation shall utilize the AZFS key.

Historical Note

New Section made by final rulemaking at 15 A.A.R. 872, effective May 5, 2009 (Supp. 09-2). Amended by final rulemaking at 29 A.A.R. 512 (February 3, 2023), within an immediate effective date of January 9, 2023 (Supp. 23-1).

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1).

R20-5-514. Standard for Elevator Suspension, Compensation, and Governor Systems

- A.** Every owner or operator of an elevator with elevator suspension, compensation, or governor systems installed, repaired, or altered on or after the effective date of this subsection shall comply with ASME A17.6-2017 (Standard for Elevator Suspension, Compensation, and Governor Systems), which is incorporated by reference. For purposes of a repair or alteration, compliance with the specified standard shall apply, to the extent possible, to the scope of the repair or alteration. This incorporation by reference does not include any later amendments or editions of the incorporated matter.
- B.** A copy of the referenced material is available for review at the Industrial Commission of Arizona, 800 West Washington Street, Phoenix, Arizona 85007, and ASME at Three Park Avenue, New York, New York 10016-5990 or at <http://www.asme.org>.

Historical Note

New Section made by final rulemaking at 29 A.A.R. 512 (February 3, 2023), within an immediate effective date of January 9, 2023 (Supp. 23-1).

R20-5-515. Safety Requirements for Stage and Orchestra Lifts

- A.** Every owner or operator of a stage lift installed, repaired, or altered on or after the effective date of this section shall comply with ANSI E1.42-2018 (Entertainment Technology - Design, Installation, and Use of Orchestra Pit Lifts), which is incorporated by reference. For purposes of a repair or alteration, compliance with the specified standard shall apply, to the extent possible, to the scope of the repair or alteration. This incorporation by reference does not include any later amendments or editions of the incorporated matter.
- B.** A copy of the reference material is available for review at the Industrial Commission of Arizona, 800 West Washington Street, Phoenix, Arizona 85007, and ANSI at 25 West 43rd Street, 4th Floor, New York, New York, 10036 or at <http://www.ansi.org>.

Historical Note

New Section made by final rulemaking at 29 A.A.R. 512 (February 3, 2023), within an immediate effective date of January 9, 2023 (Supp. 23-1).

ARTICLE 6. OCCUPATIONAL SAFETY AND HEALTH STANDARDS**R20-5-601. The Federal Occupational Safety and Health Standards for Construction, 29 CFR 1926**

Each employer shall comply with the standards in the Federal Occupational Safety and Health Standards for Construction, as published in 29 CFR 1926, with amendments as of February 24, 2021, incorporated by reference. Copies of these referenced materials are available for review at the Industrial Commission of Arizona and may be obtained from the United States Government Printing Office, Superintendent of Documents, Washington, D.C. 20402. These standards shall apply to all conditions and practices related to construction activity by all employers, both public and private, in the state of Arizona. This incorporation by reference does not include amendments or editions to 29 CFR 1926 published after February 24, 2021.

Historical Note

Editorial correction (Supp. 75-1). Amended as an emergency effective November 16, 1977 pursuant to A.R.S. §

41-1003, valid for only 90 days (Supp. 77-6). Amended as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-601 repealed, former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). Amended effective June 17, 1981 (Supp. 81-3). Amended effective November 14, 1984 (Supp. 84-6). Amended effective March 3, 1987 (Supp. 87-1). Amended effective April 22, 1988; amended effective May 26, 1988 (Supp. 88-2). Amended effective October 14, 1988 (Supp. 88-4). Amended effective September 14, 1989 (Supp. 89-3). Amended effective April 2, 1990 (Supp. 90-2). Amended effective August 6, 1990 (Supp. 90-3). Amended effective February 8, 1991 (Supp. 91-1). Amended effective November 21, 1991 (Supp. 91-4). Amended effective February 28, 1992 (Supp. 91-2). Amended effective October 22, 1992; amended effective December 23, 1992 (Supp. 92-4). Amended effective September 13, 1993 (Supp. 93-3). Amended effective October 21, 1993; amended effective December 17, 1993 (Supp. 93-4). Amended effective May 11, 1994 (Supp. 94-2). Amended effective November 18, 1994 (Supp. 94-4). Amended effective January 12, 1995; R20-5-601 recodified from R4-13-601 (Supp. 95-1). Amended effective August 28, 1996 (Supp. 96-3). Amended effective April 1, 1997 (Supp. 97-2). Amended effective December 12, 1997 (Supp. 97-4). Amended effective August 27, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 592, effective January 14, 2000 (Supp. 00-1). Amended by final rulemaking at 8 A.A.R. 851, effective February 5, 2002 (Supp. 02-1). Amended by final rulemaking at 9 A.A.R. 2108, effective June 2, 2003 (Supp. 03-2). Amended by final rulemaking at 12 A.A.R. 4102, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 1417, effective March 30, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 2711, effective June 17, 2008 (Supp. 08-2). Amended by final rulemaking at 16 A.A.R. 1469, effective September 11, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1264, effective June 13, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 1492, effective August 5, 2012 by Notice of Public Information at 18 A.A.R. 1653 (Supp. 12-2). Amended by final rulemaking at 18 A.A.R. 3007, effective October 24, 2012 (Supp. 12-4). Amended by final rulemaking at 22 A.A.R. 773, effective March 16, 2016 (Supp. 16-1). Amended by final rulemaking at 22 A.A.R. 1391, effective May 10, 2016 (Supp. 16-2). Amended by final rulemaking at 24 A.A.R. 2316, effective July 23, 2018 (Supp. 18-3). Amended by final rulemaking at 26 A.A.R. 373, with an immediate effective date of February 11, 2020 (Supp. 20-1). Amended by final rulemaking at 28 A.A.R. 1761 (July 22, 2022), with an immediate effective date of July 8, 2022 (Supp. 22-3).

R20-5-601.01. Expired**Historical Note**

New Section made by exempt rulemaking at 18 A.A.R. 1144, effective May 25, 2012 (Supp. 12-2). Section expired under A.R.S. § 41-1056(J) at 26 A.A.R. 290, effective January 15, 2020 (Supp. 20-1).

R20-5-602. The Federal Occupational Safety and Health

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Standards for General Industry, 29 CFR 1910

Each employer shall comply with the standards in Subparts B through Z inclusive of the Federal Occupational Safety and Health Standards for General Industry, as published in 29 CFR 1910, with amendments as of July 14, 2020, incorporated by reference. Copies of these reference materials are available for review at the Industrial Commission of Arizona and may be obtained from the United States Government Printing Office, Superintendent of Documents, Washington, D.C. 20402. These standards shall apply to all conditions and practices related to general industry activity by all employers, both public and private, in the state of Arizona; provided that this Section shall not apply to those conditions and practices which are the subject of R20-5-601. This incorporation by reference does not include amendments or editions to 29 CFR 1910 published after July 14, 2020.

Historical Note

Editorial correction (Supp. 75-1). Amended as an emergency effective November 16, 1977 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). New Section R4-13-602 adopted effective July 30, 1980 (Supp. 80-4). Amended as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-602 repealed, former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). Amended effective June 17, 1981 (Supp. 81-3). Amended subsection (A) effective October 1, 1981 (Supp. 81-5). Amended subsection (A) effective March 5, 1982 (Supp. 82-2). Amended subsection (A) effective May 6, 1983 (Supp. 83-3). Amended subsection (A) effective April 6, 1984 (Supp. 84-2). Amended subsection (A) effective July 3, 1984 (Supp. 84-4). Amended subsection (A) effective October 18, 1984 (Supp. 84-5). Editorial correction, amendment October 18, 1984, withdrawn for subsequent certification. Amended effective November 14, 1984, and December 14, 1984 (Supp. 84-6). Amended subsection (A) effective June 9, 1986 (Supp. 86-3). Amended subsection (A) effective March 3, 1987 (Supp. 87-1). Amended subsection (A) effective June 26, 1987 (Supp. 87-2). Amended subsection (A) effective April 22, 1988; amended subsection (A) effective May 26, 1988 (Supp. 88-2). Amended subsection (A) effective October 14, 1988 (Supp. 88-4). Amended effective September 14, 1989 (Supp. 89-3). Amended effective April 2, 1990 (Supp. 90-2). Amended effective August 6, 1990 (Supp. 90-3). Amended effective February 8, 1991 (Supp. 91-1). Amended effective November 21, 1991 (Supp. 91-4). Amended effective February 28, 1992 (Supp. 91-2). Amended effective March 20, 1992 (Supp. 91-2). Amended effective June 16, 1992 (Supp. 92-2). Amended effective October 22, 1992; amended effective December 23, 1992 (Supp. 92-4). Amended effective May 14, 1993 (Supp. 93-2). Amended effective September 13, 1993 (Supp. 93-3). Amended effective October 21, 1993; amended effective December 17, 1993 (Supp. 93-4). Amended effective May 11, 1994 (Supp. 94-2). Amended effective July 19, 1994 (Supp. 94-3). Amended effective November 18, 1994 (Supp. 94-4). Amended effective January 12, 1995; Amended effective February 10, 1995; R20-5-602 recodified from R4-13-602 (Supp. 95-1). Amended effective August 28, 1996 (Supp. 96-3). Amended effective April 1, 1997 (Supp. 97-2). Amended effective December 12, 1997 (Supp. 97-4). Amended effective August 27, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 592, effective January 14,

2000 (Supp. 00-1). Amended by final rulemaking at 7 A.A.R. 5137, effective October 19, 2001 (Supp. 01-4). Amended by final rulemaking at 9 A.A.R. 2108, effective June 2, 2003 (Supp. 03-2). Amended by final rulemaking at 11 A.A.R. 576, effective January 4, 2005 (Supp. 05-1). Amended by final rulemaking at 12 A.A.R. 4102, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 1417, effective March 30, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 2927, effective July 31, 2007 (07-3). Amended by final rulemaking at 14 A.A.R. 193, effective January 8, 2008 (Supp. 08-1). Amended by final rulemaking at 14 A.A.R. 2711, effective June 17, 2008 (Supp. 08-2). Amended by final rulemaking at 14 A.A.R. 4337, effective December 30, 2008 (Supp. 08-4). Amended by final rulemaking at 15 A.A.R. 1564, effective August 31, 2009 (Supp. 09-3). Amended by final rulemaking at 16 A.A.R. 1469, effective September 11, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 109, effective January 12, 2011 (Supp. 11-1). Amended by final rulemaking at 17 A.A.R. 1264, effective June 13, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 1492, effective August 5, 2012 by Notice of Public Information at 18 A.A.R. 1653 (Supp. 12-2). Amended by final rulemaking at 18 A.A.R. 3007, effective October 24, 2012 (Supp. 12-4). Amended by final rulemaking at 22 A.A.R. 773, effective March 16, 2016 (Supp. 16-1). Amended by final rulemaking at 24 A.A.R. 2316, effective July 23, 2018 (Supp. 18-3). Amended by final rulemaking at 26 A.A.R. 373, with an immediate effective date of February 11, 2020 (Supp. 20-1). Amended by final rulemaking at 28 A.A.R. 1761 (July 22, 2022), with an immediate effective date of July 8, 2022 (Supp. 22-3).

R20-5-602.01. Subpart T, Commercial Diving Operations

Each employer shall comply with the standards in Subpart T of the Federal Occupational Safety and Health Standards for the General Industry as published in 29 CFR 1910, with amendments as specified in R20-5-602, except that the exemption set forth in 29 CFR 1910.401(a)(2)(ii) shall not apply. Subpart T shall apply to any diving operation performed solely for search, rescue, or related public safety purposes by or under the control of a governmental agency.

Historical Note

New Section made by final rulemaking at 14 A.A.R. 193, effective January 8, 2008 (Supp. 08-1).

R20-5-602.02. Subpart U; COVID-19 Healthcare Standards

Unless expired or withdrawn by the Federal Occupational Safety and Health Administration and except as otherwise provided in Arizona Revised Statutes (A.R.S.), Title 23, Chapter 2, Articles 8 and 8.1 and A.R.S. § 23-425, each covered employer shall comply with the standards in Subpart U of the Federal Occupational Safety and Health Standards for the General Industry, as published in 29 CFR 1910(U). For purposes of this Section, a “covered employer” means an employer subject to Subpart U, as set forth in 29 CFR 1910.502. Copies of the referenced material is available for review at the Industrial Commission of Arizona and may be obtained from the United States Government Printing Office, Superintendent of Documents, Washington, D.C. 20402. This incorporation by reference does not include amendments or editions to 29 CFR 1910(U) published after June 21, 2021.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 589 (March 31, 2022), with an immediate effective date of February 16, 2022 (Supp. 22-1).

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R20-5-603. The Federal Occupational Safety and Health Standards for Agriculture, 29 CFR 1928

Each employer shall comply with the standards in Subparts A through D inclusive of the Federal Occupational Safety and Health Standards for Agriculture, as published in 29 CFR 1928, with amendments as of March 7, 1996, incorporated by reference and on file with the Office of the Secretary of State. Copies of these referenced materials are available for review at the Industrial Commission of Arizona and may be obtained from the United States Government Printing Office, Superintendent of Documents, Washington, D.C. 20402. This incorporation by reference does not include amendments or editions to 29 CFR 1928 published after March 7, 1996.

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1). Former Section R4-13-603 repealed, new Section R4-13-603 adopted as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-603 repealed, former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). Amended effective April 22, 1988 (Supp. 88-2). Amended effective December 17, 1993 (Supp. 93-4). Amended effective May 11, 1994 (Supp. 94-2). Amended effective November 18, 1994 (Supp. 94-4). Amended effective February 10, 1995. R20-5-603 recodified from R4-13-603 (Supp. 95-1). Amended effective April 1, 1997 (Supp. 97-2).

R20-5-604. Rules of Agency Practice and Procedure concerning OSHA Access to Employee Medical Records, 29 CFR 1913

Each employer pursuant to A.R.S. § 23-403(B) shall comply with Federal Regulations, Title 29, Part 1913, with amendments as of May 23, 1980 (amendments of May 23, 1980 on file with the Secretary of State), which are hereby adopted and incorporated by reference as if set forth fully herein. This regulation applies to OSHA Access to Employee Medical Records.

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Repealed as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Repealed effective March 2, 1981 (Supp. 81-2). New rule adopted effective November 14, 1984 (Supp. 84-6). R20-5-604 recodified from R4-13-604 (Supp. 95-1).

R20-5-605. Hoes for Weeding or Thinning Crops

- A. The use of a hoe with a handle less than four feet in length for weeding or thinning crops is prohibited. This prohibition is based upon the existence of other practical and adequate alternatives to the use of these short-handle hoes.
- B. This rule does not apply to greenhouse or nursery operations.

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1). Repealed as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Repealed effective March 2, 1981 (Supp. 81-2). New Section R4-13-605 adopted effective September 7, 1984 (Supp. 84-5). R20-5-605 recodified from R4-13-605 (Supp. 95-1).

R20-5-606. State Definition of Terms Used in Adopting Fed-**eral Standards Pursuant to R20-5-601, R20-5-602, R20-5-603 and R20-5-604**

For the purposes of the standards enumerated in the federal occupational safety and health standards incorporated into R20-5-601, R20-5-602, R20-5-603, and R20-5-604:

1. "Agency" means the Industrial Commission of Arizona.
2. "Assistant Secretary" means the Director of the Arizona Division of Occupational Safety and Health of the Industrial Commission of Arizona.
3. "Assistant Secretary of Labor for Occupational Safety and Health" means the Director of the Arizona Division of Occupational Safety and Health of the Industrial Commission of Arizona.
4. "Office of the Solicitor of Labor" means Legal Counsel for the Industrial Commission of Arizona.
5. "OSHA" means Arizona Division of Occupational Safety and Health.

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1). Repealed as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Repealed effective March 2, 1981 (Supp. 81-2). New Section R4-13-606 adopted effective May 31, 1985 (Supp. 85-3). R20-5-606 recodified from R4-13-606 (Supp. 95-1).

R20-5-607. Expired**Historical Note**

Adopted effective February 28, 1975 (Supp. 75-1). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-607 repealed, former emergency adoption effective October 29, 1980, adopted and amended effective March 2, 1981 (Supp. 81-2). R20-5-607 recodified from R4-13-607 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 5062, effective September 30, 2003 (Supp. 03-4).

R20-5-608. Definitions

- A. "Act" means the Arizona Occupational Safety and Health Act of 1972, with amendments effective August 27, 1977 (Arizona Revised Statutes, Title 23, Chapter 2, Article 10).
- B. The definitions and interpretations contained in A.R.S. § 23-401 of the Act shall be applicable to such terms when used in these rules.
- C. "Working days" means Mondays through Fridays but shall not include Saturdays, Sundays, or state holidays. In computing fifteen working days, the day of the receipt of any notice shall not be included, and the last day of the fifteen working days shall be included.
- D. "Compliance Safety and Health Officer" means a person authorized by the Occupational Safety and Health Division, Industrial Commission of Arizona, to conduct inspections.
- E. "Establishment" means a single physical location where business is conducted or where services or industrial operations are performed. (For example: a factory, mill, stores, hotel, restaurant, movie theatre, farm, ranch, bank, sales office, warehouse, or central administrative office.) Where distinctly separate activities are performed at a single physical location (such as contract construction activities from the same physical location as a lumber yard), each activity shall be treated as a separate physical establishment, and a separate notice or notices shall be posted in each such establishment, to the extent that such notices have been furnished by the Industrial Commission of Arizona, Division of Occupational Safety and Health.

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Where employers are engaged in activities which are physically dispersed, such as agriculture, construction, transportation, communications, and electric, gas and sanitary services, the notice or notices required by this Section shall be posted at the location to which employees report each day. Where employees do not usually work at, or report to, a single establishment, such as traveling salesmen, technicians, engineers, etc., such notice or notices shall be posted at the location from which the employees operate to carry out their activities. In all cases, such notice or notices shall be posted in accordance with requirements of subsection (A) of this Section.

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1).
 Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-608 repealed, new Section R4-13-608 adopted effective March 2, 1981 (Supp. 81-2). R20-5-608 recodified from R4-13-608 (Supp. 95-1).

R20-5-609. Posting of Notice: Availability of the Act, Regulations and Applicable Standards

- A. Each employer shall post and keep posted a notice or notices, to be furnished by the Industrial Commission of Arizona, Division of Occupational Safety and Health, informing employees of the protections and obligations provided for in the Act, and that for assistance and information, including copies of the Act and of specific safety and health standards, employees should contact the employer or the nearest office of the Industrial Commission. Such notice or notices shall be posted by the employer in each establishment in a conspicuous place or places where notices to employees are customarily posted. Each employer shall take steps to ensure that such notices are not altered, defaced, or covered by other material.
- B. Copies of the Act, all regulations published in this Chapter and applicable standards will be available at all offices of the Arizona Division of Occupational Safety and Health. If an employer has obtained copies of these materials, he shall make them available upon request to any employee or his authorized representative for review in the establishment where the employee is employed on the same day the request is made or at the earliest time mutually convenient to the employee or his authorized representative and the employer.
- C. Any employer failing to comply with the provisions of this Section shall be subject to citation and penalty in accordance with the provisions of A.R.S. § 23-418 of the Act.

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1).
 Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-609 repealed, former Section R4-13-608 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-609 effective March 2, 1981 (Supp. 81-2). R20-5-609 recodified from R4-13-609 (Supp. 95-1).

R20-5-610. Authority for Inspection

- A. The Director of the Division of Occupational Safety and Health or his authorized representative upon presentation of credentials shall be permitted to enter without delay and at reasonable times any factory, plant, establishment, construction site, or other area, or place of environment where work is performed by an employee of an employer; to inspect and investi-

gate during regular working hours and in a reasonable manner, any such place of employment, and all pertinent conditions, structures, machines, apparatus, devices, equipment and materials therein; to question privately any employer, owner, operator, agent or employee and to review records required by the Act and regulations published in this Article and other records which are directly related to the purpose of the inspection.

- B. Representatives of the Secretary of Health, Education, and Welfare are authorized to make inspections and to question employers and employees in order to carry out the functions of the Secretary of Health, Education, and Welfare under the Williams-Steiger Occupational Safety and Health Act. Inspections conducted by Department of Labor Compliance Safety and Health Officers and representatives of the Secretary of Health, Education and Welfare under Section 8 of the Williams-Steiger Occupational Safety and Health Act and pursuant to 29 CFR Part 1903 shall not affect the authority of any state to conduct inspections in accordance with agreements and plans under Section 18 of the Williams-Steiger Occupational Safety and Health Act.
- C. Prior to inspecting areas containing information which is classified by an agency of the United States government in the interests of national security, Compliance Safety and Health Officers shall have obtained the appropriate security clearance.

Historical Note

Adopted effective February 28, 1975 (Supp. 75-1).
 Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-610 repealed, former Section R4-13-609 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-610 effective March 2, 1981 (Supp. 81-2). R20-5-610 recodified from R4-13-610 (Supp. 95-1).

R20-5-611. Objection to Inspection

- A. Upon a refusal to permit a Compliance Safety and Health Officer, in the exercise of his official duties, to enter without delay and at reasonable times any place of employment or any place therein, to inspect, to review records, or to privately question any employer, owner, operator, agent, or employee, in accordance with rule R20-5-610, or to permit a representative of employees to accompany the Compliance Safety and Health Officer during the physical inspection of any workplace in accordance with rule R20-5-615, the Compliance Safety and Health Officer shall terminate the inspection or confine the inspection to other areas, conditions, structures, machines, apparatus, devices, equipment, materials, records, or interviews concerning which no objection is raised. The Compliance Safety and Health Officer shall endeavor to ascertain the reason for such refusal and shall immediately report the refusal and the reason therefore to the Director of the Division. The Director shall immediately consult with the Industrial Commission and its legal counsel, who shall promptly take appropriate action, including compulsory process if necessary.
- B. Compulsory process may be sought in advance of an inspection or reinvestigation if, in the judgment of the Director of the Division and the Industrial Commission Chief Legal Counsel, circumstances exist including but not limited to specific evidence of an existing violation or reasonable legislative or administrative standards for conducting an inspection which make pre-inspection process desirable or necessary.
- C. With the approval of the Industrial Commission, and the Industrial Commission Chief Legal Counsel, compulsory process may also be obtained by the Director of the Division or his designee.

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- D. For purposes of this Section, the term compulsory process shall mean the institution of any appropriate action, including ex parte application for an inspection warrant or its equivalent.

Historical Note

Adopted effective June 19, 1975 (Supp. 75-1). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6).

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-611 repealed, former Section R4-13-610 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-611 effective March 2, 1981 (Supp. 81-2). R20-5-611 recodified from R4-13-611 (Supp. 95-1).

R20-5-612. Entry Not a Waiver

Any permission to enter, inspect, review records, or question any person shall not imply or be conditioned upon a waiver of any cause of action, citation, or penalty under the Act. Compliance Safety and Health Officers are not authorized to grant any such waiver.

Historical Note

Adopted effective June 19, 1975 (Supp. 75-1). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6).

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-612 repealed, former Section R4-13-611 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-612 effective March 2, 1981 (Supp. 81-2). R20-5-612 recodified from R4-13-612 (Supp. 95-1).

R20-5-613. Advance Notice of Inspections

- A. Advance notice of inspections may not be given except in the following situations:
1. In cases of apparent imminent danger, to enable the employer to abate the danger as quickly as possible;
 2. In circumstances where the inspection can most effectively be conducted after regular business hours or where special preparations are necessary for an inspection;
 3. Where necessary to ensure the presence of representatives of the employer and employees or the appropriate personnel needed to aid in an inspection; and
 4. In other circumstances where the Division Director determines that the giving of advance notice would enhance the probability of an effective and thorough inspection.
- B. In the situations described in subsection (A) of this Section, advance notice of inspections may be given only if authorized by the Division Director. When advance notice is given, it shall be the employer's responsibility promptly to notify the authorized representative of employees of the inspection, if the identity of such representative is known to the employer. (See rule R20-5-615(B) as to situations where there is no authorized representative of employees.) Upon the request of the employer, the Compliance Safety and Health Officer will inform the authorized representative of employees of the inspection, provided that the employer furnishes the Compliance Safety and Health Officer with the identity of such representative and with such other information as is necessary to enable him promptly to inform such representative of the inspection. An employer who fails to comply with his obligation under this subsection promptly to inform the authorized representative of the employees of the inspection or to furnish such information as is necessary to enable the Compliance Safety and Health Officer to promptly inform such representa-

tive of the inspection may be subject to citation and penalty under A.R.S. § 23-408 of the Act. Advance notice in any of the situations described in subsection (A) of this Section shall not be given more than 24 hours before the inspection is scheduled to be conducted, except in apparent imminent danger situations and other unusual circumstances.

Historical Note

Adopted effective July 28, 1975 (Supp. 75-1). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6).

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-613 repealed, former Section R4-13-612 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-613 effective March 2, 1981 (Supp. 81-2). R20-5-613 recodified from R4-13-613 (Supp. 95-1).

R20-5-614. Conduct of Inspections

- A. At the beginning of an inspection, Compliance Safety and Health Officers shall present their credentials to the owner, operator, or agent in charge at the establishment; explain the nature and purpose of the inspection; and indicate generally the scope of the inspection and the records specified in rule R20-5-610 which they wish to review.
- B. Compliance Safety and Health Officers shall have authority to take environmental samples and to take or obtain photographs related to the purpose of the inspection, employ other reasonable investigative techniques, and question privately any employer, owner, operator, agent or employee of an establishment.
- C. In taking photographs and samples, Compliance Safety and Health Officers shall take reasonable precautions to ensure that such actions with flash, spark producing, or other equipment would not be hazardous. Compliance Safety and Health Officers shall comply with all employer safety and health rules and practices at the establishment being inspected, and they shall wear and use appropriate protective clothing and equipment.
- D. The conduct of inspections shall be such as to preclude unreasonable disruption to the operations of the employer's establishment.
- E. At the conclusion of an inspection, a Compliance Safety and Health Officer shall confer with the employer or his representative and informally advise him of any apparent safety or health violations disclosed by the inspection. During such conference, the employer shall be afforded an opportunity to bring to the attention of the Compliance Safety and Health Officer any pertinent information regarding conditions in the workplace.

Historical Note

Adopted effective March 2, 1976 (Supp. 76-2). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6).

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-614 repealed, former Section R4-13-613 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-614 effective March 2, 1981 (Supp. 81-2). R20-5-614 recodified from R4-13-614 (Supp. 95-1).

R20-5-615. Representatives of Employers and Employees

- A. Compliance Safety and Health Officers shall be in charge of inspections and questioning of persons. A Compliance Safety

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and Health Officer may permit additional employer representatives and additional representatives authorized by employees to accompany him where he determines that such additional representatives will further aid the inspection. A different employer and employee representative may accompany the Compliance Officer during each different phase of an inspection if this will not interfere with the conduct of the inspection.

- B. Compliance Safety and Health Officers shall have authority to resolve all disputes as to who is the representative authorized by the employer and employees for the purpose of this rule. If there is no authorized representative of employees, or if the Compliance Safety and Health Officer is unable to determine with reasonable certainty who is such representative, he shall consult with a reasonable number of employees concerning matters of safety and health in the workplace.
- C. The representative(s) authorized by employees shall be an employee(s) of the employer. However, if in the judgment of the Compliance Safety and Health Officer, good cause has been shown why accompaniment by a third party who is not an employee is reasonably necessary to the conduct of an effective and thorough physical inspection of the workplace, such third party may accompany the Compliance Safety and Health Officer during the inspection.
- D. Compliance Safety and Health Officers are authorized to deny the right of accompaniment under this Section to any person whose conduct interferes with a fair and orderly inspection. The right of accompaniment in areas containing trade secrets shall be subject to the provisions of rule R20-5-616(B). With regard to information classified by an agency of the United States government in the interest of national security, only persons authorized to have access to such information may accompany a Compliance Safety and Health Officer in areas containing such information.

Historical Note

Adopted effective March 2, 1976 (Supp. 76-2). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6).

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-615 repealed, former Section R4-13-614 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-615 effective March 2, 1981 (Supp. 81-2).

R20-5-615 recodified from R4-13-615 (Supp. 95-1).

R20-5-616. Trade Secrets

- A. At the commencement of an inspection, the employer may identify areas in the establishment which contain or which might reveal a trade secret. If the Compliance Safety and Health Officer has no clear reason to question such identification, information obtained in such areas, including all negatives and prints of photographs, environmental samples, shall be labeled "confidential-trade secret" and shall not be disclosed except in accordance with provisions of A.R.S. § 23-426.
- B. Upon the request of an employer, any authorized representative of employees under rule R20-5-615 in an area containing trade secrets shall be an employee in that area or an employee authorized by the employer to enter that area. Where there is no such representative or employee, a Compliance Safety and Health officer shall consult with a reasonable number of employees who work in that area concerning matters of safety and health.

Historical Note

Adopted effective March 2, 1976 (Supp. 76-2). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6).

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-616 repealed, former Section R4-13-615 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-616 effective March 2, 1981 (Supp. 81-2). R20-5-616 recodified from R4-13-616 (Supp. 95-1).

R20-5-617. Consultation with Employees

Compliance Safety and Health Officers may privately consult with employees concerning matters of occupational safety and health to the extent they deem necessary for the conduct of an effective and thorough inspection. During the course of an inspection, any employee shall be afforded an opportunity to bring any violation of the Act, which he has reason to believe exists in the workplace, to the attention of the Compliance Safety and Health Officer.

Historical Note

Adopted effective January 21, 1976 (Supp. 76-1). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-617 repealed, former Section R4-13-616 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-617 effective March 2, 1981 (Supp. 81-2). R20-5-617 recodified from R4-13-617 (Supp. 95-1).

R20-5-618. Complaints by Employees

- A. A copy of a complaint submitted pursuant to A.R.S. § 23-408(E) shall be provided to the employer or his agent by the Director of the Division of Occupational Safety and Health or his representative no later than the time of inspection, except that, upon the request of the person giving such notice, his name shall not appear in such copy or in any record published, released, or made available by the Arizona Division of Occupational Safety and Health.
- B. If upon receipt of such notification the Division Director determines that the complaint meets the requirements set forth in subsection (A) of this rule, and that there are reasonable grounds to believe that the alleged violation exists, he shall cause an inspection to be made as soon as practicable, to determine if such alleged violation exists. Inspections under this rule shall not be limited to matters referred to in the complaint.

Historical Note

Adopted effective January 21, 1976 (Supp. 76-1). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-618 repealed, former Section R4-13-617 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-618 effective March 2, 1981 (Supp. 81-2). R20-5-618 recodified from R4-13-618 (Supp. 95-1).

R20-5-619. Inspection Not Warranted; Informal Review

If the Division Director determines that an inspection is not warranted because there are no reasonable grounds to believe that a violation or danger exists with respect to a complaint in accordance with A.R.S. § 23-408(E), he shall notify the complaining party in

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writing of such determination. The complaining party may obtain review of such determination by submitting a written statement of position with the Industrial Commission and, at the same time, providing the employer with a copy of such statement by certified mail. The employer may submit an opposing written statement of position with the Industrial Commission and, at the same time, provide the complaining party with a copy of such statement by certified mail. Upon the request of the complaining party or the employer, the Industrial Commission, at their discretion, may hold an informal conference in which the complaining party and the employer may orally present their views. After considering all written and oral views presented, the Industrial Commission shall affirm, modify, or reverse the determination of the Division Director and furnish the complaining party and the employer a written notification of their decision and the reasons therefore. The decision of the Industrial Commission shall be final and not subject to further review. Such determination shall be without prejudice to the filing of a new complaint meeting the requirements of A.R.S. § 23-408(E).

Historical Note

Adopted effective May 25, 1977 (Supp. 77-3). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-619 repealed, former Section R4-13-618 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-619 effective March 2, 1981 (Supp. 81-2). R20-5-619 recodified from R4-13-619 (Supp. 95-1).

R20-5-620. Expired**Historical Note**

Adopted effective May 25, 1977 (Supp. 77-3). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-620 repealed, former Section R4-13-619 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-620 effective March 2, 1981 (Supp. 81-2). R20-5-620 recodified from R4-13-620 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 5062, effective September 30, 2003 (Supp. 03-4).

R20-5-621. Citations: Notices of De Minimis Violations

- A. The Division Director shall review the inspection reports of the Compliance Safety and Health Officer. If, on the basis of the report, the Division Director believes that the employer has violated a requirement of A.R.S. § 23-403 of the Act, of any standard, rule or order promulgated pursuant to A.R.S. § 23-410 of the Act, or of any substantive rule published in these rules, he shall, if appropriate, consult with the Industrial Commission's counsel and shall issue to the employer either a citation or notice of de minimis violations. An appropriate citation or notice of de minimis violation shall be issued even though after being informed of an alleged violation by the Compliance Safety and Health Officer, the employer immediately abates, or initiates steps to abate, such alleged violation. Any citation or notice of de minimis violations shall be issued with reasonable promptness after termination of the inspection. No citation may be issued under this rule after the expiration of six months following the occurrence of any alleged violation.

- B. If a citation or notice of de minimis violation issued for a violation alleged in a request for inspection under A.R.S. § 23-408(E), a copy of the citation or notice of de minimis violation shall also be sent to the employee or representative of employees who made such request or notification.
- C. After an inspection, if the Division Director determines that a citation is not warranted with respect to a danger or violation alleged to exist in a request for inspection under A.R.S. § 23-408(E), the informal review procedures prescribed in rule R20-5-619(A) shall be applicable. After considering all views presented, the Industrial Commission shall affirm the determination of the Division Director, order a reinspection, or issue a citation if the Industrial Commission believes that the inspection disclosed a violation. The Industrial Commission shall furnish the complaining party and the employer with a written notification of their determination and the reasons therefore. The determination of the Industrial Commission shall be final and not subject to review.
- D. Every citation shall state that the issuance of a citation does not constitute a finding that a violation of the Act has occurred unless there is a failure to contest as provided for in the Act or, if contested, unless a citation is affirmed by the Hearing Division or the Review Commission.

Historical Note

Adopted as an emergency effective May 24, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-3). Repealed as an emergency effective November 16, 1977, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 77-6). Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-620 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-621 effective March 2, 1981 (Supp. 81-2). R20-5-621 recodified from R4-13-621 (Supp. 95-1).

R20-5-622. Proposed Penalties

- A. All employers shall be notified of any proposed penalties, issued pursuant to A.R.S. § 23-418, by certified mail or by a signed verification in person.
- B. The Division Director shall determine the amount of any proposed penalty, giving due consideration to the appropriateness of penalty with respect to the size of the business of the employer being charged, the gravity of the violation, the good faith of the employer, and the history of previous violations in accordance with the provisions of A.R.S. § 23-418 of the Act.
- C. Appropriate penalties may be proposed with respect to an alleged violation even though after being informed of such alleged violation by the Compliance Safety and Health Officer, the employer immediately abates, or initiates steps to abate, such alleged violation. Penalties shall not be proposed for de minimis violations which have no direct or immediate relationship to safety or health.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-621 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-622 effective March 2, 1981 (Supp. 81-2). R20-5-622 recodified from R4-13-622 (Supp. 95-1).

R20-5-623. Posting of Citations

- A. Upon receipt of any citation under the Act, the employer shall immediately post such citation, or a copy thereof, unedited, at

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or near each place an alleged violation referred to in the citation occurred, except as provided below. Where, because of the nature of the employer's operations, it is not practicable to post the citation at or near each place of alleged violation, such citation shall be posted, unedited, in a prominent place where it will be readily observable by all affected employees. For example, where employers are engaged in activities which are physically dispersed, the citation may be posted at the location to which the employees report each day. Where employees do not primarily work at or report to a single location, the citation may be posted at the location from which the employees operate to carry out their activities. The employer shall take steps to ensure that the citation is not altered, defaced, or covered by other material. Notices of de minimis violations need not be posted.

- B. Each citation, or a copy thereof, shall remain posted until the violation has been abated, or for three working days, whichever is later. The filing by the employer of a notice of intention to contest under A.R.S. § 23-471(A) shall not affect his posting responsibility under this rule unless and until the Hearing Division and/or Review Commission issues a final order vacating the citation.
- C. An employer to whom a citation has been issued may post a notice in the same location where such citation is posted indicating that the citation is being contested before the Hearing Division and/or Review Commission, and such notice may explain the reasons for such contest. The employer may also indicate that specified steps have been taken to abate the violation.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-622 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-623 effective March 2, 1981 (Supp. 81-2). R20-5-623 recodified from R4-13-623 (Supp. 95-1).

R20-5-624. Employer and Employee Contests before the Hearing Division

- A. All notices to contest citations and/or penalties shall be submitted to the Division Director and immediately transmitted to the Hearing Division in accordance with the Rules of Procedure prescribed by the Industrial Commission.
- B. Any affected employee or employee representative appealing the period allowed an employer to abate a particular violation shall submit the notice of contest to the Division Director who shall immediately transmit such notice to the Hearing Division in accordance with the Rules of Procedure prescribed by the Industrial Commission.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-623 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-624 effective March 2, 1981 (Supp. 81-2). R20-5-624 recodified from R4-13-624 (Supp. 95-1).

R20-5-625. Failure to Correct a Violation for Which a Citation Has Been Issued

- A. All employers failing to correct an alleged violation for which a citation has been issued, within the period permitted for its correction, shall be notified of such failure and any proposed

penalties issued pursuant to A.R.S. § 23-418 by certified mail or by signed verification in person.

- B. All notices to contest a notification of failure to correct a violation and of proposed additional penalty shall be submitted to the Division Director and immediately transmitted to the Hearing Division in accordance with the Rules of Procedure prescribed by the Industrial Commission.
- C. Each notification of failure to correct a violation and of proposed additional penalty shall state that it shall be deemed to be the final order of the Industrial Commission and not subject to review by any court or agency unless within fifteen working days from the receipt of such notification, the employer notifies the Division Director in writing that he intends to contest the notification or the proposed additional penalty before the Hearing Division.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-624 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-625 effective March 2, 1981 (Supp. 81-2). R20-5-625 recodified from R4-13-625 (Supp. 95-1).

R20-5-626. Informal Conferences

At the request of an affected employer, employee, or representative of employees, the Industrial Commission, or their designee, may hold an informal conference for the purpose of discussing any issues raised by an inspection, citation, notice of proposed penalty, or notice of intention to contest. The settlement of any issue at such conference shall be subject to rules and procedures prescribed by the Industrial Commission. If the conference is requested by the employer, an affected employee or his representative shall be afforded an opportunity to participate, at the discretion of the Industrial Commission or their designee. If the conference is requested by an employee or representative of employees, the employer shall be afforded an opportunity to participate, at the discretion of the Industrial Commission or their designee. Any party may be represented by counsel in such conference. No such conference or request for such conference shall operate as a stay of any fifteen working day period for filing a notice of intention to contest as prescribed in rule R20-5-624.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-625 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-626 effective March 2, 1981 (Supp. 81-2). R20-5-626 recodified from R4-13-626 (Supp. 95-1).

R20-5-627. Abatement Verification

- A. Scope and application. This Section applies to employers, as defined in A.R.S. § 23-401, who receive a citation for a violation of the Arizona Occupational Safety and Health Act.
- B. Definitions:
 1. Abatement means action by an employer to comply with a cited standard or rule or to eliminate a recognized hazard, as defined in A.R.S. § 23-401, identified by the Division during an inspection.
 2. Abatement date means:
 - a. For an uncontested citation item, the later of:
 - i. The date in the citation for abatement of the violation;

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- ii. The date approved by the Division as a result of a petition for modification of the abatement date (PMA); or
 - iii. The date for abatement completion as established in a citation by an informal conference agreement.
 - b. For a contested citation item for which an administrative law judge has issued a final decision affirming the violation, the later of:
 - i. The date identified in the final decision for completion of abatement;
 - ii. The date computed by adding the original period allowed for abatement in the citation to begin 15 days from the final decision date of an administrative law judge; or
 - iii. The date established by a formal settlement agreement.
 - 3. Affected employee means an employee who is exposed to the hazard identified as a violation in a citation.
 - 4. Final order date means:
 - a. The date on which an uncontested citation is deemed final under A.R.S. § 23-417 (A); or
 - b. For a contested citation item: The date on which a decision or order of an administrative law judge becomes final under A.R.S. § 23-421 or § 23-423.
 - 5. Movable equipment means a hand-held or non-hand-held machine or device, powered or unpowered, that is used to do work and is moved within or between workplaces.
- C. Abatement certification.**
- 1. Within 10 calendar days after the abatement date, an employer shall certify to the Division that the employer has abated each cited violation except as provided in subsection (C)(2). An employer may use Appendix A to certify abatement.
 - 2. An employer is not required to certify abatement if a Compliance Safety and Health Officer, during an onsite inspection:
 - a. Observes, within 24 hours after a violation is identified, that abatement has occurred; and
 - b. Notes the abatement action on the citation.
 - 3. An employer's certification that abatement is complete shall include, for each cited violation, in addition to the information required by subsection (H), the completion date and method of abatement and a statement that affected employees and their representatives have been informed of the completed abatement.
- D. Abatement documentation.**
- 1. Within 10 days after the abatement date, an employer shall submit to the Division, documents which evidence that abatement is complete for each willful or repeat violation and for any serious violation for which abatement documentation is required.
 - 2. Documents which evidence that abatement is complete may include documents for purchase or repair of equipment, photographs or videos of the abatement, or other written records.
- E. Abatement plans.**
- 1. The Division may require an employer to submit an abatement plan, except for a nonserious violation, when the time permitted for abatement is more than 90 days. The citation shall state that an abatement plan is required. An employer may use Appendix B for an abatement plan.
 - 2. An employer shall submit an abatement plan for each cited violation within 25 days from the date of a final order when the citation states that a plan is required. In the abatement plan, the employer shall identify:
 - a. The violation,
 - b. The steps necessary to achieve abatement,
 - c. A schedule for completing abatement, and
 - d. How the employer will protect employees from the violative condition until abatement is complete.
- F. Progress reports.**
- 1. The Division may require an employer who submits an abatement plan under subsection (E), to submit periodic progress reports for each cited violation. If the Division requires a periodic progress report, the citation shall include the following information:
 - a. Periodic progress reports are required and the cited violations for which periodic progress reports are required;
 - b. The date on which an initial progress report must be submitted. The date of the initial progress report shall be no sooner than 30 days after the submission date required for abatement;
 - c. Whether additional progress reports are required; and
 - d. The date on which additional progress reports shall be submitted.
 - 2. For each violation, the employer shall summarize in the progress report, the action taken to achieve abatement and the date the action was taken.
- G. Employee notification.**
- 1. An employer shall inform affected employees and the employees' representative of abatement activities covered by this Section by posting a copy of each document submitted to the Division or a summary of the document at the location of the cited violation.
 - 2. For employers who have mobile work operations, the employer shall:
 - a. Post each document or a summary of the document submitted to the Division in a conspicuous place where it can be readily seen by employees and the employee representative; or
 - b. Take other steps to communicate fully to affected employees and the employees' representative about abatement actions.
 - 3. The employer shall inform employees and the employees' representative of the right to examine and copy all abatement documents submitted by the employer to the Division.
 - a. An employee or an employee representative shall submit a written request to examine and copy abatement documents within three working days of receiving notice that the documents have been submitted to the Division.
 - b. An employer shall comply with an employee's or employee representative's written request to examine and copy abatement documents within five working days of receiving the request.
 - 4. An employer shall ensure that notice in subsection (G)(1) to employees and a employee representative is provided at the same time or before the information is provided to the Division and that abatement documents are:
 - a. Not altered, defaced, or physically covered by other material; and
 - b. Remain posted for at least three working days after submission to the Division.
- H. Transmitting abatement documents.**

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1. An employer shall include, in each submission required by this Section, the following information:
 - a. The employer's name and address;
 - b. The inspection number to which the submission relates;
 - c. The citation, item number, and location to which the submission relates;
 - d. A statement that the information submitted is accurate; and
 - e. The signature of the employer or the employer's authorized representative.

2. The date of postmark is the date of submission for mailed documents. For documents transmitted by other means, the date the Division receives the document is the date of submission.

I. Movable equipment.

1. For serious, repeat, and willful violations involving movable equipment, an employer shall attach a warning tag or a copy of the citation to the operating controls or to the cited component of equipment that is moved within or between workplaces. The Division shall deem attaching a copy of the citation to the equipment to meet the tagging requirement of subsection (I)(3) and the posting requirement of R20-5-623.
2. The employer shall use a warning tag to warn employees about the nature of the violation involving the movable equipment and identifies the location of the violation. An employer may use the tag in Appendix C to meet this requirement.
3. If a violation has not been abated, an employer shall attach a warning tag or a copy of the citation to the equipment as follows:
 - a. For hand-held equipment, the employer shall attach a warning tag or copy of the citation within eight hours after the employer receives the citation; and
 - b. For non-hand-held equipment, the employer shall attach a warning tag or copy of the citation before moving the equipment within or between workplaces.
4. For the construction industry, a tag that is designed and used in accordance with 29 CFR 1926.20(b)(3) and 29 CFR 1926.200(h) is deemed by the Division to meet the requirements of this Section when the information required by subsection (I)(2) is included on the tag.
5. An employer shall ensure that the tag or copy of the citation attached to movable equipment is not altered, defaced, or physically covered by other material.
6. An employer shall ensure that the tag or copy of the citation attached to movable equipment remains attached until:
 - a. The employer has abated the violation and all abatement verification documents required by this Section have been submitted to the Division;
 - b. The employer has permanently removed the cited equipment from service or the cited equipment is no longer within the employer's control; or
 - c. The Division, administrative law judge, or Review Board vacates the citation.

Historical Note

Adopted effective June 26, 1998 (Supp. 98-2).

Appendix A. Sample Abatement - Certification Letter (Non-mandatory)

[Name], Director
The Industrial Commission of Arizona

Division of Occupational Safety and Health
P. O. Box 19070
Phoenix, Arizona 85005

[Company's Name]

[Company's Address]

The hazard referenced in Inspection Number [Insert 9-digit #] for violation identified as:

Citation [insert #] and item [insert #] was corrected on [insert date] by:

Citation [insert #] and item [insert #] was corrected on [insert date] by:

Citation [insert #] and item [insert #] was corrected on [insert date] by:

Citation [insert #] and item [insert #] was corrected on [insert date] by:

Citation [insert #] and item [insert #] was corrected on [insert date] by:

I attest that the information contained in this document is accurate.

Signature

Typed or Printed Name

Historical Note

Appendix A adopted effective June 26, 1998 (Supp. 98-2).

Appendix B. Sample Abatement Plan or Progress Report (Nonmandatory)

(Name), Director
The Industrial Commission of Arizona
Division of Occupational Safety and Health
P. O. Box 19070
Phoenix, Arizona 85005

[Company's Name]
[Company's Address]

Check one:

Abatement Plan []

Progress Report []

Inspection Number _____

Page _____ of _____

Citation Number(s)* _____

Item Number(s)* _____

Action	Proposed Completion Date (for abatement plans only)	Completion Date (for progress reports only)
1.
2.
3.

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4.

 5.

Date required for final abatement: _____
 I attest that the information contained in this document
 is accurate.

 Signature

 Typed or Printed Name

Name of primary point of contact for questions: (optional)

Telephone number: _____

*Abatement plans or progress reports for more than one
 citation item may be combined in a single abatement plan
 or progress report if the abatement actions, proposed
 completion dates, and actual completion dates (for pro-
 gress reports only) are the same for each of the citation
 items.

Historical Note

Appendix B adopted effective June 26, 1998 (Supp. 98-
 2).

Appendix C. Sample Warning Tag (Nonmandatory)

<p>0</p> <p>WARNING:</p> <p>EQUIPMENT HAZARD BY ADOSH</p> <p>EQUIPMENT CITED:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>HAZARD CITED:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>FOR DETAILED INFORMATION: SEE ADOSH CITATION POSTED AT:</p> <p>_____</p> <p>_____</p>

BACKGROUND COLOR--ORANGE

MESSAGE COLOR--BLACK

Historical Note

Appendix C adopted effective June 26, 1998 (Supp. 98-
 2).

R20-5-628. Safe Transportation of Compressed Air or Other**Gases**

An employer shall not use Polyvinyl Chloride (PVC) piping in a
 place of employment for the transportation and distribution of com-
 pressed air or other compressed gases in an above-ground installa-
 tion.

Historical Note

New Section made by final rulemaking at 9 A.A.R. 1161,
 effective March 11, 2003 (Supp. 03-1).

R20-5-629. The Occupational Injury and Illness Recording and Reporting Requirements, 29 CFR 1904

Each employer shall comply with the standards in the Federal
 Occupational Safety and Health Standards for Recordkeeping, as
 published in 29 CFR 1904, with amendments as of May 14, 2019,
 incorporated by reference. Copies of the incorporated materials are
 available for review at the Industrial Commission of Arizona and
 may be obtained from the United States Government Printing
 Office, Superintendent of Documents, Washington, D.C. 20402.
 These standards shall apply to all conditions and practices related to
 recordkeeping by all employers, both public and private, in the state
 of Arizona. This incorporation by reference does not include
 amendments or editions to 29 CFR 1904 published after May 14,
 2019.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 364,
 effective December 31, 2001 (Supp. 01-4). Amended by
 final rulemaking at 9 A.A.R. 874, effective February 19,
 2003 (Supp. 03-1). Amended by final rulemaking at 10
 A.A.R. 318, effective January 1, 2004 (Supp. 03-4).
 Amended by final rulemaking at 22 A.A.R. 775, effective
 March 16, 2016 (Supp. 16-1). Amended by final
 rulemaking at 24 A.A.R. 2263, effective July 23, 2018
 (Supp. 18-3). Amended by final rulemaking at 26 A.A.R.
 373, with an immediate effective date of February 11,
 2020 (Supp. 20-1). Amended by final rulemaking at 28
 A.A.R. 1761 (July 22, 2022), with an immediate effective
 date of July 8, 2022 (Supp. 22-3).

R20-5-630. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980,
 pursuant to A.R.S. § 41-1003, valid for only 90 days
 (Supp. 80-5). Former Section R4-13-640 adopted as an
 emergency effective October 29, 1980, renumbered and
 amended as Section R4-13-630 effective March 2, 1981
 (Supp. 81-2). R20-5-630 recodified from R4-13-631
 (Supp. 95-1). Section repealed by final rulemaking at 8
 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-631. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980,
 pursuant to A.R.S. § 41-1003, valid for only 90 days
 (Supp. 80-5). Former emergency adoption effective Octo-
 ber 29, 1980, adopted effective March 2, 1981 (Supp. 81-
 2). R20-5-631 recodified from R4-13-631 (Supp. 95-1).
 Section repealed by final rulemaking at 8 A.A.R. 364,
 effective December 31, 2001 (Supp. 01-4).

R20-5-632. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980,
 pursuant to A.R.S. § 41-1003, valid for only 90 days
 (Supp. 80-5). Former emergency adoption effective Octo-

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ber 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). R20-5-632 recodified from R4-13-632 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-633. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). R20-5-633 recodified from R4-13-633 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-634. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). R20-5-634 recodified from R4-13-634 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-635. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). R20-5-635 recodified from R4-13-635 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-636. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted and amended effective March 2, 1981 (Supp. 81-2). R20-5-636 recodified from R4-13-636 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-637. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). Amended effective December 14, 1994 (Supp. 94-4). R20-5-637 recodified from R4-13-637 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-638. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). R20-5-638 recodified from R4-13-638 (Supp. 95-1).

Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-639. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former emergency adoption effective October 29, 1980, adopted effective March 2, 1981 (Supp. 81-2). R20-5-639 recodified from R4-13-639 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-640. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-641 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-640 effective March 2, 1981 (Supp. 81-2). R20-5-640 recodified from R4-13-640 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-641. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-642 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-641 effective March 2, 1981 (Supp. 81-2). R20-5-641 recodified from R4-13-641 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-642. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-643 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-642 effective March 2, 1981 (Supp. 81-2). R20-5-642 recodified from R4-13-642 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-643. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-644 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-643 effective March 2, 1981 (Supp. 81-2). R20-5-643 recodified from R4-13-643 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-644. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-645 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-644 effective March 2, 1981

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(Supp. 81-2). R20-5-644 recodified from R4-13-644 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-645. Repealed**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-646 adopted as an emergency effective October 29, 1980, renumbered and amended as Section R4-13-645 effective March 2, 1981 (Supp. 81-2). R20-5-645 recodified from R4-13-645 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 364, effective December 31, 2001 (Supp. 01-4).

R20-5-646. Emergency Expired**Historical Note**

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Emergency expired. R20-5-646 recodified from R4-13-646 (Supp. 95-1).

R20-5-647. Reserved**R20-5-648. Reserved****R20-5-649. Reserved****R20-5-650. Definitions**

As used in rules R20-5-650 through R20-5-669 inclusive, unless the context clearly requires otherwise:

1. "Act" means the Arizona Occupational Safety and Health Act of 1972 (Arizona Revised Statutes, Title 23, Chapter 2, Article 10).
2. "Commission" means the Industrial Commission of Arizona.
3. "Person" means an individual, partnership, association, corporation, business trust, legal representative, an organized group of individuals, or political subdivision.
4. "Party" means a person admitted to participate in a hearing conducted in accordance with subsection (3). An applicant for relief and any affected employee shall be entitled to be named as parties.
5. "Affected employee" means an employee or any one of his authorized representatives, such as his collective bargaining agent, who would be affected by the granting or denial of a variance.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-651 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-650 effective March 2, 1981 (Supp. 81-2). R20-5-650 recodified from R4-13-650 (Supp. 95-1).

R20-5-651. Petitions for Amendments

Any person may at any time petition the Commission in writing to revise, amend, or revoke any provisions of rules R20-5-650 through R20-5-669 inclusive. The petition should set forth either the terms or the substance of the rule desired, with a concise statement of the reasons therefor and the effects thereof.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-652 adopted as an

emergency effective October 29, 1980, renumbered and adopted as Section R4-13-651 effective March 2, 1981 (Supp. 81-2). R20-5-651 recodified from R4-13-651 (Supp. 95-1).

R20-5-652. Effects of Variances

All variances granted hereunder shall have only future effect. In their discretion, the Commission may decline to entertain an application for variance on the subject or issue concerning which a citation has been issued to the employer involved and a proceeding on the citation or a related issue concerning a proposed penalty or period of abatement is pending before the Federal Occupational Safety and Health Review Commission, State of Arizona Hearing Division or the Arizona Review Board until the completion of such proceeding.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-654 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-652 effective March 2, 1981 (Supp. 81-2). R20-5-652 recodified from R4-13-652 (Supp. 95-1).

R20-5-653. Public Notice of a Granted Variance

Every final action granting a variance, shall be published in statewide newspapers. Every such final action shall specify the alternative to the standard involved which the particular variance permits.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-655 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-653 effective March 2, 1981 (Supp. 81-2). R20-5-653 recodified from R4-13-653 (Supp. 95-1).

R20-5-654. Form of Documents; Subscription; Copies

- A. No particular form is prescribed for applications and other papers which may be filed in proceedings hereunder. However, any applications and other papers shall be clearly legible. An original and six copies of any application and other papers shall be filed. The original shall be typewritten. Clear carbon copies or printed or processed copies are acceptable copies.
- B. Each application or other paper which is filed in proceedings hereunder shall be signed by the person filing the same or by his attorney or other authorized representative and where required by these regulations shall be verified by the applicant.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-646 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-654 effective March 2, 1981 (Supp. 81-2). R20-5-654 recodified from R4-13-654 (Supp. 95-1).

R20-5-655. Variances

- A. Application for variance. Any employer, or class of employers, desiring a variance from a standard or regulation or any portion thereof, authorized by A.R.S. § 23-411 of the Act may file a written application containing the information specified in subsection (B) of this Section with the Industrial Commission of Arizona, 1601 West Jefferson, Phoenix, Arizona 85005.

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- B.** Contents. An application filed pursuant to subsection (A) of this Section shall contain the information specified in A.R.S. § 23-411(B) and (C) of the Act.
- C.** Interim order.
1. Application. In accordance with A.R.S. § 23-411(B)(3) of the Act, an application may also be made for an interim order to be effective until a decision is rendered on the application for the variance filed previously or concurrently. An application for an interim order shall include a verified statement of facts and arguments supporting such application. The Commission may rule ex parte upon the application.
 2. Notice of denial of application. If an application filed pursuant to subsection (C)(1) is denied, the applicant shall be given prompt notice of the denial, which shall include, or be accompanied by, a brief statement of the grounds therefore.
 3. Notice of the grant of an interim order. If an interim order is granted, a copy of the order shall be served upon the applicant for the order and other parties and the terms of the order shall be published in statewide newspapers. It shall be a condition of the order that the affected employer shall give notice thereof to affected employees by the same means to be used to inform them of an application for variance.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-657 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-655 effective March 2, 1981 (Supp. 81-2). R20-5-655 recodified from R4-13-655 (Supp. 95-1).

R20-5-656. Variances under A.R.S. § 23-412

- A.** Application for variance. Any employer, or class of employers, desiring a variance authorized by A.R.S. § 23-412 of the Act may file a written application containing the information specified in subsection (B) of this Section, with the Industrial Commission of Arizona, 1601 W. Jefferson, Phoenix, Arizona 85005.
- B.** Contents. An application filed pursuant to subsection (A) of this Section shall contain the information specified in A.R.S. § 23-412 of the Act.
- C.** Interim order
1. Application. An application may also be made for an interim order to be effective until a decision is rendered on the application for the variance filed previously or concurrently. An application for an interim order shall include a verified statement of facts and arguments supporting such application. The Commission may rule ex parte upon the application.
 2. Notice of denial of application. If an application filed pursuant to subsection (C)(1) is denied, the applicant shall be given prompt notice of the denial, which shall include, or be accompanied by, a brief statement of the grounds therefore.
 3. Notice of the grant of an interim order. If an interim order is granted, a copy of the order shall be served upon the applicant and other parties, and the terms of the order shall be published in statewide newspapers. It shall be a condition of the order that the affected employer shall give notice thereof to affected employees by the same means to be used to inform them of an application for a variance.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-658 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-656 effective March 2, 1981 (Supp. 81-2). R20-5-656 recodified from R4-13-656 (Supp. 95-1).

R20-5-657. Renewal of Rules or Orders: Federal Multi-state Variances

- A.** Renewal or rules or orders. Any final rule or order issued under A.R.S. § 23-411 of the Act may be renewed or extended as permitted by the applicable Section and in the manner prescribed for its issuance.
- B.** Multi-state variances. Where a federal variance has been granted with multi-state applicability, including applicability in this state operating under a state plan approved under Section 18 of the Act, from a standard or portion thereof identical to this state's standard or regulation or portion thereof such variance shall likewise be deemed an authoritative interpretation of the employer(s)' compliance obligation with regard to the state standard or portion thereof provided no objections of substance are found to be interposed by the Commission.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-659 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-657 effective March 2, 1981 (Supp. 81-2). R20-5-657 recodified from R4-13-657 (Supp. 95-1).

R20-5-658. Action on Applications

- A.** Defective applications
1. If an application filed pursuant to rule R20-5-655, R20-5-656, R20-5-657 and R20-5-658 does not conform to the applicable Section, the Commission may deny the application.
 2. Prompt notice of the denial of an application shall be given to the applicant.
 3. A notice of denial shall include, or be accompanied by, a brief statement of the grounds for denial.
 4. A denial of an application pursuant to this subsection shall be without prejudice to the filing of another application.
- B.** Adequate applications
1. If an application has not been denied pursuant to subsection (A) of this Section, the Commission shall cause to be published in statewide newspapers a notice of the filing of the application.
 2. A notice of the filing of an application shall include:
 - a. The terms, or an accurate summary, of the application;
 - b. A reference to the Section of the Act under which the application has been filed;
 - c. An invitation to interested persons to submit within a stated period of time written data, views, or arguments regarding the application; and
 - d. Information to affected employers, employees, of any right to request a hearing on the application.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-660 adopted as an

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emergency effective October 29, 1980, renumbered and adopted as Section R4-13-658 effective March 2, 1981 (Supp. 81-2). R20-5-658 recodified from R4-13-658 (Supp. 95-1).

R20-5-659. Request for Hearings on Petition

- A.** Request for hearing. Any employer, employee, authorized employee representative, representative, or other person interested in or affected by an order of the Commission may petition for a hearing on the reasonableness and lawfulness of an order issued under A.R.S. §§ 23-411 or 23-412, by a verified petition filed with the Commission.
- B.** Contents of a petition. A request for a hearing filed pursuant to subsection (A) of this Section shall include:
1. The name and address of the applicant;
 2. A concise statement of facts showing how the employer, employee, authorized employee representative, representative, or other person would be affected by the relief applied for;
 3. A petition shall set forth specifically and in detail the order upon which a hearing is desired;
 4. The reasons why the order is unreasonable or unlawful;
 5. The issue to be considered by the Commission on the hearing. Objections other than those set forth in the petition are deemed finally waived.
 6. If the applicant is an employer, a certification that the applicant has informed his affected employees of the application by:
 - a. Giving a copy thereof to their authorized representative;
 - b. Posting at the place or places where notices to employees are normally posted, a statement giving a summary of the petition specifying where a copy of the full petition may be examined (or, in lieu of the summary, posting the application itself); and
 - c. Other appropriate means.
 7. If the applicant is an affected employee, a certification that a copy of the petition has been furnished to the employer.
- C.** The Commission may on its own motion proceed to modify or revoke a rule or order issued under A.R.S. §§ 23-411 or 23-412 of the Act. In such event, the Commission shall cause to be published in statewide newspapers a notice of its intention, affording interested persons an opportunity to submit written data, views, or arguments regarding the proposal and informing the affected employer and employees of their right to request a hearing and shall take such other action as may be appropriate to give actual notice to the affected employees. Any request for a hearing shall include a short and plain statement of:
1. How the proposed modification or revocation would affect the requesting party; and
 2. What the requesting party would seek to show on the subjects or issues involved.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-661 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-659 effective March 2, 1981 (Supp. 81-2). R20-5-659 recodified from R4-13-659 (Supp. 95-1).

R20-5-660. Consolidation of Proceedings

The Commission on its own motion or that of any party may consolidate or contemporaneously consider two or more proceedings which involve the same or closely related issues.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-662 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-660 effective March 2, 1981 (Supp. 81-2). R20-5-660 recodified from R4-13-660 (Supp. 95-1).

R20-5-661. Notice of Hearing

- A.** Service. Upon request for a hearing as provided in this Section, or upon its own initiative, the Commission shall serve, or cause to be served, a reasonable notice of hearing.
- B.** Contents. A notice of hearing served under subsection (A) of this Section shall include:
1. The time, place, and nature of the hearing;
 2. The legal authority under which the hearing is to be held;
 3. A specification of issues of fact and law.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-663 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-661 effective March 2, 1981 (Supp. 81-2). R20-5-661 recodified from R4-13-661 (Supp. 95-1).

R20-5-662. Manner of Service

Service of any document upon any party may be made by personal delivery of, or by mailing, a copy of the document to the last known address of the party. The person serving the document shall certify to the manner and the date of the service.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-664 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-662 effective March 2, 1981 (Supp. 81-2). R20-5-662 recodified from R4-13-662 (Supp. 95-1).

R20-5-663. Industrial Commission; Powers and Duties

- A.** Powers. The Commissioners shall have all powers necessary or appropriate to conduct a fair, full, and impartial hearing, including the following:
1. To administer oaths and affirmations;
 2. To rule upon offers of proof and receive relevant evidence;
 3. To provide for discovery and to determine its scope;
 4. To regulate the course of the hearing and the conduct of the parties and their counsel therein;
 5. To consider and rule upon procedural requests;
 6. To hold conferences for the settlement or simplification of the issues by consent of the parties;
 7. To make, or to cause to be made, an inspection of the employment or place of employment involved;
 8. To make decisions in accordance with A.R.S. §§ 23-405.5, 23-411, 23-412, and 23-945; and
 9. To take any other appropriate action authorized by the Act, this Section, or A.R.S. § 23-945.

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- B.** Contumacious conduct; failure or refusal to appear or obey the rulings of the Commission.
1. Contumacious conduct at any hearing before the Commission shall be grounds for exclusion from the hearing.
 2. If a witness or a party refuses to answer a question after being directed to do so, or refuses to obey an order to provide or permit discovery, the Commission may make such orders with regard to the refusal as are just and appropriate, including an order denying an application of an applicant or regulating the contents of the record of the hearing.
- C.** Referral to Rules of Procedure for Occupational Safety and Health hearings. On any procedural question not regulated by this Section, the Act, or A.R.S. § 23-945, Commission shall be guided to the extent practicable by any pertinent provisions of the Rules of Procedure for Occupational Safety and Health hearings before the Industrial Commission of Arizona.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-665 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-663 effective March 2, 1981 (Supp. 81-2). R20-5-663 recodified from R4-13-663 (Supp. 95-1).

R20-5-664. Prehearing Conferences

- A.** Convening a conference. Upon its own motion or the motion of a party, the Commission may direct the parties or their counsel to meet with them for a conference to consider:
1. Simplification of the issues;
 2. Necessity or desirability of amendments to documents for purposes of clarification, simplification, or limitation;
 3. Stipulations, admissions of fact, and of contents and authenticity of documents;
 4. Limitation of the number of parties and of expert witnesses; and
 5. Such other matters as may tend to expedite the disposition of the proceeding and to assure a just conclusion thereof.
- B.** Record of conference. The Commission shall make an order which recites the action taken at the conference, the amendments allowed to any documents which have been filed, and the agreements made between the parties as to any of the matters considered, and which limits the issues for hearings to those not disposed of by admission or agreements; and such order when entered controls the subsequent course of the hearing, unless modified at the hearing, to prevent manifest injustice.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-666 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-664 effective March 2, 1981 (Supp. 81-2). R20-5-664 recodified from R4-13-664 (Supp. 95-1).

R20-5-665. Consent Findings and Rules or Orders

- A.** General. At any time before the reception of evidence in any hearing, or during any hearing, a reasonable opportunity may be afforded to permit the negotiation by the parties of an agreement containing consent findings and a rule or order disposing of the whole or any part of the proceeding. The allowance of such opportunity and the duration thereof shall be in

the discretion of the Commission. After consideration of the nature of the proceeding, the requirements of the public interest, the representations of the parties, and the probability of an agreement which will result in a just disposition of the issues involved.

- B.** Contents. Any agreement containing consent findings in rule or other disposing of a proceeding shall also provide:
1. That the rule or order shall have the same force and effect as if made after a full hearing;
 2. That the entire record on which any rule or order may be based shall consist solely of the application and the agreement;
 3. A waiver of any further procedural steps before the Commission; and
 4. A waiver of any right to challenge or contest the validity of the findings and of the rule or order made in accordance with the agreement.
- C.** Submission. On or before the expiration of the time granted for negotiations, the parties or their counsel may:
1. Submit the proposed agreement to the Commission for its consideration; or
 2. Inform the Commission that agreement cannot be reached.
- D.** In the event an agreement containing consent findings and rule or order is submitted within the time allowed therefor, the Commission may accept such agreement by issuing its decision based upon the agreed findings.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-667 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-665 effective March 2, 1981 (Supp. 81-2). R20-5-665 recodified from R4-13-665 (Supp. 95-1).

R20-5-666. Discovery

- A.** Depositions
1. For reasons of unavailability or for other good cause shown, the testimony of any witness may be taken by deposition. Depositions may be taken orally or upon written interrogatories before any person designated by the Commission and having power to administer oaths.
 2. Application. Any party desiring to take the deposition of a witness may make application in writing to the Commission, setting forth:
 - a. The reasons why such deposition should be taken;
 - b. The time when, the place where, and the name and post office address of the person before whom the deposition is to be taken;
 - c. The name and address of each witness; and
 - d. The subject matter concerning which each witness is expected to testify.
 3. Notice. Such notice as the Commission may order shall be given by the party taking the deposition to every other party.
 4. Taking and receiving in evidence. Each witness testifying upon deposition shall be sworn, and the parties not calling him shall have the right to cross-examine him. The questions propounded and the answers thereto, together with all objections made, shall be reduced to writing, read to the witness, subscribed by him, and certified by the officer before whom the deposition is taken. Thereafter, the officer shall seal the deposition, with two copies thereof, in an envelope and mail the same by registered

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mail to the presiding hearing examiner. Subject to such objections to the questions and answers as were noted at the time of taking the deposition and would be valid were the witness personally present and testifying, such deposition may be read and offered in evidence by the party taking it as against any party who was present, represented at the taking of the deposition, or who had due notice thereof. No part of a deposition shall be admitted in evidence unless there is a showing that the reasons for the taking of the deposition in the first instance exist at the time of the hearing.

- B.** Other discovery. Whenever appropriate to a just disposition of any issue in a hearing, the Commission may allow discovery by any other appropriate procedure, such as by written interrogatories upon a party, production of documents by a party, or by entry for inspection of the employment or place of employment involved.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-668 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-666 effective March 2, 1981 (Supp. 81-2). R20-5-666 recodified from R4-13-666 (Supp. 95-1).

R20-5-667. Hearings

- A.** Order of proceeding. Except as may be ordered otherwise by the Commission, the party applicant for relief shall proceed first at a hearing.
- B.** Burden of proof. The party applicant shall have the burden of proof.
- C.** Evidence
1. Admissibility. A party shall be entitled to present its case or defense by oral or documentary evidence, to submit rebuttal evidence, and to conduct such cross-examination as may be required for a full and true disclosure of the facts. Any oral or documentary evidence may be received, but the Commission shall exclude evidence which is irrelevant, immaterial, or unduly repetitious.
 2. Testimony of witnesses. The testimony of a witness shall be upon oath or affirmation administered by the Commission.
- D.** Official notice. Official notice may be taken of any material fact not appearing in evidence in the record, which is among the traditional matters of judicial notice: provided that the parties shall be given adequate notice, at the hearing or by reference in the Commission's decision, of the matters so noticed and shall be given adequate opportunity to show the contrary.
- E.** Record. Minutes shall be taken of the Commission hearings. Copies of the minutes may be obtained by the parties upon written application filed with the secretary of the Commission and upon the payment of fees at the rate provided in the agreement with the Commission.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-669 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-667 effective March 2, 1981 (Supp. 81-2). R20-5-667 recodified from R4-13-667 (Supp. 95-1).

R20-5-668. Decisions of the Commission

- A.** Proposed findings of fact, conclusions, and rules or orders. Within 10 days after completion of the hearing or such additional time as the Commission may allow, each party may file with the Commission proposed findings of fact, conclusions of law, and rule or order, together with a supporting brief expressing the reasons for such proposals. Such proposals and brief shall be served on all other parties and shall refer to all portions of the record and to all authorities relied upon in support of each proposal.
- B.** Decisions of the Commission. Within a reasonable time after the time allowed for the filing of proposed findings of fact, conclusions of law, and rule or order, the Commission shall make and serve upon each party its decision, which shall become final upon the 30th day after service thereof, unless exceptions are filed thereto, as provided in rule R20-5-669. The decision of the Commission shall include:
1. A statement of findings and conclusions, with reasons and basis therefor, upon each material issue of fact, law, or discretion presented on the record, and
 2. The appropriate rule, order, relief, or denial thereof. The decision of the hearing examiner shall be based upon a consideration of the whole record and shall state all facts officially notice and relied upon. It shall be made on the basis of a preponderance of reliable and probative evidence.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-670 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-668 effective March 2, 1981 (Supp. 81-2). R20-5-668 recodified from R4-13-668 (Supp. 95-1).

R20-5-669. Judicial Review

Any employer, employee, authorized employee representative, representative, or any person in interest is dissatisfied with an order of the Commission may appeal in accordance with A.R.S. § 23-413 of the Act.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Former Section R4-13-674 adopted as an emergency effective October 29, 1980, renumbered and adopted as Section R4-13-670 effective March 2, 1980 (Supp. 81-2). R20-5-669 recodified from R4-13-669 (Supp. 95-1).

R20-5-670. Field Sanitation

- A.** This Section applies to any agricultural establishment where a crew of five or more employees are engaged on any given day in hand-labor operations in one location.
- B.** As used in this Section:
1. "Agricultural establishment" means a business operation that uses paid employees in the production of food, fiber or other material such as seed, seedlings, plants or parts of plants.
 2. "Crew of employees" means a group of persons who are employed to perform hand-labor operations as a unit at an agricultural establishment. "Crew of employees" does not include the employer and the employer's immediate family members.
 3. "Hand-labor operations" means agricultural activities or operations performed in the field by hand or with hand

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tools. Hand-labor operations include the hand-harvest of vegetables, nuts and fruits, hand-weeding of crops and hand-planting of seedlings. Hand-labor operations do not include such activities as logging operations, irrigation operations, the care or feeding of livestock or hand-labor operations in permanent structure, such as canning facilities or packing houses. Hand-labor operations do not include activities in which persons are acting as equipment operators.

4. "Handwashing facility" means a facility providing either a basin, container or outlet with an adequate supply of potable water, soap and single-use towels.
 5. "Potable water" means water that meets the standards for drinking purposes prescribed by the state or local authority having jurisdiction or water that meets the quality standards prescribed by the United States Environmental Protection Agency's National Interim Primary Drinking Water Regulations, published in 40 CFR Part 141 (July 1983), incorporated by reference and on file in the Office of the Secretary of State.
 6. "Toilet facility" means a facility designed for the purpose of both defecation and urination, including biological or chemical toilets, combustion toilets or sanitary privies, which is supplied with toilet paper adequate for employee needs. Toilet facilities may be either fixed or portable.
- C. Employers shall provide the following for employees engaged in hand-labor operations at an agricultural establishment without cost to the employee:
1. Potable drinking water as follows:
 - a. Potable water shall be provided and shall be placed in locations readily accessible to all employees.
 - b. The water shall be suitably cool, no more than 80°F, and in sufficient amounts, a minimum of two gallons per employee, taking into account the air temperature, humidity and the nature of the work performed, to meet employees' need.
 - c. The water shall be dispensed in single-use drinking cups or by fountains. The use of common drinking cups or dippers is prohibited.
 2. Toilet and handwashing facilities as follows:
 - a. One toilet facility and one handwashing facility shall be provided for each 40 employees or fraction thereof, except as provided in subsection (D) of this Section.
 - b. Toilet facilities shall have doors that can be closed and latched from the inside and shall be constructed to ensure privacy.
 - c. Toilet and handwashing facilities shall be accessibly located, in close proximity to each other and within 1/4 mile of each employee's place of work in the field. If it is not feasible to locate facilities accessibly and within the required distance due to the terrain, facilities shall be located at the point of closest vehicular access.
- D. Toilet and handwashing facilities are not required for employees who perform field work for a period of three hours or less (including transportation time to and from the field) during the day.
- E. Potable drinking water and toilet and handwashing facilities shall be maintained in accordance with appropriate public health sanitation practices, including all of the following:
1. Drinking water containers shall be covered, cleaned and refilled daily.

2. Toilet facilities shall be operational and maintained in clean and sanitary condition and shall be supplied with toilet paper adequate for employee needs.
 3. Handwashing facilities shall be maintained in clean and sanitary condition.
 4. Disposal of wastes from facilities shall not cause unsanitary conditions.
- F. Employees shall be allowed reasonable opportunities during the workday to use the facilities.

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Adopted effective May 2, 1986 (Supp. 86-3). R20-5-670 recodified from R4-13-670 (Supp. 95-1).

R20-5-671. Reserved

R20-5-672. Reserved

R20-5-673. Reserved

R20-5-674. Emergency expired

Historical Note

Adopted as an emergency effective October 29, 1980, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 80-5). Emergency expired. R20-5-674 recodified from R4-13-674 (Supp. 95-1).

R20-5-675. Reserved

R20-5-676. Reserved

R20-5-677. Reserved

R20-5-678. Reserved

R20-5-679. Reserved

R20-5-680. Protected Activity

- A. All complaints pursuant to A.R.S. § 23-425 shall relate to conditions at the workplace. The filing of complaints need not be in writing for purposes of this subsection except that those complaints filed pursuant to R20-5-682 shall comply with R20-5-682. The term "filed any complaint" as used in A.R.S. § 23-425(A) includes:
1. Employee requests for inspection pursuant to A.R.S. § 23-408(F);
 2. Complaints registered with other state, local or federal governmental agencies which have the authority to regulate or investigate occupational safety and health conditions;
 3. Complaints lodged with employers; or
 4. Complaints filed as specified in R20-5-682.
- B. The term "instituted or caused to be instituted any proceeding" as used in A.R.S. § 23-425(A) includes:
1. Inspections of worksites under A.R.S. § 23-408(A);
 2. Employee contest of abatement date under A.R.S. § 23-417(D);
 3. Employee initiation of proceedings for promulgation of an occupational safety and health standard under A.R.S. § 23-410(A);
 4. Employee application for modification or revocation of a variance under A.R.S. § 23-413;
 5. Employee judicial challenge to a standard under A.R.S. § 23-410(E);
 6. Employee appeal of an Administrative Law Judge Division order under A.R.S. § 23-421(C);
 7. Exercise of rights by any employee pursuant to A.R.S. § 23-418.01;

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8. Any other employee action authorized by the Arizona Occupational Safety and Health Act of 1972; or
 9. Setting into motion the activities of others which result in the proceedings specified in subsections (B)(1) through (8).
- C. The term “testified or is about to testify in any such proceeding” as used in A.R.S. § 23-425(A) includes:
1. Testimony in proceedings instituted or caused to be instituted by the employee; or
 2. Any statements given in the course of judicial, quasi-judicial or administrative proceedings. For this purpose, administrative proceedings include inspections, investigations and administrative rulemaking or adjudicative functions.
- D. The term “the exercise by such employee on behalf of himself or others of any right afforded by this Article” as used in A.R.S. § 23-425(A) includes:
1. The right to participate as a party in enforcement proceedings pursuant to A.R.S. § 23-408(D);
 2. The right to request information from the Industrial Commission; or
 3. To cooperate with inspections or investigations by the Industrial Commission.
- E. If the employee, with no reasonable alternative, refuses in good faith to expose himself to a dangerous condition, the employee is engaged in protected activity. The condition causing the employee’s apprehension of death or injury must be of such a nature that a reasonable person, under the circumstances then confronting the employee, would conclude there is a real danger of death or serious injury and that there is insufficient time, due to the urgency of the situation, to eliminate the dangers through resort to regular statutory enforcement channels. In addition, in such circumstances, the employee, where possible, must also have sought from his employer and been unable to obtain a correction of the dangerous condition.
- F. Employees who refuse to comply with valid occupational safety and health standards or valid safety rules implemented by the employer are not protected by A.R.S. § 23-425.

Historical Note

Adopted effective May 3, 1989 (Supp. 89-2). R20-5-680
recodified from R4-13-680 (Supp. 95-1).

R20-5-681. Elements of a Violation of A.R.S. § 23-425

To establish a violation of A.R.S. § 23-425(A), the employee shall prove all of the following:

1. The employee was engaged in protected activities as defined in R20-5-680.
2. The employer had knowledge of the employee’s protected activities prior to the adverse action which the employee claims to be a discharge or discrimination.
3. The action claimed to be discharge or discrimination was adverse to the employee.
4. The protected activity was a substantial reason for the alleged discharge or discrimination or the alleged discharge or discrimination would not have taken place but for the employee’s engagement in the protected activity.

Historical Note

Adopted effective May 3, 1989 (Supp. 89-2). R20-5-681
recodified from R4-13-681 (Supp. 95-1).

R20-5-682. Procedure

- A. A complaint of A.R.S. § 23-425(A) discharge or discrimination shall be filed with the Division of Occupational Safety and Health by the employee or by a representative authorized

by A.R.S. § 23-408(F) to do so on the employee’s behalf. The complaint shall be written and shall be signed by the person filing the complaint.

- B. The date of filing a complaint under A.R.S. § 23-425(B) is the date of receipt of the complaint by the Division.
- C. The Division may accept or deny an employee’s withdrawal of a complaint. The Industrial Commission’s investigatory jurisdiction shall not be foreclosed by unilateral action of the employee.
- D. The Industrial Commission may resolve an A.R.S. § 23-425 complaint with the employer without the consent of the employee.
- E. The Industrial Commission’s jurisdiction to investigate and determine A.R.S. § 23-425 complaints is independent of the jurisdiction of other agencies or bodies. The Industrial Commission may defer to the results of other such proceedings where:
1. The rights asserted in those other proceedings are substantially the same as the rights pursuant to A.R.S. § 23-425;
 2. The factual issues in such proceedings are substantially the same as the factual issues before the Industrial Commission;
 3. The proceedings were fair and regular; and
 4. The outcome of the proceedings was not inconsistent with the purposes of this Chapter and the Act.
- F. A determination pursuant to A.R.S. § 23-425(C) includes:
1. A decision to not proceed with the case;
 2. To defer the case to another forum; or
 3. To proceed to litigation in Superior Court.

Historical Note

Adopted effective May 3, 1989 (Supp. 89-2). R20-5-682
recodified from R4-13-682 (Supp. 95-1).

ARTICLE 7. REPEALED**R20-5-701. Repealed****Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-702. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-703. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-704. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

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R20-5-705. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-706. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-707. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-708. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-709. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-710. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-711. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-712. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-713. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-714. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-715. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 22 A.A.R. 2782, effective September 7, 2016 (Supp. 16-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-716. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-717. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-718. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-719. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-720. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-721. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-722. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

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R20-5-723. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-724. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-725. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-726. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-727. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-728. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-729. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-730. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-731. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-732. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-733. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-734. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-735. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-736. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-737. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-738. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-739. Repealed**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

**ARTICLE 8. OCCUPATIONAL SAFETY AND HEALTH
RULES OF PROCEDURE BEFORE THE INDUSTRIAL
COMMISSION OF ARIZONA****R20-5-801. Notice of Rules**

Sections R20-5-801 et seq. apply to all actions and proceedings of or before the Commission and Review Board pertaining to those issues arising out of Title 23, Chapter 2, Article 10.

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Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-801 recodified from R4-13-801 (Supp. 95-1).

R20-5-802. Location of Office and Office Hours

The main office of the Industrial Commission of Arizona is located in Phoenix, Arizona. An office is also located in Tucson, Arizona. The offices are open for the transaction of business from 8:00 a.m. until 5:00 p.m. every day except Saturdays, Sundays and legal holidays.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-802 recodified from R4-13-802 (Supp. 95-1).

R20-5-803. Definitions

In these Rules of Procedures, unless the context otherwise requires, the following words and terms shall have the following meanings:

1. "Commission" means the Industrial Commission of Arizona.
2. "Affected employee" means an employee of a cited employer who is exposed to the alleged hazard described in the citation, as a result of his assigned duties.
3. "Authorized employee representative" means a labor organization which has a collective bargaining relationship with the cited employer and which represents affected employees.
4. "Representative" means any person, including an authorized employee representative, authorized by a party to represent him in a proceeding.
5. "Citation" means a written communication issued by the Division of Occupational Safety and Health of the Industrial Commission of Arizona pursuant to A.R.S. § 23-415.
6. "Notification of proposed penalty" means a written communication issued by the Industrial Commission of Arizona pursuant to A.R.S. § 23-418.
7. "Party" means the Occupational Safety and Health Division of the Commission, the affected employer and affected employees.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-803 recodified from R4-13-803 (Supp. 95-1).

R20-5-804. Computation of Time

In computing any period of time prescribed or allowed in these rules, the day from which the designated period begins to run shall not be included. The last day of the period so computed shall be included unless it is a Saturday, Sunday, or legal holiday. When the period of time prescribed or allowed is less than seven days, intermediate Saturdays, Sundays, and legal holidays shall be excluded in the computation.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-804 recodified from R4-13-804 (Supp. 95-1).

R20-5-805. Record Address

The initial pleading filed by any person shall contain his name, address and telephone number. Any change in such information must be communicated promptly in writing to the Commission and to all other parties. A party who fails to furnish such correct and current information shall be deemed to have waived his right to object to the validity of any notice and/or service which has been made to the last known address of the party as shown by the records of the Commission.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-805 recodified from R4-13-805 (Supp. 95-1).

R20-5-806. Service and Notice

- A. At the time of filing pleadings or other documents a copy thereof shall be served by the filing party on every other party.
- B. Service upon a party who has appeared through a representative shall be made only upon such representative.
- C. Unless otherwise herein indicated, service may be accomplished by postage prepaid first class mail or by personal delivery. Service is deemed effected at the time of mailing (if by mail) or at the time of personal delivery (if by personal delivery).
- D. Proof of service shall be accomplished by a written statement of the same which sets forth the date and manner of service. Such statement shall be filed with the pleading or document.
- E. Service and notice to employees represented by an authorized employee representative shall be deemed accomplished by serving the representative in the manner prescribed in subsection (C).
- F. In the event that there are any affected employees who are not represented by an authorized employee representative, the employer shall, immediately upon receipt of Notice of the Date of Hearing, post, where the citation is required to be posted, a copy of the Notice of Date of Hearing and a notice informing such affected employees of their right to appear at the hearing and state their position and of the availability of all pleadings for inspection and copying at reasonable times. A notice in the following form shall be deemed to comply with this subsection:
(Name of employer)

Your employer has been cited by the Industrial Commission of Arizona for violation of the Arizona Occupational Safety and Health Act of 1972. The citation has been contested and will be the subject of a hearing before the Industrial Commission. Affected employees are entitled to appear in this hearing under the terms and conditions established by the Industrial Commission in its Rules of Procedure. Notice of Intent to Participate should be sent to:

THE INDUSTRIAL COMMISSION
OF ARIZONA

1601 West Jefferson Street,
Phoenix, Arizona 85007.

All papers relevant to this matter may be inspected at:

(Place reasonably convenient to employees, preferably at or near workplace.)

Where appropriate, the second sentence of the above Notice will be deleted and the following sentence will be substituted:

The reasonableness of the period prescribed by the Industrial Commission for abatement of the violation has been contested and will be the subject of a hearing before the Industrial Commission.

- G. Where service is accomplished by posting, proof of such posting shall be filed not later than the first working day following the posting.
- H. The authorized employee representative, if any, shall be served with the notice set forth in subsection (G) and with a copy of the Notice of the Date of Hearing.
- I. A copy of the Notice of the Date of Hearing shall be served by the employer on affected employees who are not represented by an authorized employee representative by posting a copy of

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the Notice of such hearing at or near the place where the citation is required to be posted.

- J. A copy of the Notice of the Date of Hearing shall be served by the employer on the authorized employee representative of affected employees in the manner prescribed in subsection (C) of this Section, if the employer has not been informed that the authorized employee representative has entered an appearance as of the date such Notice is received by the employer.
- K. Where a petition for hearing is filed by an affected employee who is not represented by an authorized employee representative and there are other affected employees who are represented by an authorized employee representative, the unrepresented employee shall, upon receipt of the Notice of the Date of Hearing, serve a copy thereof on such authorized employee representative in the manner prescribed in subsection (C) of this Section and shall file proof of such service.
- L. Where a Petition for Hearing is filed by an affected employee or an authorized employee representative, a copy of the Petition for Hearing shall be provided to the employer for posting by the employer at the place the citation is required to be posted.
- M. An authorized employee representative who files a Notice of Contest shall be responsible for serving any other authorized employee representative whose members are affected employees.
- N. Where posting is required by this Section, such posting shall be maintained until the commencement of the hearing or until earlier disposition.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-806 recodified from R4-13-806 (Supp. 95-1).

R20-5-807. Consolidation

Cases may be consolidated on the motion of any party, or on the hearing officer's own motion, where there exist common parties, common questions of law or fact, or both, or in such other circumstances as justice and the administration of the Act require.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-807 recodified from R4-13-807 (Supp. 95-1).

R20-5-808. Severance

Upon its own motion, or upon motion of any party, the hearing officer may, for good cause, order any proceeding severed with respect to some or all issues or parties.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-808 recodified from R4-13-808 (Supp. 95-1).

R20-5-809. Election to Appear

- A. Affected employees may elect to appear at a hearing for the purpose of testifying or stating their position concerning the subject matter of the hearing.
- B. If affected employees desire to appear at the hearing they must so notify in writing the Commission or the hearing officer, if the case has been assigned.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-809 recodified from R4-13-809 (Supp. 95-1).

R20-5-810. Employee Representatives

- A. Employees may appear in person or through a representative.
- B. An authorized employee representative shall be deemed to control all matters respecting the interest of such employees in the proceeding.

- C. Affected employees who are represented by an authorized employee representative may appear only through such authorized employee representative.
- D. Withdrawal of appearance of any representative may be effected by filing a written Notice of Withdrawal and by serving a copy thereof on all parties.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-810 recodified from R4-13-810 (Supp. 95-1).

R20-5-811. Form of Pleadings

- A. Except as provided herein, there are no specific requirements as to the form of any pleading. A pleading is simply required to contain a caption sufficient to identify the parties in accordance with R20-5-812, which shall include the Commission's citation number, and a clear and plain statement of the relief that is sought, together with the grounds therefor.
- B. Pleadings and other documents (other than exhibits and petitions for hearing) shall be typewritten and double spaced, on letter size opaque paper (approximately 8 1/2 inches by 11 inches). The left margin shall be 1 1/2 inches and the right margin 1 inch. Pleadings and other documents shall be fastened at the upper left corner.
- C. Pleadings shall be signed by the party filing or by his representative. Such signing constitutes a representation by the signer that he has read the document or pleading, that to the best of his knowledge, information and belief the statements made therein are true, and that it is not interposed for delay.
- D. The Commission may refuse for filing any pleading or document which does not comply with the requirements of subsections (A), (B), and (C) of this Section.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-811 recodified from R4-13-811 (Supp. 95-1).

R20-5-812. Caption; Titles of Cases

- A. Cases initiated by the cited employer filing a Petition for Hearing contesting the violations cited shall be titled:
Division of Occupational Safety and Health of the Industrial Commission of Arizona, Complainant, vs. (name of employer), Respondent.
- B. Cases initiated by the cited employer filing a Petition of Hearing for modification of the abatement period shall be titled:
(name of employer), Petitioner vs. Division of Occupational Safety and Health of the Industrial Commission of Arizona, Respondent.
- C. Cases initiated by an affected employee filing a Petition for Hearing for modification of the abatement period shall be titled:
(name of affected employee or authorized employee representative), Petition vs. Division of Occupational Safety and Health of the Industrial Commission of Arizona, Respondent, and (employer), Respondent.
- D. The Titles listed in subsections (A) and (B) of this Section shall appear at the left upper portion of the initial page of any pleading or document (other than exhibits and Petitions for Hearing filed).
- E. The initial page of any pleading or document (other than exhibits and requests for hearing) shall show the citation number at the upper right of the page, opposite the title.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-812 recodified from R4-13-811 (Supp. 95-1).

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R20-5-813. Requests for Hearing

- A. Requests for hearing shall be filed with the Commission.
- B. Requests for hearing shall be in writing and contain a clear and plain statement of the relief that is sought, together with the grounds thereof.
- C. The Commission shall, after receipt of a request for hearing, refer the file to the Hearing Officer Division for determination.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-813 recodified from R4-13-813 (Supp. 95-1).

R20-5-814. Pre-hearing Conference

- A. At any time before a hearing, the hearing officer, on his own motion or on motion of a party, may direct the parties, or their representatives, to exchange information or to participate in a pre-hearing conference for the purpose of considering matters which will tend to simplify the issues or expedite the proceedings.
- B. The hearing officer may issue a pre-hearing order which includes the agreements reached by the parties. Such order shall be served on all parties and shall be part of the record.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-814 recodified from R4-13-814 (Supp. 95-1).

R20-5-815. Payment of Witness Fees and Mileage

Witnesses summoned before the hearing officer shall be paid the same fees and mileage that are paid witnesses in the courts of Arizona. Witness fees and mileage shall be paid by the party at whose instance the witness appears.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-815 recodified from R4-13-815 (Supp. 95-1).

R20-5-816. Expired**Historical Note**

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-816 recodified from R4-13-816 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 3475, effective November 8, 2016 (Supp. 16-4).

R20-5-817. Failure to Appear -- Withdrawal of Request for Hearing

- A. The failure of a party who has requested a hearing to appear at such scheduled hearing shall be deemed to be an admission of the validity of any citation, abatement period, or penalty issued or proposed, and additionally a waiver of all rights except the right to be served with a copy of the decision of the hearing officer and to request review.
- B. Withdrawal of request for hearing shall be construed as an admission of the validity of any citation, abatement period or penalty issued or proposed. No decision need be issued in this case as the subject instrument is deemed to be admitted.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-817 recodified from R4-13-817 (Supp. 95-1).

R20-5-818. Duties and Powers of Hearing Officers

It shall be the duty of the hearing officer to conduct a fair and impartial hearing, to assure that the facts are fully elicited, to adjudicate all issues and avoid delay. The hearing officer shall have authority with respect to cases assigned to him, between the time he is designated and the time he issued his decision, subject to the rules and regulations of the Commission, to:

1. Administer oaths and affirmations;

2. Rule upon admissibility of exhibits;
3. Rule upon applications for depositions;
4. Regulate the course of the hearing and, if appropriate or necessary, exclude persons or counsel from the hearing for contemptuous conduct and strike all related testimony of witnesses refusing to answer any proper questions;
5. Call and examine witnesses;
6. Request the parties at any time during the hearing to state their respective positions concerning any issue in the case or theory in support thereof;
7. Adjourn the hearing as the needs of justice and good administration require;
8. Issue appropriate orders for protection of trade secrets;
9. Take any other action necessary under the foregoing and authorized by the rules and regulations of the Commission.

Historical Note

Adopted effective August 27, 1975 (Supp. 75-1). R20-5-818 recodified from R4-13-818 (Supp. 95-1).

R20-5-819. Witnesses' Oral Deposition; In State

- A. After a request for hearing has been filed with the Commission, any party desiring to take the oral deposition of any other party or witness residing within the state of Arizona shall file with the hearing officer, in duplicate, notice of taking deposition by oral examination. Copies of such Notice shall be served at least five days prior to the date of the deposition upon the deponent and upon every party by the party desiring to take the oral deposition.
- B. If any party or the deponent has any objection to the taking of the oral deposition of the party or witness, he shall file with the presiding hearing officer and serve on all parties written objections thereto setting forth the basis of the opposition to the deposition. Such objection shall be filed with the hearing officer within two days after the notice of taking deposition by oral examination is served.
- C. If objections to the taking of the oral deposition are filed with the hearing officer as provided in subsection (B) hereof, the hearing officer shall rule on the objections within five days after the filing of the objections. The taking of the oral deposition shall be held in abeyance pending the ruling of the hearing officer. The hearing officer shall either order the deposition to proceed, order that the deposition not be taken, or enter such other protective order as may be appropriate.
- D. The party taking the deposition shall comply with the Arizona Rules of Civil Procedure governing the taking of depositions.
- E. The expense of any deposition shall be borne by the party taking the deposition but shall not include the expense of any other party.
- F. No scheduled hearing shall be cancelled or continued for failure to take or complete a deposition taken pursuant to the provisions of this rule.
- G. Depositions taken pursuant to the provisions of this rule shall only be used at the time of a hearing for impeachment of a witness, unless the deponent is deceased at the time of the scheduled hearing, in which event it may be admitted into evidence.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-819 recodified from R4-13-819 (Supp. 95-1).

R20-5-820. Witnesses' Oral Deposition; Out-of-State

- A. After a request for hearing is filed with the Commission, any party desiring to take the oral deposition of any other party or witness residing without the state of Arizona shall file with the hearing officer, in duplicate, a request for permission to take

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the deposition of such witness or witnesses. Such request shall show the name and address of such witness or witnesses and set forth the reason why said witness or witnesses' testimony is necessary for an adjudication of the issue. Copies of such request shall be served upon each party by the party requesting permission to take the deposition. If no objection to the request for permission to take the deposition is filed as provided in subsection (B) hereof, the hearing officer may, within 10 days, in his discretion, grant or deny the permission to take the deposition. If the hearing officer permits the taking of the deposition, the party may proceed in the manner provided by and subject to the limitations of subsections (A), (D), (E), and (F).

- B. If any party has any objections to the taking of the oral deposition of the party or witness, he shall file with the hearing officer and serve on all other parties written objections thereto setting forth the basis for the opposition to the deposition. Such objection shall be filed with the hearing officer within five days after the request to take the deposition is served.
- C. If objections to the taking of the oral deposition are filed with the hearing officer as provided in subsection (B) hereof, the hearing officer shall rule on the objections within five days after the filing of the objections. The taking of the oral deposition shall be held in abeyance pending the ruling of the hearing officer. The hearing officer shall either order the deposition to proceed, order that the deposition not be taken, or enter such other protective order as may be appropriate. If the hearing officer orders that the deposition proceed, the party may proceed to take the deposition in the manner provided by and subject to the limitation of R20-5-819, subsections (A), (D), (E), and (F).
- D. Any deposition taken pursuant to the provisions of this rule shall be filed with the Commission at least five days prior to the hearing date or any scheduled hearing and may be admitted into evidence. If the deposition is not filed within the time prescribed herein, it shall not be considered for any purpose except by stipulation of all interested parties, and then only with the concurrence of the hearing officer.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-820 recodified from R4-13-820 (Supp. 95-1).

R20-5-821. Parties' Disposition upon Written Interrogatories

- A. After a request for hearing is filed with the Commission, any party desiring to take the deposition of another party upon written interrogatories shall file with the hearing officer, in duplicate, copies of the interrogatories sought to be submitted to the party. The written interrogatories submitted pursuant to this rule shall be limited to 25 in number with no subsections. Copies of such interrogatories shall be filed at least five days prior to any scheduled hearing.
- B. Answers to the interrogatories shall be served on all parties by the party answering the interrogatories within 10 days after service of the interrogatories, or within 10 days after a ruling by the hearing officer that the interrogatories be answered.
- C. No scheduled hearing shall be cancelled or continued for failure to take or complete the taking of a deposition taken pursuant to the provisions of this rule.
- D. Depositions taken pursuant to the provisions of this rule shall only be used at the time of hearing for impeachment of a witness unless the deponent is deceased at the time of the scheduled hearing in which event they may be admitted into evidence.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-821 recodified from R4-13-821 (Supp. 95-1).

R20-5-822. Refusal to Answer; Refusal to Attend

- A. If a party or other deponent refuses to answer any question propounded upon oral examination pursuant to R20-5-819 and R20-5-820, the examination shall be completed in other matters or adjourned, as the proponent of the question may prefer. Thereafter on reasonable notice to all persons affected thereby the proponent of the question may apply to the hearing officer for an order compelling an answer. Upon the refusal of a deponent to answer any interrogatory submitted under R20-5-821, the proponent of the question may on like notice make like application for such an order. If the motion is granted and if the hearing officer finds that the refusal was without substantial justification, the hearing officer shall require the refusing party, or deponent and the party, or representative advising the refusal or either of them to pay to the examining party the amount of the reasonable attorney's fees incurred in obtaining the order and the reasonable expenses which will be incurred to obtain the requested answers. If the motion is denied and if the hearing officer finds that the motion was made without substantial justification, the hearing officer shall require the examining party or the representative advising the motion, or both of them, to pay to the refusing party or witness the amount of the reasonable attorney's fees incurred in opposing the motion.
- B. If a party or an officer or managing agent of a party wilfully fails to appear before an officer who is to take his deposition after being served with the proper notice, or fails to serve answers to interrogatories after proper service of such interrogatories, the hearing officer, on motion and notice, may strike out all or any part of any pleading of that party, dismiss the action or proceeding or any part thereof, or preclude the introduction of evidence.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-822 recodified from R4-13-822 (Supp. 95-1).

R20-5-823. Burden of Proof

- A. In all proceedings other than those stated in subsection (B) commenced by the filing of a request for hearing, the burden of proof shall rest with the Commission.
- B. In proceedings commenced by a request for hearing requesting modification of the abatement period, the burden of establishing the necessity for such modification shall rest with the petitioner.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-823 recodified from R4-13-823 (Supp. 95-1).

R20-5-824. Intermediary Rulings or Orders by the Hearing Officer

No intermediary rulings or orders by the hearing officer may be appealed to the Review Board but shall become a part of the record.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-824 recodified from R4-13-824 (Supp. 95-1).

R20-5-825. Legal Memoranda

Legal memoranda may be filed if request is granted by the hearing officer. If such request is granted the hearing officer shall establish a reasonable time for such filing and response or simultaneous filing.

Historical Note

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Adopted effective March 20, 1975 (Supp. 75-1). R20-5-825 recodified from R4-13-825 (Supp. 95-1).

R20-5-826. Decisions of Hearing Officers

- A. The decision of the hearing officer shall include findings and conclusions of fact and law, and an order.
- B. The hearing officer shall sign the decision. Upon issuance of the decision, jurisdiction shall rest solely in the Commission, and if a request for review is filed it shall be addressed to the Commission.

Historical Note

Amended effective August 27, 1975 (Supp. 75-1). R20-5-826 recodified from R4-13-826 (Supp. 95-1).

R20-5-827. Settlement

- A. Settlement is encouraged at any stage of the proceedings where such settlement is consistent with the provisions and objectives of the Act.
- B. Settlement agreement submitted by the parties shall be accompanied by an appropriate proposed order which shall be signed by the assigned hearing officer or chief hearing officer.
- C. Where parties to the settlement agree upon a proposal, it shall be served upon represented and unrepresented affected employees in the manner set forth in R20-5-806. Proof of such service shall accompany the proposed settlement when submitted to the Commission or the hearing officer.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-827 recodified from R4-13-827 (Supp. 95-1).

R20-5-828. Special Circumstances; Waiver of Rules

In special circumstances, or for good cause shown, the hearing officer may, upon application by any party, or on his own motion, waive any rule or make such orders as justice or the administration of the Act requires.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-828 recodified from R4-13-828 (Supp. 95-1).

R20-5-829. Variances

- A. Any hearing concerning variances shall be filed before the Commissioners at a time set by the Commission.
- B. Such proceeding shall be informal but shall be transcribed at the expense of the person seeking the variance if a written record of the proceeding is desired.

Historical Note

Adopted effective March 20, 1975 (Supp. 75-1). R20-5-829 recodified from R4-13-829 (Supp. 95-1).

ARTICLE 9. EXPIRED**R20-5-901. Expired****Historical Note**

Adopted effective January 13, 1976 (Supp. 76-1). Former Section R4-13-901 repealed, new Section R4-13-901 adopted effective May 27, 1977 (Supp. 77-3). R20-5-901 recodified from R4-13-901 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-902. Expired**Historical Note**

Adopted effective January 13, 1976 (Supp. 76-1). Former Section R4-13-902 repealed, new Section R4-13-902 adopted effective May 27, 1977 (Supp. 77-3). R20-5-902

recodified from R4-13-902 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-903. Expired**Historical Note**

Adopted effective January 13, 1976 (Supp. 76-1). Former Section R4-13-903 repealed, new Section R4-13-903 adopted effective May 27, 1977 (Supp. 77-3). R20-5-903 recodified from R4-13-903 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-904. Expired**Historical Note**

Adopted effective January 13, 1976 (Supp. 76-1). Former Section R4-13-904 repealed, new Section R4-13-904 adopted effective May 27, 1977 (Supp. 77-3). R20-5-904 recodified from R4-13-904 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-905. Expired**Historical Note**

Adopted effective January 13, 1976 (Supp. 76-1). Former Section R4-13-905 repealed, new Section R4-13-905 adopted effective May 27, 1977 (Supp. 77-3). R20-5-905 recodified from R4-13-905 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-906. Expired**Historical Note**

Adopted effective January 13, 1976 (Supp. 76-1). Former Section R4-13-906 repealed, new Section R4-13-906 adopted effective May 27, 1977 (Supp. 77-3). R20-5-906 recodified from R4-13-906 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-907. Expired**Historical Note**

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-907 recodified from R4-13-907 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-908. Expired**Historical Note**

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-908 recodified from R4-13-908 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-909. Expired**Historical Note**

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-909 recodified from R4-13-909 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-910. Expired**Historical Note**

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Adopted effective May 27, 1977 (Supp. 77-3). R20-5-910 recodified from R4-13-910 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-911. Expired**Historical Note**

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-911 recodified from R4-13-911 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-912. Expired**Historical Note**

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-912 recodified from R4-13-912 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-913. Expired**Historical Note**

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-913 recodified from R4-13-913 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

R20-5-914. Expired**Historical Note**

Adopted effective May 27, 1977 (Supp. 77-3). R20-5-914 recodified from R4-13-914 (Supp. 95-1). Section expired pursuant to A.R.S. § 41-1056(E), filed in the Office of the Secretary of State February 4, 2000 (Supp. 00-1).

ARTICLE 10. WAGE CLAIMS**R20-5-1001. Definitions**

In this Article, unless the context otherwise requires:

1. "Claim" means a wage claim pursuant to A.R.S. § 23-356.
2. "Claimant" means an individual who files a claim.
3. "Day" means calendar day.
4. "Department" means the Labor Department of the Industrial Commission of Arizona.
5. "Determination" means a finding by the Department under A.R.S. § 23-357 that a claim is either valid or invalid or that the Department cannot resolve the dispute.
6. "Director" means the Director of the Department.
7. "Dismissal" means an action by the Department in which the Department dismisses the claim and refers the claimant to other statutory remedies.
8. "Notice" or "notification" when made by the Department or the Director means a written communication served on the employer or claimant, or both.

Historical Note

Adopted effective January 26, 1988 (Supp. 88-1). R20-5-1001 recodified from R4-13-1001 (Supp. 95-1). Amended by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2). Amended by final rulemaking 27 A.A.R. 515, effective May 14, 2021 (Supp. 21-1).

R20-5-1002. Forms

The following forms are available upon request from the Department or from the Industrial Commission of Arizona's website at www.azica.gov:

1. Wage claim. When making a claim, a claimant shall provide the following information to the Department:
 - a. Claimant's name, mailing address, e-mail address, telephone number, and date of birth;
 - b. Employer's name, address, telephone number, and description of business;
 - c. Claimant's dates of employment, position, and pay;
 - d. The amount of the wages owed and the time period worked related to the unpaid wages; and
 - e. Claimant's signature or electronic signature and signature date.
2. Employer response. The employer responding to a claim shall provide the following information to the Department:
 - a. Employer's legal name, including any trade names, legal domicile state, address, telephone number, description of business, and an e-mail address for the designated representative of employer;
 - b. Claimant's dates of employment, position, and pay;
 - c. Whether claimant is owed any wages, and, if so, employer's reason for nonpayment; and
 - d. Employer's signature or electronic signature and signature date.

Historical Note

Adopted effective January 26, 1988 (Supp. 88-1). R20-5-1002 recodified from R4-13-1002 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2). Amended by final rulemaking 27 A.A.R. 515, effective May 14, 2021 (Supp. 21-1).

R20-5-1003. Filing Requirements; Time for Filing; Computation of Time

- A. A claimant shall file a claim with the Department within one year of the date of the accrual of the claim.
- B. In computing any period of time prescribed or allowed by this Article, the day of the act or event from which the designated period of time begins to run is not included. The last day of the period and Saturdays, Sundays, and legal holidays are included in the computation of time.
- C. The date of filing of the claim is the date the claimant's wage claim form is received by the Department.
- D. The Department shall deem a form, document, instrument, or other written record filed at the Tucson office as filed at the Phoenix office for the purpose of computing time.
- E. An individual filing a form or document related to a claim shall legibly fill out the form or document.
- F. If the wage claim form received from a claimant does not include the information required by R20-5-1002(1), the Department shall return the wage claim form to the claimant with a request that the claimant provide the required information and return the completed wage claim form to the Department within 14 days of the date of service of the Department's request. If the Department does not receive the completed wage claim form within 14 days, the Department shall not initiate an investigation of the claim and the Department shall consider the claim withdrawn without prejudice. The claimant may re-file a withdrawn wage claim with the information required by R20-5-1002(1), if the claim is re-filed within one year of the date of the accrual of the claim.

Historical Note

Adopted effective January 26, 1988 (Supp. 88-1). R20-5-1003 recodified from R4-13-1003 (Supp. 95-1). Former R20-5-1003 renumbered to R20-5-1004; new R20-5-

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1003 made by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2). Amended by final rulemaking 27 A.A.R. 515, effective May 14, 2021 (Supp. 21-1).

R20-5-1004. Investigation of Claim

- A. The Department shall serve a copy of a claimant's wage claim form on the employer listed on the wage claim, with a request that the employer complete and file the employer response form within 14 days of the date of service of the Department's request.
- B. If the Department does not receive the employer response form under subsection (A), the Department shall serve written notice on the employer stating that the employer must pay the amount claimed or file a written response to the wage claim within 14 days of the date of service of the Department's written notice.
- C. The Department shall serve a copy of the employer's response on the claimant and offer the claimant the opportunity to file a written reply to the employer's response within 14 days from the date of service. If the Department does not receive claimant's reply within 14 days, the Department shall make a determination of the claim based on the evidence in the file.
- D. If the employer fails or refuses to pay the amount claimed or submit a written response to the claim in accordance with subsection (B), the Department shall make a determination of the claim based on the evidence in the file.
- E. Upon request from the Department, and if necessary to complete the Department's investigation, the claimant, the employer, or both, shall submit further written information or meet with the Director or the Director's designee. Except for statements made during settlement, mediation, or an informal conference, the Director or the Director's designee may administer oaths for the purpose of taking affidavits and may record the meeting.
- F. Upon completion of its investigation, the Department shall serve the Department's determination in writing on the parties.

Historical Note

Adopted effective January 26, 1988 (Supp. 88-1). R20-5-1004 recodified from R4-13-1004 (Supp. 95-1). Former R20-5-1004 renumbered to R20-5-1005; new R20-5-1004 renumbered from R20-5-1003 and amended by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2). Amended by final rulemaking 27 A.A.R. 515, effective May 14, 2021 (Supp. 21-1).

R20-5-1005. Mediation of Disputes

- A. During the investigation of a claim, the Department may mediate and conciliate a dispute between the claimant and the employer.
- B. If mediation results in an informal resolution of the claim, the Director or the Director's designee shall prepare and ensure execution of documents providing for the resolution of the claim.

Historical Note

Adopted effective January 26, 1988 (Supp. 88-1). R20-5-1005 recodified from R4-13-1005 (Supp. 95-1). Former R20-5-1005 renumbered to R20-5-1006; new R20-5-1005 renumbered from R20-5-1004 and amended by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2).

R20-5-1006. Dismissal of Claim

- A. The Department shall dismiss a claim if:

1. The claim is filed more than one year after the date of the accrual of the claim,
2. The claimant does not comply with R20-5-1003(F),
3. The amount of wages owed exceeds \$5,000.00,
4. The Department's investigation of the claimant's evidence reveals no possible violation of A.R.S. § 23-350 et seq.,
5. The claimant has filed a civil action regarding the same claim,
6. The employer listed on the claim is in bankruptcy,
7. The Department is unable to locate the employer based on the information provided by the claimant, or
8. The wages in question have been withheld from the claimant pursuant to the claimant's prior written authorization.

- B. The Department shall send a notice of dismissal to the claimant and, except as provided in subsections (A)(1) through (A)(3) and (7), the Department shall send a notice of dismissal to the employer. Notices of dismissal shall notify the claimant of the availability of other remedies.

Historical Note

Adopted effective January 26, 1988 (Supp. 88-1). R20-5-1006 recodified from R4-13-1006 (Supp. 95-1). Former R20-5-1006 renumbered to R20-5-1007; new R20-5-1006 renumbered from R20-5-1005 and amended by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2). Amended by final rulemaking 27 A.A.R. 515, effective May 14, 2021 (Supp. 21-1).

R20-5-1007. Notice of Right of Review

A determination issued under A.R.S. § 23-357 shall include a notice informing the parties of their right to seek review under A.R.S. § 23-358 and § 12-901 et seq.

Historical Note

Adopted effective January 26, 1988 (Supp. 88-1). R20-5-1007 recodified from R4-13-1007 (Supp. 95-1). Former R20-5-1007 renumbered to R20-5-1008; new R20-5-1007 renumbered from R20-5-1006 and amended by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2). Amended by final rulemaking 27 A.A.R. 515, effective May 14, 2021 (Supp. 21-1).

R20-5-1008. Payment of Claim

- A. The Department shall send any payment of a wage claim received by the Department to the claimant by certified mail, return receipt requested, unless the claimant elects to pick up the check in person at the Department.
- B. If the Department discovers that payment of a wage claim is alleged to have been made directly to the claimant, the Department shall verify the payment by serving the claimant with notice that payment of the wage claim is alleged to have been made directly to the claimant. If the claimant confirms that payment of the wage claim was made directly to the claimant or does not respond to the Department's notice within 14 days of the date of service of the Department's notice, the Department shall deem the claim to have been paid and shall dismiss the wage claim.
- C. Payment of a partial amount of a wage claim does not preclude the Department from completing its investigation of the balance of the claim.
- D. In the case of a determination and directive for payment issued by the Department under A.R.S. § 23-357, the Department shall, if the employer agrees and with the written consent of the claimant, enter into a payment agreement with the

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employer for payment of the amount of wages found to be owed the claimant.

Historical Note

New R20-5-1008 renumbered from R20-5-1007; Section amended by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2). Amended by final rulemaking 27 A.A.R. 515, effective May 14, 2021 (Supp. 21-1).

R20-5-1009. Service of Determinations, Notices, and Other Documents

- A. A determination, notice, or other document required by this Article or other law to be served upon a party, shall be made upon the party, or, if represented by legal counsel, the party's legal counsel. Service upon legal counsel is considered service upon the party.
- B. Service may be made and is deemed complete by:
1. Depositing the document in regular or certified mail, addressed to the party served at the address shown in the records of the Department, or by personal delivery upon the party.
 2. With a party's consent, transmission by e-mail to the e-mail address shown in the records of the Department.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 1416, effective June 4, 2006 (Supp. 06-2). Amended by final rulemaking 27 A.A.R. 515, effective May 14, 2021 (Supp. 21-1).

ARTICLE 11. REPEALED**R20-5-1101. Repealed****Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1102. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1103. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1104. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1105. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1106. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1107. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1108. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1109. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1110. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1111. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1112. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

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R20-5-1129. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1130. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1131. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1132. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1133. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1134. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1135. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1136. Repealed**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1008, effective April 4, 2005 (Supp. 05-1). Section repealed by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

ARTICLE 12. ARIZONA MINIMUM WAGE AND EARNED PAID SICK TIME PRACTICE AND PROCEDURE**R20-5-1201. Notice of Rules**

- A. This Article applies to all actions and proceedings before the Industrial Commission of Arizona arising under A.R.S. Title 23, Articles 8 and 8.1.
- B. The Industrial Commission of Arizona shall provide a copy of this Article upon request to any person free of charge.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4). Amended by final rulemaking at 23 A.A.R. 2907, effective October 3, 2017 (Supp. 17-4).

R20-5-1202. Definitions

In this Article, the definitions of A.R.S. §§ 23-362 (version two), 23-371, and 23-364 apply. In addition, unless the context otherwise requires, the following definitions shall apply to both the Act and this Article:

“Act” means A.R.S. Title 23, Chapter 2, Articles 8 and 8.1.

“Affected employee” means an employee or employees on whose behalf a complaint may be filed alleging a violation under the Act.

“Amount of earned paid sick time available to the employee” means the amount of earned paid sick time or equivalent paid time off that is available to the employee for use in the current year.

“Amount of earned paid sick time taken by the employee to date in the year” means the amount of earned paid sick time or equivalent paid time off taken by the employee to date in the current year. Where an employee has used available equivalent paid time off for either the purposes enumerated in A.R.S. § 23-373 or other purposes, the employer may count that usage towards the “amount of earned paid sick time taken by the employee to date in the year.”

“Amount of pay the employee has received as earned paid sick time” means the amount of pay the employee has received as earned paid sick time or equivalent paid time off to date in the current year. Where an employee has received pay for equivalent paid time off for the purposes enumerated in A.R.S. § 23-373 or other purposes, the employer may count that pay towards the “amount of pay the employee has received as earned paid sick time.”

“Authorized representative” means a person prescribed by law to act on behalf of a party who files with the Department a written instrument advising of the person’s authority to act on behalf of the party.

“Casual Basis,” when applied to babysitting services, means employment which is irregular or intermittent.

“Commission” means monetary compensation based on:

A percentage of total sales,

A percentage of sales in excess of a specified amount,

A fixed allowance per unit, or

Some other formula the employer and employee agree to as a measure of accomplishment.

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“Communicable disease” has the meaning prescribed by A.R.S. § 36-661.

“Complainant” means a person or organization filing an administrative complaint under the Act.

“Department” means the Labor Department of the Industrial Commission of Arizona or other authorized division of the Industrial Commission as designated by the Industrial Commission.

“Earned sick time” under A.R.S. § 23-364(G) means earned paid sick time.

“Employee’s regular paycheck” means a regular payroll record that is readily available to employees and contains the information required by A.R.S. § 23-375(C), including physical or electronic paychecks or paystubs.

“Equivalent paid time off” means paid time off provided under a paid leave policy, such as a paid time off policy, that makes available an amount of paid leave sufficient to meet the accrual requirements of the Act that may be used for the same purposes and under the same conditions as earned paid sick time.

“Filing” means receipt of a report, document, instrument, videotape, audiotape, or other written matter at an office of the Department.

The term “health care professional” in A.R.S. § 23-373(G) has the same meaning as “health care professional,” as defined in this Section.

“Health care professional” means any of the following:

A “physician” as defined by A.R.S. § 36-2351;

A “physician assistant” as defined by A.R.S. § 32-2501;

A “registered nurse practitioner” as defined by A.R.S. § 32-1601.

A certified nurse midwife who is a registered nurse practitioner approved by the Arizona State Board of Nursing to provide primary care services during pregnancy, childbirth, and the postpartum period;

A dentist licensed under A.R.S. Title 32, Chapter 11, Article 2; or

A behavioral health provider practicing as:

A psychologist licensed under A.R.S. Title 32, Chapter 19.1;

A clinical social worker licensed under A.R.S. § 32-3293;

A marriage and family therapist licensed under A.R.S. § 32-3311; or

A professional counselor licensed under A.R.S. § 32-3301.

“Health care provider” has the meaning prescribed by A.R.S. § 36-661.

“Hours worked” means all hours for which an employee covered under the Act is employed and required to give to the employer, including all time during which an employee is on duty or at a prescribed work place and all time the employee is suffered or permitted to work.

“Minimum wage” means the lowest rate of monetary compensation required under the Act.

“Monetary compensation” means cash or its equivalent due to an employee by reason of employment.

“On duty” means time spent working or waiting that the employer controls and that the employee is not permitted to use for the employee’s own purpose.

“Public benefits” has the same meaning as “state or local public benefit,” as prescribed by A.R.S. § 1-502(I).

“Public health emergency” means a state of emergency declared by the governor in which there is an occurrence or imminent threat of an illness or health condition caused by bioterrorism, an epidemic or pandemic disease or a highly fatal infectious agent or biological toxin and that poses a substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability.

“Salaried” means receiving a fixed amount of pay regardless of how many hours are worked each week.

“Salary” means a fixed compensation paid regularly for employment.

“Same hourly rate” means the following:

For employees paid on the basis of a single hourly rate, “same hourly rate” shall be the hourly rate the employee would have earned for the period of time in which earned paid sick time or equivalent paid time off is used, but shall in no case be less than minimum wage.

For employees who are paid multiple hourly rates of pay, “same hourly rate” shall be determined in the following order of priority, but shall in no case be less than minimum wage:

The hourly rate the employee would have earned, if known, for each hour of earned paid sick time or equivalent paid time off used.

The weighted average of all hourly rates of pay during the previous pay period.

For employees who are paid a salary, no additional pay is due when the employee’s use of earned paid sick time or equivalent paid time off results in no reduction in the employee’s regular salary during the pay period in which the earned paid sick time or equivalent paid time off is used. “Same hourly rate” for salaried employees shall be determined in the following order of priority, but shall in no case be less than minimum wage:

The wages an employee earns during each pay period covered by the salary divided by the number of hours agreed to be worked during each pay period, if the number of hours to be worked during each pay period was previously established.

The wages an employee earns during each work-week covered by the salary in the current year divided by 40 hours.

For employees paid on a commission, piece-rate, or fee-for-service basis, “same hourly rate” shall be determined in the following order of priority, but shall in no case be less than minimum wage:

The hourly rate of pay previously agreed upon by the employer and the employee as:

A minimum hourly rate for work performed; or

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An hourly rate for payment of earned paid sick time or equivalent paid time off.

The wages that the employee would have been paid, if known, for the period of time in which earned paid sick time or equivalent paid time off is used, divided by the number of hours of earned paid sick time or equivalent paid time off used.

A reasonable estimation of the commission, piece-rate, or fee-for-service compensation that the employee would have been paid for the period of time in which the earned paid sick time or equivalent paid time off is used divided by the number of hours of earned paid sick time or equivalent paid time off used.

The hourly average of all commission, piece rate, or fee-for-service compensation that the employee earned during the previous 90 days, if the employee worked regularly during the previous 90-day period, based on:

Hours that the employee actually worked; or

A 40-hour workweek.

The hourly average of all commission, piece rate, or fee-for-service compensation that the employee earned during the previous 365 days, based on:

Hours that the employee actually worked; or

A 40-hour workweek.

“Same hourly rate” includes shift differentials and premiums meant to compensate an employee for work performed under differing conditions (such as hazard pay or a shift differential for working at night) if the employee would have been entitled to the shift differential or premium for the period of time in which earned paid sick time or equivalent paid time off is used.

“Same hourly rate” does not include:

Additions to an employee’s base rate for overtime or holiday pay;

Subject to the “Same hourly rate,” bonuses or other types of incentive pay; and

Tips or gifts.

“Smallest increment that the employer’s payroll system uses to account for absences or use of other time” means the smallest increment of time that an employer utilizes, by policy or practice, to account for absences or use of other paid time off.

“Tip” means a sum that a customer presents as a gift in recognition of some service performed, and includes gratuities. The sum may be in the form of cash, amounts paid by bank check or other negotiable instrument payable at par, or amounts the employer transfers to the employee under directions from a credit customer who designates an amount to be added to a bill as a tip. Gifts in forms other than cash or its equivalent as described in this definition, such as event tickets, passes, or merchandise, are not tips.

“Violation” means a transgression of any statute or rule, or any part of a statute or rule, including both acts and omissions.

“Willfully” means acting with actual knowledge of the requirements of the Act or this Article, or acting with reckless disregard of the requirements of the Act or this Article.

“Workday” means any fixed period of 24 consecutive hours.

“Workweek” means any fixed and regularly recurring period of seven consecutive workdays.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4). Amended by final rulemaking at 23 A.A.R. 2907, effective October 3, 2017 (Supp. 17-4). Amended by final rulemaking at 29 A.A.R. 607 (February 24, 2023), with an immediate effective date of February 9, 2023 (Supp. 23-1).

R20-5-1203. Duty to Provide Current Address

- A. A complainant shall provide and keep the Labor Department advised of the complainant’s current mailing address and telephone number.
- B. An employer under investigation by the Department shall provide and keep the Labor Department advised of the employer’s current mailing address and telephone number.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1204. Forms Prescribed by the Department

Forms prescribed by the Department, including the poster required under R20-5-1208, shall not be changed, amended, or otherwise altered without the prior written approval of the Department.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1205. Determination of Employment Relationship

- A. Determination of an employment relationship under the Act, which includes whether an individual is an independent contractor, shall be based upon the economic realities of the relationship. Consideration of whether an individual is economically dependent on the employer for which the individual performs work shall be determined by factors showing dependence, which non-exclusive factors shall include those factors identified in A.R.S. §§ 23-902(D) and 23-1601(B).
- B. An individual who works for another person without any express or implied compensation agreement is not an employee under the Act. This may include an individual that volunteers to work for civic, charitable, or humanitarian reasons that are offered freely and without direct or implied pressure or coercion from an employer, provided that the volunteer is not otherwise employed by the employer to perform the same type of services as those which the individual proposes to volunteer.

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- C. An individual who works for another individual as a babysitter on a casual basis and whose vocation is not babysitting, is not an employee under the Act even if the individual performs other household work not related to caring for the children, provided the household work does not exceed 20% of the total hours worked on the particular babysitting assignment.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4). Amended by final rulemaking at 23 A.A.R. 2907, effective October 3, 2017 (Supp. 17-4).

R20-5-1206. Payment of Minimum Wage; Commissions; Tips; Front Loading Earned Paid Sick Time; Limitation on Carry Over of Unused Earned Paid Sick Time

- A. Subject to the requirements of the Act and this Article, no less than the minimum wage shall be paid for all hours worked, regardless of the frequency of payment and regardless of whether the wage is paid on an hourly, salaried, commissioned, piece rate, or any other basis.
- B. If the combined wages of an employee are less than the applicable minimum wage for a work week, the employer shall pay monetary compensation already earned, and no less than the difference between the amounts earned and the minimum wage as required under the Act.
- C. The workweek is the basis for determining an employee's hourly wage. Upon hire, an employer shall advise the employee of the employee's designated workweek. Once established, an employer shall not change or manipulate an employee's workweek to evade the requirements of the Act.
- D. In computing the minimum wage, an employer shall consider only monetary compensation and shall count tips and commissions in the workweek in which the tip or commission is earned.
- E. An employer is allowed to:
1. Require or permit employees to pool, share, or split tips; and
 2. Require an employee to report tips to the employer in order to meet reporting requirements of this Article and federal law.
- F. An employer who hires an employee after the beginning of the employer's year is not required to provide additional earned paid sick time or equivalent paid time off during that year if the employer provides the employee for immediate use on the employee's ninetieth calendar day after commencing employment an amount of earned paid sick time or equivalent paid time off that meets or exceeds the employer's reasonable projection of the amount of earned paid sick time or equivalent paid time off that the employee would have accrued from the date of hire through the end of the employer's year at a rate of one hour for every 30 hours worked. If the amount of earned paid sick time or equivalent paid time off provided is less than the employee would have accrued based on hours actually worked during the employer's year, the employer shall immediately provide an amount of earned paid sick time or equivalent paid time off that reflects the difference between the employer's projection and the amount of earned paid sick time or equivalent paid time off that the employee would have accrued for hours actually worked in the year.
- G. Subject to subsection (F), an employer with 15 or more employees that provides its employees for immediate use at

the beginning of each year 40 or more hours of earned paid sick time or 40 or more hours of equivalent paid time off is not required to provide carryover or additional accrual.

- H. Subject to subsection (F), an employer with fewer than 15 employees that provides its employees for immediate use at the beginning of each year 24 or more hours of earned paid sick time or 24 or more hours of equivalent paid time off is not required to provide carryover or additional accrual.
- I. Unless an employer: (1) elects to pay an employee for unused earned paid sick time or equivalent paid time off at the end of a year pursuant to A.R.S. § 23-372(D)(4); or (2) meets the requirements of subsections (G) or (H), unused earned paid sick time and equivalent paid time off may be carried over to the next year, as follows:
1. Subject to an employer's entitlement to permit greater carry over, an employee of an employer with 15 or more employees may carry over to the following year up to 40 hours of unused earned paid sick time or equivalent paid time off.
 2. Subject to an employer's entitlement to permit greater carry over, an employee of an employer with fewer than 15 employees may carryover to the following year up to 24 hours of unused earned paid sick time or equivalent paid time off.
 3. Carry over shall not affect accrual, usage rights, or usage limits under the Act.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4). Amended by final rulemaking at 23 A.A.R. 2907, effective October 3, 2017 (Supp. 17-4).

R20-5-1207. Tip Credit Toward Minimum Wage

- A. In this Section, unless the context otherwise requires, "customarily and regularly" means receiving tips on a consistent and recurrent basis, the frequency of which may be greater than occasional, but less than constant, and includes the occupations of waiter, waitress, bellhop, busboy, car wash attendant, hairdresser, barber, valet, and service bartender.
- B. For purposes of calculating the permissible credit for tips under A.R.S. § 23-363(C), the following applies:
1. Tips are customarily and regularly received in the occupation in which the employee is engaged;
 2. Except as provided in R20-5-1206(E), the employee actually receives the tip free of employer control as to how the employee uses the tip and the tip becomes the employee's property;
 3. Employees who customarily and regularly receive tips may pool, share, or split tips between them, and the amount each employee actually retains is considered the tip of the employee who retains it;
 4. Employer-required sharing of tips with employees who do not customarily and regularly receive tips in the occupation in which the employee is engaged, including management or food preparers, are not credited toward that employee's minimum wage; and
 5. A compulsory charge for service imposed on a customer by an employer's establishment are not credited toward an employee's minimum wage unless the employer actually distributes the charge to the employee in the pay period in which the charge is earned.

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- C. Upon hiring or assigning an individual to a position that customarily and regularly receives tips, an employer intending to exercise a tip credit shall provide written notice to the employee prior to exercising the tip credit. Thereafter, the employer shall notify the employee in writing each pay period of the amount per hour that the employer takes as a tip credit.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1208. Posting Requirements; Small Employer Exemption

- A. With the exception of small employers, every employer subject to the Act shall place the posters prescribed by the Department informing employees of their rights under the Act in a conspicuous place in every establishment where employees are employed and where notices to employees are customarily placed. The employer shall ensure that the notices are not removed, altered, defaced, or covered by other material.
- B. In this Section, unless context otherwise requires, "small employer" means a corporation, proprietorship, partnership, joint venture, limited liability company, trust, or association that has less than \$500,000 in gross annual revenue.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4). Amended by final rulemaking at 23 A.A.R. 2907, effective October 3, 2017 (Supp. 17-4).

R20-5-1209. Records Availability

- A. Each employer shall keep the records required under the Act and this Article safe and accessible at the place or places of employment, or at one or more established central recordkeeping offices where the records are customarily maintained. When the employer maintains the records at a central recordkeeping office other than in the place or places of employment, the employer shall make the records available to the Department within 72 hours following notice from the Department.
- B. Employers or technology that is necessary to facilitate inspection and copying of the records.
- C. Each employer required to maintain records under the Act shall make enlargement, recomputation, or transcription of the records and shall submit to the Department the records or reports in a readable format upon the Department's written request.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4). Amended by final rulemaking at 23 A.A.R. 2907, effective October 3, 2017 (Supp. 17-4).

R20-5-1210. General Recordkeeping Requirements

- A. Payroll records required to be kept under the Act include:

1. All time and earning cards or sheets on which are entered the daily starting and stopping time of individual employees, or of separate work forces, or the amounts of work accomplished by individual employees on a daily, weekly, or pay period basis (for example, units produced) when those amounts determine in whole or in part those employees' pay period wages and earned paid sick time or equivalent paid time off;
2. From their last effective date, all wage-rate tables or schedules of the employer that provide the piece rates or other rates used in computing wages; and
3. Records of additions to or deductions from wages paid and records that support or corroborate the additions or deductions.

- B. Except as otherwise provided in this Section, every employer shall maintain and preserve payroll or other records containing the following information and data with respect to each employee to whom the Act applies:

1. Name in full, and on the same record, the employee's identifying symbol or number if it is used in place of the employee's name on any time, work, or payroll record;
2. Home address, including zip code;
3. Date of birth, if under 19;
4. Occupation in which employed;
5. Time of day and day of week on which the employee's workweek begins. If the employee is part of a workforce or employed in or by an establishment all of whose workers have a workweek beginning at the same time on the same day, then a single notation of the time of the day and beginning day of the workweek for the whole workforce or establishment is permitted;
6. Regular hourly rate of pay for any workweek and an explanation of the basis of pay by indicating the monetary amount paid on a per hour, per day, per week, per piece, commission on sales, or other basis, including the amount and nature of each payment;
7. Hours worked each workday and total hours worked each workweek;
8. Total daily or weekly wages due for hours worked during the workday or workweek;
9. Total additions to or deductions from wages paid each pay period including employee purchase orders or wage assignments, including, for individual employee records, the dates, amounts, and nature of the items that make up the total additions and deductions;
10. Total wages paid each pay period;
11. Date of payment and the pay period covered by payment;
12. The amount of earned paid sick time available to the employee;
13. The amount of earned paid sick time taken by the employee to date in the year;
14. The amount of pay the employee has received as earned paid sick time; and

- C. For an employee who is compensated on a salary basis at a rate that exceeds the minimum wage required under the Act and who, under 29 CFR 541, is an exempt bona fide executive, administrative, or professional employee, including an employee employed in the capacity of academic administrative personnel or teachers in elementary or secondary schools, or in outside sales, an employer shall maintain and preserve:

1. Records containing the information and data required under subsections (B)(1) through (B)(5), and (B)(10) through (B)(14); and
2. Records containing the basis on which wages are paid in sufficient detail to permit a determination or calculation

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of whether the salary received exceeds the minimum wage required under the Act, including a record of the hours upon which payment of the salary is based, whether full time or part time.

- D. With respect to employees working on fixed schedules, an employer may maintain records showing instead of the hours worked each day and each workweek as required under this Section, the schedule of daily and weekly hours the employee normally works, provided:
 1. In weeks in which an employee adheres to this schedule, the employer indicates by check mark, statement, or other method, that the employee actually worked the hours; and
 2. In weeks in which more or fewer than the scheduled hours are worked, the employer records the number of hours actually worked each day and each week.
- E. With respect to an employee that customarily and regularly receives tips, the employer shall ensure that the records required under this Article include the following information:
 1. A symbol, letter, or other notation placed on the pay records identifying each employee whose wage is determined in part by tips;
 2. Amount of tips the employee reports to the employer;
 3. The hourly wage of each tipped employee after taking into consideration the employee's tips;
 4. Hours worked each workday in any occupation in which the employee does not receive tips, and total daily or week straight-time payment made by the employer for the hours;
 5. Hours worked each workday in occupations in which the employee receives tips and total daily or weekly straight-time wages for the hours; and
 6. Copy of the notice required under R20-5-1207(C).
- F. An employer who makes retroactive payment of wages, voluntarily or involuntarily, shall record on the pay records, the amount of the payment to each employee, the period covered by the payment, and the date of payment.
- G. For an employee who is signed to a contract to play minor league baseball and is exempt pursuant to 29 U.S.C. 213(a)(19), an employer shall maintain and preserve records containing the information and data required under subsections (B)(1) through (B)(5), (B)(10) and (B)(11).

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4). Amended by final rulemaking at 23 A.A.R. 2907, effective October 3, 2017 (Supp. 17-4). Amended by final rulemaking at 29 A.A.R. 607 (February 24, 2023), with an immediate effective date of February 9, 2023 (Supp. 23-1).

R20-5-1211. Administrative Complaints

- A. A person or organization alleging a minimum wage, earned paid sick time, or equivalent paid time off violation shall file a complaint with the Labor Department within one year from the date the wages, earned paid sick time, or equivalent paid time off were due.
- B. A person or organization alleging retaliation, discrimination, or a violation of A.R.S. § 23-377 shall file a complaint with the Labor Department within one year from the date the alleged violation occurred or when the employee knew or should have known of the alleged violation.

- C. The person or organization filing a complaint with the Labor Department shall sign the complaint.
- D. Any person or organization other than an affected employee who files a complaint shall include the names of affected employees.
- E. Upon its own complaint, the Department may investigate violations under the Act.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4). Amended by final rulemaking at 23 A.A.R. 2907, effective October 3, 2017 (Supp. 17-4).

R20-5-1212. Conduct that Hinders Investigation

An employer hinders an investigation under the Act if the employer engages in conduct, or causes another person to engage in conduct, that delays or otherwise interferes with the Department's investigation, including:

1. Obstructing or refusing to admit the Department to any place of employment authorized under the Act;
2. Obstructing or refusing to permit interviews authorized under the Act;
3. Failing to make, keep, or preserve records required under the Act or this Article;
4. Failing to permit the review and copying of records required under the Act and this Article; and
5. Falsifying any record required under the Act or this Article.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1213. Findings and Order Issued by the Department

- A. Except as provided in R20-5-1219, after receipt of a complaint alleging a violation of the Act, the Department shall issue a Findings and Order of its determination. The Department shall serve its Findings and Order to both the employer and the complainant. Service may be made and is deemed complete by either depositing the document in regular or certified mail, addressed to the party served at the address shown in the records of the Department, by personal delivery upon the party, or with a party's consent, transmission by email to the email address shown in the records of the Department.
- B. If the Department determines that an employer has violated the minimum wage, earned paid sick time, or equivalent paid time off requirements, the Department shall order the employer to pay the employee, and if applicable, affected employees, the balance of the wages, earned paid sick time, or equivalent paid time off owed, including interest at the legal rate and an additional amount equal to twice the underpaid wages, earned paid sick time, or equivalent paid time off owed.
- C. If the Department determines that a retaliation, discrimination, confidentiality, or nondisclosure violation has occurred, the Department shall direct the employer or other person to cease and desist from the violation and may take action necessary to remedy the violation, including:
 1. Rehiring or reinstatement,

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2. Reimbursement of lost wages and interest,
 3. Payment of penalty to employees or affected employees as provided for in the Act and this Article, and
 4. Posting of notices to employees.
- D.** If the Department determines that no violation of the Act has occurred, or if the Department is unable to reach a conclusion based on the evidence submitted, the Department shall notify the parties and shall dismiss the complaint without prejudice. After notification of the Department's determination, the complainant may bring a civil action under A.R.S. § 23-364(E).
- E.** The Department may assess civil penalties for recordkeeping, posting, and other violations under the Act and this Article as part of a Findings and Order issued under subsection (A) or the civil penalties and other violations may be assessed as a separate Findings and Order. If issued as a separate Findings and Order, the Department shall serve, personally or by regular first class mail, the Findings and Order on the employer and, if a complaint has been filed, the complainant.
- F.** The Director of the Department shall sign the written Findings and Order issued by the Department.
- G.** If an employer does not comply with a Findings and Order issued by the Department within 10 days following finality of the Findings and Order, the Department may refer the matter to a law enforcement officer.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4). Amended by final rulemaking at 23 A.A.R. 2907, effective October 3, 2017 (Supp. 17-4). Amended by final rulemaking at 29 A.A.R. 607 (February 24, 2023), with an immediate effective date of February 9, 2023 (Supp. 23-1).

R20-5-1214. Review of Department Findings and Order; Hearings; Issuance of Decision Upon Hearing

- A.** Except as provided in R20-5-1213(D), a party aggrieved by a Findings and Order issued by the Department may request a hearing by filing a written request for hearing with the Department within 30 days after the Findings and Order is served upon the party. Failure to timely file a request for hearing means that the Findings and Order issued by the Department is final and res judicata to all parties.
- B.** A request for hearing shall be in writing and contain:
1. The name and address of the party requesting the hearing,
 2. The signature of the party or the party's authorized representative, and
 3. A statement that a hearing is requested.
- C.** Upon receipt of a timely filed request for hearing, the Department shall refer the matter to the Administrative Law Judge Division of the Commission for hearing.
- D.** Except as otherwise provided in this Section, the hearing shall be conducted under A.R.S. § 41-1061 et seq.
- E.** A person submitting correspondence or other documents, including subpoena requests, to an administrative law judge concerning a matter pending before the administrative law judge, shall contemporaneously serve a copy of the correspondence or other document upon all other parties, or if represented, the parties' authorized representative.
- F.** The administrative law judge may dismiss a request for hearing when it appears to the judge's satisfaction that the parties have resolved the disputed issue or issues.

- G.** The administrative law judge shall issue a written decision upon hearing containing findings of fact and conclusions of law no later than 30 days after the matter is submitted for decision. The decision shall be sent to the parties at their last known addresses served personally or by regular first class mail.
- H.** A decision issued under this Section is final when entered unless a party files a request for rehearing or review as provided in R20-5-1215 or commences an action in the Superior Court as provided in R20-5-1216 and A.R.S. § 12-901 et seq. The decision shall contain a statement explaining the review rights of a party.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1215. Request for Rehearing or Review of Decision Upon Hearing

- A.** A party may request rehearing or review of a decision issued under R20-5-1214 by filing with the Administrative Law Judge a written request for rehearing or review no later than 15 days after the written decision is served personally or by regular first class mail upon the parties.
- B.** A request for rehearing or review shall be based upon any of the following causes that materially affected the rights of an aggrieved party:
1. Irregularities in the hearing proceeding or any order, or abuse of discretion that deprives a party seeking review of a fair hearing;
 2. Accident or surprise that could not have been prevented by ordinary prudence;
 3. Newly discovered material evidence that could not have been discovered with reasonable diligence and produced at the hearing;
 4. Error in the admission or rejection of evidence, or errors of law occurring at the hearing;
 5. Bias or prejudice of the Department or administrative law judge; and
 6. The findings of fact or conclusions of law contained in the decision are not justified by the evidence or are contrary to law.
- C.** A request for rehearing or review shall state the specific facts and law in support of the request and shall specify the relief sought by the request.
- D.** A party shall have 15 days from the date of the filing of a request for rehearing or review to file a written response. Failure to respond shall not be deemed an admission against interest.
- E.** The administrative law judge shall issue a decision upon review no later than 30 days after receiving a request for review or response, if one is filed.
- F.** A decision upon review is final unless a party seeks judicial review as provided in R20-5-1216.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

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R20-5-1216. Judicial Review of Decision Upon Hearing or Decision Upon Review

- A. A party aggrieved by a decision upon hearing issued under R20-5-1214 or a decision upon review issued under R20-5-1215 may seek review by commencing an action in the Superior Court as provided in A.R.S. § 12-901 et seq. within 35 days from the date a copy of the decision sought to be reviewed is served personally or by regular first class mail upon the party affected.
- B. A decision upon hearing issued under R20-5-1214 or a decision upon review issued under R20-5-1215 is final unless a party seeks judicial review as provided under A.R.S. § 12-901 et seq.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1217. Assessment of Civil Penalties Under A.R.S. § 23-364(F)

The Department may assess civil penalties for violations of the Act and this Article, including the assessment of civil penalties for engaging in conduct that hinders an investigation of the Department as specified in R20-5-1212.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1218. Collection of Wages, Earned Paid Sick Time, Equivalent Paid Time Off, or Penalty Payments Owed

- A. Upon determination that wages, earned paid sick time, equivalent paid time off, or penalty payments are due and unpaid to any employee, the employee may, or the Department may on behalf of an employee, obtain judgment and execution, garnishment, attachment, or other available remedies for collection of unpaid wages and penalty payments established by a final Findings and Order of the Department.
- B. If payment cannot be made to the employee, the Department shall receive monetary compensation or penalty payments on behalf of the employee and transmit monies it receives as payment in a special state fund as provided in A.R.S. § 23-356(C).
- C. The Department may amend a Findings and Order to conform to the legal name of the business or the person who is the defendant employer to a complaint under the Act, provided service of the Findings and Order was made on the defendant or the defendant's agent. If a judgment has been entered on the order, the Department may apply to the clerk of the superior court to amend a judgment that has been issued under a final order, provided service was made on the defendant or the defendant's agent.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4). Amended by

final rulemaking at 23 A.A.R. 2907, effective October 3, 2017 (Supp. 17-4).

R20-5-1219. Resolution of Disputes

Notwithstanding any other provision of law, the Department may mediate and conciliate a dispute between the parties.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

R20-5-1220. Small Employer Request for Exception to Recordkeeping Requirements

- A. In this Section, unless context otherwise requires, "small employer" means a corporation, proprietorship, partnership, joint venture, limited liability company, trust, or association that has less than \$500,000 in gross annual revenue.
- B. A small employer, or any category of small employer that is unreasonably burdened by the recordkeeping requirements of the Act and this Article may file a written petition for exception with the Department requesting relief from certain recordkeeping requirements under this Article. The petition shall:
1. State the reasons for the request for relief;
 2. State an alternate manner or method of making, keeping, and preserving records that will enable the Department to determine hours worked and wages paid; and
 3. Include the signature of the employer or an authorized representative of the employer.
- C. Subject to any conditions or limitations necessary to ensure fulfillment of the purpose and intent of Act, the Department may grant a petition for exception if it finds that:
1. The small employer, or category of small employer is unreasonably burdened by the recordkeeping requirements of the Act and this Article; and
 2. The relief requested and alternative proposed will not hinder the Department's enforcement of the Act and this Article.
- D. For good cause, the Department may rescind a prior order granting relief under this Section.
- E. Relief under this Section is effective upon the Department's written authorization.

Historical Note

New Section made by emergency rulemaking at 13 A.A.R. 473, effective January 25, 2007 for 180 days (Supp. 07-1). Emergency renewed at 13 A.A.R. 2785, effective July 17, 2007 for 180 days (Supp. 07-3). New Section made by final rulemaking at 13 A.A.R. 4315, effective January 13, 2008 (Supp. 07-4).

ARTICLE 13. TREATMENT GUIDELINES**R20-5-1301. Adoption and Applicability of the Article**

- A. The Industrial Commission of Arizona (Commission) has adopted the Work Loss Data Institute's *Official Disability Guidelines – Treatment in Workers Compensation* (ODG) as the standard reference for evidence-based medicine used in treating injured workers within the context of Arizona's workers' compensation system. By adopting and referencing the most recent edition (at the time of treatment), and continuously updated Official Disability Guidelines, the Commission can ensure the latest available medical evidence is used in making medical treatment decisions for injured workers.

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- B. Until further action of the Commission, the guidelines shall apply to all body parts and conditions.
- C. The Commission may modify or change the applicability of the guidelines as described in subsection (B) if the Commission determines that modification or changing the applicability of the guidelines will: 1) improve medical treatment for injured workers, 2) make treatment and claims processing more efficient and cost effective, and 3) if the Commission's modification expands the applicability of the guidelines, the guidelines adequately cover the relevant body parts or conditions. Before taking action to modify or change the applicability of the guidelines, the Commission shall provide an opportunity for public comment and hold a public hearing. A decision of the Commission under this subsection shall be made by a majority vote of a quorum of Commission members present at a public meeting.
- D. Action taken by the Commission to modify or change the applicability of the guidelines under subsection (C) shall be published in the minutes of the Commission meeting when such action was taken. The minutes of this action shall be published on the Commission's website and shall be available from the Commission upon request.
- E. The guidelines shall apply prospectively. Recommendations provided in the guidelines related to the management of chronic pain and the use of opioids for all stages of pain management shall apply to medical treatment or services occurring on or after October 1, 2016. For purposes of this process, chronic pain shall be defined by the guidelines. Recommendations provided in the guidelines related to all other body parts and conditions shall apply to medical treatment or services occurring on or after October 1, 2018.
- F. This Article applies to all claims filed with the Commission.
- G. This Article only applies to medical treatment and services for body parts and conditions that have been accepted as compensable.
- H. The guidelines are to be used as a tool to support clinical decision making and quality health care delivery to injured employees. The guidelines set forth care that is generally considered reasonable and are presumed correct if the guidelines provide recommendations related to the requested treatment or service. This is a rebuttable presumption and reasonable medical care may include deviations from the guidelines. To support a request to deviate from the guidelines, the provider must produce documentation and justification that demonstrates by a preponderance of credible medical evidence a medical basis for departing from the guidelines. Credible medical evidence may include clinical expertise and judgment.
- I. The Commission shall provide administrative review and oversight of this Article.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 1730, effective October 1, 2016 (Supp. 16-2). Amended by final rulemaking at 24 A.A.R. 2069, effective October 1, 2018 (Supp. 18-3).

R20-5-1302. Definitions

In this Article and R20-5-106(A)(12), unless the context otherwise requires:

"Act" means the Arizona Workers' Compensation Act, A.R.S. Title 23, Chapter 6.

"Active Practice" means performing patient care for a minimum of eight hours per week in one of the five preceding years.

"Administrative Law Judge" or "ALJ" means a hearing officer appointed under A.R.S. § 23-108.02.

"Administrative Review" means a process that includes a peer review for preauthorization of a request for medical treatment or services conducted pursuant to R20-5-1311. The administrative review process will be managed by the Medical Resource Office (MRO) at the Industrial Commission of Arizona.

"American Board of Medical Specialties" means the organization that develops a uniform system for specialty boards to administer examinations for certification of physicians within specific medicine specialties.

"American Osteopathic Association" means the organization that develops a uniform system for specialty boards to administer examinations for certification of osteopathic physicians within specific osteopathic medicine specialties.

"Applicability" means the body parts and medical conditions that are covered under this Article and authorized by the Commission under R20-5-1301(B) and (C).

"Claim" means the workers' compensation claim filed by the injured employee under the Act.

"Contractor" means an independent peer review organization accredited by URAC.

"Fast Track ALJ Dispute Resolution Program" or "fast track process" means the voluntary dispute resolution process set forth in R20-5-1312(B).

"International Classification of Diseases Code" or "ICD Code" means a set of medical diagnostic codes that creates a universal language for reporting diseases and injury.

"International Classification of Diseases" or "ICD" means an official list of categories of diseases, physical and mental, that is issued and maintained by the World Health Organization.

"IME" means an independent medical examination scheduled under R20-5-114.

"Injured Employee" means a person defined in A.R.S. § 23-901 whose claim has been accepted for workers' compensation benefits.

"Medical File Review Opinions" means a formal examination of patient data and medical records for the purpose of determining the need for medical treatment, services or both.

"Payer" means an insurance carrier defined under A.R.S. § 23-901, a self-insured employer defined in R20-5-102, a third-party administrator, and the Special Fund of the Industrial Commission of Arizona.

"Peer Review" means an independent medical review conducted by an individual meeting the requirements of R20-5-1311(I).

"Preauthorization" means the written request prescribed by R20-5-1303 from a provider to a payer requesting approval to provide medical treatment or services to an injured employee.

"Provider" means a physician as defined in R20-5-102.

"Reconsideration" means a written request to the payer or identified review organization by an injured employee or medical provider to reconsider a previous payer decision to deny medical treatment or services and that identifies the specific justification to support the request.

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“Third-Party Administrator” means an organization that processes insurance or employee benefit claims for a separate entity.

“Treatment Guidelines” or “guidelines” means medical treatment guidelines that are used as a tool to support clinical decision making and quality health care delivery to injured employees.

“URAC” refers to URAC, a non-profit organization formerly known as the Utilization Review Accreditation Commission.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 1730, effective October 1, 2016 (Supp. 16-2). Amended by final rulemaking at 24 A.A.R. 2069, effective October 1, 2018 (Supp. 18-3).

R20-5-1303. Provider Request for Preauthorization

- A. No preauthorization is required under the Act to ensure payment for reasonably required medical treatment or services. While preauthorization is not required under the Act, a provider may seek preauthorization as provided in this subsection.
- B. A provider shall submit a request for preauthorization in writing using Section I (Provider Request for Preauthorization) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12). A provider shall attach documentation to a request for preauthorization that supports the medical necessity and appropriateness of the treatment or services requested, such as office notes and diagnostic reports.
- C. A provider may submit the request for preauthorization by mail, electronically or by fax.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 1730, effective October 1, 2016 (Supp. 16-2). Amended by final rulemaking at 24 A.A.R. 2069, effective October 1, 2018 (Supp. 18-3).

R20-5-1304. Payer Denial of Request for Preauthorization

- A. A payer shall not deny a request for preauthorization solely because the guidelines do not address the requested treatment or services.
- B. A payer shall not deny a request for preauthorization that is supported by the guidelines, unless the payer can rebut the presumption of reasonableness and correctness with a medical or psychological opinion establishing by a preponderance of the evidence that there is a contraindication or significant medical or psychological reason not to authorize the requested treatment or services. Upon request by the provider or injured employee, a denial of preauthorization in this situation shall be processed as an immediate referral to the Commission for administrative review as provided in R20-5-1311 unless the payer obtains an IME in support of its denial. If the payer obtains an IME which serves as the basis for the denial, then review of the payer’s decision shall be processed as a request for investigation under A.R.S. § 23-1061(J) if filed by the injured employee.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 1730, effective October 1, 2016 (Supp. 16-2).

R20-5-1305. Payer Denial of Payment for Provided Treatment or Services

- A. A payer shall not deny payment for provided treatment or services solely because the guidelines do not address the requested treatment or services.

- B. A payer shall not deny payment for provided treatment or services supported by the guidelines, unless the payer can rebut the presumption of reasonableness and correctness with a medical or psychological opinion establishing by a preponderance of the evidence that there is a medical contraindication or significant medical or psychological reason not to pay for the treatment or services.
- C. A dispute related to a payer’s failure to pay for provided treatment or services may be processed as a request for investigation under A.R.S. § 23-1061(J) if filed by an injured employee.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 1730, effective October 1, 2016 (Supp. 16-2).

R20-5-1306. Payer Reversal of Decision to Deny Treatment or Services

A payer may reverse its decision to deny treatment or services at any time throughout the process described in this Article. In this situation, the payer’s subsequent authorization or agreement to pay for the treatment or services at issue shall end this process.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 1730, effective October 1, 2016 (Supp. 16-2).

R20-5-1307. Payer Decision, In Whole or In Part

A payer may issue a decision approving or denying a request for preauthorization in whole, or in part.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 1730, effective October 1, 2016 (Supp. 16-2).

R20-5-1308. Failure to Comply with Required Time Limits

A payer’s failure to comply with the required time limits of this process may be considered unreasonable delay under R20-5-163.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 1730, effective October 1, 2016 (Supp. 16-2).

R20-5-1309. Payer Decision on Request for Preauthorization

- A. Except as provided in subsections (C) or (D), a payer shall communicate to the provider its decision on a request for preauthorization no later than 7 business days after the request is received. The decision shall be issued in writing using Section II (Payer Decision on Request for Preauthorization) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12). A payer shall attach to the decision a statement of what has been authorized, including, if applicable, a partial authorization, and, if the request for preauthorization is denied, in whole or in part, a statement of explanation that includes the medical reason supporting the payer’s decision. For purposes of this Section, the 7 business days begin to run the day after the payer receives the request.
- B. If a payer fails to communicate to a provider its decision on request for preauthorization within 7 business days, then the payer’s failure to take action is deemed a “no response” and the provider or injured employee may submit a request for administrative review directly to the Commission as provided in R20-5-1311.
- C. If a payer receives a request for preauthorization not submitted on Section I (Provider Request for Preauthorization) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12) or an incomplete request for preauthorization using Section I (Provider Request for Preauthorization) of the Medical Treatment Preauthoriza-

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tion Form approved by the Commission under R20-5-106(A)(12), the payer shall:

1. No later than 7 business days after the request is received and identified, act on the request for preauthorization pursuant to subsection (A); or
 2. No later than 7 business days after the request is received and identified, notify the provider in writing that the request for preauthorization is incomplete or, if applicable, that a request for preauthorization must be submitted on Section I (Provider Request for Preauthorization) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12).
- D.** If, no later than 7 business days after a request for preauthorization has been received, a payer provides written notice to the provider that an IME has been requested under R20-5-114 using Section II (Payer Decision on Request for Preauthorization) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12), then the payer's decision on a request for preauthorization shall be issued no later than 7 business days after the final IME report has been received by the payer. The payer shall provide a copy of the final IME report to the provider upon receipt of the IME report.
- E.** Unless the payer decision was supported by an IME or otherwise falls within subsection R20-5-1304(B), an injured employee or provider may seek reconsideration of a payer decision by submitting a written request to the payer (or review organization identified by the payer) using Section III (Provider or Employee Request for Reconsideration) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12). A provider shall attach to a request for reconsideration a statement of the specific reasons and justifications to support the request. If not previously provided, the injured employee or provider shall attach supporting medical documentation with the request for reconsideration.
- F.** An injured employee may seek review of a payer decision that is supported by an IME by requesting an investigation under A.R.S. § 23-1061(J).
- G.** Unless the decision was supported by an IME, an injured employee or provider may seek review of a payer decision issued under R20-5-1304(B) by requesting administrative review by the Commission as provided in R20-5-1311.
- H.** A payer shall provide a copy of its written decision to deny treatment or services to the injured employee or, if represented, to the injured employee's authorized representative.
- B.** If a payer fails to respond to a request for reconsideration within 7 business days, the provider or injured employee may submit a request for administrative review directly to the Commission as provided in R20-5-1311.
- C.** If, no later than 7 business days after a request for reconsideration has been received, a payer provides written notice to the provider that an IME has been requested under R20-5-114 using Section IV (Payer Decision on Request for Reconsideration) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12), then the payer's decision on a request for reconsideration shall be issued no later than 7 business days after the final IME report has been received by the payer. The payer shall provide a copy of the final IME report to the provider upon receipt of the report.
- D.** Commission Review of Payer Reconsideration Decision:
1. An injured employee or provider may seek review of a payer reconsideration decision by requesting an administrative review by the Commission as provided in R20-5-1311 unless the payer decision was supported by an IME.
 2. An injured employee may seek review of a payer reconsideration decision that is supported by an IME by requesting an investigation under A.R.S. § 23-1061(J).
- E.** A payer shall provide a copy of its written reconsideration decision to deny treatment or services to the injured employee or, if represented, to the injured employee's authorized representative.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 1730, effective October 1, 2016 (Supp. 16-2). Amended by final rulemaking at 24 A.A.R. 2069, effective October 1, 2018 (Supp. 18-3).

R20-5-1311. Administrative Review by Commission

- A.** Absent further action of the Commission under R20-5-1301(C), administrative review under this Article is available for requests for medical treatment or services related to all body parts and conditions.
- B.** A request for administrative review shall be in writing using Section V (Provider or Employee Request for Administrative Peer Review) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12). A request for administrative review must attach copies of relevant medical information or records and copies of all documentation related to the payer's decision or non-response. A request for administrative review must be submitted to the Commission by mail, electronically or by fax.
- C.** Upon receipt of a request for administrative review, the Commission shall determine whether the administrative review is available under this Article.
1. If administrative review is not available, then no later than three business days after receiving a request for administrative review, the Commission shall send notice to the injured employee and payer that administrative review is not available.
 2. If administrative review is available, then no later than three business days after receiving the request, the Commission shall send notice to the payer that a request for administrative review has been received and provide information on how to participate in the process.
- D.** The administrative review conducted under this Section shall apply the guidelines as described in this Article and include a

Historical Note

New Section made by final rulemaking at 22 A.A.R. 1730, effective October 1, 2016 (Supp. 16-2). Amended by final rulemaking at 24 A.A.R. 2069, effective October 1, 2018 (Supp. 18-3).

R20-5-1310. Payer Reconsideration on Request for Preauthorization

- A.** Except as provided in subsection (C), a payer shall communicate to the provider its decision on a request for reconsideration no later than 7 business days after the request is received. This decision shall be issued in writing using Section IV (Payer Decision on Request for Reconsideration) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12). A payer shall attach to the decision a statement of what has been authorized, including, if applicable, a partial authorization, and, if the request for preauthorization is denied, in whole or in part, a statement of explanation that includes the medical reason supporting the

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peer review performed by an individual meeting the requirements of subsection (I). The peer review shall consist of a records review and, when possible as described in subsection (I)(5), a conversation between the provider and individual conducting the peer review.

- E. The Commission may enter into an agreement with one or more contractors, who shall be URAC accredited, to provide the review described in subsection (D).
- F. The payer shall pay for the costs of the peer review conducted by the contractor.
- G. To assist in its review, the Commission or its contractor may request or receive additional information and documentation from the provider, injured employee or payer, who shall cooperate and provide the Commission or its contractor with any necessary medical information, including information pertaining to the payer's decision.
- H. Before the Commission or its contractor issues a determination denying the request for treatment or services, a good faith effort shall be made to conduct a peer review with the provider requesting authorization to perform the treatment or services.
- I. The individual conducting the peer review shall:
 - 1. Hold an active, unrestricted license or certification to practice medicine or a health profession and be involved in the active practice of medicine or a health profession during the five preceding years. For purposes of this subsection, "active practice" means performing patient care for a minimum of eight hours per week in one of the five preceding years;
 - 2. Be licensed in Arizona, unless the Commission or its contractor is unable to find such an individual, in which case the peer review may be conducted by an individual who is licensed in another state of the United States and who meets the other requirements of this subsection;
 - 3. For a review of a request from an allopathic or osteopathic physician, nurse practitioner, physician assistant, or other mid-level provider, hold a current certification from the American Board of Medical Specialties or the American Osteopathic Association in the area or areas appropriate to the condition, procedure or treatment under review;
 - 4. Be in the same profession and the same specialty or subspecialty as typically performs or prescribes the medical procedure or treatment requested; and
 - 5. Make a good faith effort to contact the provider requesting the preauthorization. This good faith effort shall include making telephone contact during the provider's normal business hours and offering to schedule the peer review at a time convenient for the provider.
- J. A provider may bill the payer for time spent participating in a peer review under this Section.
- K. The Commission or its contractor shall issue a written determination of its administrative review that contains the name and title of the person that performed the administrative review, and includes the following information:
 - 1. Whether the request for treatment or services is authorized or denied, in whole or in part;
 - 2. The information reviewed;
 - 3. The principle reason for the decision; and
 - 4. The clinical basis and rationale for the decision.
- L. An interested party dissatisfied with the administrative review determination may request that the dispute be referred to the Commission's Administrative Law Judge Division for hearing. This request for hearing shall:
 - 1. Be in writing;
 - 2. Filed no later than 10 business days after the administrative review determination is issued; and
 - 3. State whether the party requests to participate in the Fast Track ALJ Dispute Resolution Program by stipulation, or declines to participate in the Fast Track ALJ Dispute Resolution Program.
- M. If a timely request for hearing is filed, the administrative review determination is deemed null and void and shall serve no evidentiary purpose.
- N. The information provided by the parties under this Section and the determination issued by the Commission shall become a part of the Commission claims file for the injured employee.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 1730, effective October 1, 2016 (Supp. 16-2). Amended by final rulemaking at 24 A.A.R. 2069, effective October 1, 2018 (Supp. 18-3).

R20-5-1312. Hearing Process

- A. A referral of a request for hearing under R20-5-1311(L) shall be processed as provided for in the Act unless all parties agree to participate in the fast track process.
- B. The following applies only to the Fast Track ALJ Dispute Resolution Program:
 - 1. Parties must agree to participate in the Fast Track ALJ Dispute Resolution Program with the understanding that a short form decision will be issued.
 - 2. Review by the presiding ALJ shall be limited to the treatment or service dispute considered at the administrative review under R20-5-1311.
 - 3. The presiding ALJ shall issue a notice of hearing within 10 business days of the receipt of the fully executed agreement to participate and certificate of readiness.
 - 4. The hearing shall be held within 30 calendar days from the day that the notice of hearing is issued to the extent practicable.
 - 5. Discovery is limited to five interrogatories and no depositions are permitted.
 - 6. The presiding ALJ shall take all lay witness testimony at the time of the hearing and will not hold any further hearings.
 - 7. The presiding ALJ shall consider documentary medical evidence only; no medical testimony shall be taken.
 - 8. Medical file review opinions shall be deemed to constitute substantial evidence to support the requested treatment or service.
 - 9. All documentary evidence shall be submitted no later than 10 business days before the scheduled hearing.
 - 10. The hearing shall be recorded, but not transcribed, unless one or more of the parties files a request for review under A.R.S. § 23-942 and A.R.S. § 23-943.
 - 11. The presiding ALJ shall issue a short form decision within five business days after the matter is deemed submitted.

Historical Note

New Section made by final rulemaking at 22 A.A.R. 1730, effective October 1, 2016 (Supp. 16-2).

ARTICLE 14. MUNICIPAL FIREFIGHTER CANCER REIMBURSEMENT FUND AND FIREFIGHTER AND FIRE INVESTIGATOR CANCER CLAIM REPORTING

R20-5-1401. Application of the Article and Definitions

- A. This Article applies to reimbursement claims submitted to the Municipal Firefighter Cancer Reimbursement Fund under Ari-

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zona Revised Statutes (“A.R.S.”), Title 23, Chapter 11, and firefighter and fire investigator cancer claim reporting under A.R.S. § 23-971.

- B. The definitions in A.R.S. §§ 23-1701 and 23-901.09 apply in this Article.
- C. “Cancer-related claims” as used in A.R.S. § 23-971 and this Article shall mean Arizona workers’ compensation claims involving any disease, infirmity, or impairment of health that is caused by cancer.
- D. “Fiscal year” or “reporting period” shall mean the 12-month cycle that begins on July 1 and ends on June 30.
- E. “Loss valuation date” shall mean the last day of the reporting period and the date on which firefighter and fire investigator cancer claim data shall be determined for reporting purposes.
- F. An “open” claim shall mean a workers’ compensation claim that is eligible for temporary compensation and/or active medical treatment. A “closed” claim shall mean a workers’ compensation claim in which temporary compensation and active medical treatment have been terminated.

Historical Note

New Section made by final exempt rulemaking at 27 A.A.R. 2920 (December 17, 2021), effective January 1, 2022 (Supp. 21-4). Amended by final rulemaking at 28 A.A.R. 1483 (June 24, 2022), with an immediate effective date of June 10, 2022 (Supp. 22-2).

R20-5-1402. Reimbursement Claims

- A. A Municipal Payor seeking reimbursement from the Fund shall submit a reimbursement claim in writing on the Municipal Firefighter Cancer Reimbursement Form approved by the Commission.
- B. The Municipal Firefighter Cancer Reimbursement Form shall include the following attestations, which shall be made by an authorized representative of a Municipal Payor seeking reimbursement from the Fund:
 1. The reimbursement request includes only eligible compensation and benefits paid under A.R.S. § 23-1702(A) on municipal firefighter or municipal fire investigator workers’ compensation claims accepted under A.R.S. § 23-901.09.
 2. The reimbursement request only includes amounts actually paid by the Municipal Payor for compensation and benefits under A.R.S. § 23-1702(A) during the immediately preceding fiscal year.
 3. The reimbursement request does not include amounts paid for expenses relating to case management, vocational rehabilitation, or similar nonmedical costs.
 4. The information included in, or submitted with, the Municipal Firefighter Cancer Reimbursement Form is true and correct.
- C. The Municipal Firefighter Cancer Reimbursement Form shall not be changed, amended, or otherwise altered without the prior written approval of the Commission.
- D. A Municipal Payor seeking reimbursement from the Fund for compensation and benefits paid during a fiscal year shall submit a reimbursement claim to the Commission between July 1 and August 31 immediately following the applicable fiscal year.
- E. Failure to timely submit a reimbursement claim for compensation and benefits paid during a fiscal year before the claim submission deadline in subsection (D) will be deemed a waiver of the right of the Municipal Payor to request reimbursement for amounts paid during the applicable fiscal year. Failure to include all eligible compensation or benefits in a reimbursement claim before the claim submission deadline in subsection

(D) will be deemed a waiver of the right of the Municipal Payor to request reimbursement for any omitted amounts paid during the applicable fiscal year.

- F. The Commission shall process reimbursements pursuant to A.R.S. § 23-1702(C) on or before December 31 of each year.
- G. The maximum annual amount of aggregate reimbursements paid by the Fund shall in no event exceed the total amount of monies in the Fund as of close of business on June 30 of the applicable fiscal year.

Historical Note

New Section made by final exempt rulemaking at 27 A.A.R. 2920 (December 17, 2021), effective January 1, 2022 (Supp. 21-4).

R20-5-1403. Recordkeeping and Record Inspections

- A. Municipal Payors seeking reimbursement from the Fund shall maintain all records supporting amounts included in a reimbursement claim for at least ten years after the reimbursement claim is filed.
- B. Municipal Payor records supporting amounts included in a reimbursement claim shall always be open for inspection by the Commission or representatives of the Commission to ascertain information necessary for its administration of A.R.S. §§ 23-1701 through 23-1703. Upon request, a Municipal Payor shall make such records available to the Commission within 30 days.

Historical Note

New Section made by final exempt rulemaking at 27 A.A.R. 2920 (December 17, 2021), effective January 1, 2022 (Supp. 21-4).

R20-5-1404. Fund Overpayments

- A. A Municipal Payor that discovers an error in a reimbursement claim which may result or has resulted in an overpayment from the Fund shall notify the Commission of the error within three business days of discovery of the error.
- B. Overpayments made by the Fund to Municipal Payors that are discovered through inspection of records, or otherwise, shall be returned to the Fund by the applicable Municipal Payor within 30 days of notification by the Commission.

Historical Note

New Section made by final exempt rulemaking at 27 A.A.R. 2920 (December 17, 2021), effective January 1, 2022 (Supp. 21-4).

R20-5-1405. Cancer Claim Reporting Method; Frequency; Deadlines; Duration

- A. Cancer-related claim reporting under A.R.S. § 23-971 and this Article shall be performed electronically through the commission’s electronic claims portal. Insurance carriers, self-insured employers, self-insurance pools, or a designee (including third-party administrators or an adjuster) are authorized to complete required claim reporting. Duplicate reporting of the same claim information is prohibited.
- B. Subject to the claim reporting durations specified in subsection (D), insurance carriers, self-insured employers, and self-insurance pools subject to A.R.S. § 23-971 shall annually report the data elements specified in R20-5-1407 and R20-5-1408 for cancer-related claims filed by or on behalf of firefighters and fire investigators.
- C. Claim data reported pursuant to subsection (B) shall be determined as of the loss valuation date for the applicable reporting period.

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- D.** Claim reporting shall be completed within 31 days after each applicable reporting period, i.e., no later than July 31 of each year.
- E.** Claim reporting under A.R.S. § 23-971 is subject to the following claim reporting durations:
1. Denied Claims: Reported one time following the reporting period during which the claim is denied by a notice of claim status. Reporting is not required for claims denied prior to July 1, 2021.
 2. Claims Accepted on or after July 1, 2021: Reported for the longer of: (a) the duration the claim remains open plus two additional annual reports after the claim is closed; or (b) ten annual reports after acceptance of the claim.
 3. Claims Accepted before July 1, 2021: If the claim was open on July 1, 2021, the claim shall be reported for the duration the claim remains open plus two additional annual reports after the claim is closed. If the claim was closed as of July 1, 2021, and was accepted on or after July 1, 2011, the claim shall be reported for two annual reports. If the claim was closed as of July 1, 2021, and was accepted prior to July 1, 2011, reporting is not required.
 4. Reopened Claims: Reported for the longer of: (1) the duration the claim remains open (following acceptance of the petition to reopen), plus two additional annual reports after the claim is closed; or (2) ten annual reports after acceptance of the petition to reopen.
 5. Claims that Develop into Cancer-Related Claims: If a claim develops into a cancer-related claim, reporting should begin following the reporting period in which the claim developed into a cancer-related claim. In these circumstances, the claim shall be reported for the longer of: (1) the duration the claim remains open plus two additional annual reports after the claim is closed; or (2) ten annual reports.
 6. Non-Cancer-Related Claims: If a cancer-related claim develops into a claim that no longer meets the definition of a cancer-related claim, no further annual reporting is required.
 7. Informational Claims: Claims that have been filed but have not been accepted or denied as of the applicable loss valuation date shall not be reported.
- F.** Data Provider Primary Contact Email Address: The email address of the Data Provider Primary Contact.
- G.** Loss valuation date: The last day of the 12-month reporting period.
- H.** Total Number of New Cancer-Related Claims: Total number of cancer-related claims filed by or on behalf of firefighters and fire investigators during the applicable reporting period (whether or not the claims are included in the detailed reporting).
1. Accepted: Total number of new cancer-related claims accepted during the applicable reporting period.
 2. Denied: Total number of cancer-related claims denied during the applicable reporting period.
 3. Pending: Total number of cancer-related claims pending decision on the applicable loss valuation date.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 1483 (June 24, 2022), with an immediate effective date of June 10, 2022 (Supp. 22-2).

R20-5-1407. Cancer Reporting; Required Claim-Specific Data Elements

- A.** Unique Claim Identifier: The unique, alphanumeric claim identifier (up to 20 characters, but no less than seven characters) assigned by the carrier, self-insured employer, or self-insurance pool to a specific claim. The claim identifier shall remain the same throughout the life of the claim. Usage of the commission's claim number is prohibited. Usage of claimant name, personally-identifiable information, or carrier/self-insured employer/self-insurance pool name in identifier is prohibited.
- B.** Transaction Type Code: The code that identifies a report as an initial report (01) or subsequent report (02).
- C.** Occupational Descriptor Code: (01) = Firefighter (02) = Fire Investigator.
- D.** Sex Code: The sex of the injured worker. (M = Male, F = Female, N = Not Reported.)
- E.** Birth Year: The 4-digit birth year of the injured worker.
- F.** Year Claim Reported: The 4-digit year the claim was reported to the carrier/self-insured employer/self-insurance pool.
- G.** Year of Loss: The 4-digit year when the injury (cancer) became manifest.
- H.** Year of Hire: The 4-digit year when the injured worker was hired by the employer as a firefighter or fire investigator (either full-time or part-time). If unknown, enter (U).
- I.** Name of Carrier, Self-Insured Employer, or Self-Insurance Pool: Complete business name of insurance carrier or self-insured employer/pool responsible for the claim.
- J.** Employer Name: The complete business name of the employer (including a DBA, if applicable) related to the claim.
- K.** County Code: The code corresponding to Arizona county primarily served by the employer (01) = Apache; (2) = Cochise; (3) = Coconino; (4) = Gila; (5) = Graham; (6) = Greenlee; (7) = La Paz; (8) = Maricopa; (9) = Mohave; (10) = Navajo; (11) = Pima; (12) = Pinal; (13) = Santa Cruz; (14) = Yavapai; (15) = Yuma.
- L.** Claim Acceptance Date: The date the claim was first accepted as compensable. If the claim was denied, enter (D).
- M.** Claim Denial Code: The code corresponding to the reason a claim was denied. (01) = Claim not compensable; (02) No coverage; (03) Other reason. If the claim was accepted, enter (A).
- N.** Claims Status Code: The code corresponding to the claim's status as of the loss valuation date. (01) = claim is open (not reopened) on the loss valuation date; (02) = claim is closed on

Historical Note

New Section made by final rulemaking at 28 A.A.R. 1483 (June 24, 2022), with an immediate effective date of June 10, 2022 (Supp. 22-2).

R20-5-1406. Cancer Reporting; Required General Data Elements

- A.** Name of Data Provider (i.e., What entity is reporting the data?): The name of the insurance carrier, self-insured employer, self-insurance pool, or designee submitting the cancer-related claim data.
- B.** Data Provider Type Code: Insurance Carrier; Self-Insured Employer; Self-Insurance Pool; Third-Party Administrator; or Other Designee.
- C.** Name of Person Submitting Data: The name of the individual submitting the cancer-related claim data.
- D.** Name of Data Provider Primary Contact: The name of the individual designated by the Data Provider who can be contacted regarding the data submission. (May be the same as the "Name of Person Submitting the Data.")
- E.** Data Provider Primary Contact Phone Number: The phone number of the Data Provider Primary Contact.

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the loss valuation date; (03) = claim is reopened on the loss valuation date. If the claim was denied, enter (D).

- O. Benefit Code: The code that identifies under which provision of the law benefits are being paid on the loss valuation date. (01) = Death; (02) = Permanent Total Disability; (03) Permanent Partial Disability - Unscheduled; (04) Permanent Partial Disability – No Loss; (05) Temporary Total Disability; (06) Temporary Partial Disability; (07) Claim Denied.
- P. Settlement Code: (00) = Claim not subject to settlement during the reporting period; (01) = Full and final settlement during the reporting period; (03) Stipulated award during the reporting period; (05) Noncompensable settlement during the reporting period; (06) = Compromise settlement during the reporting period; (09) Other settlement during the reporting period; (10) Multiple settlements during the reporting period.
- Q. Lump Sum Indicator: Indicates whether the claim has been settled by a lump sum amount. N = No; Y = Yes.
- R. Closed Date: If the claim closed during the reporting period, report the date of claim closure. (Required if the claim closed during the reporting period.)
- S. Reopened Date: If the claim re-opened during reporting period, report the date of claim reopening. (Required if the claim reopened during the reporting period.)
- T. Primary Type of Cancer Code: The primary type of cancer involved in the claim on the loss valuation date. Options are brain (01), bladder (02), rectal (03), colon (04), lymphoma (05), leukemia (06), adenocarcinoma (07), mesothelioma of the respiratory tract (08), buccal cavity (09), pharynx (10), esophagus (11), large intestine (12), lung (13), kidney (14), prostate (15), skin (16), stomach (17), ovarian (18), breast (19), testicular (20), non-Hodgkin's lymphoma (21), multiple myeloma (22), and malignant melanoma (23). Non-listed cancers may be designated as "other" (30).
- U. Secondary Type of Cancer Code: If applicable, the secondary type of cancer involved in the claim on the loss valuation date. Options are brain (01), bladder (02), rectal (03), colon (04), lymphoma (05), leukemia (06), adenocarcinoma (07), mesothelioma of the respiratory tract (08), buccal cavity (09), pharynx (10), esophagus (11), large intestine (12), lung (13), kidney (14), prostate (15), skin (16), stomach (17), ovarian (18), breast (19), testicular (20), non-Hodgkin's lymphoma (21), multiple myeloma (22), and malignant melanoma (23). Non-listed cancers may be designated as "other" (30). (Required if applicable.)
- V. Amounts Paid (as of loss valuation date):
 - 1. Indemnity Paid: The total amount of paid indemnity for the claim as of the loss valuation date. These losses consist of all paid benefits due to an employee's lost wages or inability to work, including compensation paid to a deceased claimant prior to death, burial expense, claimant's attorney fees, vocational rehabilitation benefits, indemnity settlement payments, and employer's liability losses and expenses. Allocated loss adjustment expense ("ALAE") for other than employer's liability coverage shall be excluded from indemnity losses.
 - 2. Medical Paid: The total amount of medical losses paid for the claim as of the loss valuation date, including medical settlement payments.
 - 3. ALAE Paid: The total amount of ALAE paid for the claim as of the loss valuation date.
 - 4. Death Benefits Paid: The total amount of death benefits paid for the claim as of the loss valuation date.
- W. Incurred Amounts (as of loss valuation date):
 - 1. Incurred Indemnity Amount: The total of "Indemnity Paid" plus the current outstanding reserve indemnity benefits, excluding loss adjustment expenses (e.g., ALAE and unallocated loss adjustment expense ("ULAE")).
 - 2. Incurred Medical Amount: The total of "Medical Paid" plus the current outstanding reserve medical benefits, excluding loss adjustment expenses (e.g., ALAE and ULAE).
 - 3. Incurred ALAE Amount: The total of "ALAE Paid" plus the current outstanding reserve ALAE.
 - 4. Incurred Death Benefits Amount: The total of "Death Benefits Paid" plus the current outstanding reserve death benefits, excluding loss adjustment expenses (e.g., ALAE and ULAE).

Historical Note

New Section made by final rulemaking at 28 A.A.R. 1483 (June 24, 2022), with an immediate effective date of June 10, 2022 (Supp. 22-2).

ARTICLE 15. WORKERS' COMPENSATION SELF-INSURANCE**R20-5-1501. Definitions**

In addition to the definitions provided in A.R.S. § 23-901, the following definitions apply to this Article:

1. "Act" means the Arizona Workers' Compensation Act, A.R.S. § 23-901 et seq.
2. "Administrator" means an individual or organization designated by a Self-Insurance Pool Board to manage the daily operations of a Self-Insurance Pool.
3. "Agreement to Process and Pay" means a written agreement that requires an entity to process and pay or guarantee the payment of another entity's liabilities.
4. "Applicant" means an entity or pool seeking initial or renewal authority to self-insure for workers' compensation, a Self-Insurance Pool seeking to add a new member, or a Self-Insurer seeking to Self-Administer.
5. "Authorization Date" means the date designated by the Commission on which self-insurance authority begins.
6. "Basic Premium Factor" means a factor used in the Retrospective Rating Plan formula to represent expenses of the Self-Insurer, such as acquisition, audit, administration, and profit or contingencies, but not taxes.
7. "Cash Flow Ratio" means a numerical relationship that reflects an entity's ability to meet current financial obligations out of cash flow and is calculated as follows: (cash flow from operations) divided by (current liabilities).
8. "Claim" or "claim" means a workers' compensation claim.
9. "Deviation Rate" means the rate applied to the Manual Premium to calculate a discount from the Manual Premium.
10. "D-Ratio" means a factor used in the Ex-Medical Plan that reflects the ratio of primary expected losses and total expected losses.
11. "Division" means the self-insurance office of the Commission.
12. "Ex-Medical Plan" means a method of determining the premium upon which taxes are calculated that provides for rate revisions based upon the Self-Insurer operating a medical facility with a program for providing medical, surgical, or hospital services to a majority of the Self-Insurer's employees that complies with the requirements of A.R.S. § 23-1070.
13. "Experience Modification Rate" means a ratio comparing actual losses to expected losses based on a formula deter-

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- mined by an approved Rating Organization or the Commission.
14. "Fiscal Year" or "fiscal year" means a 12-month financial or accounting period.
 15. "Fixed Premium Plan" means a method of determining the premium upon which taxes are calculated in which neither losses nor incurred loss reserves are used for the net taxable premium calculation.
 16. "Guaranteed Cost Plan" means a method of determining the premium upon which taxes are calculated that provides for a direct relationship, on an annual basis, of the premium for tax purposes and the Experience Modification Rate developed to reflect the loss payment and incurred loss experience of the Self-Insurer.
 17. "Local Government Investment Pool" means a pooled investment fund operated by the Arizona State Treasurer according to A.R.S. § 35-326.
 18. "Loss Conversion Factor" means a factor used in the Retrospective Rating Plan formula that is used to cover unallocated claims and the costs of the Self-Insurer's claims services.
 19. "Manual Premium" means the aggregate payroll by individual Payroll Classification Code multiplied by the Payroll Classification Rate.
 20. "Member" or "member" means an employer described in A.R.S. §§ 11-952.01, 15-382 23-961.01, or 41-621.01 that has joined with other employers to operate a Self-Insurance Pool.
 21. "Parent Company" means a company that has sufficient ownership in another entity (the Subsidiary) to have control, directly or indirectly, of the Subsidiary.
 22. "Payroll" or "payroll" means the total wages and salaries paid by an employer.
 23. "Payroll Classification Code" means a four-digit numerical code assigned by a Rating Organization or the Commission to differentiate between the various job duties or scope of work performed by employees.
 24. "Payroll Classification Rate" means a rate assigned to an individual Payroll Classification Code by a Rating Organization or the Commission.
 25. "Public Entity" means an individual employer that is a state, county, municipality, school district, or any other entity with taxing authority.
 26. "Public Entity Pool" means a workers' compensation pool organized under A.R.S. §§ 11-952.01, 15-382, or 41-621.01.
 27. "Public Entity Trust Fund" means an internal service fund or sub-fund dedicated to workers' compensation or risk management established by a Public Entity from which money is used to pay workers' compensation claim liabilities and expenses.
 28. "Rating Organization" means an entity that meets the requirements of A.R.S. § 20-363 and is approved by the Department of Insurance and Financial Institutions to establish rates, codes, and formulas used to calculate workers' compensation premiums.
 29. "Renewal Date" means the date designated by the Commission by which a renewal application shall be filed with the Division.
 30. "Reserves" or "reserves" means an amount of money that is set aside to satisfy the financial and legal obligations associated with a workers' compensation claim or group of claims.
 31. "Resolution of Authorization" means a document issued by the Commission that grants authority to self-insure for purposes of workers' compensation.
 32. "Retrospective Rating Plan" means a method of determining the premium upon which taxes are calculated that provides for a relationship between the premiums for tax purposes, the Experience Modification Rate developed to reflect the loss payment and incurred loss experience of the Self-Insurer, and the actual incurred losses for the tax year.
 33. "Security" or "security" means any financial instrument authorized by R20-5-1521 through R20-5-1524, or appropriate documents renewing, amending, or continuing any of these.
 34. "Self-Administer" means the process under which a Self-Insurer administers its own claims, once approved by the Division.
 35. "Self-Insurance Pool" means a Public Entity Pool or Similar Industry Pool.
 36. "Self-Insurance Pool Board" means a body of individuals that directs a Self-Insurance Pool according to R20-5-1527.
 37. "Self-Insurer" means an entity authorized by the Commission to self-insure for workers' compensation and may include a Public Entity, an individual private employer under A.R.S. § 23-961(A)(2), a Public Entity Pool, or a Similar Industry Pool.
 38. "Similar Industry Pool" means a pool with members in similar industries as authorized by A.R.S. § 23-961.01.
 39. "Subsidiary" means an entity of which a Parent Company has sufficient ownership to have control, directly or indirectly.
 40. "Third-Party Administrator" means an organization that processes workers' compensation claims for a Self-Insurer.
 41. "Workers' Compensation Pool Loss Account" means an account or sub-account in the Workers' Compensation Pool Operations Account established by a Self-Insurance Pool from which money is used to pay workers' compensation claims, liabilities, and expenses.
 42. "Workers' Compensation Pool Operations Account" means an account or sub-account into which premiums, investment proceeds, and other revenues are deposited for purposes of a Self-Insurance Pool.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1502. Computation of Time; Extension of Time Limits

- A. In computing any time period prescribed or allowed by this Article, the day of the event from which the time period begins to run shall not be included, but the last day of the period computed shall be included unless it is a Saturday, Sunday, or legal holiday, in which event the period shall run until the end of the next day that is not a Saturday, Sunday, or legal holiday. When the time period prescribed or allowed is less than 11 days, intermediate Saturdays, Sundays, and legal holidays shall not be included in the computation of time.
- B. Except as otherwise precluded by law, the Division may extend time limits prescribed by this Article for good cause. A request for an extension of a time limit shall be filed with the Division in writing and shall state the reasons for the request.

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New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1503. Forms and Reports

The following forms, available at <http://www.azica.gov> and upon request from the Division, shall be used when applicable:

1. Initial Application for Authority to Self-Insure Form,
2. Self-Insurance Renewal Application Form,
3. New Pool Member Application Form,
4. Workers' Compensation Liability Form,
5. Application to Self-Administer Form,
6. Self-Provider of Medical Benefits Form,
7. Parent Guaranty Form,
8. Workers' Compensation Guaranty Bond Form,
9. Statutory Deposit Agreement Form,
10. Custody Agreement Form,
11. Request for Waiver of Security Form,
12. Notice of Termination of Self-Insurance Form,
13. Annual Payroll Report Form,
14. Annual Medical Report Form,
15. Annual Injury Report Form,
16. Annual Hospital Report Form,
17. Quarterly Tax Payment Form.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1504. Self-Insurance Criteria

- A. A Public Entity may file an application for authority to self-insure if:
 1. The Public Entity's annual payroll is at least \$2 million; and
 2. The Public Entity's total assets are at least \$25 million.
- B. An individual employer that is not a Public Entity may file an application for authority to self-insure if:
 1. The employer has been engaged in business in Arizona for at least five consecutive years immediately before the prospective Authorization Date;
 2. The employer's annual Arizona payroll is at least \$2 million, including the combined payrolls of any Subsidiaries that will be covered by the self-insurance program; and
 3. The employer meets one of the following criteria:
 - a. The employer's total assets are at least \$25 million; or
 - b. The employer's net worth is at least \$5 million and Cash Flow Ratio is at least 0.25.
- C. A Public Entity Pool may file an application for authority to self-insure if:
 1. The requirements set forth in A.R.S. §§ 11-952.01, 15-382, or 41-621.01, as applicable, are satisfied;
 2. The combined annual payroll of the members of the Public Entity Pool is at least \$2 million; and
 3. The combined net worth of the members of the Public Entity Pool is at least \$1 million.
- D. A Similar Industry Pool may file an application for authority to self-insure if:
 1. The requirements set forth in A.R.S. § 23-961.01 are satisfied;
 2. The members of the Similar Industry Pool have been engaged in business in Arizona for at least five consecutive years immediately before the prospective Authorization Date;

3. The combined annual Arizona payroll of the members of the Similar Industry Pool is at least \$2 million; and
4. The combined net worth of the members of the Similar Industry Pool is at least \$1 million.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1505. Initial Application Requirements

- A. An individual employer or pool seeking to apply for initial authority to self-insure shall file with the Division a completed Initial Application for Authority to Self-Insure Form and the documentation and information required in subsection (B).
- B. For an initial application to self-insure to be deemed complete, the following documentation and information shall be provided by the Applicant:
 1. A resolution of the Applicant's board of directors or governing body, authorizing the filing of the application. If the Applicant does not have a board of directors or governing body, an authorized representative shall sign the resolution.
 2. A list of the aggregate payroll by Payroll Classification Code for the most current and prior two fiscal years.
 3. A copy of the Applicant's audited financial statements for the most current and prior two fiscal years, including any notes to the financial statements. If audited financial statements for the most current or prior two fiscal years are not reasonably available, internally-reviewed and signed financial statements that conform with Generally Accepted Accounting Principles may be substituted. If a new Self-Insurance Pool does not have the financial statements required by this subsection, the pool shall provide detailed projections for capitalization, cash flow, and liabilities of the pool.
 4. A detailed description of the Applicant's loss control program, including a description of existing or planned occupational safety and health requirements and training programs.
 5. Except for a new Self-Insurance Pool that does not have the information required by this subsection, a loss run of all claims incurred in Arizona from the most current complete calendar year and the prior three calendar years. The loss run must include the following information, if applicable, for each incurred claim: Payroll Classification Code, Commission claim number, employee name, date of injury, total paid medical, medical reserves, total paid indemnity (including death benefits), and indemnity reserves.
 6. If applicable, copies of excess insurance policies that meet the requirements of R20-5-1526, or written confirmation from an authorized insurance company that it will provide excess insurance coverage to the Applicant by the prospective Authorization Date.
 7. Except for a new Self-Insurance Pool that does not have the information required by this subsection, if the Applicant's Experience Modification Rate specific to Arizona for the most recent complete fiscal year is greater than 1.10, a written statement describing the causes of the inflated Experience Modification Rate and outlining remedial measures the Applicant has taken or will take to lower the Experience Modification Rate.
 8. Except for an Applicant seeking to Self-Administer under R20-5-1510, a copy of a signed agreement between the Applicant and a Third-Party Administrator or, if an agree-

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ment has not been completed, a written confirmation from a Third-Party Administrator that it will contract with the Applicant on or before the prospective Authorization Date to process workers' compensation claims for the Applicant.

9. If an Applicant is seeking to Self-Administer, a completed Application to Self-Administer Form and the information and documentation required in R20-5-1510(C).
10. If an eligible Applicant intends to direct medical care under A.R.S. § 23-1070, a completed Self-Provider of Medical Benefits Form, the detailed statement of the arrangements required in A.R.S. § 23-1070(B), and a copy of the current medical or hospital agreements, if applicable.
11. If the Applicant is a Public Entity or a Public Entity Pool seeking a waiver of security under R20-5-1525, a completed Request for Waiver of Security Form and a current actuarial report that satisfies the requirements in R20-5-1513(B).
12. If the Applicant is a Subsidiary:
 - a. A completed Parent Guaranty Form or an Agreement to Process and Pay signed by a designated representative of the Parent Company that guarantees the payment of the Subsidiary's obligations.
 - b. A resolution of the Parent Company's board of directors or governing body authorizing the designated representative to complete, sign, and file the Parent Guaranty Form or Agreement to Process and Pay. If the Parent Company does not have a board of directors or governing body, an authorized representative shall sign the resolution.
 - c. A copy of the Parent Company's audited financial statements for the most current and prior two fiscal years, including any notes to the financial statements. If audited financial statements for the most current or prior two fiscal years are not reasonably available, internally-reviewed and signed financial statements that conform with Generally Accepted Accounting Principles may be substituted.
13. If the Applicant is a Self-Insurance Pool:
 - a. The contract or agreement required under A.R.S. §§ 11-952.01, 15-382, 23-961.01, or 41-621.01, as applicable, to establish the pool.
 - b. The articles of incorporation and bylaws governing the pool, if applicable.
 - c. The participation, coverage, and indemnity agreements between the pool and each member.
 - d. Written authorization from the board of directors or governing body of each member, authorizing membership in the pool. If a member does not have a board of directors or governing body, an authorized representative shall sign the written authorization.
 - e. A signed resolution from the Self-Insurance Pool Board approving each member for membership in the pool.
 - f. An original or a certified copy of fidelity or crime insurance policy that meets the requirements of R20-5-1528 or written confirmation from an authorized insurance company that it will issue the required fidelity or crime insurance policy on or before the prospective Authorization Date.
 - g. A copy of the signed agreement or contract of hire between the Self-Insurance Pool Board and the designated Administrator.
- h. A detailed description of the underwriting program required under R20-5-1529.
- i. A current actuarial report that meets the requirements of R20-15-1513(B) and documents the rate structure needed to set member premium levels to adequately cover potential losses and expenses of the pool.
- j. For each member, a schedule showing, for the most recent complete fiscal year and the prior two fiscal years, net workers' compensation premiums paid, total workers' compensation losses incurred, and, if available, Experience Modification Rate specific to Arizona.
- k. A copy of each member's audited financial statements for the most current and prior two fiscal years, including any notes to the financial statements. If audited financial statements for the most current or prior two fiscal years are not reasonably available, internally-reviewed and signed financial statements that conform with Generally Accepted Accounting Principles may be substituted.
- l. If any member's Experience Modification Rate specific to Arizona for the most recent complete fiscal year is greater than 1.10, a written statement describing the causes of the inflated Experience Modification Rate and outlining remedial measures the member has taken or will take to lower the Experience Modification Rate.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1506. Renewal Application Requirements

- A. A Self-Insurer seeking to apply for renewal of authority to self-insure shall file with the Division a completed Self-Insurance Renewal Application Form and the documentation and information required under subsection (B) on or before the Renewal Date or, if applicable, the date specified in subsection (D).
- B. For a renewal application to be deemed complete, the following documentation and information shall be provided by the Applicant:
 1. A copy of the Applicant's most-recent audited financial statements completed according to R20-5-1513(A), including any notes to the financial statement.
 2. A completed Workers' Compensation Liability Form.
 3. A current loss run of all open claims incurred in Arizona on or after the Authorization Date. The loss run must include the following information, if applicable, for each claim: Payroll Classification Code, Commission claim number, employee name, date of injury, total paid medical, medical reserves, total paid indemnity (including death benefits), indemnity reserves, excess insurance carrier name (if applicable), amount of excess credit expected (if applicable), and excess insurance self-insured retention amount per occurrence (if applicable).
 4. If applicable, copies of excess insurance policies that meet the requirements of R20-5-1526 or written confirmation from an authorized insurance company that it will provide excess insurance coverage to the Applicant. For each claim accepted by an excess insurance carrier on or after the Authorization Date, documentation to establish claim acceptance. For each claim submitted to an excess insurance carrier that is pending review by the excess

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- insurance carrier, documentation to establish claim submission.
5. If the Applicant's Experience Modification Rate specific to Arizona for the most recent complete fiscal year is greater than 1.10, a written statement describing the causes of the inflated Experience Modification Rate and outlining remedial measures the Applicant has taken and will take to lower the Experience Modification Rate.
 6. If the Applicant's denial rate exceeds 12% of claims filed during the prior approved period of self-insurance, a written statement from the Applicant identifying the reason or reasons for each denial.
 7. Except for Applicants that have been approved to Self-Administer or are seeking to Self-Administer under R20-5-1510, a copy of the signed agreement between the Self-Insurer and a Third-Party Administrator, if different from the last filing approved by the Commission.
 8. If an Applicant intends to Self-Administer, regardless of whether the Applicant has been previously approved to Self-Administer, a completed Application to Self-Administer Form and current information and documentation required under R20-5-1510(C).
 9. If an eligible Applicant directs or intends to direct medical care under A.R.S. § 23-1070, a completed Self-Provider of Medical Benefits Form, the detailed statement of the arrangements required in A.R.S. § 23-1070(B), and a copy of the current medical or hospital agreements, if applicable.
 10. If the Applicant is a Public Entity or a Public Entity Pool that is seeking a waiver of security under R20-5-1525, a completed Request for Waiver of Security Form and a current actuarial report that satisfies the requirements in R20-5-1513(B).
 11. If the Applicant is a Subsidiary, a copy of the Parent Company's most-recent audited financial statements, including any notes to the financial statements. If audited financial statements are not reasonably available, internally-reviewed and signed financial statements that conform with Generally Accepted Accounting Principles may be substituted.
 12. If the Applicant is a Subsidiary and the Parent Company has changed since the last application or renewal approved by the Commission:
 - a. A completed Parent Guaranty Form or Agreement to Process and Pay signed by a designated representative of the Parent Company that guarantees the payment of the Subsidiary's obligations.
 - b. A resolution of the Parent Company's board of directors or governing body authorizing the designated representative to complete, sign, and file the Parent Guaranty Form or Agreement to Process and Pay. If a Parent Company does not have a board of directors or governing body, an authorized representative shall sign the resolution.
 13. If the Applicant is a Self-Insurance Pool:
 - a. Updated copies of the documentation and information required in R20-5-1505(B)(13)(a) through (c), (g), and (h), if changed since the last filing approved by the Commission.
 - b. A current actuarial report that meets the requirements of R20-5-1513(B).
 - c. An original or a certified copy of the Self-Insurance Pool's current fidelity or crime insurance policy that meets the requirements of R20-5-1528.
 - C. A complete renewal application submitted to the Division before the Self-Insurer's Renewal Date shall serve to extend existing authority to self-insure until the earliest of the following:
 1. The date the Commission takes action on the application according to R20-5-1509;
 2. The date the Self-Insurer terminates self-insurance under R20-5-1518; or
 3. The date the renewal application is withdrawn.
 - D. Upon written request, the Commission may temporarily extend the duration of an existing authorization to self-insure for up to 90 days after a designated Renewal Date if the Self-Insurer is working in good faith to file a complete renewal application with the Division and additional time is necessary to file a complete renewal application.
 - E. If a Self-Insurer does not file a complete renewal application on or before the Renewal Date or the date specified in subsection (D), if applicable, or a renewal application is deemed withdrawn, self-insurance authority ceases and the individual employer or each member of the pool shall provide the Commission proof of compliance with A.R.S. § 23-961(A) not later than 10 days after the Self-Insurer's Renewal Date, the date specified in subsection (D), or the date the renewal application is withdrawn, whichever is later.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1507. New Member Application Requirements for Self-Insurance Pools

- A. Except as authorized in subsection (C), a previously authorized Self-Insurance Pool seeking to add a new member shall file with the Division a completed New Pool Member Application Form and the documentation and information required in subsection (B).
- B. For a new member application to be deemed complete, the following documentation and information shall be provided by the Applicant:
 1. A resolution of the Self-Insurance Pool Board authorizing the filing of the New Pool Member Application Form.
 2. The documentation and information listed in R20-5-1505(B)(2), (B)(5), (B)(7), (B)(13)(c) through (e), and (B)(13)(j) through (l) specifically pertaining to the employer seeking to join the Self-Insurance Pool.
- C. An approved Self-Insurance Pool in good standing that has operated for one year or more may admit new members without Commission approval. Upon admission of a new member into a Self-Insurance Pool under this subsection, the Self-Insurance Pool shall provide to the Division a list of the new member's coverage locations and the documentation and information listed in R20-5-1505(B)(13)(c) through (e) specifically pertaining to the new member.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1508. Processing of Initial, Renewal, and New Member Applications

- A. The Division shall administratively review an initial, renewal, or new member application within 20 days of receipt of the application to determine if the application is complete. If the application is incomplete, the Division shall notify the Appli-

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cant in writing of the missing documentation or information necessary to comply with this Article.

- B. The Division shall deem an initial, renewal, or new member application withdrawn if the Applicant fails to file a complete application within 30 days of being notified by the Division that the application is incomplete according to subsection (A) or fails to submit requested information or documentation within 30 days of receiving a request under subsection (F).
- C. Unless the substantive review time frame is extended under A.R.S. § 41-1075, the Commission shall determine whether an initial, renewal, or new member application meets the substantive criteria of A.R.S. §§ 11-952.01, 15-382, 23-961, 23-961.01, and 41-621.01, and this Article, as applicable, within 60 days after the initial, renewal, or new member application is deemed complete.
- D. The overall timeframe for processing initial, renewal, and new member applications is 80 days, unless extended under A.R.S. § 41-1072 et seq.
- E. Upon the filing of a complete initial, renewal, or new member application, the Division shall review the submitted documentation and information and:
 1. Evaluate and determine whether the Applicant meets the requirements of A.R.S. §§ 11-952.01, 15-382, 23-961, 23-961.01, and 41-621.01 and this Article, as applicable;
 2. Evaluate and determine whether the Applicant has the financial ability to process and pay benefits required under the Act;
 3. Evaluate and determine whether a waiver of security is appropriate under R20-5-1525 or, if security is required, the appropriate amount of security; and
 4. If the Division recommends approval of an initial or renewal application, evaluate and determine a recommended term of self-insurance, which may not be less than one year or more than two years from the date of Commission approval under R20-5-1509.
- F. The Division may request an Applicant to provide additional information and documentation reasonably related to the Division's review and evaluation under subsection (E).
- G. The Division shall consider the following information in determining whether two or more employers meet the "similar industry" requirement in A.R.S. § 23-961.01(A):
 1. The two-digit sector designation of the most recent edition of the North American Industry Classification System assigned to the employers;
 2. The extent to which the employers are engaged in business involving similar products, services, activities, and processes; and
 3. Other relevant information describing or concerning the business of the employers.
- H. The Division shall present its evaluation, findings, and recommendations according to subsection (E) to the Commission.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1509. Commission Review of Initial, Renewal, and New Member Applications

- A. The Commission shall consider the following before approving or denying an initial, renewal, or new member application:
 1. The documentation and information submitted by Applicant according to R20-5-1505, R20-5-1506, R20-5-1507, or R20-5-1508(F);
 2. The evaluation, findings, and recommendations of the Division according to R20-5-1508; and
- 3. The requirements of A.R.S. §§ 11-952.01, 15-382, 23-961, 23-961.01, and 41-621.01 and this Article, as applicable.
- B. The Commission may approve or deny an initial, renewal, or new member application or may remand an application to the Division for further review or to request additional information or documents according to R20-5-5-1508(F). A decision to approve, deny, or remand an application shall be made by a majority vote of a quorum of Commission members present at a public meeting.
- C. When approving an initial or renewal application, the Commission shall determine: (1) the term of self-insurance authorization, which may not be less than one year or more than two years from the date of Commission approval; (2) whether to grant a waiver of security under R20-5-1525; and (3) if security is required, the amount of security that must be posted. The Commission shall require an amount of security that reasonably reflects the Self-Insurer's future total estimated liability and is sufficient to fully protect the Special Fund in the event of an assignment under A.R.S. § 23-966, which amount may exceed the amounts specified in R20-5-1520(A).
- D. The Commission shall deny an initial, renewal, or new member application if the Commission finds either of the following:
 1. The Applicant does not meet the requirements of A.R.S. §§ 11-952.01, 15-382, 23-961, 23-961.01, and 41-621.01 or this Article, as applicable; or
 2. The Applicant is unable to process and pay benefits required under the Act.
- E. On or before the Authorization Date, following Commission approval of an initial application for self-insurance authority, or within 30 days after Commission approval of a renewal or new member application, a Self-Insurer shall:
 1. Unless the Commission has granted a waiver of security under R20-5-1525, post required security;
 2. Secure excess insurance coverage that meets the requirements of R20-5-1526, if applicable;
 3. Either obtain Division approval to Self-Administer under R20-5-1510 or complete the process of contracting with a Third-Party Administrator; and
 4. For Self-Insurance Pools, secure an active fidelity or crime insurance policy, unless the pool is exempt according to R20-5-1528(C).
- F. Upon approval of an initial, renewal, or new Member application, the Division shall serve a Resolution of Authorization on the Applicant no later than 30 days after Commission approval. The Resolution of Authorization approving an initial application shall contain the Authorization Date, the applicable Renewal Date, and the amount of security required. The Resolution of Authorization approving a renewal application shall contain the applicable Renewal Date and the amount of security required. The Resolution of Authorization approving addition of a new member shall contain the amount of additional security the Self-Insurance Pool is required to post. The Resolution of Authorization may be electronically signed by the Commission.
- G. If the Commission denies an initial, renewal, or new member application, the Commission shall issue and serve written findings and an order on the Applicant no later than 30 days after the Commission denial. The findings and order may be electronically signed by the Commission.
- H. If an Applicant's current Experience Modification Rate specific to Arizona exceeds 1.10, the Commission may approve authorization to self-insure that is contingent upon the Applicant receiving, within six months of the Commission's

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approval, occupational safety and health services from either the Arizona Division of Occupational Safety and Health or a qualified occupational safety and health professional. Upon written request and for good cause shown, the Division may extend the six-month deadline for receiving safety and health consultation services.

- I. A Self-Insurer shall maintain all security, insurance policies, and contracts required under this Article during an approved period of self-insurance and while a renewal application is pending before the Commission.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1510. Processing of Workers' Compensation Claims; Authorization to Self-Administer

- A. A Self-Insurer shall utilize a Third-Party Administrator to process workers' compensation claims unless the Division authorizes the Self-Insurer to Self-Administer.
- B. A Self-Insurer seeking to Self-Administer shall file with the Division a completed Application to Self-Administer Form and all documentation and information required under subsection (C).
- C. The Division, in consultation with the Claims Division of the Commission, shall authorize a Self-Insurer to Self-Administer if the Self-Insurer provides documentation and information establishing the following:
1. The Self-Insurer has facilities and equipment sufficient to manage, process, and store its own information pertaining to the Self-Insurer's workers' compensation claims;
 2. The Self-Insurer's workers' compensation claims are processed by persons with experience, training, and knowledge regarding the processing of Arizona workers' compensation claims and the requirements of the Act and applicable administrative rules; and
 3. The persons processing the Self-Insurer's claims have completed the Claims Division's workers' compensation training program within the prior two years.
- D. The Division shall administratively review an application to Self-Administer within 20 days of receipt to determine if the application is complete. If the application is incomplete, the Division shall notify the Applicant in writing of the missing documentation or information necessary to comply with this section.
- E. The Division shall deem an application to Self-Administer withdrawn if the Applicant fails to file a completed application within 10 days of being notified by the Division that the application is incomplete according to subsection (D).
- F. Unless the substantive review time frame is extended under A.R.S. § 41-1075, the Division shall determine whether an application to Self-Administer meets the substantive criteria of subsection (C) within 30 days after the application to Self-Administer is deemed complete.
- G. The overall timeframe for processing an application to Self-Administer is 50 days, unless extended under A.R.S. § 41-1072 et seq.
- H. Upon approval of an application to Self-Administer, the Division shall serve a certificate of authorization on the Applicant no later than 30 days after approval.
- I. The Division shall revoke a certificate of authorization to Self-Administer if the Self-Insurer no longer satisfies the requirements in subsection (C).
- J. If the Division denies a request to Self-Administer or revokes a certificate of authorization, the Division shall issue and serve

written findings and an order on the Applicant no later than 30 days after the denial or revocation.

- K. Authorization to Self-Administer shall continue until any of the following occurs: (1) self-insurance authority ceases; (2) the Self-Insurer contracts with a Third-Party Administrator to process workers' compensation claims; or (3) authority to Self-Administer is revoked by the Division.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1511. Location of Claims Files

A Self-Insurer shall provide written notice to the Division regarding the location of the Self-Insurer's open and closed claims files within 90 days of the Authorization Date. If a Self-Insurer or Third-Party Administrator intends to change the location of its claims files, the Self-Insurer shall provide written notice to the Division of the change in location at least 30 days before the files are moved.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1512. Reports, Books, Records, and Data Review by the Commission; Audit

- A. All reports, books, records, minutes, and data of a Self-Insurer relating to matters governed by the Act and this Article are subject to review by the Commission or its authorized representative upon request. A Self-Insurer shall ensure that reports, books, records, minutes, and data relating to matters governed by the Act and this Article are accurate and maintained in a legible and understandable manner.
- B. The Commission may, upon notice of three days, perform or have performed for its benefit an audit of the reports, books, records, minutes, and data of a Self-Insurer relating to matters governed by the Act and this Article. The Commission shall be responsible for the cost of an audit.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1513. Financial Statements and Actuarial Reports

- A. A Self-Insurer shall ensure that audited financial statements are prepared annually at the end of the Self-Insurer's fiscal year by a certified public accountant experienced in auditing financial statements.
- B. Actuarial reports and studies required in this Article must be completed by an actuary that is a member of the American Academy of Actuaries (MAAA) or a fellow of the Casualty Actuarial Society (FCAS). At a minimum, actuarial reports must address claim reserves, supplemental reserves, and actuarial liabilities using an expected confidence level and a discount rate consistent with Actuarial Standard of Practice No. 20 (or a successor standard).
- C. Upon request, a Self-Insurer shall file its most-recent annual audited financial statements or actuarial report with the Division.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

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R20-5-1514. Claim Processing and Reserving

- A. Self-Insurers and Third-Party Administrators shall ensure that claims are processed and benefits are paid in compliance with the Act and applicable administrative rules.
- B. Self-Insurers and Third-Party Administrators shall adopt and adhere to industry-standard reserving practices and maintain claim reserves at the full undiscounted value of each claim, including related claim expenses.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1515. Notice of Adverse Condition, Bankruptcy, Change in Ownership Status, or Change in Business Address

- A. A Self-Insurer shall notify the Division in writing within 10 days of any adverse condition or material change that impacts or could impact the Self-Insurer's ability to process and pay benefits required under the Act. When a Self-Insurer provides notice to the Commission under this subsection, the Self-Insurer shall provide a written proposal to correct the actual or potential adverse condition or material change.
- B. A Public Entity Pool shall notify the Division within 30 days of receipt of any notification from the Director of the Department of Insurance and Financial Institutions according to A.R.S. §§ 11-952.01(N) and 41-621.01(L).
- C. A Self-Insurer shall notify the Division in writing within 10 days of any bankruptcy filing under federal law or insolvency proceeding under any state's laws.
- D. A Self-Insurer shall notify the Division in writing within 30 days of any change in the ownership status or business address of the Self-Insurer.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1516. Revocation of Self-Insurance Authorization

- A. The Commission may revoke authorization to self-insure for good cause. Good cause for revocation includes, but is not limited to, any of the following:
 - 1. Impairment of the solvency of the Self-Insurer;
 - 2. An inability or failure to process and pay benefits required under the Act, including the failure to pay or comply with any award of the Commission;
 - 3. The failure of the Self-Insurer to respond within 10 days to a demand by the Commission to substitute security when the posted security is unsatisfactory or insufficient in amount or character;
 - 4. The failure of the Self-Insurer to pay tax assessments levied by the Commission within 30 days of the due dates prescribed by A.R.S. §§ 23-961 and 23-1065;
 - 5. The failure of the Self-Insurer to promptly provide the Commission with notices or information required under this Article;
 - 6. The failure of the Self-Insurer to comply with the Act or administrative rules contained in Title 20, Chapter 5, Articles 1, 13, 14 and this Article;
 - 7. The willful misstating of material fact in any documentation or information provided to the Commission;
 - 8. The failure of a Public Entity Pool to comply with the recommendations of the Director of the Department of Insurance and Financial Institutions within 60 days of the date of notice issued under A.R.S. §§ 11-952.01(N) and 41-621.01(L); or

- 9. Except for a Self-Insurer approved to Self-Administer, the failure to contract with or adequately fund a Third-Party Administrator for claim processing and payment.

- B. Upon receiving information indicating that any of the grounds for revocation described in subsection (A) may apply, the Division shall conduct an investigation. If, upon completion of the investigation, the Division determines that sufficient evidence exists to warrant revocation of authorization to self-insure, the Division shall promptly present its findings and recommendations to the Commission.
- C. The decision of the Commission to revoke authorization to self-insure shall be made by a majority vote of a quorum of Commissioners present at a public meeting. The Commission shall issue and serve written findings and an order revoking self-insurance authority no later than 10 days after the Commission vote. The findings and order may be electronically signed by the Commission.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1517. Retaining Authorization to Self-Insure Through Insolvency or Bankruptcy

- A. If a Self-Insurer becomes insolvent or files for protection under the United States Bankruptcy Code seeking to reorganize, and desires to remain self-insured, it shall file with the Division a written statement regarding its intent to reorganize under the applicable provisions of the United States Bankruptcy Code. The statement shall discuss in detail the Self-Insurer's financial ability to continue self-insurance.
- B. A Self-Insurer shall file the statement described in subsection (A) with the Division within 10 days of the insolvency or bankruptcy filing. The letter shall be signed by an authorized representative of the Self-Insurer.
- C. A Self-Insurer seeking to retain authorization to self-insure through bankruptcy shall ensure that a provision addressing the Self-Insurer's obligations to workers' compensation claimants and the Commission is included in the plan of reorganization filed with the United States Bankruptcy Court.
- D. During the period between the initial bankruptcy filing and a final bankruptcy court determination, the Self-Insurer may continue its self-insurance status only after demonstrating to the Commission ongoing ability to process and pay benefits required under the Act. The Commission may require the Self-Insurer to post additional security in an amount the Commission deems appropriate to fully protect the Special Fund in the event of an assignment under A.R.S. § 23-966, which amount may exceed the amount specified in R20-5-1520(A).
- E. A Self-Insurer shall file with the Division a copy of any proposed plan of reorganization or liquidation, including amendments, within 10 days of filing.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1518. Voluntary Termination of Self-Insurance Authorization

- A. A Self-Insurer voluntarily terminating self-insurance shall file a completed Notice of Termination of Self-Insurance Form at least 30 days before the effective date of the termination.
- B. If a Self-Insurer voluntarily terminates self-insurance, the individual employer or each member of a Self-Insurance Pool shall provide the Commission proof of compliance with

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A.R.S. § 23-961(A) not later than 10 days after the termination is effective.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1519. Withdrawal from a Self-Insurance Pool; Termination of Membership by a Self-Insurance Pool

- A. A member of a Self-Insurance Pool may voluntarily withdraw from a Self-Insurance Pool or a Self-Insurance Pool may terminate an employer's membership in a Self-Insurance Pool under the bylaws of the Self-Insurance Pool and applicable law.
- B. A Self-Insurance Pool shall provide the Commission written notice of a member's intent to withdraw from a Self-Insurance Pool or a Self-Insurance Pool's intent to terminate an employer's membership in a Self-Insurance Pool at least 30 days before the withdrawal or termination is effective.
- C. If a member of a Self-Insurance Pool withdraws from a Self-Insurance Pool or a Self-Insurance Pool terminates an employer's membership in a Self-Insurance Pool, the terminated or withdrawing member shall provide the Commission proof of compliance with A.R.S. § 23-961(A) not later than 10 days after the termination or withdrawal is effective.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1520. Security Amount and Type; Apportionment Credit; Excess Insurance Credit; Release

- A. Except as provided in R20-5-1525, and subject to the minimum requirements in A.R.S. § 23-961:
 - 1. A newly approved Self-Insurer shall post security in an amount equal to the prior three-year average of annual total paid medical and indemnity benefits, unless the Commission requires a different amount according to R20-5-1509(C).
 - 2. A Self-Insurer renewing authority to self-insure shall post security in an amount equal to 125% of its total estimated future indemnity and medical liability as calculated on the Workers' Compensation Liability Form, unless the Commission requires a different amount according to R20-5-1509(C).
 - 3. A Self-Insurance Pool adding a new member shall post security in an amount equal to the prior three-year average of annual total paid medical and indemnity benefits of the new member, unless the Commission requires a different amount according to R20-5-1509(C).
- B. Except as provided in R20-5-1525, a Self-Insurer shall post a type of security authorized in R20-5-1521 through R20-5-1524. A Self-Insurer or former Self-Insurer may substitute one type of authorized security with a different type of authorized security.
- C. The Commission shall approve a credit for apportionment against the amount of security required under this Article, which credit may not result in an amount of security that is less than the minimum security required by A.R.S. § 23-961, if the Self-Insurer provides proof that apportionment has been approved for one or more claims.
- D. The Commission shall approve a credit for excess insurance against the amount of security required under this Article, which credit may not result in an amount of security that is less than the minimum security required by A.R.S. § 23-961, if:

- 1. The excess insurance requirements in R20-5-1526(A) are satisfied;
- 2. The Self-Insurer provides proof that excess insurance coverage exists for incurred claims;
- 3. The Self-Insurer has timely notified the excess insurance carrier of the incurred claims or the excess insurance carrier has accepted the incurred claims;
- 4. The excess insurance carrier has not denied coverage for the incurred claims; and
- 5. The excess insurance carrier is solvent.
- E. The Self-Insurer shall calculate apportionment or excess insurance credits using the Workers' Compensation Liability Form.
- F. Subject to A.R.S. § 23-961(A)(2), a former Self-Insurer may request a reduction in the amount of security that must remain posted with the Commission by filing a written request with the Division. The written request must attach the information specified in R20-5-1506(B)(1) through (4). The Division may request additional information and documentation reasonably related to the Division's review and evaluation under subsection (G).
- G. Upon the filing of a request to reduce the amount of security by a former Self-Insurer, the Division shall review the documentation and information and:
 - 1. Evaluate and determine whether the former Self-Insurer has the financial ability to process and pay benefits required under the Act for claims that were incurred during the period of self-insurance; and
 - 2. Evaluate and determine an appropriate amount of security to fully protect the Special Fund in the event of an assignment under A.R.S. § 23-966.
- H. The Division shall present its evaluation, findings, and recommendations according to subsection (G) to the Commission. The Commission may approve a reduction in the amount of security, deny a reduction, or remand an application to the Division for further review or to request additional documentation or information. A decision of the Commission shall be made by a majority vote of a quorum of Commission members present at a public meeting.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1521. Guaranty Bond; Effective Date

A Self-Insurer may post a guaranty bond or rider of a guaranty bond as security if:

- 1. The insurance carrier providing the guaranty bond submits the bond to the Commission on the Workers' Compensation Guaranty Bond Form, which is signed by an authorized representative of the Self-Insurer and the insurance carrier;
- 2. Any rider of a guaranty bond is signed and dated by an authorized representative of the insurance carrier and the Self-Insurer;
- 3. The penal sum of the guaranty bond or rider is no less than the amount the Self-Insurer is required to post as security under this Article;
- 4. The insurance carrier issuing the guaranty bond or rider is authorized to transact the business of surety insurance in Arizona by the Department of Insurance and Financial Institutions;
- 5. The insurance carrier issuing the guaranty bond or rider does not have an affiliate relationship with the Self-Insurer;

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6. The insurance carrier issuing the guaranty bond or rider has a rating with A.M. Best of at least A-; and
7. The guaranty bond or rider bears the same effective date as the Authorization Date.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1522. Letter of Credit

- A. A Self-Insurer may post a letter of credit as security if:
1. The letter of credit is registered to: "The Industrial Commission of Arizona, in trust for the fulfillment by [INSERT SELF-INSURER'S NAME] of its obligations under the Arizona Workers' Compensation laws";
 2. The bank issuing the letter of credit is a federal or Arizona-chartered bank upon which demand may be made and from which funds will be immediately payable on demand;
 3. The letter of credit includes the name and address of the Self-Insurer;
 4. An authorized representative of the issuing bank executes the letter of credit;
 5. The original letter of credit and original amendments to a letter of credit are provided to the Commission;
 6. The initial letter of credit is valid for a period of one year from the effective date;
 7. The issuing bank does not have an affiliate relationship with the Self-Insurer;
 8. The letter of credit includes a provision that the letter of credit automatically extends for consecutive periods of one year, unless the issuing bank provides written notice to the Commission 60 days before the expiration of any one-year term that the issuing bank will not renew the letter of credit for the additional period;
 9. The letter of credit states the amount available under the letter of credit, which shall be no less than the amount the Self-Insurer is required to post as security under this Article; and
 10. The letter of credit includes a statement that the Commission may make a demand on the letter of credit by providing the issuing bank a signed statement by an official of the Commission stating either that the Self-Insurer has failed to comply with its workers' compensation obligations or failed to renew or substitute acceptable security for its workers' compensation liability 30 days before the expiration of the letter of credit.
- B. The written notice required in subsection (A)(8) shall be sent to the Division via e-mail or by mail with delivery confirmation.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1523. Local Government Investment Pool Funds

A Public Entity or Public Entity Pool may post Local Government Investment Pool funds as security if:

1. The Public Entity or Public Entity Pool completes a Statutory Deposit Agreement Form, which is signed by an authorized representative of the Self-Insurer, the Arizona State Treasurer, and the Commission; and
2. The funds deposited with the Arizona State Treasurer are no less than the amount the Self-Insurer is required to post as security under this Article.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1524. Federal Money Market Fund or Treasury Note

A Self-Insurer may post a federal money market fund or a treasury note as security if:

1. The Self-Insurer completes a Custody Agreement Form, which is signed by an authorized representative of the Self-Insurer, the custodial bank, the Arizona State Treasurer, and the Commission; and
2. The amount of the Federal money market fund or treasury note posted shall be no less than the amount the Self-Insurer is required to post as security under this Article.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1525. Waiver from Requirement to Post Security for a Public Entity or Public Entity Pool

- A. Only a Public Entity or Public Entity Pool is eligible for a waiver from posting security.
- B. A Public Entity or Public Entity Pool may receive a waiver from posting security if:
1. The Public Entity has conducted business or the Public Entity Pool has operated in Arizona for a minimum of five consecutive years;
 2. The Public Entity Trust Fund (for a Public Entity) or the Workers' Compensation Pool Loss Account (for a Public Entity Pool) continually maintains a positive fund/account balance; and
 3. The Public Entity Trust Fund (for a Public Entity) or the Workers' Compensation Pool Loss Account (for a Public Entity Pool) is continually funded to cover actuarial liabilities of the Self-Insurer's incurred claims in accordance with the February 1996 Governmental Accounting Standards Board Statement No. 30 (Risk Financing Omnibus, An Amendment of GASB Statement No. 10), available from the Governmental Accounting Standards Board. This incorporation by reference does not include any later amendments or editions of the incorporated matter. A copy of the incorporated matter is available from the Commission or may be obtained from the Governmental Accounting Standards Board at 401 Merritt 7, P.O. Box 5116, Norwalk, CT 06856-5116.
- C. The decision of the Commission to approve, deny, or revoke a request for waiver of security shall be made by a majority vote of a quorum of Commissioners present at a public meeting.
- D. If the Commission grants a waiver of security, the waiver shall be included in the Resolution of Authorization issued under R20-5-1509(F). The Division shall return any security previously posted or provided to the Commission within 30 days after the approval of a waiver of security.
- E. A Public Entity or Public Entity Pool which has been granted a waiver of security must file current financial statements and a statement of unpaid liabilities with the Division every six months, beginning six months after a waiver is granted.
- F. If the Commission denies a request for waiver of security or revokes a waiver of security, the Commission shall issue and serve written findings and an order on the Applicant no later than 30 days after the Commission denial or revocation. The findings and order may be electronically signed by the Commission.

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- G.** The Commission shall revoke a waiver of security if the Commission determines a Public Entity or Public Entity Pool no longer satisfies the criteria in subsection (B) or does not comply with subsection (E) and the Public Entity or Public Entity Pool does not cure the deficiency within 30 days of being notified by the Division. Within 10 days of service of a written findings and order revoking a waiver of security, a Public Entity or Public Entity Pool must file with the Commission a completed Workers' Compensation Liability Form and post security as required by the Commission.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1526. Excess Insurance

- A.** A Self-Insurer may secure specific and aggregate excess insurance if all of the following are satisfied:
1. The insurance carrier issuing excess insurance is authorized to transact the business of excess insurance in Arizona by the Department of Insurance and Financial Institutions;
 2. The retention for specific excess insurance is not less than \$100,000 without advance written approval by the Commission;
 3. Payments of workers' compensation benefits on a claim made by a Self-Insurer, member, or through security posted by a Self-Insurer are applied toward reaching the retention level in the excess insurance policy;
 4. The excess insurance carrier does not have an affiliate relationship with the Self-Insurer; and
 5. The excess insurance policy provides that insolvency of the Self-Insurer does not relieve the excess insurance carrier of liability under the policy.
- B.** A Self-Insurer or insurance company seeking to cancel or refuse renewal of an excess insurance policy shall provide 60 days written notice of the proposed cancellation or non-renewal to the Commission. The written notice shall be sent by registered or certified mail. Failure to provide notice as required by this subsection shall preclude cancellation or non-renewal of the policy.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1527. Self-Insurance Pool Board; Administrator

- A.** A Self-Insurance Pool shall be directed by a Self-Insurance Pool Board consistent with A.R.S. §§ 11-952.01, 15-382, 23-961.01, 41-621.01, and this Article, as applicable.
- B.** The Self-Insurance Pool Board of a Similar Industry Pool shall consist of five or more individuals elected for a stated term of office, at least 60% of which shall be representatives of members of the Similar Industry Pool.
- C.** The duties of a Self-Insurance Pool Board shall include:
1. Responsibility for all operations of the Self-Insurance Pool;
 2. Ensuring compliance with the Act and this Article;
 3. Hiring an Administrator to manage the daily operations of the Self-Insurance Pool;
 4. Reviewing and acting on applications for membership in the Self-Insurance Pool;
 5. Contracting with a Third-Party Administrator, unless the Division has authorized the Self-Insurance Pool to Self-Administer;

6. Ensuring the Self-Insurance Pool complies with statutory accounting principles (SAP) and provides accurate financial information to enable complete and accurate preparation of financial reports;
7. Maintaining all records and documents relating to the formation and ongoing operations of the Self-Insurance Pool;
8. Ensuring that accurate minutes of meetings of the Self-Insurance Pool Board are completed and signed by an authorized representative of the Self-Insurance Pool;
9. Maintaining all reports, books, records, and data relating to matters governed by this Article according to R20-5-1512; and
10. Ensuring that accounts and records of the Self-Insurance Pool are audited as required under R20-5-1513(A).

- D.** Except as prohibited by law, a Self-Insurance Pool Board may delegate duties to an Administrator. Delegation of duties to an Administrator shall be contained in a signed agreement or contract of hire between the Self-Insurance Pool Board and the Administrator.

- E.** An Administrator of a Self-Insurance Pool is subject to all of the following requirements:

1. Unless otherwise authorized by law, an Administrator for a Self-Insurance Pool shall not be a member of the Self-Insurance Pool Board.
2. Unless otherwise authorized by law, an Administrator for a Self-Insurance Pool shall not be a member of the Self-Insurance Pool or an employee of a member of the Self-Insurance Pool.
3. Before a Self-Insurance Pool Board can hire an Administrator, the Self-Insurance Pool shall disclose to the prospective Administrator all existing agreements between the pool and providers of services or insurance coverage and the prospective Administrator shall disclose to the Self-Insurance Pool Board any actual or perceived employment or financial interest that the Administrator or relative (as defined in A.R.S. § 38-502) of the Administrator has in the providers of services or insurance coverage.
4. Before a Self-Insurance Pool enters into an agreement with a provider of services or insurance coverage, the Administrator shall disclose to the Self-Insurance Pool Board any actual or perceived employment or financial interest that the Administrator or a relative (as defined in A.R.S. § 38-502) of the Administrator has in the prospective provider of services or insurance coverage.

- F.** Self-Insurance Pool Boards and Administrators shall not:

1. Extend credit to members for payment of a premium;
2. Utilize money collected as premiums for any purpose not authorized by this Article;
3. Borrow money from the Self-Insurance Pool;
4. Borrow money in the name and on behalf of the Self-Insurance Pool without providing prior written notice to the Division of the nature and purpose of the loan; and
5. Admit into the Self-Insurance Pool an employer whose admission would impair the ability of the Self-Insurance Pool to process and pay benefits required under the Act.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1528. Self-Insurance Pool Fidelity or Crime Insurance

- A.** Except as stated in subsection (C), a Self-Insurance Pool shall maintain during all periods of self-insurance a fidelity or crime

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insurance policy that protects the pool from unlawful actions of the following:

1. Individuals appointed to the Self-Insurance Pool Board (individual and collective liability);
 2. The Administrator of the Self-Insurance Pool;
 3. Employees of the Self-Insurance Pool; and
 4. Employees of the Administrator, if applicable.
- B.** The limit of liability of the fidelity or crime insurance policy required in subsection (A) shall be no less than \$1 million per occurrence and shall be sufficient to protect the Self-Insurance Pool from damages resulting from unlawful acts related to of any assets controlled or managed by the Self-Insurance Pool Board, the Administrator, employees of the Self-Insurance Pool, and employees of the Administrator, if applicable.
- C.** A Self-Insurance Pool that maintains at least \$3 million in surplus funds at all times during an approved period of self-insurance is exempt from the requirements in this Section.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1529. Self-Insurance Pool Loss Control and Underwriting Programs

- A.** A Self-Insurance Pool shall maintain during all periods of self-insurance a loss control program that includes, at a minimum, written safety requirements and training programs for all employees of the members. A Self-Insurance Pool shall ensure that the loss control program is administered by persons with education, experience, or training in loss control.
- B.** A Self-Insurance Pool shall maintain during all periods of self-insurance an underwriting program that enables the pool to establish workers' compensation premiums and to fully discharge the Self-Insurance Pool's obligation to process and pay benefits required under the Act. A Self-Insurance Pool shall ensure that the underwriting program is administered by persons with education, experience, or training in underwriting.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1530. Self-Insurance Pool Workers' Compensation Pool Operations Account; Workers' Compensation Pool Loss Account

- A.** A Self-Insurance Pool shall maintain a Workers' Compensation Pool Operations Account, which is subject to all of the following:
1. All workers' compensation premiums charged to members of the Self-Insurance Pool shall be deposited into the Workers' Compensation Pool Operations Account, which account shall be maintained in a designated federally-insured depository.
 2. A Self-Insurance Pool shall pay all operational expenses of the pool relating to workers' compensation, excluding administrative expenses associated with processing workers' compensation claims, from the Workers' Compensation Pool Operations Account.
 3. Funds from the Workers' Compensation Pool Operations Account shall be transferred to the Workers' Compensation Pool Loss Account, as needed, to enable the Self-Insurance Pool to pay from the Workers' Compensation Pool Loss Account all liabilities imposed or arising under the Act and all administrative expenses associated with processing workers' compensation claims.

4. If the Workers' Compensation Pool Operations Account is co-mingled with another account, the activities of the Workers' Compensation Pool Operations Account are segregated in the financial records.

- B.** A Self-Insurance Pool shall maintain a Workers' Compensation Pool Loss Account, which is subject to all of the following:

1. A Self-Insurance Pool shall maintain its Workers' Compensation Pool Loss Account in a designated federally-insured depository.
2. A Self-Insurance Pool shall pay all workers' compensation claim expenses, including current and contingent workers' compensation claim liabilities of and administrative expenses associated with processing workers' compensation claims, from the Workers' Compensation Pool Loss Account.
3. A Self-Insurance Pool shall ensure that its Workers' Compensation Pool Loss Account is actuarially sound and able to process and pay benefits required under the Act.
4. If the Workers' Compensation Pool Loss Account is co-mingled with another account, the activities of the Workers' Compensation Pool Loss Account are segregated in the financial records.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1531. Gross Annual Premium of a Self-Insurance Pool; Calculation of Member Premiums; Discounts; Penalties; Refunds

- A.** The gross annual workers' compensation premium for a Self-Insurance Pool shall be sufficient to fund the workers' compensation administrative expenses and total incurred workers' compensation losses of the pool.
- B.** A Self-Insurance Pool shall calculate and collect member premiums using industry best practices and formulas generally accepted in the industry.
- C.** A Self-Insurance Pool shall not discount established Payroll Classification Rates unless the discount is based upon the expense and loss experience of the Self-Insurance Pool and is supported and justified by an actuarial feasibility study.
- D.** A Self-Insurance Pool may apply a penalty rate in excess of an annual premium to any member, provided the Self-Insurance Pool serves written justification and notice on the member 30 days before the effective date of the penalty rate.
- E.** A Self-Insurance Pool may declare a refund of surplus funds, including excess investment income, to its members if the amount of the refund is supported by an actuarial report.
- F.** A Self-Insurance Pool discounting established Payroll Classification Rates under subsection (C) or declaring a refund of surplus funds under subsection (E) shall notify the Division at least 60 days before the Self-Insurance Pool discounts the Payroll Classification Rates or refunds surplus funds.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1532. Similar Industry Pool; Joint and Several Liability of Members

- A.** The joint and several liability clause required by A.R.S. § 23-961.01(E) applies to any agreements used to form a Similar Industry Pool on a cooperative or contract basis, through a

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joint formation of a nonprofit corporation, or by the execution of a trust agreement.

- B.** A Similar Industry Pool shall ensure that the pool and all members read and agree, in writing, to the following terms:
1. The members of the pool are jointly and severally liable for the liabilities of the pool to the extent the pool is unable to, or does not, satisfy the liabilities;
 2. Member liability under subsection (B)(1) extends to all liabilities incurred by the pool during the member's period of membership in the pool, including all future liabilities that accrued during the member's period of membership in the pool; and
 3. In the event that claims are assigned to the Special Fund under A.R.S. § 23-966, the Commission shall have a right of reimbursement against the members jointly and severally for any and all amounts paid by the Special Fund, including costs, necessary expenses, and reasonable attorney's fees, to the extent that such liabilities are not covered by the pool's security or other assets.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1533. Completion of Reports in Support of Tax Rating Plans; Calculation and Payment of Self-Insurance Taxes

- A.** A Self-Insurer shall submit to the Division the information required in R20-5-1536, R20-5-1537, R20-5-1538, or R20-5-1539, as applicable, by January 31 of each year. A request for an extension may be filed with the Division in writing and shall state the reasons the Self-Insurer is unable to meet the deadline. A request for an extension shall be granted for good cause.
- B.** After receiving the information required in R20-5-1536, R20-5-1537, R20-5-1538, or R20-5-1539, as applicable, the Division shall determine the annual taxes owed by the Self-Insurer. The Division shall also determine whether the Self-Insurer has overpaid or underpaid its taxes for the previous calendar year. If the total of the quarterly payments is less than the actual taxes for the year, the Self-Insurer shall pay the difference on or before March 31 of the calendar year in which the taxes are due. If the total of the quarterly payments exceeds the amount of the actual taxes for the year, the Division shall refund the amount described in A.R.S. § 23-961 or § 23-1065, as applicable.
- C.** A Self-Insurer shall pay to the Commission the Self-Insurer's annual workers' compensation premium taxes on or before March 31 based on the net taxable premium calculated for the preceding calendar year. A Self-Insurer shall pay a premium tax of at least \$250.00 per calendar year.
- D.** The Division shall calculate a Self-Insurer's quarterly taxes owed under A.R.S. §§ 23-961 and 23-1065 in one of the following ways:
1. 25% of the tax calculated for the previous year; or
 2. A calculation based on actual payroll and losses calculated for each quarter, using the same rating plan to calculate the quarterly payment as used to calculate the taxes required under A.R.S. §§ 23-961 and 23-1065. If the Division selects this method, the Self-Insurer shall submit quarterly payroll and loss information by Payroll Classification Code upon request.
- E.** Quarterly tax payments are due April 30, July 31, October 31, and January 31 for the periods ending March 31, June 30, September 30, and December 31, respectively.

- F.** If the Self-Insurer fails to pay the annual or quarterly taxes to the Commission when due, the Self-Insurer shall pay a penalty of \$25.00 or 5% of the tax or payment due, whichever is more, plus interest at the rate of 1% per month from the date the tax or payment was due until paid.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1534. Premium Rates; Deviation Rates

- A.** Annually, by September 15, premium calculation rates and a schedule of Deviation Rates shall be calculated and approved by the Commission at a public rate hearing. The premium calculation rates and the schedule of Deviation Rates shall be effective the following calendar year.
- B.** The Deviation Rate applicable to a Self-Insurer relates directly to the Self-Insurer's safety record, which is measured by the Self-Insurer's Experience Modification Rating specific to Arizona for the prior year. The schedule of Deviation Rates will include the Experience Modification Rate ranges that apply to each Deviation Rate.
- C.** The Experience Modification Rate for purposes of determining the Deviation Rate shall be calculated as follows:
1. In the first year of self-insurance, the Experience Modification Rate is set at 1.00;
 2. In the second and third years of self-insurance, the Division calculates the Experience Modification Rate based upon the payroll and loss data accumulated by the Self-Insurer during its entire term of self-insurance; and
 3. In the fourth year of self-insurance and all following years, the Division calculates the Experience Modification Rate based upon the payroll and loss data of the prior three tax years.
- D.** If the Division cannot calculate an Experience Modification Rate in the second and all following years because the Self-Insurer does not have any injuries, the Self-Insurer shall receive the highest Deviation Rate.
- E.** The lowest Deviation Rate included in the schedule of Deviation Rates shall not be less than 10%.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1535. Basis for Definitions, Classifications, Rating Procedures, and Plans

The Division may use the definitions, classifications, and rating procedures specified in rating plans filed by a Rating Organization or developed by the Division to calculate the net taxable premium under A.R.S. §§ 23-961 and 23-1065.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1536. Fixed Premium Plan; Eligibility; Formula; Necessary Information

- A.** Except as provided in R20-5-1539, a Self-Insurer shall use a Fixed Premium Plan for purposes of premium taxes required under A.R.S. §§ 23-961 and 23-1065 if the Self-Insurer's annual net taxable premium does not exceed \$100,000.
- B.** Except as provided in R20-5-1539, a Self-Insurer may elect to use a Fixed Premium Plan for purposes of premium taxes

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required under A.R.S. §§ 23-961 and 23-1065 if the Self-Insurer's annual net taxable premium exceeds \$100,000.

- C. The Division shall calculate the net taxable premium under a Fixed Premium Plan as follows: [(payroll multiplied by the applicable Payroll Classification Rate) multiplied by (1 minus the Deviation Rate)] less premium discounts.
- D. The Fixed Premium Plan applies only to operations and payroll in Arizona. The Self-Insurer shall combine all operations in Arizona to calculate the premium taxes required under A.R.S. §§ 23-961 and 23-1065.
- E. A Self-Insurer shall provide the following in support of using a Fixed Premium Plan:
 1. Completed Annual Payroll Report Form for the current tax year;
 2. Completed Annual Medical Report Form for the current tax year;
 3. Completed Annual Injury Report Forms for current and prior three tax years; and
 4. Completed Quarterly Tax Payment Form.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1537. Ex-Medical Plan; Eligibility; Formula; Necessary Information

- A. Except as provided in R20-5-1539, a Self-Insurer may elect to use an Ex-Medical for purposes of premium taxes required under A.R.S. §§ 23-961 and 23-1065 if the Self-Insurer's annual net taxable premium exceeds \$100,000 and the Self-Insurer operates a medical facility with a program for providing medical, surgical, or hospital services to a majority of the employees of the Self-Insurer or the employees of the members of a Self-Insurance Pool that complies with the requirements of A.R.S. § 23-1070.
- B. The Division shall calculate the net taxable premium under an Ex-Medical Plan on a Payroll Classification Code basis as follows: [(payroll multiplied by the Payroll Classification Rate) multiplied by (1 minus the Deviation Rate) multiplied by (1 minus the D-Ratio)] less premium discounts.
- C. The Ex-Medical Plan applies only to operations and payroll in Arizona. The Self-Insurer shall combine all operations in Arizona to calculate the premium taxes required under A.R.S. §§ 23-961 and 23-1065.
- D. A Self-Insurer shall provide the following in support of using an Ex-Medical Plan:
 1. The completed forms required in R20-5-1536(E); and
 2. Completed Annual Hospital Report Form for the current tax year.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1538. Guaranteed Cost Plan; Eligibility; Formula; Necessary Information

- A. Except as provided in R20-5-1539, a Self-Insurer may elect to use a Guaranteed Cost Plan for purposes of premium taxes required under A.R.S. §§ 23-961 and 23-1065 if the Self-Insurer's annual net taxable premium exceeds \$100,000.
- B. The Division shall calculate the net taxable premium under a Guaranteed Cost Plan, using the most recent year's data, as follows: [(payroll multiplied by the Payroll Classification Rate) multiplied by (the Experience Modification Rate spe-

cific to Arizona) multiplied by (1 minus the Deviation Rate)] less premium discounts.

- C. The Guaranteed Cost Plan applies only to operations and payroll in Arizona. The Self-Insurer shall combine all operations in Arizona to calculate the premium taxes required under A.R.S. §§ 23-961 and 23-1065.
- D. The Experience Modification Rate specific to Arizona for purposes of determining the net taxable premium under a Guaranteed Cost Plan shall be calculated in the manner described in R20-5-1534(C). If the Division cannot calculate an Experience Modification Rate in the second and all following tax years because the Self-Insurer does not have any injuries, the Experience Modification Rate shall be set at 1.00.
- E. A Self-Insurer shall provide the completed forms required by R20-5-1536(E) in support of using a Guaranteed Cost Plan.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1539. Retrospective Rating Plan; Eligibility; Formula; Necessary Information

- A. The Division may require a Self-Insurer to use a Retrospective Rating Plan for purposes of premium taxes required under A.R.S. §§ 23-961 and 23-1065 if:
 1. The Self-Insurer has an Experience Modification Rate specific to Arizona that exceeds 1.10 for two consecutive years; or
 2. The Self-Insurer demonstrates financial instability as evidenced by declining financial ratios, an increase in leveraged debt or a net loss.
- B. The Division shall calculate the net taxable premium under a Retrospective Rating Plan, using the most recent year's data, as follows: {[(payroll multiplied by the Payroll Classification Rate) multiplied by (the Experience Modification Rate specific to Arizona) multiplied by (1 minus the Deviation Rate) multiplied by the (Basic Premium Factor)] plus [(losses for the current year plus adjusted losses from the previous year) multiplied by (the Loss Conversion Factor)]} multiplied by the tax multiplier.
- C. The Retrospective Rating Plan applies only to operations and payroll in Arizona. The Self-Insurer shall combine all operations in Arizona to calculate the premium taxes required under A.R.S. §§ 23-961 and 23-1065.
- D. The Experience Modification Rate specific to Arizona for purposes of determining the net taxable premium under a Guaranteed Cost Plan shall be calculated in the manner described in R20-5-1534(C). If the Division cannot calculate an Experience Modification Rate in the second and all following tax years because the Self-Insurer does not have any injuries, the Experience Modification Rate shall be set at 1.00.
- E. The Division shall use assigned risk rates to calculate the premium taxes required under A.R.S. §§ 23-961 and 23-1065 for all Self-Insurers on the Retrospective Rating Plan. The assigned risk rates shall be established annually by an actuary retained by the Commission that is a member the American Academy of Actuaries (MAAA) or a fellow of the Casualty Actuarial Society (FCAS).
- F. A Self-Insurer shall provide the information required by R20-5-1536(E) in support of using a Retrospective Rating Plan.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

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R20-5-1540. Hearing Procedure on Denied Initial Application, Denied Renewal Application, Denied New Member Application, Revocation of Authority, or Denied Application for Waiver of Security

- A.** A party may request a hearing under A.R.S. § 23-945 in the following circumstances:
 - 1. Denial of an initial application, renewal application, or new member application under R20-5-1509.
 - 2. Denial of an application to Self-Administer or revocation of authority to Self-Administer under R20-5-1510.
 - 3. Revocation of self-insurance authorization under R20-5-1516.
 - 4. Denial of a request for waiver of security or revocation of a waiver of security under R20-5-1525.
- B.** A request for hearing shall comply with A.R.S. § 23-945 and be signed by an authorized representative of the party. The party shall file the request for hearing with the Commission within 30 days from the date the Commission's written findings and order under R20-5-1509, R20-5-1510, R20-5-1516, or R20-5-1525 is served on the party. A written findings and order of the Commission under R20-5-1509, R20-5-1510, R20-5-1516, or R20-5-1525 is deemed final if a request for hearing is not received by the Chief Counsel of the Commission within the time specified in this subsection.
- C.** The party filing a request for hearing under subsection (A)(1), (A)(2), or (A)(4) has the burden of proof to establish that it has met the applicable requirements of the Act and this Article. If a party files a request for hearing under subsection (A)(3), the Commission has the burden of proof to establish that good cause existed for revocation of self-insurance authorization.
- D.** The Chair of the Commission or designee shall preside over hearings held under this section. Except as otherwise provided in this section, the Chair or designee shall apply the provisions of A.R.S. § 41-1062 to hearings held under this section and shall have the authority and power of a presiding officer as described in A.R.S. § 41-1062.
- E.** The Chief Counsel of the Commission shall represent the Commission in hearings held under this section and, upon direction of the Chair of the Commission, shall issue on behalf of the Commission all notices and subpoenas required under this section.
- F.** Except as otherwise provided by law, a party to a hearing may appear on its own behalf or through an authorized legal representative. When an authorized legal representative appears or intends to appear before the Commission, the representative shall file a notice of appearance with the Commission.
- G.** For purposes of this section, a document is considered filed when the Commission receives the document. All documents required to be filed with the Commission under R20-5-1541 and this section shall be served upon the Chief Counsel of the Commission and, if applicable, upon all parties to the proceeding.
- H.** The Commission shall serve written notice of hearing upon all parties at least 20 days before a scheduled hearing. The notice of hearing shall comply with the requirements in A.R.S. § 41-1061.
- I.** In addition to the provisions contained in A.R.S. §§ 41-1061 and 41-1062, the following provisions apply to all hearings conducted under this section:
 - 1. A party may make an opening and closing statement with the permission of the Chair of the Commission or designee if the Chair or designee determines that the statement will be helpful to a determination of the issues.
 - 2. All witnesses at a hearing shall testify under oath or affirmation.

- 3. The Chair or designee may admit documents into evidence if filed no later than 15 days before the date of the hearing. Upon request or upon direction from the Chair or designee, the Commission may issue a subpoena to the author of any document submitted into evidence to appear and testify at the hearing.
- 4. Upon written request by a party or upon direction from the Chair or designee, the Commission may issue a subpoena requiring the attendance and testimony of a witness. A party shall submit its subpoena request no later than 10 days before the date of the hearing.
- 5. Upon written request by a party or upon direction from the Chair or designee, the Commission may issue a subpoena duces tecum requiring the production of documents or other tangible evidence. The written request by a party shall contain a statement explaining the general relevance, materiality, and reasonable particularity of the documentary or other tangible evidence and the facts to be proved by them.
- J.** The Commission shall make a record of all hearings under this section. Any party desiring a copy of record may request a copy from the Commission.
- K.** Upon the completion of a hearing, the Commission shall issue a decision upon hearing either affirming, modifying, or reversing the original decision. The decision of the Commission shall be made by a majority vote of the quorum of Commission members present at a public meeting. The decision upon hearing shall comply with the provisions of A.R.S. § 41-1063.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

R20-5-1541. Request for Review of Decision Upon Hearing

- A.** A party may request review of a Commission decision upon hearing issued under R20-5-1540 by filing with the Commission a written request for review no later than 15 days after the decision upon hearing is served upon the parties. A decision upon hearing under R20-5-1540 is deemed final if a request for hearing is not received by the Commission within the time specified in this subsection.
- B.** A request for review of a Commission decision upon hearing must be based upon one or more of the following grounds materially affecting the rights of the requesting party:
 - 1. Irregularities in the hearing proceedings or any order or abuse of discretion that deprives a party seeking review of a fair hearing;
 - 2. Misconduct of the prevailing party;
 - 3. Accident or surprise, which could not have been prevented;
 - 4. Newly discovered material evidence that could not have been discovered with reasonable diligence and produced at the hearing;
 - 5. Error in the admission or rejection of evidence, or errors of law occurring at, or during the hearing;
 - 6. Bias or prejudice of the Division or Commission; or
 - 7. The decision upon hearing is not justified by the evidence or is contrary to law.
- C.** The request for review shall state the specific facts and law in support of the request and shall specify the relief sought.
- D.** Upon the completion of a review, the Commission shall issue a decision upon review either affirming, modifying, or reversing the decision upon hearing no later than 30 days after receiving a request for review. The decision of the Commission shall be made by a majority vote of the quorum of Commission mem-

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bers present at a public meeting. The decision upon hearing shall comply with the provisions of A.R.S. § 41-1063.

- E. The Commission's decision upon review is final unless a party seeks judicial review as provided in A.R.S. § 23-946.

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New Section made by final rulemaking at 28 A.A.R. 3435 (October 28, 2022), with an immediate effective date of October 5, 2022 (Supp. 22-4).

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Appendix A. Arizona Physicians' and Pharmaceutical Fee Schedule 2022/2023

Adopted by The Industrial Commission of Arizona

Contact Medical Resource Office

Phone (602) 542-4308 / Fax (602) 542-4797

mro@azica.gov

Effective October 1, 2022 through September 30, 2023

INTRODUCTION

Since 1925, when the Arizona Legislature passed the state's first Workers' Compensation Act ("Act"), the Industrial Commission of Arizona ("Commission") has administered the workers' compensation laws of that Act. The Act includes the authority of the Commission to set a schedule of fees to be charged by healthcare providers attending injured employees (also referred to in this document as "injured worker" or "claimant." A.R.S. § 23-908(B). In 2004, the Act was amended to include the setting of fees for prescription medicines required to treat an injured employee. A.R.S. § 23-908(C). This fee schedule is referred to as the Arizona Physicians' and Pharmaceutical Fee Schedule (Fee Schedule).

Any reference to "healthcare providers" in the Fee Schedule is intended to include all licensed professionals whose scope of practice allows them to legally provide services to injured workers. Any reference to "physician" in relation to workers' compensation cases includes the following: doctors of medicine, doctors of osteopathy, doctors of podiatric medicine, doctors of chiropractic, doctors of naturopathic medicine, certified registered nurse anesthetists, physician assistants and nurse practitioners. Healthcare providers treating employees under industrial coverage are entitled by law to charge according to the schedule of fees adopted by the Commission. Accurate calculation of fees based upon this schedule, the monthly filing of reports and bills for payment, and the use of forms prescribed are essential to timely and correct payment for a provider's services and can be vital in the award of benefits to the injured worker and their dependents.

This Fee Schedule has been updated to incorporate by reference the 2022 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT® are preceded by an AZ identifier and numbered in the following format: AZxxx. To the extent that a conflict may exist between an adopted portion of the CPT® and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

- a. The Commission has also adopted by reference: 1) The unit values and guidance for consultative, diagnostic and therapeutic services published in the most recent edition of *Relative Value Guide*, American Society of Anesthesiologists <https://www.asahq.org>; 2) The *1995 and 1997 Documentation Guidelines for Evaluation and Management Services*, Centers for Medicare and Medicaid Services (CMS) <https://www.cms.gov>; 3) The *2022 Clinical Diagnostic Laboratory Fee Schedule*, Centers for Medicare and Medicaid Services (CMS) Clinical Laboratory fee Schedule <https://www.cms.gov>; 4) The *National Correct Coding Initiative Edits*, CMS; <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>; 5) *2022 Optum360 The Essential RBRVS* <https://www.optum360.com/>; and 6) Physicians as Assistants at Surgery: 2020 Update <https://www.facs.org/>. The RBRVS based fee schedule adopts surgical global periods published by CMS.

Except as otherwise noted, unit values assigned to the service codes listed in this document are the product of the Industrial Commission of Arizona and are not associated in any way with the American Medical Association or any other entity or organization.

A. GENERAL GUIDANCE

1. Reimbursements and billing associated with Pharmaceuticals are found in the Pharmaceutical Fee Schedule Section of this document.
2. Except when governed by a separate contract or network that governs fees pursuant to A.R.S. § 23-908(J)(1), this Fee Schedule establishes the maximum reimbursement values for services performed by healthcare providers to injured workers under Arizona's workers' compensation law.
3. If a healthcare provider or insurance carrier is referring an injured worker to a medical specialist for evaluation and/or treatment, the medical specialist's diagnosis becomes the foundational diagnosis for billing purposes.
4. Routine progress and routine final reports filed by the attending healthcare provider do not ordinarily command a fee.
5. Payment will be made for only one professional visit in any one day except when the submitted report clearly demonstrates the need for the additional visit and fee.
6. Fees for hospital, office, or home visits, subsequent to the initial visit, are not to be added to coded surgical procedures performed on the same day.

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7. Routine office treatment principally by injection of drugs, other than antibiotics, requires authorization by the carrier or self-insured employer for each series of 10 after the first series of 10.
8. Except in emergencies, a carrier must be given notice regarding a consultation and the consultant must provide his/her report to the carrier and the attending healthcare provider within a reasonable period of time to facilitate processing of the claim.
9. The Commission requests that carriers notify attending healthcare providers at the same time the claimant is notified that their claim is closed with or without supportive care. If a claim is approved for reopening, the carrier should also notify the attending healthcare provider of that approval.
10. Missed individual appointments for consultants, without prior notification, will be compensated at 50% of consultation fee.
11. No fees may be charged for services not personally rendered by the healthcare provider, unless otherwise specified.
12. The Commission will investigate an injured workers' complaint of bad faith/unfair claims processing practices, and if appropriate, impose penalties under A.R.S. § 23-930, in those circumstances where a "peer to peer" review was not conducted by a healthcare provider with appropriate skill, training, and knowledge or where the individual performing the "peer to peer" review was not licensed. The Commission will also investigate an injured workers' complaint of bad faith/unfair claims processing practice, and if appropriate, impose penalties under A.R.S. § 23-930, for a denial of treatment based on the failure of the treating doctor to participate in a "peer to peer" review, when the treating doctor has not been given reasonable time or opportunity to participate in the "peer to peer" review.
13. As authorized under A.A.C. R20-5-128, the fee for the reproduction of medical records for workers' compensation purposes shall be 25¢ per page and \$10.00 per hour per person for reasonable clerical costs associated with locating and reproducing the documents.
14. Reimbursement values for telehealth services are governed by the Fee Schedule. Performance of telehealth services are governed by Arizona Revised Statutes, Title 36, Chapter 36.

B. PAYMENT AND REVIEW OF BILLINGS

1. Under Arizona workers' compensation law, an insurance carrier, self-insured employer or their representative is not responsible for payment of a billing for medical, surgical, and hospital benefits that the insurance carrier, employer or representative received more than 24 months from the date that the medical service was rendered, or from the date on which the provider knew or should have known that the service was rendered, whichever occurs later. A subsequent billing or corrective billing does not restart the limitations period. *See* A.R.S. § 23-1062.01.
2. It is incumbent upon the insurance carrier, self-insured employer and third party processing service to inform all parties, including the Commission, regarding changes in addresses for bill processing locations.
3. Under Arizona workers' compensation law, a healthcare provider is entitled to timely payment for services rendered. An insurance carrier, self-insured employer or claims processing representative shall make a determination whether to deny or pay a medical bill on an accepted claim, in whole or in part, including the decision as to the amount to pay, within thirty days from the date the claim is accepted, if the billing is received before the date of acceptance, or within thirty days from the date of the receipt of the billing if the billing is received after the date of acceptance. All billing denials shall be based on reasonable justification. The insurance carrier, self-insured employer, or claims processing representative shall pay the approved portion of the billing within thirty days after the determination for payment is made. If the billing is not paid within the applicable time period, the insurance carrier, self-insured employer, or claims processing representative shall pay interest to the health provider on the billing at a rate that is equal to the legal rate. Interest shall be calculated beginning on the date that the payment to the healthcare provider is due. *See* A.R.S. § 23-1062.01.

To ensure timely payment of a medical billing, a billing must contain the information required under A.R.S. § 23-1062.01. A billing must contain at least the following information: Correct demographic patient information including claim number, if known; Correct provider information, including name, address, telephone number, and federal taxpayer identification number; Appropriate medical coding with dollar amounts and units clearly stated with all descriptions and dates of services clearly printed; and legible medical reports required for each date of service if the billing is for direct treatment of the injured worker.

4. Payment of a workers' compensation medical billing is governed by A.R.S. § 23-1062.01, which includes:
 - a. Timeframes for processing and payment of medical bills;
 - b. Criteria for billing denials;
 - c. A provision that the injured worker is not responsible for payment of any portion of a medical bill on an accepted claim or payment of any portion of a medical billing that is being disputed;

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- d. A provision that the insurance carrier or self-insured employer may establish an internal system for resolving payment disputes;
 - e. A provision that A.R.S. § 23-1062.01 does not apply to written contracts entered into between medical providers and insurance carriers and self-insured employers or their representatives that specify payment periods or contractual remedies for untimely payments; and
 - f. A provision that the Industrial Commission does not have jurisdiction over contract disputes between the parties.
5. “Reasonable justification” to deny a bill does not include that the payment/billing policies of other private or public entities (publications) do not allow it unless the publication has been adopted by reference in the Fee Schedule.
6. Excluding bundling and unbundling issues, it is not the Commission’s intent to restrict an insurance carrier’s, self-insured employers or third party processing service’s ability to address issues not addressed by the Fee Schedule. This includes evaluating unlisted procedures, establishment of values for unlisted procedures, establishment of values for codes that are listed as “BR” or “RNE”, new CPT® codes that have not been adopted by the Industrial Commission, or issues outside the jurisdiction of the Fee Schedule, such as hospital billings.
7. Healthcare providers shall provide legible medical documentation and reports that are sufficient for insurance carriers/self-insured employers to determine if treatment is being directed towards injuries sustained in an industrial accident or incident. The healthcare provider shall ensure that their patients’ medical files include the information required by A.R.S. § 32-1401.2. The healthcare provider is not required to provide copies of documents or reports that they did not author and that are not in their possession (*i.e.*, Employers’ First Report of Injury).
8. Treating physicians shall submit a narrative that justifies the billing of a level 4 or 5 E/M service.
9. The Commission has adopted by reference the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services. Medical billings shall be prepared and reviewed consistent with how these guidelines are used and interpreted by CMS. Additionally, payers are required to disclose the guideline utilized in their Explanation of Reviews (or other similar document).
10. A payer’s Explanation of Review (or other similar document) shall contain sufficient information to allow the healthcare provider to determine whether the amount of payment is correct and whom to contact regarding any questions related to the payment. Information in the Explanation of Review (or other similar document) shall include the following:
- a. The name of the injured worker;
 - b. The name of the payer and the name of the third party administrator (“TPA”), if applicable;
 - c. If applicable, the name, telephone number, and address of all entities that reviewed the medical billing on behalf of the payer;
 - d. If applicable, the name, telephone number and address of the party that has a written contract signed by the healthcare provider that allows the contracting party or other third party to access and pay rates that are different from those provided under this Fee Schedule;
 - e. The amount billed by the healthcare provider;
 - f. The amount of any reduction due to a written contract with the healthcare provider; and
 - g. The amount of payment.
11. Nothing in this Fee Schedule precludes a healthcare provider from entering into a separate contract that governs fees. In this instance, reimbursement shall be made according to the applicable contracted charge. In the absence of a separate contract that governs a healthcare provider’s fees, reimbursement shall be made according to this Fee Schedule. A payer shall demonstrate that it is entitled to pay the contracted rate in the event of a dispute by providing a valid copy of the governing contract to the healthcare provider. If a payer fails to provide evidence that it is entitled to pay a contracted rate, then the payer shall be required to make payment as provided in this Fee Schedule.
12. Billing for Pharmaceuticals is found in the Pharmaceutical Fee Schedule Section of this document.
13. The Fee Schedule does not apply to ambulance service providers. Service fees for ground ambulance transportation are set and mandated by the Arizona Department of Health Services through its Arizona Ground Ambulance Service Rate Schedule. [A.R.S. § 36-2239\(D\)](#) states “an ambulance service shall not charge, demand or collect any remuneration for any service greater or less than

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or different from the rate or charge determined and fixed by the department as the rate or charge for that service.” Service fees published in the Arizona Ground Ambulance Service Rate Schedule are applicable in the workers’ compensation setting.

C. REIMBURSEMENT OF MID-LEVEL PROVIDERS

1. Certified Registered Nurse Anesthetists (“CRNA’s”) are reimbursed at 85% of the fee schedule.
2. Physician Assistants and Nurse Practitioners are reimbursed at 85% of the fee schedule *except* if services are provided “incident to” a physician’s professional services. In that instance, reimbursement is required to be at 100% of the fee schedule. The following criteria are identified as establishing the “incident to” exception:
 - a. The Physician Assistant and Nurse Practitioner must work under the direct supervision of an appropriately licensed physician,
 - b. The Physician must initially see that patient and establish a plan of care for that patient (“treatment plan”),
 - c. Subsequent service provided by the Physician Assistant and Nurse Practitioner must be a part of the documented treatment plan, and
 - d. The Physician must always be involved in the patient’s treatment plan and see the patient often enough to demonstrate that the Physician is actively participating in and managing the patient’s care.
3. For purposes of the Fee Schedule, the Commission recognizes that direct supervision of a Physician Assistant or Nurse Practitioner by a Physician can be accomplished through the use modern technology and telecommunications (telemedicine) and may not require the on-site presence of the Physician when the Physician Assistant or Nurse Practitioner sees the patient. In all instances, however, and regardless of the extent to which telemedicine is used, the Physician must actively participate in and manage the patient’s care if services provided by a Physician Assistant or Nurse Practitioner are billed at 100% of the fee schedule under the “incident to” exception.
4. It is the responsibility of the Physician to document if the services provided by a Physician Assistant and Nurse Practitioner are “incident to” the Physician’s professional service. If either the incident to criteria is not met, or the documentation submitted fails to support the “incident to” criteria, the reimbursement should be made at 85% of the fee schedule.

D. DIRECTED CARE AND USE OF NETWORKS

The Arizona Workers’ Compensation Act only permits private self-insured employers to direct medical care. A.R.S. § 23-1070(A); See also *Southwest Gas Corp. v. Industrial Commission of Arizona*, 200 Ariz. 292, 25 P.3d 1164 (2001). This limitation on the scope of directed care means that employees of private self-insured employers do not have an unrestricted right to choose their own medical providers, while employees of all other employers do (including public self-insured employers).¹ Notwithstanding an employee’s right to choose, many workers’ compensation insurance carriers (“carriers”) and public self-insured employers (“employers”) have taken advantage of “networks” to reduce their costs. This is done by either creating their own network of “preferred providers” or by contracting with a third party to access private health-care networks.

Actions or conduct that impair or limit the right of an employee to choose their medical provider may rise to the level of bad faith and/or unfair claims processing practices under A.R.S. § 23-930. The Commission will investigate a complaint of bad faith/unfair claims processing practices, and if appropriate, impose penalties under A.R.S. § 23-930, in those circumstances where a carrier, employer, or TPA has engaged in conduct that results in directing a claimant to a “network” provider. The following are examples of conduct that the Commission would consider appropriate for investigation under A.R.S. § 23-930.

- A claimant is told that they must see a healthcare provider that is “in the network;”
- A claimant is told that care from a “non-network” healthcare provider is not authorized;
- A “network” healthcare provider is told that referrals are required to be made to another “network” healthcare provider;
- A “network” healthcare provider is told that they may not recommend a “non-network” healthcare provider to a patient;
- A “non-network” healthcare provider is told that care will only be authorized if provided by a “network” provider; and
- A “non-network” healthcare provider is told that reimbursement will be made according to “network” discounts.

¹ It should be noted that the law governing directed care is not limited to “medical doctors,” but instead applies to medical, surgical, and hospital benefits. See A.R.S. § 23-1070. The phrase, “medical, surgical, and hospital benefits” is defined in A.R.S. § 23-1062(A), which states: “Promptly, upon notice to the employer, every injured employee shall receive medical, surgical and hospital benefits or other treatment, nursing, medicine, surgical supplies, crutches and other apparatus, including artificial members, reasonable required at the time of the injury, and during the period of disability. Such benefits shall be termed ‘medical, surgical and hospital benefits.’”

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E. TREATMENT OF INDUSTRIAL INJURIES AND DISEASES

1. Only physicians and surgeons licensed in the State of Arizona are permitted to treat injured or disabled employees under the jurisdiction of the Commission, unless others are specifically authorized.
2. An employee who sustains an injury arising out of, or in the course of, employment is entitled, under Arizona law, to select a healthcare provider of his/her own choice unless that employee is employed by a private self-insured employer as described in A.R.S. § 23-1070. Employers described in A.R.S. § 23-1070, excluding the State or Political Subdivisions thereof, are allowed to direct medical care.
3. The attending healthcare provider's promptness and professional exactness in the completion and filing of workers' compensation forms are extremely important to the employee being treated. The injured or disabled employee's claim to medical benefits and compensation can rest on the conscientious attention of the healthcare provider in processing the required reports. Rules addressing the completion of these forms are found in the Title 20, Chapter 5, Article 1 of the Arizona Administrative Code, which can be obtained at: http://apps.azsos.gov/public_services/Title_20/20-05.pdf
4. The Commission, the employer and the insurance carrier may, at any time, designate a healthcare provider or healthcare providers to examine an employee. Additionally, upon application of the employer, employee, or insurance carrier, the Commission may order a change of healthcare provider or a change of conditions of treatment when there are reasonable grounds or a belief that the employee's health or progress can thus be improved.
5. A claimant may not change doctors without the written authorization of the insurance carrier, the Commission or the attending physician. A claimant may not transfer from one hospital to another without the written authorization of the insurance carrier or the Commission. If the patient's employment requires leaving the locale in which he/she is receiving treatment, the attending physician should arrange for continued treatment and notify the carrier of such arrangement. It is the responsibility of the physician or the hospital to which a patient has transferred to ascertain whether such a change has been authorized.
6. Treatment of conditions unrelated to the injuries sustained in the industrial accident may be denied as unauthorized if the treatment seems directed principally toward the non-industrial condition or if the treatment does not seem necessary for the patient's physical rehabilitation from the industrial injury.
7. If the patient refuses to submit to medical examination or to cooperate with the healthcare provider's treatments, the carrier or self-insured employer should be notified.
8. If an employee is capable of some form of gainful employment, it is proper for the healthcare provider to release the employee to light work and make a specific report to the carrier or self-insured employer as to the date of such release. It can be to the employee's economic advantage to be released to light work, since he/she can receive compensation based on 66 2/3% of the difference between one's earnings and one's established wage. On the other hand, it would not be to the employee's economic advantage to be released to light work if, in fact, the employee is not capable of performing such work. The healthcare provider's judgment in such matters is extremely important.
9. If the employee no longer requires active medical care for the industrial injury and is discharged from treatment, the healthcare provider is required to provide a signed report with the date of discharge to the carrier or self-insured employer, even if, as a private patient, the employee may require further medical care for conditions unrelated to the industrial accident. This final report and discharge date are necessary for closing the claim file.
10. When a healthcare provider discharges a claimant from treatment, the healthcare provider shall determine whether the employee has suffered any impairment of function, or disfigurement about the head or face, including injury to or loss of teeth, and include this information in the final signed report provided to the carrier or self-insured employer. The Rules of Procedure Before the Industrial Commission of Arizona require that any rating of the percentage of functional impairment should be made in accordance with the standards of evaluation published in the most recent edition of the American Medical Association Guides to the Evaluation of Permanent Impairment.
11. Once an exposure to blood-borne pathogen occurs, the workers' compensation insurance carrier/self-insured employer is responsible for payment of the accepted treatment protocol which includes the HBIG vaccination (Hepatitis B Immune Globulin), and, if necessary, the three (3) Hepatitis B vaccinations.

When a work-related incident occurs that may have exposed an employee to Hepatitis, the insurance carrier/self-insured employer is responsible for paying for the testing and/or treatment of Hepatitis B or C. As to treatment of HIV, if a bona fide claim exists under A.R.S. § 23-1043.02, then the insurance carrier/self-insured employer is responsible for paying for the treatment.

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12. It is the employer's responsibility, in accordance with existing OSHA standards, to pay for HIV testing. The insurance carrier may seek reimbursement from the employer for the costs associated with providing the series of three (3) Hepatitis B vaccinations if the employer failed to provide them in violation of federal and state laws.

F. REOPENING OF CLAIMS

1. Whether or not the employee has suffered a permanent disability, on a claim that has been previously accepted, the claim may be reopened on the basis of a new, additional or previously undiscovered disability or condition, but:
 - a. The claimant should use the form of petition prescribed by the Commission;
 - b. The petition must be personally signed by the worker or his authorized representative and must be filed at any office of the Industrial Commission of Arizona;
 - c. The petition, in order to be considered, must be accompanied by the healthcare provider's medical report.
2. If the claim is reopened, the payment for such reasonable and necessary medical, hospital and laboratory work expenses shall be paid by the insurance carrier if such expenses are incurred within 15 days of the filing of the petition to reopen.
3. No monetary compensation is payable for any period prior to the date of filing of the petition to reopen. Surgical benefits are not payable for any period prior to the date of filing of a petition to reopen, except that surgical benefits are payable for a period prior to the date of filing not to exceed seven (7) days if a bona fide medical emergency precludes the employee from filing a petition to reopen prior to the surgery. Other information relative to reopening rights may be found at A.R.S. § 23-1061(H).
4. If a claim is approved for reopening, the carrier must notify the attending healthcare provider of that approval.

G. NO-INSURANCE CLAIMS

"No-Insurance" claims are workers' compensation claims involving injuries to employees of employers who do not have workers' compensation insurance coverage as required by Arizona law. In such cases, all claims and reports are to be addressed to the No-Insurance Section of the Special Fund of The Industrial Commission of Arizona.

H. CONSULTATIONS

Workers' compensation cases can present additional medical and legal problems that justify consultation sooner and more frequently than for the average private patient. In complex cases and in cases requiring an estimate of general or unscheduled disability, consultation with specialists in the appropriate field may be requested by any interested party. The Industrial Commission continues to recognize the necessity for consultations in workers' compensation and establishes relative value units and rates for consultation codes.

I. WITNESS FEES

1. Insurance providers, self-insured employers, and the Special Fund of the Commission are responsible for paying \$150.00 for the first hour of testimony (or any portion thereof) and \$50.00 for each 20 minute increment following the initial hour (or any portion thereof) to a healthcare provider who testifies at hearing at their request.
2. The Commission is responsible for paying \$150.00 for the first hour of testimony (or any portion thereof) and \$50.00 for each 20 minute increment following the initial hour (or any portion thereof) to a healthcare provider who testifies at hearing on request of a workers' compensation claimant.

J. DEFINITIONS OF SELECT UNIT VALUES

1. BY REPORT "BR" ITEMS: "BR" in the value column indicates that the value of this service is to be determined "by report", because the service is too unusual or variable to be assigned a unit relativity. Pertinent information concerning the nature, intent and need for the procedure or service, the time, the skill and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary.
2. RELATIVITY NOT ESTABLISHED "RNE" ITEMS: "RNE" in the value column indicates new or infrequently performed services for which sufficient data has not been collected to allow establishment of a relativity. "RNE" items are clearly definable and not inherently variable as are BR procedures. A report may be necessary.
3. SERVICE "SV" ITEMS: "SV" in the value column indicates the value is to be calculated as the sum of the various services rendered (e.g., office, home, nursing home or hospital visits, consultation or detention, etc.), according to the ground rules covering those

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services. Identify by using the code number of the “SV” item. The Value is established by identifying each individual service, listing the code number and its value.

4. **MATERIALS AND SUPPLIES:** A healthcare provider is not entitled to be reimbursed for supplies and materials normally necessary to perform the service. A healthcare provider may charge for other supplies and materials using code 99070² in accordance with this subsection. A healthcare provider may use an applicable HCPCS code in lieu of code 99070 if the HCPCS code more accurately describes the materials and supplies provided by the healthcare provider; however, the Commission has **not** adopted the RVUs for HCPCS codes. Examples of those items that are and are not reimbursable are listed below. Documentation showing actual costs (*i.e.*, manufacturer’s invoice) associated with providing supplies and materials plus fifteen percent (15%) to cover overhead costs and is adequate justification for payment only when the documentation is dated within one year of the billed date. This provision does not apply to retail operations or locations not maintained by a healthcare provider’s office, including, but not limited to: hospitals, ambulatory surgery centers, ambulance service providers, and durable medical equipment providers. Drugs that are administered to patients in a clinical setting are covered under code 99070 and reimbursed according to the Pharmaceutical Fee Schedule Guidelines. Prescription drugs provided to patients as a part of the overall treatment regimen but outside of the clinical setting are not included under this code.

Examples of supplies that are usually not separately reimbursable include:

- Applied hot or cold packs
- Eye patches, injections or debridement trays
- Steristrips
- Needles
- Syringes
- Eye/ear trays
- Drapes
- Sterile gloves
- Applied eye wash or eye drops
- Creams (massage)
- Fluorescein
- Ultrasound pads and gel
- Tissues
- Urine collection kits
- Gauze
- Cotton balls/fluff
- Sterile water
- Band-Aids and dressings for simple wound occlusion
- Head sheets
- Aspiration trays
- Sterile trays for laceration repair and more complex surgeries
- Tape for dressings

Examples of material and supplies that are generally reimbursable include:

- Cast and strapping materials
- Applied dressings beyond simple wound occlusion
- Taping supplies for sprains
- Iontophoresis electrodes
- Reusable patient specific electrodes
- Dispensed items, including:
 - Canes
 - Braces
 - Slings
 - Ace wraps
 - TENS electrodes
 - Crutches
 - Splints
 - Back support
 - Dressings

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Hot or cold packs

5. “Modifiers: A two-digit (numeric or alpha) sequence that provides the means by which the reporting healthcare provider can specify that a procedure performed has been altered under a special circumstance. This allows defining the modifying circumstance of the service or procedure without creating a separate procedure or listing.

Modifier Examples

Professional Component (PC): Certain procedures are a combination of a physician, or Professional component and a technical component. When modifier 26 is added to an Appropriate code a PC allowable amount will be paid.

Technical Component (TC): The TC component reflects the technical portion of the procedure code. When the technical component is provided by a healthcare provider other than the one providing the professional component, the healthcare provider bills for the technical component by adding modifier TC to the applicable code.

K. LIST OF ACRONYMS

AMA	American Medical Association
AS	Assistant Surgeon
AWP	Average Wholesale Price
BR	By Report
CCI	Current Coding Initiative (National)
CF	Conversion Factor
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
DME	Durable Medical Equipment
E/M	Evaluation and management services
FCE	Functional Capacity Evaluation
FUD	Follow-up day(s)
HCPCS	Healthcare Common Procedure Coding System
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IME	Independent medical examination
MPFS	Medicare physician fee schedule
MRI	Magnetic resonance imaging
NCCI	(see CCI)
NP	Nurse practitioner
OTC	Over-the-counter
PA	Physician assistant
RBRVS	Resource based relative value scale
RVU	Relative value unit

Historical Note

New Appendix A, Introduction made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Introduction will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Introduction repealed; new Appendix A, Introduction made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Introduction repealed; new Appendix A, Introduction made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Introduction repealed; new Appendix A, Introduction made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

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PHARMACEUTICAL FEE SCHEDULE

I. GENERAL PROVISIONS AND APPLICABILITY OF THE PHARMACEUTICAL FEE SCHEDULE.

- A. The Pharmaceutical Fee Schedule (PFS) applies to prescription and over-the-counter (OTC) medications required to treat an injured employee, whether dispensed by a pharmacy (including online or mail order pharmacies) or by a medical practitioner.
- B. Medications are not reimbursable unless “reasonably required” at the time of injury or during the period of disability. *See* A.R.S. § 23-1062(A); A.A.C. R20-5-1303(A). The Industrial Commission of Arizona has adopted the Official Disability Guidelines (ODG), including ODG’s Drug Formulary Appendix A (ODG Formulary), as the standard reference for evidence-based medicine used in treating injured employees within the context of Arizona’s workers’ compensation system. Effective October 1, 2018, ODG applies to all body parts and conditions. *See* A.A.C. R20-5-1301(B), (E). ODG is to be used as a tool to support clinical decision making and quality health care delivery to injured employees. The ODG Formulary sets forth pharmaceutical guidelines that are generally considered reasonable and are presumed correct if the guidelines provide recommendations related to a particular medication. *See* A.A.C. R20-5-1301(H). Medical practitioners are encouraged to consult the ODG Formulary before dispensing or prescribing medications to injured employees.
- C. Generic drugs must be dispensed to injured employees when appropriate, consistent with A.R.S. § 32-1963.01(A),¹ (B), and (D) through (L).² *See* A.R.S. § 23-908(C). For purposes of this subsection, the definitions in A.R.S. § 32-1963.01(L) apply.³ Whenever possible: (1) medical practitioners should prescribe less costly drugs; and (2) pharmacies and medical practitioners (under Section VII) should dispense generic drugs with lower AWP values.

II. DEFINITIONS.

- A. “Administer” has the meaning set forth in A.R.S. 32-1901(1).
- B. “Average Wholesale Price” or “AWP” means the wholesale price charged on a specific commodity that is assigned by the drug manufacturer and is listed in a nationally-recognized drug pricing file.
- C. “Commercially available” means a drug product is widely available for purchase in pharmacies accessible to the general public, including in brick and mortar pharmacies accessible to the general public.
- D. “Compound medication” means a pharmaceutical product created by virtue of mixing or combining drugs and/or components to meet the unique needs of an individual patient when the finished product does not recreate a commercially-available product.
- E. “Dispense” or “dispensing” means to deliver to an ultimate user by or pursuant to the lawful order of a medical practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare for that delivery. *See* A.R.S. § 32-1901(27).
- F. “Drug” has the meaning set forth in A.R.S. § 32-1901(31).
- G. “Hospital” means any institution for the care and treatment of the sick and injured that is approved and licensed as a hospital by: (1) the Arizona Department of Health Services; or (2) an equivalent regulatory agency in another U.S. state, territory, or district. *See* A.R.S. § 32-1901(42).

¹ A.R.S. § 32-1963.01(A) states: “If a medical practitioner prescribes a brand name drug and does not indicate an intent to prevent substitution as prescribed in subsection E of this section, a pharmacist may fill the prescription with a generic equivalent drug.”

² A.R.S. § 32-1963.01(E) states: “A prescription generated in this state must be dispensed as written only if the prescriber writes or clearly displays ‘DAW’, ‘dispense as written’, ‘do not substitute’ or ‘medically necessary’ or any statement by the prescriber that clearly indicates an intent to prevent substitution on the face of the prescription form. A prescription from out of state or from agencies of the United States government must be dispensed as written only if the prescriber writes or clearly displays ‘do not substitute’, ‘dispense as written’ or ‘medically necessary’ or any statement by the prescriber that clearly indicates an intent to prevent substitution on the face of the prescription form.”

³ A.R.S. § 32-1963.01(L) states, in part:

2. “Brand name drug” means a drug with a proprietary name assigned to it by the manufacturer or distributor.
4. “Generic equivalent” or “generically equivalent” means a drug that has an identical amount of the same active chemical ingredients in the same dosage form, that meets applicable standards of strength, quality and purity according to the United States pharmacopeia or other nationally recognized compendium and that, if administered in the same amounts, will provide comparable therapeutic effects. Generic equivalent or generically equivalent does not include a drug that is listed by the United States food and drug administration as having unresolved bioequivalence concerns according to the administration’s most recent publication of approved drug products with therapeutic equivalence evaluations.

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- H. “Medical practitioner” means any person who is permitted/licensed and authorized by law to use and prescribe prescription medications, acting within the scope of such authority, for the treatment of sick and injured human beings or for the diagnosis or prevention of sickness in human beings in the State of Arizona or any U.S. state, territory or district. *See* A.R.S. § 32-1901(53).
- I. “Non-traditional strength” medication means a finished drug product in a strength (*i.e.*, dosage) that is not commercially available in pharmacies accessible to the general public.
- J. “Over-the-counter medication” or “OTC medication” means a finished drug product, including label and container according to context, which does not require a prescription order.
- K. “Pharmacy” has the meaning set forth in A.R.S. § 32-1901(71).
- L. “Pharmacy accessible to the general public” means a pharmacy that is readily accessible and provides pharmaceutical services (including prescription medication services) to all segments of the general public without restricting services to a defined or exclusive group of consumers, including but not limited to consumers who have access to services because they are treated by or have an affiliation with a specific entity or medical practitioner. This definition includes mail order pharmacies delivering pharmaceutical services to workers’ compensation claimants if both of the following apply:
1. The pharmacy does not limit or restrict access to claimants with an affiliation to a medical provider or other entity.
 2. Any medical provider or other entity referring a claimant to the pharmacy does not receive or accept any rebate, refund, commission, preference, or other consideration as compensation for the referral.
- M. “Pharmacy not accessible to the general public” means a pharmacy that provides pharmaceutical services (including prescription medication services) only to a defined or exclusive group of consumers, including but not limited to consumers who have access to services because they are treated by or have an affiliation with a specific entity or medical practitioner. “Pharmacy not accessible to the general public” does not include a hospital pharmacy. This definition does not include mail order pharmacies delivering pharmaceutical services to workers’ compensation claimants if both of the following apply:
1. The pharmacy does not limit or restrict access to claimants with an affiliation to a medical provider or other entity.
 2. Any medical provider or other entity referring a claimant to the pharmacy does not receive or accept any rebate, refund, commission, preference, or other consideration as compensation for the referral.
- N. “Prescription” means either a prescription order or a prescription medication. *See* A.R.S. § 32-1901(80).
- O. “Prescription medication” means any drug, including label and container according to context, which is dispensed pursuant to a prescription order. *See* A.R.S. § 32-1901(81).
- P. “Prescription order” shall have the meaning set forth in A.R.S. § 32-1901(84).
- Q. “Repackaged medication” means a finished drug product removed from the container in which it was distributed by the original manufacturer and placed into a different container without further manipulation of the drug. The term also includes the act of placing the contents of multiple containers of the same finished drug product into one container. The term also includes “co-pack drug” products which contain two or more separate finished medications that are contained in a single package or unit. The term does not include a drug that is manipulated in any other way, including if the drug is reconstituted, diluted, mixed, or combined with another ingredient.
- R. “Therapeutically-similar” medication means a medication that is expected to produce a clinical effect comparable to the original product. Key considerations for determining the “most therapeutically-similar” medications are: (1) the similarity of the clinical effects; (2) the extent to which active ingredients overlap; (3) the similarity of the dosage profiles; (4) the similarity of the mode of administration; and (5) the similarity of the intended strength.
- S. “Traditional strength” medication means a finished drug product in a formulation that is commercially available in pharmacies accessible to the general public.
- T. “Ultimate user” means a person who lawfully possesses a prescription medication for that person's own use or for the use of a member of that person's household. *See* A.R.S. § 32-1901(95).

III. GENERAL GUIDELINES FOR BILLING AND REIMBURSEMENT OF PRESCRIPTION MEDICATIONS.

- A. Except as permitted in Sections VI and VII of the current PFS, an insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications only if all of the following apply:

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1. The prescription medication is dispensed by an individual who is currently licensed to practice the profession of pharmacy by either:
(i) the Arizona State Board of Pharmacy; or (ii) an equivalent regulatory agency in another U.S. state, territory, or district; and
 2. The prescription medication is dispensed by a pharmacy accessible to the general public, including online or mail-order pharmacies that are accessible to the general public.
- B. Subject to Sections III(G), IV, V, and VI(B), reimbursement for prescription medications shall be based on the actual medication dispensed, including a substituted medication that is dispensed pursuant to A.R.S. § 32-1963.01.
- C. Except as specified in Sections IV and V of the current PFS, a pharmaceutical bill submitted for a prescription medication must include the National Drug Code (NDC) of the original manufacturer registered with the U.S. Food & Drug Administration (FDA), the quantity dispensed, and the reimbursement value of the medication. Under no circumstance shall an NDC other than the original manufacturer's NDC be used.
- D. The reimbursement value for prescription medications shall be based on the current PFS reimbursement methodology in the absence of a contractual agreement between the pharmacy or medical practitioner and payer governing reimbursement. Network discounts may not be applied in the absence of a contractual agreement with the pharmacy or medical practitioner authorizing such discounts.
- E. The reimbursement value for a prescription medication shall be determined on the date a drug is dispensed from pricing published in the most recent issue, as updated in the most-recent update, of a nationally-recognized pharmaceutical publication designated by the Commission. For purposes of determining AWP, the Commission has selected Medi-span®.
- F. The reimbursement value for a prescription medication shall be determined by reference to the original manufacturer's NDC and shall be calculated on a per unit basis as follows:
1. Generic drugs:
 - a. $(75\% \text{ of AWP per unit}) \times (\text{number of units dispensed})$.
 2. Brand name drugs:
 - a. $(85\% \text{ of AWP per unit}) \times (\text{number of units dispensed})$.
- G. Reimbursement for non-traditional strength prescription medications shall be calculated on a per unit basis, as of the date of dispensing, based on the original manufacturer's NDC and corresponding AWP of the most therapeutically-similar traditional strength form of the same medication. Under no circumstance shall the NDC of the non-traditional strength medication be used.
- H. The reimbursement value for OTC medications shall be calculated on a per unit basis, as of the date of dispensing, based on the retail price (per unit) of the OTC medication in settings where the medication is commercially available.
- I. Subject to Section III(J), the reimbursement value for OTC medications that are not commercially available in pharmacies accessible to the general public shall be calculated on a per unit basis, as of the date of dispensing, based on the retail price (per unit) of the most therapeutically-similar OTC medication commercially available in pharmacies accessible to the general public. Under no circumstance shall the NDC or AWP of the non-commercially available OTC medication be used.
- J. The reimbursement value for OTC medications that are not commercially available may not exceed:
1. Thirty dollars (\$30.00) for a thirty-day supply (or a pro-rated amount if the supply is greater or less than thirty days) for a topical cream or lotion.
 2. Seventy-five dollars (\$75.00) for a thirty-day supply (or a pro-rated amount if the supply is greater or less than thirty days) for topical patches.

IV. BILLING AND REIMBURSEMENT FOR REPACKAGED MEDICATIONS.

- A. A pharmaceutical bill submitted for a repackaged medication must identify the NDC of the repackaged medication, the NDC of the original manufacturer registered with the U.S. FDA, the quantity dispensed, and the reimbursement value of the repackaged medication. Under no circumstances shall the reimbursement value of a repackaged medication be based upon an NDC other than the original manufacturer's NDC. A repackaged NDC shall not be used for calculating the reimbursement value of a repackaged medication and shall not be considered the original manufacturer's NDC.

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- B. If a pharmaceutical bill for a repackaged medication is submitted without the original manufacturer's NDC, the payer has the discretion to determine the appropriate NDC (and corresponding AWP) to use or, alternatively, may deny coverage until the appropriate NDC is furnished.
- C. The reimbursement value for a repackaged medication shall be based on the current PFS reimbursement methodology contained in Section III of the PFS, utilizing the NDC(s) and corresponding AWP(s) of the original manufacturer(s).
- D. Any component of a co-pack drug product for which there is no NDC shall not be reimbursed.

V. BILLING AND REIMBURSEMENT FOR COMPOUND MEDICATIONS.

- A. A pharmaceutical bill submitted for a compound medication must identify each reimbursable component ingredient, the applicable NDC of each reimbursable component ingredient, the corresponding quantity of each component ingredient, and the calculated reimbursement value of each component ingredient. All component ingredients of a compound medication must be billed on a single bill.
- B. The reimbursement value for a compound medication shall be calculated at the component ingredient level. The reimbursement value for a compound medication shall be based on the sum of the reimbursement values of each component ingredient and the corresponding component ingredient's NDC, based on the current PFS reimbursement methodology set forth in Section III.
- C. Any component ingredient in a compound medication for which there is no NDC shall not be reimbursed.
- D. Any component ingredient in a topical compound medication that is not FDA approved for topical use shall not be reimbursed.
- E. If any component ingredient in a compound medication is a repackaged medication, the reimbursement value for the repackaged medication ingredient shall be determined based on the current PFS reimbursement methodology set forth in Section III, using the AWP corresponding to the NDC of the original manufacturer. *See* Section IV.
- F. The maximum reimbursement value for a topical compound medication shall be the lesser of:
 - 1. Two hundred dollars (\$200.00) for a thirty-day supply (or a pro-rated amount if the supply is greater or less than thirty days), or
 - 2. The reimbursement value of the compound medication calculated under this section.

VI. BILLING AND REIMBURSEMENT FOR MEDICATIONS ADMINISTERED BY A MEDICAL PRACTITIONER.

- A. A pharmaceutical bill submitted for a medication administered by a medical practitioner must comply with billing procedures outlined in Sections III, IV, and V of the current PFS, as applicable.
- B. The reimbursement value for a medication administered by a medical practitioner shall be based on the current PFS reimbursement methodology contained in Sections III, IV, and V of the PFS, as applicable.

VII. REIMBURSEMENT FOR MEDICATIONS DISPENSED BY A MEDICAL PRACTITIONER OR IN A PHARMACY NOT ACCESSIBLE TO THE GENERAL PUBLIC.^{4,5}

- A. An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications that are dispensed by a medical practitioner or in a pharmacy not accessible to the general public if all of the following apply:
 - 1. The prescription medication is dispensed by a medical practitioner or a pharmacy not accessible to the general public to the injured employee within seven days of the date of the industrial injury;
 - 2. The prescription medication is limited to no more than a one-time, ten-day supply;

⁴ Dispensing pursuant to Section VII is subject to the Arizona Opioid Epidemic Act, which imposes statutory limits on the prescribing and dispensing of schedule II opioids. For more information about the Arizona Opioid Epidemic Act, please see the FAQs published by the Arizona State Board of Pharmacy, available at <https://drive.google.com/file/d/1JCIs8VwtdJ1T-DyGfjN3WWUm4KhDMXe-/view>.

⁵ Section VII sets forth reimbursement guidelines for medications dispensed in settings that are not accessible to the general public in Arizona's worker's compensation system and does not interfere with a medical practitioner's ability to dispense medications pursuant to A.R.S. § 32-1491 or seek payment from sources unrelated to workers' compensation.

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3. The prescription medication conforms to dosages and formulations that are commercially available in pharmacies accessible to the general public.
- B. An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications that are dispensed by a medical practitioner or in a pharmacy not accessible to the general public if all of the following apply:
 1. The injured employee does not have access to a pharmacy accessible to the general public within 20 miles of the injured employee's home address, work address, or the address of the prescribing medical practitioner;
 2. The injured employee cannot reasonably acquire the prescription medication from an online or mail order pharmacy accessible to the general public; and
 3. The prescription medication conforms to dosages and formulations which are commercially available in pharmacies accessible to the general public.
- C. An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications that are dispensed by a medical practitioner or in a pharmacy not accessible to the general public if the dispensing of a prescription medication for an individual claim and specified duration has been pre-approved in writing by the insurance carrier, self-insured employer, or the Special Fund of the Commission. Nothing in this section requires an insurance carrier, self-insured employer, or the Special Fund of the Commission to pre-approve the dispensing of prescription medications under this subsection.
- D. An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications that are dispensed by a pharmacy not accessible to the general public if all of the following apply:
 1. The prescription medication was dispensed to an injured employee whose workers' compensation claim was initially denied by the carrier, self-insured employer, or the Special Fund of the Commission;
 2. The injured employee protested the claim denial by filing a timely request for hearing;
 3. The workers' compensation claim was either: (a) subsequently accepted by the carrier, self-insured employer, or the Special Fund of the Commission; or (b) the claim was found to be compensable by the Commission's Administrative Law Judge Division, the Arizona Court of Appeals, or the Arizona Supreme Court;
 4. The prescription medication was dispensed during the time period between: (a) the initial claim denial and (b) the subsequent acceptance of the claim or the compensability determination by the Commission's Administrative Law Judge Division, the Arizona Court of Appeals, or the Arizona Supreme Court; and
 5. The prescription medication conforms to dosages and formulations that are commercially available in pharmacies accessible to the general public.
- E. The guidelines in Section III(A) and this section do not apply to prescription medications dispensed during in-patient hospital care or upon discharge from in-patient hospital care.
- F. Subject to the limitations in this section, medications that have been provided as free samples to a medical practitioner may be dispensed to an injured employee when appropriate, but are not reimbursable.

VIII. DISPENSING FEE.

- A. If a prescription medication is dispensed by a pharmacy accessible to the general public pursuant to a prescription order, a dispensing fee of up to seven dollars (\$7.00) per prescription medication, repackaged medication, or compound medication may be charged. The dispensing fee does not apply to OTC medications that are not prescribed by a medical practitioner.
- B. If a prescription medication is dispensed by a medical practitioner or in a pharmacy not accessible to the general public pursuant to Section VII(A), (B), or (C), a dispensing fee of up to seven dollars (\$7.00) per prescription medication, repackaged medication, or compound medication may be charged. If an OTC medication is dispensed by a medical practitioner or by a pharmacy not accessible to the general public, a dispensing fee is not permitted.
- C. If a prescription or OTC medication is administered by a medical practitioner, a dispensing fee is not permitted.

IX. ADDITIONAL BILLING GUIDELINES.

- A. Paper billing by a medical practitioner:

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The following is an example of how to report both the repackaged NDC and original NDC on the CMS 1500 form using the shaded area of line 24. The information is reported in the following order: qualifier (N4), NDC code, one space, unit/basis of measurement qualifier, quantity, one space, ORIG, qualifier (N4), NDC code.”

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E.	F.		G.	H.	I.	J.		
From To						EMG		CPT/HCPCS MODIFIER				DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS	PREP Family Per	ID. QUAL.	RENDERING PROVIDER ID. #			
MM	DD	YY	MM	DD	YY																
N455289047590 UN30 ORIGN400025152531																		N	G2	12345678901	
10	01	05	10	01	05	11			J3490				A	500	00	30	N	NPI	0123456789		

If a physician does not bill using the CMS 1500 form or is not able to include all the required information on the CMS 1500 form (due to software/system limitations), then the physician may provide the required information (in the required order) separately or as an attachment to the CMS 1500 form.

B. Paper billing by non-physician entities.

A non-physician entity using paper billing to bill for medications shall use the most recent version of the Workers' Compensation/Property & Casualty Universal claim Form (WC/PC UCF) adopted by the National Council for Prescription Drug Programs.

X. SEVERABILITY CLAUSE.

If any provision of Pharmaceutical Fee Schedule or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or application of the Pharmaceutical Fee Schedule which can be given effect without the invalid provisions or application, and to this end the provisions of this Pharmaceutical Fee Schedule are severable.

Historical Note

New Appendix A, Pharmaceutical Fee Schedule made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Pharmaceutical Fee Schedule will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Pharmaceutical Fee Schedule repealed; new Appendix A, Pharmaceutical Fee Schedule made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20- 3). Appendix A, Pharmaceutical Fee Schedule repealed; new Appendix A, Pharmaceutical Fee Schedule made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Pharmaceutical Fee Schedule repealed; new Appendix A, Pharmaceutical Fee Schedule made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

ANESTHESIA GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2022 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT® are preceded by an AZ identifier and numbered in the following format: AZxxx.

The Commission has also adopted by reference the unit values and guidance for consultative, diagnostic and therapeutic services published in the most recent edition of *Relative Value Guide*, American Society of Anesthesiologists. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to unit values for anesthesia services. To the extent that a conflict may exist between an adopted portion of the CPT® and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

A. CERTIFIED REGISTERED NURSE ANESTHETISTS: Are reimbursed at 85% of the fee schedule when billed with modifier QZ.

B. ANESTHESIA MODIFIERS: Anesthesia modifiers, which may include physical status and other optional modifiers, may be added to the basic values. Unit values for physical status modifiers are as follows:

Unit Values		
P1 –	A normal healthy patient	0
P2 –	A patient with mild systemic disease	0
P3 –	A patient with severe systemic disease	1
P4 –	A patient with severe systemic disease that is a constant threat to life	2
P5 –	A moribund patient who is not expected to survive without the operation	3

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P6 – A declared brain-dead patient whose organs are being removed for donor purposes 0

- AA- Anesthesia services personally performed by an anesthesiologist reimbursed at 100% of the lesser of billed charges or fee schedule Calculation
- AD- Medical supervision by a physician: more than four (4) concurrent anesthesia reimbursed at 50% of the lesser of billed charges or fee schedule calculation
- QK- Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals reimbursed at 50% of the lesser of billed charges or fee schedule
- QX- Qualified nonphysician anesthetist with medical direction by a physician reimbursed at 50% of fee schedule calculation
- QZ- CRNA without medical direction by a physician reimbursed at 85% of the lesser of billed charges or fee schedule calculation

C. REPORTING OF TIME: Time reporting is described in the Anesthesia Guidelines of the CPT® publication. IN ARIZONA, TIME UNITS WILL BE ADDED TO THE BASIC VALUE AND MODIFYING UNITS AS IS CUSTOMARY IN THE LOCAL AREA USING THE FOLLOWING UNIT VALUES:

1 unit value is equal to Fifteen (15) minutes or any Seven (7) minute portion thereof.

D. UNIT VALUES FOR OTHER QUALIFYING CIRCUMSTANCES: (more than one may be selected)

Qualifying circumstances are described in the Anesthesia Guidelines of the CPT® book. The unit values for these procedures, which are reported as an additional service and may be added to the basic unit values, are as follows:

Code	Unit Value
99100	1
99116	5
99135	5
99140	2

Historical Note

New Appendix A. Anesthesia Guidelines made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A Anesthesia Guidelines will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Anesthesia Guidelines repealed; new Appendix A, Anesthesia Guidelines made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Anesthesia Guidelines repealed; new Appendix A, Anesthesia Guidelines made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Anesthesia Guidelines repealed; new Appendix A, Anesthesia Guidelines made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

ARIZONA PHYSICIANS' FEE SCHEDULE
Anesthesia Codes 2022
Anesthesia Conversion Factor \$61.00

MPFS Basic			
Code	Category	Unit	RBRVS Rate
00100	Anesthesia	5	\$ 305.00
00102	Anesthesia	6	\$ 366.00
00103	Anesthesia	5	\$ 305.00
00104	Anesthesia	4	\$ 244.00
00120	Anesthesia	5	\$ 305.00
00124	Anesthesia	4	\$ 244.00
00126	Anesthesia	4	\$ 244.00
00140	Anesthesia	5	\$ 305.00
00142	Anesthesia	4	\$ 244.00
00144	Anesthesia	6	\$ 366.00

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CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

MPFS Basic			
Code	Category	Unit	RBRVS Rate
00145	Anesthesia	6	\$ 366.00
00147	Anesthesia	4	\$ 244.00
00148	Anesthesia	4	\$ 244.00
00160	Anesthesia	5	\$ 305.00
00162	Anesthesia	7	\$ 427.00
00164	Anesthesia	4	\$ 244.00
00170	Anesthesia	5	\$ 305.00
00172	Anesthesia	6	\$ 366.00
00174	Anesthesia	6	\$ 366.00
00176	Anesthesia	7	\$ 427.00
00190	Anesthesia	5	\$ 305.00
00192	Anesthesia	7	\$ 427.00
00210	Anesthesia	11	\$ 671.00
00211	Anesthesia	10	\$ 610.00
00212	Anesthesia	5	\$ 305.00
00214	Anesthesia	9	\$ 549.00
00215	Anesthesia	9	\$ 549.00
00216	Anesthesia	15	\$ 915.00
00218	Anesthesia	13	\$ 793.00
00220	Anesthesia	10	\$ 610.00
00222	Anesthesia	6	\$ 366.00
00300	Anesthesia	5	\$ 305.00
00320	Anesthesia	6	\$ 366.00
00322	Anesthesia	3	\$ 183.00
00326	Anesthesia	7	\$ 427.00
00350	Anesthesia	10	\$ 610.00
00352	Anesthesia	5	\$ 305.00
00400	Anesthesia	3	\$ 183.00
00402	Anesthesia	5	\$ 305.00
00404	Anesthesia	5	\$ 305.00
00406	Anesthesia	13	\$ 793.00
00410	Anesthesia	4	\$ 244.00
00450	Anesthesia	5	\$ 305.00
00454	Anesthesia	3	\$ 183.00
00470	Anesthesia	6	\$ 366.00
00472	Anesthesia	10	\$ 610.00
00474	Anesthesia	13	\$ 793.00
00500	Anesthesia	15	\$ 915.00
00520	Anesthesia	6	\$ 366.00
00522	Anesthesia	4	\$ 244.00
00524	Anesthesia	4	\$ 244.00
00528	Anesthesia	8	\$ 488.00
00529	Anesthesia	11	\$ 671.00
00530	Anesthesia	4	\$ 244.00
00532	Anesthesia	4	\$ 244.00
00534	Anesthesia	7	\$ 427.00
00537	Anesthesia	10	\$ 610.00
00539	Anesthesia	18	\$ 1,098.00
00540	Anesthesia	12	\$ 732.00
00541	Anesthesia	15	\$ 915.00
00542	Anesthesia	15	\$ 915.00
00546	Anesthesia	15	\$ 915.00
00548	Anesthesia	17	\$ 1,037.00
00550	Anesthesia	10	\$ 610.00
00560	Anesthesia	15	\$ 915.00
00561	Anesthesia	25	\$ 1,525.00
00562	Anesthesia	20	\$ 1,220.00
00563	Anesthesia	25	\$ 1,525.00
00566	Anesthesia	25	\$ 1,525.00
00567	Anesthesia	18	\$ 1,098.00
00580	Anesthesia	20	\$ 1,220.00

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MPFS Basic			
Code	Category	Unit	RBRVS Rate
00600	Anesthesia	10	\$ 610.00
00604	Anesthesia	13	\$ 793.00
00620	Anesthesia	10	\$ 610.00
00625	Anesthesia	13	\$ 793.00
00626	Anesthesia	15	\$ 915.00
00630	Anesthesia	8	\$ 488.00
00632	Anesthesia	7	\$ 427.00
00635	Anesthesia	4	\$ 244.00
00640	Anesthesia	3	\$ 183.00
00670	Anesthesia	13	\$ 793.00
00700	Anesthesia	4	\$ 244.00
00702	Anesthesia	4	\$ 244.00
00730	Anesthesia	5	\$ 305.00
00731	Anesthesia	5	\$ 305.00
00732	Anesthesia	6	\$ 366.00
00750	Anesthesia	4	\$ 244.00
00752	Anesthesia	6	\$ 366.00
00754	Anesthesia	7	\$ 427.00
00756	Anesthesia	7	\$ 427.00
00770	Anesthesia	15	\$ 915.00
00790	Anesthesia	7	\$ 427.00
00792	Anesthesia	13	\$ 793.00
00794	Anesthesia	8	\$ 488.00
00796	Anesthesia	30	\$ 1,830.00
00797	Anesthesia	11	\$ 671.00
00800	Anesthesia	4	\$ 244.00
00802	Anesthesia	5	\$ 305.00
00811	Anesthesia	4	\$ 244.00
00812	Anesthesia	3	\$ 183.00
00812	Anesthesia	3	\$ 183.00
00813	Anesthesia	5	\$ 305.00
00820	Anesthesia	5	\$ 305.00
00830	Anesthesia	4	\$ 244.00
00832	Anesthesia	6	\$ 366.00
00834	Anesthesia	5	\$ 305.00
00836	Anesthesia	6	\$ 366.00
00840	Anesthesia	6	\$ 366.00
00842	Anesthesia	4	\$ 244.00
00844	Anesthesia	7	\$ 427.00
00846	Anesthesia	8	\$ 488.00
00848	Anesthesia	8	\$ 488.00
00851	Anesthesia	6	\$ 366.00
00860	Anesthesia	6	\$ 366.00
00862	Anesthesia	7	\$ 427.00
00864	Anesthesia	8	\$ 488.00
00865	Anesthesia	7	\$ 427.00
00866	Anesthesia	10	\$ 610.00
00868	Anesthesia	10	\$ 610.00
00870	Anesthesia	5	\$ 305.00
00872	Anesthesia	7	\$ 427.00
00873	Anesthesia	5	\$ 305.00
00880	Anesthesia	15	\$ 915.00
00882	Anesthesia	10	\$ 610.00
00902	Anesthesia	5	\$ 305.00
00904	Anesthesia	7	\$ 427.00
00906	Anesthesia	4	\$ 244.00
00908	Anesthesia	6	\$ 366.00
00910	Anesthesia	3	\$ 183.00
00912	Anesthesia	5	\$ 305.00
00914	Anesthesia	5	\$ 305.00
00916	Anesthesia	5	\$ 305.00

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CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	MPFS Basic	
		Unit	RBRVS Rate
00918	Anesthesia	5	\$ 305.00
00920	Anesthesia	3	\$ 183.00
00921	Anesthesia	3	\$ 183.00
00922	Anesthesia	6	\$ 366.00
00924	Anesthesia	4	\$ 244.00
00926	Anesthesia	4	\$ 244.00
00928	Anesthesia	6	\$ 366.00
00930	Anesthesia	4	\$ 244.00
00932	Anesthesia	4	\$ 244.00
00934	Anesthesia	6	\$ 366.00
00936	Anesthesia	8	\$ 488.00
00938	Anesthesia	4	\$ 244.00
00940	Anesthesia	3	\$ 183.00
00942	Anesthesia	4	\$ 244.00
00944	Anesthesia	6	\$ 366.00
00948	Anesthesia	4	\$ 244.00
00950	Anesthesia	5	\$ 305.00
00952	Anesthesia	4	\$ 244.00
01112	Anesthesia	5	\$ 305.00
01120	Anesthesia	6	\$ 366.00
01130	Anesthesia	3	\$ 183.00
01140	Anesthesia	15	\$ 915.00
01150	Anesthesia	10	\$ 610.00
01160	Anesthesia	4	\$ 244.00
01170	Anesthesia	8	\$ 488.00
01173	Anesthesia	12	\$ 732.00
01200	Anesthesia	4	\$ 244.00
01202	Anesthesia	4	\$ 244.00
01210	Anesthesia	6	\$ 366.00
01212	Anesthesia	10	\$ 610.00
01214	Anesthesia	8	\$ 488.00
01215	Anesthesia	10	\$ 610.00
01220	Anesthesia	4	\$ 244.00
01230	Anesthesia	6	\$ 366.00
01232	Anesthesia	5	\$ 305.00
01234	Anesthesia	8	\$ 488.00
01250	Anesthesia	4	\$ 244.00
01260	Anesthesia	3	\$ 183.00
01270	Anesthesia	8	\$ 488.00
01272	Anesthesia	4	\$ 244.00
01274	Anesthesia	6	\$ 366.00
01320	Anesthesia	4	\$ 244.00
01340	Anesthesia	4	\$ 244.00
01360	Anesthesia	5	\$ 305.00
01380	Anesthesia	3	\$ 183.00
01382	Anesthesia	3	\$ 183.00
01390	Anesthesia	3	\$ 183.00
01392	Anesthesia	4	\$ 244.00
01400	Anesthesia	4	\$ 244.00
01402	Anesthesia	7	\$ 427.00
01404	Anesthesia	5	\$ 305.00
01420	Anesthesia	3	\$ 183.00
01430	Anesthesia	3	\$ 183.00
01432	Anesthesia	6	\$ 366.00
01440	Anesthesia	8	\$ 488.00
01442	Anesthesia	8	\$ 488.00
01444	Anesthesia	8	\$ 488.00
01462	Anesthesia	3	\$ 183.00
01464	Anesthesia	3	\$ 183.00
01470	Anesthesia	3	\$ 183.00
01472	Anesthesia	5	\$ 305.00

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CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

MPFS Basic			
Code	Category	Unit	RBRVS Rate
01474	Anesthesia	5	\$ 305.00
01480	Anesthesia	3	\$ 183.00
01482	Anesthesia	4	\$ 244.00
01484	Anesthesia	4	\$ 244.00
01486	Anesthesia	7	\$ 427.00
01490	Anesthesia	3	\$ 183.00
01500	Anesthesia	8	\$ 488.00
01502	Anesthesia	6	\$ 366.00
01520	Anesthesia	3	\$ 183.00
01522	Anesthesia	5	\$ 305.00
01610	Anesthesia	5	\$ 305.00
01620	Anesthesia	4	\$ 244.00
01622	Anesthesia	4	\$ 244.00
01630	Anesthesia	5	\$ 305.00
01634	Anesthesia	9	\$ 549.00
01636	Anesthesia	15	\$ 915.00
01638	Anesthesia	10	\$ 610.00
01650	Anesthesia	6	\$ 366.00
01652	Anesthesia	10	\$ 610.00
01654	Anesthesia	8	\$ 488.00
01656	Anesthesia	10	\$ 610.00
01670	Anesthesia	4	\$ 244.00
01680	Anesthesia	3	\$ 183.00
01710	Anesthesia	3	\$ 183.00
01712	Anesthesia	5	\$ 305.00
01714	Anesthesia	5	\$ 305.00
01716	Anesthesia	5	\$ 305.00
01730	Anesthesia	3	\$ 183.00
01732	Anesthesia	3	\$ 183.00
01740	Anesthesia	4	\$ 244.00
01742	Anesthesia	5	\$ 305.00
01744	Anesthesia	5	\$ 305.00
01756	Anesthesia	6	\$ 366.00
01758	Anesthesia	5	\$ 305.00
01760	Anesthesia	7	\$ 427.00
01770	Anesthesia	6	\$ 366.00
01772	Anesthesia	6	\$ 366.00
01780	Anesthesia	3	\$ 183.00
01782	Anesthesia	4	\$ 244.00
01810	Anesthesia	3	\$ 183.00
01820	Anesthesia	3	\$ 183.00
01829	Anesthesia	3	\$ 183.00
01830	Anesthesia	3	\$ 183.00
01832	Anesthesia	6	\$ 366.00
01840	Anesthesia	6	\$ 366.00
01842	Anesthesia	6	\$ 366.00
01844	Anesthesia	6	\$ 366.00
01850	Anesthesia	3	\$ 183.00
01852	Anesthesia	4	\$ 244.00
01860	Anesthesia	3	\$ 183.00
01916	Anesthesia	5	\$ 305.00
01920	Anesthesia	7	\$ 427.00
01922	Anesthesia	7	\$ 427.00
01924	Anesthesia	5	\$ 305.00
01925	Anesthesia	7	\$ 427.00
01926	Anesthesia	8	\$ 488.00
01930	Anesthesia	5	\$ 305.00
01931	Anesthesia	7	\$ 427.00
01932	Anesthesia	6	\$ 366.00
01933	Anesthesia	7	\$ 427.00
01937	Anesthesia	4	\$ 244.00

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CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

MPFS Basic			
Code	Category	Unit	RBRVS Rate
01938	Anesthesia	4	\$ 244.00
01939	Anesthesia	4	\$ 244.00
01940	Anesthesia	4	\$ 244.00
01941	Anesthesia	5	\$ 305.00
01942	Anesthesia	5	\$ 305.00
01951	Anesthesia	3	\$ 183.00
01952	Anesthesia	5	\$ 305.00
01953	Anesthesia	1	\$ 61.00
01958	Anesthesia	5	\$ 305.00
01960	Anesthesia	5	\$ 305.00
01961	Anesthesia	7	\$ 427.00
01962	Anesthesia	8	\$ 488.00
01963	Anesthesia	8	\$ 488.00
01965	Anesthesia	4	\$ 244.00
01966	Anesthesia	4	\$ 244.00
01967	Anesthesia	5	\$ 305.00
01968	Anesthesia	2	\$ 122.00
01969	Anesthesia	5	\$ 305.00
01990	Anesthesia	7	\$ 427.00
01991	Anesthesia	3	\$ 183.00
01992	Anesthesia	5	\$ 305.00
01996	Anesthesia	3	\$ 183.00
01999	Anesthesia	0	BR
99100	Anesthesia	1	\$ 61.00
99116	Anesthesia	5	\$ 305.00
99135	Anesthesia	5	\$ 305.00
99140	Anesthesia	2	\$ 122.00

Historical Note

Anesthesia Codes 2019-2020 made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Anesthesia Codes 2019-2020 will remain in effect through September 30, 2020 (Supp. 19-3). Anesthesia Codes 2019-2020 repealed; new Anesthesia Codes 2020-2021 made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Anesthesia Codes 2020-2021 repealed; new

Appendix A, Anesthesia Codes 2021-2022 made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3).

Appendix A, Anesthesia Codes 2021-2022 repealed; new Anesthesia Codes 2022-2023 made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

SURGERY GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2022 Editions of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT® are preceded by an AZ identifier and numbered in the following format: AZxxx.

The Commission has also adopted by reference: 1) The 1995 and 1997 Documentation Guidelines for Evaluation and Management Services, Centers for Medicare and Medicaid Services (CMS) <https://www.cms.gov/>; 2) 2022 Optum 360 The Essential RBRVS <https://www.optum360.com/>; 3) The National Correct Coding Initiative Edits, CMS <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>; and, 4) Physicians as Assistants at Surgery: 2020 Update <https://www.facs.org>. The RBRVS-based fee schedule adopts surgical global periods published by CMS. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to unit values for surgical services. To the extent that a conflict may exist between CMS, an adopted portion of the CPT® and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

- A. **MATERIALS AND SUPPLIES:** A healthcare provider may charge for materials and supplies as described in subsection (J)(4) of the Introduction Section of the Physician's Fee Schedule.
- B. **MULTIPLE PROCEDURES:** It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes.

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

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- C. **SPECIAL REPORT:** A typical request for more detailed information from an insurance carrier regarding a billing does not constitute a “special report”, which is defined in the CPT® book.
- D. **MODIFIERS:** Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code, which may be reported in either of two ways. The modifier may be reported by a two-digit number placed after the usual procedure number from which it is separated by a hyphen. Or the modifier may be reported by a separate five-digit code that is used in addition to the procedure code. If more than one modifier is used, the “Multiple Modifiers” code placed first after the procedure code indicates that one or more additional modifier codes will follow.

Modifiers either unique to Arizona or containing explanatory language specific to Arizona are as follows:

- Δ-22 Increased Procedural Services: Use of this modifier will result in a twenty-five percent (25%) increase in the listed value for the listed procedure.
- Δ-25 Separately Identifiable Evaluation and Management Service by the same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service. It may be necessary to indicate that on the day a procedure or service identified by a CPT® code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). As such, different diagnoses are not required for reporting of the E/M services on the same date. The circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.
- Δ-47 Anesthesia by Surgeon: The value shall be fifty percent (50%) of the calculated American Society of Anesthesiologists Relative Value Guide value.
- Δ-50 Bilateral Procedure: Unless otherwise identified in the listings, when bilateral procedures which add significant time or complexity to patient care are provided at the same operative session, identify and value the first or major procedure as listed. Identify the secondary or lesser procedure(s) by adding this modifier 50 to the usual procedure number(s) and value at fifty percent (50%) of the listed value(s). If, however, the procedures are independently complex and involve different parts of the body, including digits, the bilateral procedure rule would not apply. In such cases, independent procedures would be billed at one hundred percent (100%) of their listed value.
- Δ-51 Multiple Procedures: When multiple procedures are performed during the same operative session*, the procedures should be valued at the appropriate percent of its listed value, as shown below:
- 100% (full value) for the first or major procedure
- 50% for the second and multiple procedure(s)
- Sixth and subsequent procedures – by report

*Multiple Procedure Guidelines do not apply to codes specifically identified as “Add-on/Additional Procedures, Global indicator ZZZ”.

The major or primary procedure is defined as the procedure with the highest value and is the code that determines the follow-up days when a surgery has multiple procedures. The second procedure is the procedure with the next highest value, the third the next highest value, and so on. If, however, the procedures are independently complex such as digits, tendons, nerves or artery repair, the multiple procedure rule would not apply. In such cases, independent procedures would be billed at one hundred percent (100%) of their listed value.

When performing multiple procedures with different global period values during the same operative session, the global period value for the session is the largest global period value.

- Δ-57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.
- Δ-62 Two Surgeons: By prior agreement, the total value of services performed by two surgeons working together as primary surgeons may be apportioned in relation to the responsibility and work done, provided the patient is made aware of the fee distribution according to medical ethics. If no apportionment is listed, the fee should be split evenly between the co-surgeons. The total value may be increased by twenty-five percent (25%) in lieu of the usual assistant’s charge. Under these circumstances, the services of each surgeon should be identified by adding this modifier 62 to the joint procedure number(s) and valued as agreed upon. (Usual charges for surgical assistance may be warranted if still another physician is required as part of the surgical team.) The value of the

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procedure should be 125% of the customary value listed. Payment of 125% of the maximum allowable would be divided between the participating surgeons.

Two Surgeons – When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on codes(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80, 81, or 82 added, as appropriate.

- Δ-80 Assistant Surgeon: These services are valued at twenty percent (20%) of the listed value of the surgical procedure(s).
- Δ-81 Minimum Assistant Surgeon: These services are valued at sixteen percent (16%) of the listed value of the surgical procedure(s).
- Δ-82 Assistant Surgeon (when qualified resident surgeon not available): These services are valued at sixteen percent (16%) of the listed value of the surgical procedure(s).
- Δ-AS Use the modifier AS for assistant at surgery services, when services are provided by a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS). These services are valued at fourteen percent (14%) of the listed value of the surgical procedure(s).

NOTE: A Medical Doctor or Doctor of Osteopathic Medicine should not submit the AS modifier. This modifier is only valid for use by a PA, NP, and CNS when billing under their own provider number.

Historical Note

New Appendix A. Surgery Guidelines made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A., Surgery Guidelines will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A. Surgery Guidelines repealed; new Appendix A. Surgery Guidelines made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Surgery Guidelines repealed; new Appendix A, Surgery Guidelines made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Surgery Guidelines repealed; new Appendix A, Surgery Guidelines made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

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ARIZONA PHYSICIANS' FEE SCHEDULE

Surgery Codes 2022

Surgery Conversion Factor \$70.00

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
10004 00	Surgery	1.51	1.26	\$ 105.70	\$ 88.20
10005 00	Surgery	4.11	2.17	\$ 287.70	\$ 151.90
10006 00	Surgery	1.78	1.48	\$ 124.60	\$ 103.60
10007 00	Surgery	9.02	2.67	\$ 631.40	\$ 186.90
10008 00	Surgery	4.92	1.68	\$ 344.40	\$ 117.60
10009 00	Surgery	13.57	3.25	\$ 949.90	\$ 227.50
10010 00	Surgery	7.96	2.33	\$ 557.20	\$ 163.10
10011 00	Surgery	-	-	\$ 681.80	\$ 681.80
10012 00	Surgery	-	-	\$ 387.10	\$ 387.10
10021 00	Surgery	3.02	1.60	\$ 211.40	\$ 112.00
10030 00	Surgery	19.91	3.94	\$ 1,393.70	\$ 275.80
10035 00	Surgery	11.38	2.48	\$ 796.60	\$ 173.60
10036 00	Surgery	9.50	1.25	\$ 665.00	\$ 87.50
10040 00	Surgery	3.45	1.52	\$ 241.50	\$ 106.40
10060 00	Surgery	3.69	3.08	\$ 258.30	\$ 215.60
10061 00	Surgery	6.32	5.40	\$ 442.40	\$ 378.00
10080 00	Surgery	7.71	3.09	\$ 539.70	\$ 216.30
10081 00	Surgery	10.47	5.05	\$ 732.90	\$ 353.50
10120 00	Surgery	4.46	3.04	\$ 312.20	\$ 212.80
10121 00	Surgery	7.89	5.41	\$ 552.30	\$ 378.70
10140 00	Surgery	5.07	3.47	\$ 354.90	\$ 242.90
10160 00	Surgery	3.84	2.79	\$ 268.80	\$ 195.30
10180 00	Surgery	7.88	5.26	\$ 551.60	\$ 368.20
11000 00	Surgery	1.73	0.81	\$ 121.10	\$ 56.70
11001 00	Surgery	0.79	0.42	\$ 55.30	\$ 29.40
11004 00	Surgery	16.79	16.79	\$ 1,175.30	\$ 1,175.30
11005 00	Surgery	22.94	22.94	\$ 1,605.80	\$ 1,605.80
11006 00	Surgery	20.70	20.70	\$ 1,449.00	\$ 1,449.00
11008 00	Surgery	8.09	8.09	\$ 566.30	\$ 566.30
11010 00	Surgery	13.58	8.13	\$ 950.60	\$ 569.10
11011 00	Surgery	14.93	8.73	\$ 1,045.10	\$ 611.10
11012 00	Surgery	19.38	12.24	\$ 1,356.60	\$ 856.80
11042 00	Surgery	3.87	1.76	\$ 270.90	\$ 123.20
11043 00	Surgery	6.92	4.51	\$ 484.40	\$ 315.70
11044 00	Surgery	9.19	6.60	\$ 643.30	\$ 462.00
11045 00	Surgery	1.21	0.77	\$ 84.70	\$ 53.90
11046 00	Surgery	2.18	1.63	\$ 152.60	\$ 114.10
11047 00	Surgery	3.57	2.85	\$ 249.90	\$ 199.50
11055 00	Surgery	2.16	0.47	\$ 151.20	\$ 32.90
11056 00	Surgery	2.47	0.65	\$ 172.90	\$ 45.50
11057 00	Surgery	2.71	0.84	\$ 189.70	\$ 58.80
11102 00	Surgery	3.05	1.10	\$ 213.50	\$ 77.00
11103 00	Surgery	1.52	0.64	\$ 106.40	\$ 44.80
11104 00	Surgery	3.79	1.37	\$ 265.30	\$ 95.90
11105 00	Surgery	1.77	0.75	\$ 123.90	\$ 52.50
11106 00	Surgery	4.69	1.66	\$ 328.30	\$ 116.20
11107 00	Surgery	2.14	0.91	\$ 149.80	\$ 63.70
11200 00	Surgery	2.67	2.22	\$ 186.90	\$ 155.40
11201 00	Surgery	0.54	0.48	\$ 37.80	\$ 33.60
11300 00	Surgery	3.06	1.00	\$ 214.20	\$ 70.00

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
11301 00	Surgery	3.66	1.49	\$ 256.20	\$ 104.30
11302 00	Surgery	4.14	1.75	\$ 289.80	\$ 122.50
11303 00	Surgery	4.56	2.06	\$ 319.20	\$ 144.20
11305 00	Surgery	3.21	1.12	\$ 224.70	\$ 78.40
11306 00	Surgery	3.68	1.44	\$ 257.60	\$ 100.80
11307 00	Surgery	4.21	1.84	\$ 294.70	\$ 128.80
11308 00	Surgery	4.46	2.07	\$ 312.20	\$ 144.90
11310 00	Surgery	3.49	1.33	\$ 244.30	\$ 93.10
11311 00	Surgery	4.11	1.82	\$ 287.70	\$ 127.40
11312 00	Surgery	4.65	2.15	\$ 325.50	\$ 150.50
11313 00	Surgery	5.43	2.81	\$ 380.10	\$ 196.70
11400 00	Surgery	3.82	2.45	\$ 267.40	\$ 171.50
11401 00	Surgery	4.67	3.10	\$ 326.90	\$ 217.00
11402 00	Surgery	5.14	3.40	\$ 359.80	\$ 238.00
11403 00	Surgery	5.89	4.35	\$ 412.30	\$ 304.50
11404 00	Surgery	6.70	4.82	\$ 469.00	\$ 337.40
11406 00	Surgery	9.51	7.31	\$ 665.70	\$ 511.70
11420 00	Surgery	3.81	2.41	\$ 266.70	\$ 168.70
11421 00	Surgery	4.77	3.20	\$ 333.90	\$ 224.00
11422 00	Surgery	5.35	3.97	\$ 374.50	\$ 277.90
11423 00	Surgery	6.10	4.56	\$ 427.00	\$ 319.20
11424 00	Surgery	6.99	5.21	\$ 489.30	\$ 364.70
11426 00	Surgery	9.92	8.00	\$ 694.40	\$ 560.00
11440 00	Surgery	4.28	3.09	\$ 299.60	\$ 216.30
11441 00	Surgery	5.20	3.89	\$ 364.00	\$ 272.30
11442 00	Surgery	5.76	4.29	\$ 403.20	\$ 300.30
11443 00	Surgery	6.79	5.24	\$ 475.30	\$ 366.80
11444 00	Surgery	8.44	6.63	\$ 590.80	\$ 464.10
11446 00	Surgery	11.48	9.39	\$ 803.60	\$ 657.30
11450 00	Surgery	13.12	7.78	\$ 918.40	\$ 544.60
11451 00	Surgery	15.90	9.79	\$ 1,113.00	\$ 685.30
11462 00	Surgery	12.73	7.39	\$ 891.10	\$ 517.30
11463 00	Surgery	16.17	9.89	\$ 1,131.90	\$ 692.30
11470 00	Surgery	13.74	8.47	\$ 961.80	\$ 592.90
11471 00	Surgery	16.44	10.43	\$ 1,150.80	\$ 730.10
11600 00	Surgery	5.91	3.58	\$ 413.70	\$ 250.60
11601 00	Surgery	6.81	4.34	\$ 476.70	\$ 303.80
11602 00	Surgery	7.26	4.71	\$ 508.20	\$ 329.70
11603 00	Surgery	8.26	5.63	\$ 578.20	\$ 394.10
11604 00	Surgery	9.21	6.21	\$ 644.70	\$ 434.70
11606 00	Surgery	13.28	9.32	\$ 929.60	\$ 652.40
11620 00	Surgery	5.93	3.60	\$ 415.10	\$ 252.00
11621 00	Surgery	6.83	4.36	\$ 478.10	\$ 305.20
11622 00	Surgery	7.50	4.93	\$ 525.00	\$ 345.10
11623 00	Surgery	8.79	6.11	\$ 615.30	\$ 427.70
11624 00	Surgery	10.01	6.96	\$ 700.70	\$ 487.20
11626 00	Surgery	12.10	8.59	\$ 847.00	\$ 601.30
11640 00	Surgery	6.07	3.70	\$ 424.90	\$ 259.00
11641 00	Surgery	7.04	4.53	\$ 492.80	\$ 317.10
11642 00	Surgery	7.96	5.31	\$ 557.20	\$ 371.70
11643 00	Surgery	9.35	6.64	\$ 654.50	\$ 464.80
11644 00	Surgery	11.53	8.26	\$ 807.10	\$ 578.20
11646 00	Surgery	15.00	11.46	\$ 1,050.00	\$ 802.20
11719 00	Surgery	0.41	0.22	\$ 28.70	\$ 15.40

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
11720 00	Surgery	0.96	0.43	\$ 67.20	\$ 30.10
11721 00	Surgery	1.30	0.70	\$ 91.00	\$ 49.00
11730 00	Surgery	3.43	1.57	\$ 240.10	\$ 109.90
11732 00	Surgery	1.00	0.51	\$ 70.00	\$ 35.70
11740 00	Surgery	1.70	0.92	\$ 119.00	\$ 64.40
11750 00	Surgery	4.76	2.97	\$ 333.20	\$ 207.90
11755 00	Surgery	3.67	1.77	\$ 256.90	\$ 123.90
11760 00	Surgery	5.63	3.27	\$ 394.10	\$ 228.90
11762 00	Surgery	8.66	5.55	\$ 606.20	\$ 388.50
11765 00	Surgery	4.95	2.69	\$ 346.50	\$ 188.30
11770 00	Surgery	10.92	5.53	\$ 764.40	\$ 387.10
11771 00	Surgery	19.02	13.40	\$ 1,331.40	\$ 938.00
11772 00	Surgery	23.40	17.34	\$ 1,638.00	\$ 1,213.80
11900 00	Surgery	1.68	0.86	\$ 117.60	\$ 60.20
11901 00	Surgery	2.09	1.34	\$ 146.30	\$ 93.80
11920 00	Surgery	5.80	3.22	\$ 406.00	\$ 225.40
11921 00	Surgery	6.60	3.81	\$ 462.00	\$ 266.70
11922 00	Surgery	1.78	0.86	\$ 124.60	\$ 60.20
11950 00	Surgery	2.37	1.52	\$ 165.90	\$ 106.40
11951 00	Surgery	3.18	2.15	\$ 222.60	\$ 150.50
11952 00	Surgery	4.25	3.03	\$ 297.50	\$ 212.10
11954 00	Surgery	4.68	3.31	\$ 327.60	\$ 231.70
11960 00	Surgery	30.02	30.02	\$ 2,101.40	\$ 2,101.40
11970 00	Surgery	16.61	16.61	\$ 1,162.70	\$ 1,162.70
11971 00	Surgery	16.24	16.24	\$ 1,136.80	\$ 1,136.80
11976 00	Surgery	4.29	2.74	\$ 300.30	\$ 191.80
11980 00	Surgery	2.74	1.60	\$ 191.80	\$ 112.00
11981 00	Surgery	3.01	1.87	\$ 210.70	\$ 130.90
11982 00	Surgery	3.37	2.19	\$ 235.90	\$ 153.30
11983 00	Surgery	4.23	3.05	\$ 296.10	\$ 213.50
12001 00	Surgery	2.80	1.33	\$ 196.00	\$ 93.10
12002 00	Surgery	3.37	1.74	\$ 235.90	\$ 121.80
12004 00	Surgery	3.91	2.15	\$ 273.70	\$ 150.50
12005 00	Surgery	5.28	2.81	\$ 369.60	\$ 196.70
12006 00	Surgery	6.17	3.45	\$ 431.90	\$ 241.50
12007 00	Surgery	6.94	4.30	\$ 485.80	\$ 301.00
12011 00	Surgery	3.35	1.63	\$ 234.50	\$ 114.10
12013 00	Surgery	3.49	1.72	\$ 244.30	\$ 120.40
12014 00	Surgery	4.28	2.21	\$ 299.60	\$ 154.70
12015 00	Surgery	5.13	2.79	\$ 359.10	\$ 195.30
12016 00	Surgery	6.56	3.81	\$ 459.20	\$ 266.70
12017 00	Surgery	4.51	4.51	\$ 315.70	\$ 315.70
12018 00	Surgery	5.12	5.12	\$ 358.40	\$ 358.40
12020 00	Surgery	8.98	5.52	\$ 628.60	\$ 386.40
12021 00	Surgery	5.28	4.15	\$ 369.60	\$ 290.50
12031 00	Surgery	7.90	4.42	\$ 553.00	\$ 309.40
12032 00	Surgery	9.03	5.52	\$ 632.10	\$ 386.40
12034 00	Surgery	10.00	6.00	\$ 700.00	\$ 420.00
12035 00	Surgery	11.65	7.09	\$ 815.50	\$ 496.30
12036 00	Surgery	12.99	8.36	\$ 909.30	\$ 585.20
12037 00	Surgery	14.50	9.68	\$ 1,015.00	\$ 677.60
12041 00	Surgery	7.93	4.21	\$ 555.10	\$ 294.70
12042 00	Surgery	9.27	5.71	\$ 648.90	\$ 399.70
12044 00	Surgery	11.39	6.24	\$ 797.30	\$ 436.80

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
12045 00	Surgery	12.20	7.98	\$ 854.00	\$ 558.60
12046 00	Surgery	15.11	9.46	\$ 1,057.70	\$ 662.20
12047 00	Surgery	16.52	10.51	\$ 1,156.40	\$ 735.70
12051 00	Surgery	8.50	4.94	\$ 595.00	\$ 345.80
12052 00	Surgery	9.43	5.81	\$ 660.10	\$ 406.70
12053 00	Surgery	10.90	6.26	\$ 763.00	\$ 438.20
12054 00	Surgery	11.56	6.41	\$ 809.20	\$ 448.70
12055 00	Surgery	15.11	8.77	\$ 1,057.70	\$ 613.90
12056 00	Surgery	17.37	11.32	\$ 1,215.90	\$ 792.40
12057 00	Surgery	18.34	12.34	\$ 1,283.80	\$ 863.80
13100 00	Surgery	10.20	5.85	\$ 714.00	\$ 409.50
13101 00	Surgery	11.90	7.25	\$ 833.00	\$ 507.50
13102 00	Surgery	3.49	2.12	\$ 244.30	\$ 148.40
13120 00	Surgery	10.64	6.82	\$ 744.80	\$ 477.40
13121 00	Surgery	12.71	7.50	\$ 889.70	\$ 525.00
13122 00	Surgery	3.78	2.41	\$ 264.60	\$ 168.70
13131 00	Surgery	11.59	7.06	\$ 811.30	\$ 494.20
13132 00	Surgery	14.07	8.83	\$ 984.90	\$ 618.10
13133 00	Surgery	4.98	3.65	\$ 348.60	\$ 255.50
13151 00	Surgery	12.63	8.13	\$ 884.10	\$ 569.10
13152 00	Surgery	14.82	9.79	\$ 1,037.40	\$ 685.30
13153 00	Surgery	5.49	4.00	\$ 384.30	\$ 280.00
13160 00	Surgery	23.56	23.56	\$ 1,649.20	\$ 1,649.20
14000 00	Surgery	18.82	14.76	\$ 1,317.40	\$ 1,033.20
14001 00	Surgery	23.97	19.18	\$ 1,677.90	\$ 1,342.60
14020 00	Surgery	20.72	16.53	\$ 1,450.40	\$ 1,157.10
14021 00	Surgery	25.52	20.71	\$ 1,786.40	\$ 1,449.70
14040 00	Surgery	22.34	18.19	\$ 1,563.80	\$ 1,273.30
14041 00	Surgery	27.08	22.21	\$ 1,895.60	\$ 1,554.70
14060 00	Surgery	22.58	19.39	\$ 1,580.60	\$ 1,357.30
14061 00	Surgery	29.17	23.84	\$ 2,041.90	\$ 1,668.80
14301 00	Surgery	32.10	25.47	\$ 2,247.00	\$ 1,782.90
14302 00	Surgery	6.34	6.34	\$ 443.80	\$ 443.80
14350 00	Surgery	20.01	20.01	\$ 1,400.70	\$ 1,400.70
15002 00	Surgery	10.40	6.45	\$ 728.00	\$ 451.50
15003 00	Surgery	2.09	1.34	\$ 146.30	\$ 93.80
15004 00	Surgery	11.81	7.67	\$ 826.70	\$ 536.90
15005 00	Surgery	3.50	2.68	\$ 245.00	\$ 187.60
15040 00	Surgery	7.93	3.64	\$ 555.10	\$ 254.80
15050 00	Surgery	17.76	13.67	\$ 1,243.20	\$ 956.90
15100 00	Surgery	25.91	21.15	\$ 1,813.70	\$ 1,480.50
15101 00	Surgery	5.65	3.31	\$ 395.50	\$ 231.70
15110 00	Surgery	24.74	20.99	\$ 1,731.80	\$ 1,469.30
15111 00	Surgery	3.35	3.01	\$ 234.50	\$ 210.70
15115 00	Surgery	23.88	20.33	\$ 1,671.60	\$ 1,423.10
15116 00	Surgery	4.83	4.38	\$ 338.10	\$ 306.60
15120 00	Surgery	25.08	20.30	\$ 1,755.60	\$ 1,421.00
15121 00	Surgery	6.34	3.99	\$ 443.80	\$ 279.30
15130 00	Surgery	21.54	17.61	\$ 1,507.80	\$ 1,232.70
15131 00	Surgery	2.87	2.64	\$ 200.90	\$ 184.80
15135 00	Surgery	26.03	22.28	\$ 1,822.10	\$ 1,559.60
15136 00	Surgery	2.84	2.64	\$ 198.80	\$ 184.80
15150 00	Surgery	21.24	19.10	\$ 1,486.80	\$ 1,337.00
15151 00	Surgery	3.54	3.26	\$ 247.80	\$ 228.20

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
15152 00	Surgery	4.35	4.10	\$ 304.50	\$ 287.00
15155 00	Surgery	23.64	21.51	\$ 1,654.80	\$ 1,505.70
15156 00	Surgery	4.76	4.48	\$ 333.20	\$ 313.60
15157 00	Surgery	5.28	4.88	\$ 369.60	\$ 341.60
15200 00	Surgery	24.87	19.78	\$ 1,740.90	\$ 1,384.60
15201 00	Surgery	4.21	2.24	\$ 294.70	\$ 156.80
15220 00	Surgery	22.71	17.83	\$ 1,589.70	\$ 1,248.10
15221 00	Surgery	3.92	2.03	\$ 274.40	\$ 142.10
15240 00	Surgery	27.39	23.24	\$ 1,917.30	\$ 1,626.80
15241 00	Surgery	5.17	3.09	\$ 361.90	\$ 216.30
15260 00	Surgery	29.34	24.65	\$ 2,053.80	\$ 1,725.50
15261 00	Surgery	6.13	3.99	\$ 429.10	\$ 279.30
15271 00	Surgery	4.62	2.46	\$ 323.40	\$ 172.20
15272 00	Surgery	0.75	0.52	\$ 52.50	\$ 36.40
15273 00	Surgery	9.47	5.82	\$ 662.90	\$ 407.40
15274 00	Surgery	2.51	1.34	\$ 175.70	\$ 93.80
15275 00	Surgery	4.75	2.74	\$ 332.50	\$ 191.80
15276 00	Surgery	0.97	0.75	\$ 67.90	\$ 52.50
15277 00	Surgery	10.39	6.63	\$ 727.30	\$ 464.10
15278 00	Surgery	2.90	1.67	\$ 203.00	\$ 116.90
15570 00	Surgery	27.08	21.62	\$ 1,895.60	\$ 1,513.40
15572 00	Surgery	25.93	21.56	\$ 1,815.10	\$ 1,509.20
15574 00	Surgery	26.10	21.75	\$ 1,827.00	\$ 1,522.50
15576 00	Surgery	23.20	19.09	\$ 1,624.00	\$ 1,336.30
15600 00	Surgery	10.08	6.22	\$ 705.60	\$ 435.40
15610 00	Surgery	10.92	7.14	\$ 764.40	\$ 499.80
15620 00	Surgery	13.29	9.60	\$ 930.30	\$ 672.00
15630 00	Surgery	13.68	10.06	\$ 957.60	\$ 704.20
15650 00	Surgery	15.17	11.21	\$ 1,061.90	\$ 784.70
15730 00	Surgery	42.58	26.79	\$ 2,980.60	\$ 1,875.30
15731 00	Surgery	33.24	29.37	\$ 2,326.80	\$ 2,055.90
15733 00	Surgery	30.41	30.41	\$ 2,128.70	\$ 2,128.70
15734 00	Surgery	44.51	44.51	\$ 3,115.70	\$ 3,115.70
15736 00	Surgery	35.95	35.95	\$ 2,516.50	\$ 2,516.50
15738 00	Surgery	37.69	37.69	\$ 2,638.30	\$ 2,638.30
15740 00	Surgery	29.75	24.61	\$ 2,082.50	\$ 1,722.70
15750 00	Surgery	27.51	27.51	\$ 1,925.70	\$ 1,925.70
15756 00	Surgery	67.55	67.55	\$ 4,728.50	\$ 4,728.50
15757 00	Surgery	67.17	67.17	\$ 4,701.90	\$ 4,701.90
15758 00	Surgery	67.08	67.08	\$ 4,695.60	\$ 4,695.60
15760 00	Surgery	24.95	20.52	\$ 1,746.50	\$ 1,436.40
15769 00	Surgery	14.15	14.15	\$ 990.50	\$ 990.50
15770 00	Surgery	19.79	19.79	\$ 1,385.30	\$ 1,385.30
15771 00	Surgery	17.47	14.59	\$ 1,222.90	\$ 1,021.30
15772 00	Surgery	5.60	4.34	\$ 392.00	\$ 303.80
15773 00	Surgery	17.89	14.97	\$ 1,252.30	\$ 1,047.90
15774 00	Surgery	5.49	4.22	\$ 384.30	\$ 295.40
15775 00	Surgery	11.26	7.51	\$ 788.20	\$ 525.70
15776 00	Surgery	15.20	10.27	\$ 1,064.00	\$ 718.90
15777 00	Surgery	6.34	6.34	\$ 443.80	\$ 443.80
15780 00	Surgery	24.93	19.26	\$ 1,745.10	\$ 1,348.20
15781 00	Surgery	16.06	12.62	\$ 1,124.20	\$ 883.40
15782 00	Surgery	14.31	10.73	\$ 1,001.70	\$ 751.10
15783 00	Surgery	13.21	10.28	\$ 924.70	\$ 719.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
15786 00	Surgery	6.89	3.90	\$ 482.30	\$ 273.00
15787 00	Surgery	0.92	0.50	\$ 64.40	\$ 35.00
15788 00	Surgery	11.66	6.27	\$ 816.20	\$ 438.90
15789 00	Surgery	15.65	11.91	\$ 1,095.50	\$ 833.70
15792 00	Surgery	9.91	6.09	\$ 693.70	\$ 426.30
15793 00	Surgery	14.01	10.38	\$ 980.70	\$ 726.60
15819 00	Surgery	23.60	23.60	\$ 1,652.00	\$ 1,652.00
15820 00	Surgery	16.99	15.05	\$ 1,189.30	\$ 1,053.50
15821 00	Surgery	18.28	16.15	\$ 1,279.60	\$ 1,130.50
15822 00	Surgery	13.67	11.76	\$ 956.90	\$ 823.20
15823 00	Surgery	18.27	16.12	\$ 1,278.90	\$ 1,128.40
15824 00	Surgery	-	-	\$ 2,325.40	\$ 2,325.40
15825 00	Surgery	-	-	\$ 2,617.30	\$ 2,617.30
15826 00	Surgery	-	-	\$ 1,890.00	\$ 1,890.00
15828 00	Surgery	-	-	\$ 4,942.70	\$ 4,942.70
15829 00	Surgery	-	-	\$ 5,524.40	\$ 5,524.40
15830 00	Surgery	34.66	34.66	\$ 2,426.20	\$ 2,426.20
15832 00	Surgery	27.12	27.12	\$ 1,898.40	\$ 1,898.40
15833 00	Surgery	25.90	25.90	\$ 1,813.00	\$ 1,813.00
15834 00	Surgery	26.38	26.38	\$ 1,846.60	\$ 1,846.60
15835 00	Surgery	27.48	27.48	\$ 1,923.60	\$ 1,923.60
15836 00	Surgery	23.54	23.54	\$ 1,647.80	\$ 1,647.80
15837 00	Surgery	25.69	21.14	\$ 1,798.30	\$ 1,479.80
15838 00	Surgery	19.17	19.17	\$ 1,341.90	\$ 1,341.90
15839 00	Surgery	26.48	21.86	\$ 1,853.60	\$ 1,530.20
15840 00	Surgery	30.02	30.02	\$ 2,101.40	\$ 2,101.40
15841 00	Surgery	52.57	52.57	\$ 3,679.90	\$ 3,679.90
15842 00	Surgery	79.68	79.68	\$ 5,577.60	\$ 5,577.60
15845 00	Surgery	31.34	31.34	\$ 2,193.80	\$ 2,193.80
15847 00	Surgery	-	-	\$ 1,017.80	\$ 1,017.80
15850 00	Surgery	0.00	0.00	Bundled Code	Bundled Code
15851 00	Surgery	3.20	1.32	\$ 224.00	\$ 92.40
15852 00	Surgery	1.38	1.38	\$ 96.60	\$ 96.60
15860 00	Surgery	3.14	3.14	\$ 219.80	\$ 219.80
15876 00	Surgery	0.00	0.00	BR	BR
15877 00	Surgery	0.00	0.00	BR	BR
15878 00	Surgery	0.00	0.00	BR	BR
15879 00	Surgery	0.00	0.00	BR	BR
15920 00	Surgery	19.06	19.06	\$ 1,334.20	\$ 1,334.20
15922 00	Surgery	23.61	23.61	\$ 1,652.70	\$ 1,652.70
15931 00	Surgery	20.84	20.84	\$ 1,458.80	\$ 1,458.80
15933 00	Surgery	25.94	25.94	\$ 1,815.80	\$ 1,815.80
15934 00	Surgery	28.18	28.18	\$ 1,972.60	\$ 1,972.60
15935 00	Surgery	34.21	34.21	\$ 2,394.70	\$ 2,394.70
15936 00	Surgery	26.88	26.88	\$ 1,881.60	\$ 1,881.60
15937 00	Surgery	31.06	31.06	\$ 2,174.20	\$ 2,174.20
15940 00	Surgery	20.87	20.87	\$ 1,460.90	\$ 1,460.90
15941 00	Surgery	27.67	27.67	\$ 1,936.90	\$ 1,936.90
15944 00	Surgery	27.66	27.66	\$ 1,936.20	\$ 1,936.20
15945 00	Surgery	30.18	30.18	\$ 2,112.60	\$ 2,112.60
15946 00	Surgery	48.03	48.03	\$ 3,362.10	\$ 3,362.10
15950 00	Surgery	18.86	18.86	\$ 1,320.20	\$ 1,320.20
15951 00	Surgery	26.66	26.66	\$ 1,866.20	\$ 1,866.20
15952 00	Surgery	27.11	27.11	\$ 1,897.70	\$ 1,897.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
15953 00	Surgery	29.89	29.89	\$ 2,092.30	\$ 2,092.30
15956 00	Surgery	34.79	34.79	\$ 2,435.30	\$ 2,435.30
15958 00	Surgery	35.36	35.36	\$ 2,475.20	\$ 2,475.20
15999 00	Surgery	0.00	0.00	BR	BR
16000 00	Surgery	2.25	1.32	\$ 157.50	\$ 92.40
16020 00	Surgery	2.51	1.60	\$ 175.70	\$ 112.00
16025 00	Surgery	4.68	3.27	\$ 327.60	\$ 228.90
16030 00	Surgery	5.87	3.87	\$ 410.90	\$ 270.90
16035 00	Surgery	5.65	5.65	\$ 395.50	\$ 395.50
16036 00	Surgery	2.31	2.31	\$ 161.70	\$ 161.70
17000 00	Surgery	1.99	1.61	\$ 139.30	\$ 112.70
17003 00	Surgery	0.20	0.06	\$ 14.00	\$ 4.20
17004 00	Surgery	5.00	2.84	\$ 350.00	\$ 198.80
17106 00	Surgery	10.09	8.03	\$ 706.30	\$ 562.10
17107 00	Surgery	13.15	10.47	\$ 920.50	\$ 732.90
17108 00	Surgery	18.56	15.31	\$ 1,299.20	\$ 1,071.70
17110 00	Surgery	3.37	1.95	\$ 235.90	\$ 136.50
17111 00	Surgery	3.94	2.38	\$ 275.80	\$ 166.60
17250 00	Surgery	2.68	1.10	\$ 187.60	\$ 77.00
17260 00	Surgery	2.96	2.06	\$ 207.20	\$ 144.20
17261 00	Surgery	4.38	2.51	\$ 306.60	\$ 175.70
17262 00	Surgery	5.30	3.20	\$ 371.00	\$ 224.00
17263 00	Surgery	5.73	3.55	\$ 401.10	\$ 248.50
17264 00	Surgery	6.13	3.79	\$ 429.10	\$ 265.30
17266 00	Surgery	6.97	4.45	\$ 487.90	\$ 311.50
17270 00	Surgery	4.40	2.74	\$ 308.00	\$ 191.80
17271 00	Surgery	4.91	3.03	\$ 343.70	\$ 212.10
17272 00	Surgery	5.60	3.52	\$ 392.00	\$ 246.40
17273 00	Surgery	6.19	3.98	\$ 433.30	\$ 278.60
17274 00	Surgery	7.23	4.86	\$ 506.10	\$ 340.20
17276 00	Surgery	8.41	5.86	\$ 588.70	\$ 410.20
17280 00	Surgery	4.14	2.50	\$ 289.80	\$ 175.00
17281 00	Surgery	5.33	3.43	\$ 373.10	\$ 240.10
17282 00	Surgery	6.09	3.96	\$ 426.30	\$ 277.20
17283 00	Surgery	7.17	4.93	\$ 501.90	\$ 345.10
17284 00	Surgery	8.17	5.78	\$ 571.90	\$ 404.60
17286 00	Surgery	10.45	7.81	\$ 731.50	\$ 546.70
17311 00	Surgery	19.87	10.34	\$ 1,390.90	\$ 723.80
17312 00	Surgery	12.11	5.50	\$ 847.70	\$ 385.00
17313 00	Surgery	18.67	9.29	\$ 1,306.90	\$ 650.30
17314 00	Surgery	11.59	5.09	\$ 811.30	\$ 356.30
17315 00	Surgery	2.27	1.46	\$ 158.90	\$ 102.20
17340 00	Surgery	1.54	1.44	\$ 107.80	\$ 100.80
17360 00	Surgery	3.59	2.66	\$ 251.30	\$ 186.20
17380 00	Surgery	-	-	\$ 161.00	\$ 161.00
17999 00	Surgery	0.00	0.00	BR	BR
19000 00	Surgery	3.08	1.25	\$ 215.60	\$ 87.50
19001 00	Surgery	0.79	0.62	\$ 55.30	\$ 43.40
19020 00	Surgery	14.17	9.31	\$ 991.90	\$ 651.70
19030 00	Surgery	4.94	2.20	\$ 345.80	\$ 154.00
19081 00	Surgery	15.34	4.81	\$ 1,073.80	\$ 336.70
19082 00	Surgery	12.02	2.42	\$ 841.40	\$ 169.40
19083 00	Surgery	15.53	4.54	\$ 1,087.10	\$ 317.80
19084 00	Surgery	11.89	2.25	\$ 832.30	\$ 157.50

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
19085 00	Surgery	23.87	5.26	\$ 1,670.90	\$ 368.20
19086 00	Surgery	18.62	2.62	\$ 1,303.40	\$ 183.40
19100 00	Surgery	4.65	2.06	\$ 325.50	\$ 144.20
19101 00	Surgery	10.00	6.68	\$ 700.00	\$ 467.60
19105 00	Surgery	73.24	6.26	\$ 5,126.80	\$ 438.20
19110 00	Surgery	14.72	10.50	\$ 1,030.40	\$ 735.00
19112 00	Surgery	13.97	9.63	\$ 977.90	\$ 674.10
19120 00	Surgery	15.54	12.43	\$ 1,087.80	\$ 870.10
19125 00	Surgery	17.14	13.79	\$ 1,199.80	\$ 965.30
19126 00	Surgery	4.77	4.77	\$ 333.90	\$ 333.90
19281 00	Surgery	7.17	2.90	\$ 501.90	\$ 203.00
19282 00	Surgery	5.11	1.45	\$ 357.70	\$ 101.50
19283 00	Surgery	7.82	2.92	\$ 547.40	\$ 204.40
19284 00	Surgery	5.85	1.47	\$ 409.50	\$ 102.90
19285 00	Surgery	11.47	2.48	\$ 802.90	\$ 173.60
19286 00	Surgery	9.47	1.25	\$ 662.90	\$ 87.50
19287 00	Surgery	19.85	3.68	\$ 1,389.50	\$ 257.60
19288 00	Surgery	15.43	1.85	\$ 1,080.10	\$ 129.50
19294 00	Surgery	4.89	4.89	\$ 342.30	\$ 342.30
19296 00	Surgery	117.25	6.23	\$ 8,207.50	\$ 436.10
19297 00	Surgery	2.79	2.79	\$ 195.30	\$ 195.30
19298 00	Surgery	26.48	9.23	\$ 1,853.60	\$ 646.10
19300 00	Surgery	17.57	12.91	\$ 1,229.90	\$ 903.70
19301 00	Surgery	19.74	19.74	\$ 1,381.80	\$ 1,381.80
19302 00	Surgery	27.11	27.11	\$ 1,897.70	\$ 1,897.70
19303 00	Surgery	28.61	28.61	\$ 2,002.70	\$ 2,002.70
19305 00	Surgery	34.30	34.30	\$ 2,401.00	\$ 2,401.00
19306 00	Surgery	36.58	36.58	\$ 2,560.60	\$ 2,560.60
19307 00	Surgery	35.29	35.29	\$ 2,470.30	\$ 2,470.30
19316 00	Surgery	23.43	23.43	\$ 1,640.10	\$ 1,640.10
19318 00	Surgery	32.33	32.33	\$ 2,263.10	\$ 2,263.10
19325 00	Surgery	18.18	18.18	\$ 1,272.60	\$ 1,272.60
19328 00	Surgery	16.40	16.40	\$ 1,148.00	\$ 1,148.00
19330 00	Surgery	19.13	19.13	\$ 1,339.10	\$ 1,339.10
19340 00	Surgery	22.44	22.44	\$ 1,570.80	\$ 1,570.80
19342 00	Surgery	22.52	22.52	\$ 1,576.40	\$ 1,576.40
19350 00	Surgery	24.65	19.90	\$ 1,725.50	\$ 1,393.00
19355 00	Surgery	22.45	18.24	\$ 1,571.50	\$ 1,276.80
19357 00	Surgery	34.32	34.32	\$ 2,402.40	\$ 2,402.40
19361 00	Surgery	46.06	46.06	\$ 3,224.20	\$ 3,224.20
19364 00	Surgery	80.47	80.47	\$ 5,632.90	\$ 5,632.90
19367 00	Surgery	52.34	52.34	\$ 3,663.80	\$ 3,663.80
19368 00	Surgery	64.21	64.21	\$ 4,494.70	\$ 4,494.70
19369 00	Surgery	59.66	59.66	\$ 4,176.20	\$ 4,176.20
19370 00	Surgery	19.85	19.85	\$ 1,389.50	\$ 1,389.50
19371 00	Surgery	21.06	21.06	\$ 1,474.20	\$ 1,474.20
19380 00	Surgery	23.87	23.87	\$ 1,670.90	\$ 1,670.90
19396 00	Surgery	8.29	4.20	\$ 580.30	\$ 294.00
19499 00	Surgery	0.00	0.00	BR	BR
20100 00	Surgery	17.89	17.89	\$ 1,252.30	\$ 1,252.30
20101 00	Surgery	18.06	6.29	\$ 1,264.20	\$ 440.30
20102 00	Surgery	18.83	7.61	\$ 1,318.10	\$ 532.70
20103 00	Surgery	16.95	10.20	\$ 1,186.50	\$ 714.00
20150 00	Surgery	29.74	29.74	\$ 2,081.80	\$ 2,081.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
20200 00	Surgery	6.64	2.79	\$ 464.80	\$ 195.30
20205 00	Surgery	9.20	4.55	\$ 644.00	\$ 318.50
20206 00	Surgery	6.90	1.67	\$ 483.00	\$ 116.90
20220 00	Surgery	7.18	2.54	\$ 502.60	\$ 177.80
20225 00	Surgery	11.85	3.79	\$ 829.50	\$ 265.30
20240 00	Surgery	4.15	4.15	\$ 290.50	\$ 290.50
20245 00	Surgery	10.22	10.22	\$ 715.40	\$ 715.40
20250 00	Surgery	11.47	11.47	\$ 802.90	\$ 802.90
20251 00	Surgery	12.54	12.54	\$ 877.80	\$ 877.80
20500 00	Surgery	3.59	2.56	\$ 251.30	\$ 179.20
20501 00	Surgery	4.42	1.09	\$ 309.40	\$ 76.30
20520 00	Surgery	6.50	4.35	\$ 455.00	\$ 304.50
20525 00	Surgery	14.01	7.30	\$ 980.70	\$ 511.00
20526 00	Surgery	2.44	1.69	\$ 170.80	\$ 118.30
20527 00	Surgery	2.58	1.93	\$ 180.60	\$ 135.10
20550 00	Surgery	1.70	1.15	\$ 119.00	\$ 80.50
20551 00	Surgery	1.72	1.15	\$ 120.40	\$ 80.50
20552 00	Surgery	1.59	1.11	\$ 111.30	\$ 77.70
20553 00	Surgery	1.83	1.26	\$ 128.10	\$ 88.20
20555 00	Surgery	9.74	9.74	\$ 681.80	\$ 681.80
20560 00	Surgery	0.78	0.44	\$ 54.60	\$ 30.80
20561 00	Surgery	1.11	0.65	\$ 77.70	\$ 45.50
20600 00	Surgery	1.57	1.05	\$ 109.90	\$ 73.50
20604 00	Surgery	2.43	1.35	\$ 170.10	\$ 94.50
20605 00	Surgery	1.62	1.09	\$ 113.40	\$ 76.30
20606 00	Surgery	2.64	1.52	\$ 184.80	\$ 106.40
20610 00	Surgery	1.92	1.33	\$ 134.40	\$ 93.10
20611 00	Surgery	2.95	1.74	\$ 206.50	\$ 121.80
20612 00	Surgery	1.90	1.21	\$ 133.00	\$ 84.70
20615 00	Surgery	7.50	4.71	\$ 525.00	\$ 329.70
20650 00	Surgery	6.63	4.76	\$ 464.10	\$ 333.20
20660 00	Surgery	7.12	7.12	\$ 498.40	\$ 498.40
20661 00	Surgery	15.18	15.18	\$ 1,062.60	\$ 1,062.60
20662 00	Surgery	15.47	15.47	\$ 1,082.90	\$ 1,082.90
20663 00	Surgery	14.25	14.25	\$ 997.50	\$ 997.50
20664 00	Surgery	26.30	26.30	\$ 1,841.00	\$ 1,841.00
20665 00	Surgery	3.42	2.82	\$ 239.40	\$ 197.40
20670 00	Surgery	10.81	4.25	\$ 756.70	\$ 297.50
20680 00	Surgery	17.98	12.39	\$ 1,258.60	\$ 867.30
20690 00	Surgery	17.68	17.68	\$ 1,237.60	\$ 1,237.60
20692 00	Surgery	33.13	33.13	\$ 2,319.10	\$ 2,319.10
20693 00	Surgery	13.13	13.13	\$ 919.10	\$ 919.10
20694 00	Surgery	12.79	10.07	\$ 895.30	\$ 704.90
20696 00	Surgery	35.00	35.00	\$ 2,450.00	\$ 2,450.00
20697 00	Surgery	56.50	56.50	\$ 3,955.00	\$ 3,955.00
20700 00	Surgery	2.51	2.51	\$ 175.70	\$ 175.70
20701 00	Surgery	1.91	1.91	\$ 133.70	\$ 133.70
20702 00	Surgery	4.23	4.23	\$ 296.10	\$ 296.10
20703 00	Surgery	3.08	3.08	\$ 215.60	\$ 215.60
20704 00	Surgery	4.47	4.47	\$ 312.90	\$ 312.90
20705 00	Surgery	3.66	3.66	\$ 256.20	\$ 256.20
20802 00	Surgery	81.08	81.08	\$ 5,675.60	\$ 5,675.60
20805 00	Surgery	96.35	96.35	\$ 6,744.50	\$ 6,744.50
20808 00	Surgery	116.30	116.30	\$ 8,141.00	\$ 8,141.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
20816 00	Surgery	60.71	60.71	\$ 4,249.70	\$ 4,249.70
20822 00	Surgery	52.43	52.43	\$ 3,670.10	\$ 3,670.10
20824 00	Surgery	60.82	60.82	\$ 4,257.40	\$ 4,257.40
20827 00	Surgery	53.81	53.81	\$ 3,766.70	\$ 3,766.70
20838 00	Surgery	82.38	82.38	\$ 5,766.60	\$ 5,766.60
20900 00	Surgery	11.79	5.35	\$ 825.30	\$ 374.50
20902 00	Surgery	8.17	8.17	\$ 571.90	\$ 571.90
20910 00	Surgery	14.09	14.09	\$ 986.30	\$ 986.30
20912 00	Surgery	14.26	14.26	\$ 998.20	\$ 998.20
20920 00	Surgery	11.78	11.78	\$ 824.60	\$ 824.60
20922 00	Surgery	17.90	14.44	\$ 1,253.00	\$ 1,010.80
20924 00	Surgery	14.99	14.99	\$ 1,049.30	\$ 1,049.30
20930 00	Surgery	-	-	\$ 242.20	\$ 242.20
20931 00	Surgery	3.26	3.26	\$ 228.20	\$ 228.20
20932 00	Surgery	22.29	22.29	\$ 1,560.30	\$ 1,560.30
20933 00	Surgery	20.47	20.47	\$ 1,432.90	\$ 1,432.90
20934 00	Surgery	22.27	22.27	\$ 1,558.90	\$ 1,558.90
20936 00	Surgery	-	-	\$ 258.30	\$ 258.30
20937 00	Surgery	4.92	4.92	\$ 344.40	\$ 344.40
20938 00	Surgery	5.43	5.43	\$ 380.10	\$ 380.10
20939 00	Surgery	2.05	2.05	\$ 143.50	\$ 143.50
20950 00	Surgery	8.03	2.59	\$ 562.10	\$ 181.30
20955 00	Surgery	72.77	72.77	\$ 5,093.90	\$ 5,093.90
20956 00	Surgery	78.03	78.03	\$ 5,462.10	\$ 5,462.10
20957 00	Surgery	81.24	81.24	\$ 5,686.80	\$ 5,686.80
20962 00	Surgery	78.69	78.69	\$ 5,508.30	\$ 5,508.30
20969 00	Surgery	80.03	80.03	\$ 5,602.10	\$ 5,602.10
20970 00	Surgery	84.12	84.12	\$ 5,888.40	\$ 5,888.40
20972 00	Surgery	83.87	83.87	\$ 5,870.90	\$ 5,870.90
20973 00	Surgery	88.63	88.63	\$ 6,204.10	\$ 6,204.10
20974 00	Surgery	2.40	1.45	\$ 168.00	\$ 101.50
20975 00	Surgery	5.10	5.10	\$ 357.00	\$ 357.00
20979 00	Surgery	1.64	0.93	\$ 114.80	\$ 65.10
20982 00	Surgery	108.38	10.67	\$ 7,586.60	\$ 746.90
20983 00	Surgery	158.61	9.88	\$ 11,102.70	\$ 691.60
20985 00	Surgery	4.28	4.28	\$ 299.60	\$ 299.60
20999 00	Surgery	0.00	0.00	BR	BR
21010 00	Surgery	21.87	21.87	\$ 1,530.90	\$ 1,530.90
21011 00	Surgery	11.18	7.66	\$ 782.60	\$ 536.20
21012 00	Surgery	10.07	10.07	\$ 704.90	\$ 704.90
21013 00	Surgery	16.02	11.89	\$ 1,121.40	\$ 832.30
21014 00	Surgery	15.46	15.46	\$ 1,082.20	\$ 1,082.20
21015 00	Surgery	20.70	20.70	\$ 1,449.00	\$ 1,449.00
21016 00	Surgery	29.83	29.83	\$ 2,088.10	\$ 2,088.10
21025 00	Surgery	23.34	19.42	\$ 1,633.80	\$ 1,359.40
21026 00	Surgery	15.84	12.59	\$ 1,108.80	\$ 881.30
21029 00	Surgery	22.69	18.22	\$ 1,588.30	\$ 1,275.40
21030 00	Surgery	13.72	10.66	\$ 960.40	\$ 746.20
21031 00	Surgery	11.45	8.01	\$ 801.50	\$ 560.70
21032 00	Surgery	11.06	7.66	\$ 774.20	\$ 536.20
21034 00	Surgery	38.55	33.34	\$ 2,698.50	\$ 2,333.80
21040 00	Surgery	13.92	10.75	\$ 974.40	\$ 752.50
21044 00	Surgery	25.57	25.57	\$ 1,789.90	\$ 1,789.90
21045 00	Surgery	35.43	35.43	\$ 2,480.10	\$ 2,480.10

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
21046 00	Surgery	29.61	29.61	\$ 2,072.70	\$ 2,072.70
21047 00	Surgery	36.93	36.93	\$ 2,585.10	\$ 2,585.10
21048 00	Surgery	29.85	29.85	\$ 2,089.50	\$ 2,089.50
21049 00	Surgery	36.07	36.07	\$ 2,524.90	\$ 2,524.90
21050 00	Surgery	25.55	25.55	\$ 1,788.50	\$ 1,788.50
21060 00	Surgery	23.19	23.19	\$ 1,623.30	\$ 1,623.30
21070 00	Surgery	18.00	18.00	\$ 1,260.00	\$ 1,260.00
21073 00	Surgery	11.17	7.25	\$ 781.90	\$ 507.50
21076 00	Surgery	25.25	20.71	\$ 1,767.50	\$ 1,449.70
21077 00	Surgery	62.04	51.02	\$ 4,342.80	\$ 3,571.40
21079 00	Surgery	42.54	34.32	\$ 2,977.80	\$ 2,402.40
21080 00	Surgery	49.22	39.14	\$ 3,445.40	\$ 2,739.80
21081 00	Surgery	45.18	35.73	\$ 3,162.60	\$ 2,501.10
21082 00	Surgery	41.46	32.51	\$ 2,902.20	\$ 2,275.70
21083 00	Surgery	39.58	30.19	\$ 2,770.60	\$ 2,113.30
21084 00	Surgery	45.19	34.94	\$ 3,163.30	\$ 2,445.80
21085 00	Surgery	19.83	14.17	\$ 1,388.10	\$ 991.90
21086 00	Surgery	46.20	37.62	\$ 3,234.00	\$ 2,633.40
21087 00	Surgery	46.20	37.62	\$ 3,234.00	\$ 2,633.40
21088 00	Surgery	-	-	\$ 6,456.10	\$ 6,456.10
21089 00	Surgery	0.00	0.00	BR	BR
21100 00	Surgery	18.59	10.40	\$ 1,301.30	\$ 728.00
21110 00	Surgery	26.12	21.66	\$ 1,828.40	\$ 1,516.20
21116 00	Surgery	6.65	1.33	\$ 465.50	\$ 93.10
21120 00	Surgery	19.87	15.16	\$ 1,390.90	\$ 1,061.20
21121 00	Surgery	18.78	15.64	\$ 1,314.60	\$ 1,094.80
21122 00	Surgery	22.30	22.30	\$ 1,561.00	\$ 1,561.00
21123 00	Surgery	25.20	25.20	\$ 1,764.00	\$ 1,764.00
21125 00	Surgery	80.67	19.62	\$ 5,646.90	\$ 1,373.40
21127 00	Surgery	123.64	22.49	\$ 8,654.80	\$ 1,574.30
21137 00	Surgery	22.21	22.21	\$ 1,554.70	\$ 1,554.70
21138 00	Surgery	27.05	27.05	\$ 1,893.50	\$ 1,893.50
21139 00	Surgery	32.38	32.38	\$ 2,266.60	\$ 2,266.60
21141 00	Surgery	39.32	39.32	\$ 2,752.40	\$ 2,752.40
21142 00	Surgery	40.37	40.37	\$ 2,825.90	\$ 2,825.90
21143 00	Surgery	41.59	41.59	\$ 2,911.30	\$ 2,911.30
21145 00	Surgery	45.76	45.76	\$ 3,203.20	\$ 3,203.20
21146 00	Surgery	47.76	47.76	\$ 3,343.20	\$ 3,343.20
21147 00	Surgery	50.28	50.28	\$ 3,519.60	\$ 3,519.60
21150 00	Surgery	48.65	48.65	\$ 3,405.50	\$ 3,405.50
21151 00	Surgery	53.52	53.52	\$ 3,746.40	\$ 3,746.40
21154 00	Surgery	57.59	57.59	\$ 4,031.30	\$ 4,031.30
21155 00	Surgery	63.86	63.86	\$ 4,470.20	\$ 4,470.20
21159 00	Surgery	76.52	76.52	\$ 5,356.40	\$ 5,356.40
21160 00	Surgery	82.98	82.98	\$ 5,808.60	\$ 5,808.60
21172 00	Surgery	63.11	63.11	\$ 4,417.70	\$ 4,417.70
21175 00	Surgery	65.49	65.49	\$ 4,584.30	\$ 4,584.30
21179 00	Surgery	45.03	45.03	\$ 3,152.10	\$ 3,152.10
21180 00	Surgery	50.29	50.29	\$ 3,520.30	\$ 3,520.30
21181 00	Surgery	21.93	21.93	\$ 1,535.10	\$ 1,535.10
21182 00	Surgery	62.56	62.56	\$ 4,379.20	\$ 4,379.20
21183 00	Surgery	68.06	68.06	\$ 4,764.20	\$ 4,764.20
21184 00	Surgery	73.20	73.20	\$ 5,124.00	\$ 5,124.00
21188 00	Surgery	46.76	46.76	\$ 3,273.20	\$ 3,273.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
21193 00	Surgery	36.30	36.30	\$ 2,541.00	\$ 2,541.00
21194 00	Surgery	42.04	42.04	\$ 2,942.80	\$ 2,942.80
21195 00	Surgery	39.71	39.71	\$ 2,779.70	\$ 2,779.70
21196 00	Surgery	42.43	42.43	\$ 2,970.10	\$ 2,970.10
21198 00	Surgery	30.63	30.63	\$ 2,144.10	\$ 2,144.10
21199 00	Surgery	29.97	29.97	\$ 2,097.90	\$ 2,097.90
21206 00	Surgery	28.61	28.61	\$ 2,002.70	\$ 2,002.70
21208 00	Surgery	49.92	21.66	\$ 3,494.40	\$ 1,516.20
21209 00	Surgery	24.37	18.29	\$ 1,705.90	\$ 1,280.30
21210 00	Surgery	53.48	22.23	\$ 3,743.60	\$ 1,556.10
21215 00	Surgery	126.09	23.08	\$ 8,826.30	\$ 1,615.60
21230 00	Surgery	22.22	22.22	\$ 1,555.40	\$ 1,555.40
21235 00	Surgery	21.73	16.75	\$ 1,521.10	\$ 1,172.50
21240 00	Surgery	30.81	30.81	\$ 2,156.70	\$ 2,156.70
21242 00	Surgery	29.81	29.81	\$ 2,086.70	\$ 2,086.70
21243 00	Surgery	47.27	47.27	\$ 3,308.90	\$ 3,308.90
21244 00	Surgery	29.78	29.78	\$ 2,084.60	\$ 2,084.60
21245 00	Surgery	34.97	27.15	\$ 2,447.90	\$ 1,900.50
21246 00	Surgery	25.06	25.06	\$ 1,754.20	\$ 1,754.20
21247 00	Surgery	46.58	46.58	\$ 3,260.60	\$ 3,260.60
21248 00	Surgery	29.05	23.24	\$ 2,033.50	\$ 1,626.80
21249 00	Surgery	39.54	32.67	\$ 2,767.80	\$ 2,286.90
21255 00	Surgery	39.58	39.58	\$ 2,770.60	\$ 2,770.60
21256 00	Surgery	36.63	36.63	\$ 2,564.10	\$ 2,564.10
21260 00	Surgery	40.72	40.72	\$ 2,850.40	\$ 2,850.40
21261 00	Surgery	71.98	71.98	\$ 5,038.60	\$ 5,038.60
21263 00	Surgery	66.61	66.61	\$ 4,662.70	\$ 4,662.70
21267 00	Surgery	47.59	47.59	\$ 3,331.30	\$ 3,331.30
21268 00	Surgery	59.67	59.67	\$ 4,176.90	\$ 4,176.90
21270 00	Surgery	30.00	22.11	\$ 2,100.00	\$ 1,547.70
21275 00	Surgery	25.05	25.05	\$ 1,753.50	\$ 1,753.50
21280 00	Surgery	17.15	17.15	\$ 1,200.50	\$ 1,200.50
21282 00	Surgery	11.68	11.68	\$ 817.60	\$ 817.60
21295 00	Surgery	5.75	5.75	\$ 402.50	\$ 402.50
21296 00	Surgery	12.09	12.09	\$ 846.30	\$ 846.30
21299 00	Surgery	0.00	0.00	BR	BR
21315 00	Surgery	4.51	1.74	\$ 315.70	\$ 121.80
21320 00	Surgery	6.55	2.81	\$ 458.50	\$ 196.70
21325 00	Surgery	13.30	13.30	\$ 931.00	\$ 931.00
21330 00	Surgery	15.96	15.96	\$ 1,117.20	\$ 1,117.20
21335 00	Surgery	21.29	21.29	\$ 1,490.30	\$ 1,490.30
21336 00	Surgery	19.22	19.22	\$ 1,345.40	\$ 1,345.40
21337 00	Surgery	12.54	8.88	\$ 877.80	\$ 621.60
21338 00	Surgery	20.09	20.09	\$ 1,406.30	\$ 1,406.30
21339 00	Surgery	22.69	22.69	\$ 1,588.30	\$ 1,588.30
21340 00	Surgery	22.26	22.26	\$ 1,558.20	\$ 1,558.20
21343 00	Surgery	32.35	32.35	\$ 2,264.50	\$ 2,264.50
21344 00	Surgery	41.43	41.43	\$ 2,900.10	\$ 2,900.10
21345 00	Surgery	23.80	18.89	\$ 1,666.00	\$ 1,322.30
21346 00	Surgery	30.73	30.73	\$ 2,151.10	\$ 2,151.10
21347 00	Surgery	31.04	31.04	\$ 2,172.80	\$ 2,172.80
21348 00	Surgery	32.36	32.36	\$ 2,265.20	\$ 2,265.20
21355 00	Surgery	13.28	9.70	\$ 929.60	\$ 679.00
21356 00	Surgery	16.23	11.98	\$ 1,136.10	\$ 838.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
21360 00	Surgery	15.47	15.47	\$ 1,082.90	\$ 1,082.90
21365 00	Surgery	32.01	32.01	\$ 2,240.70	\$ 2,240.70
21366 00	Surgery	37.78	37.78	\$ 2,644.60	\$ 2,644.60
21385 00	Surgery	21.78	21.78	\$ 1,524.60	\$ 1,524.60
21386 00	Surgery	20.48	20.48	\$ 1,433.60	\$ 1,433.60
21387 00	Surgery	22.72	22.72	\$ 1,590.40	\$ 1,590.40
21390 00	Surgery	23.70	23.70	\$ 1,659.00	\$ 1,659.00
21395 00	Surgery	29.91	29.91	\$ 2,093.70	\$ 2,093.70
21400 00	Surgery	6.27	4.88	\$ 438.90	\$ 341.60
21401 00	Surgery	15.22	9.69	\$ 1,065.40	\$ 678.30
21406 00	Surgery	17.32	17.32	\$ 1,212.40	\$ 1,212.40
21407 00	Surgery	18.95	18.95	\$ 1,326.50	\$ 1,326.50
21408 00	Surgery	26.75	26.75	\$ 1,872.50	\$ 1,872.50
21421 00	Surgery	19.25	16.21	\$ 1,347.50	\$ 1,134.70
21422 00	Surgery	18.52	18.52	\$ 1,296.40	\$ 1,296.40
21423 00	Surgery	23.73	23.73	\$ 1,661.10	\$ 1,661.10
21431 00	Surgery	20.76	20.76	\$ 1,453.20	\$ 1,453.20
21432 00	Surgery	21.42	21.42	\$ 1,499.40	\$ 1,499.40
21433 00	Surgery	51.31	51.31	\$ 3,591.70	\$ 3,591.70
21435 00	Surgery	41.62	41.62	\$ 2,913.40	\$ 2,913.40
21436 00	Surgery	60.19	60.19	\$ 4,213.30	\$ 4,213.30
21440 00	Surgery	20.77	16.66	\$ 1,453.90	\$ 1,166.20
21445 00	Surgery	24.16	19.45	\$ 1,691.20	\$ 1,361.50
21450 00	Surgery	17.89	14.50	\$ 1,252.30	\$ 1,015.00
21451 00	Surgery	23.20	19.34	\$ 1,624.00	\$ 1,353.80
21452 00	Surgery	22.79	14.05	\$ 1,595.30	\$ 983.50
21453 00	Surgery	33.05	28.11	\$ 2,313.50	\$ 1,967.70
21454 00	Surgery	14.31	14.31	\$ 1,001.70	\$ 1,001.70
21461 00	Surgery	55.51	31.69	\$ 3,885.70	\$ 2,218.30
21462 00	Surgery	60.72	35.32	\$ 4,250.40	\$ 2,472.40
21465 00	Surgery	23.39	23.39	\$ 1,637.30	\$ 1,637.30
21470 00	Surgery	34.29	34.29	\$ 2,400.30	\$ 2,400.30
21480 00	Surgery	4.22	0.91	\$ 295.40	\$ 63.70
21485 00	Surgery	29.47	24.04	\$ 2,062.90	\$ 1,682.80
21490 00	Surgery	23.04	23.04	\$ 1,612.80	\$ 1,612.80
21497 00	Surgery	21.40	17.77	\$ 1,498.00	\$ 1,243.90
21499 00	Surgery	0.00	0.00	BR	BR
21501 00	Surgery	14.58	9.90	\$ 1,020.60	\$ 693.00
21502 00	Surgery	15.16	15.16	\$ 1,061.20	\$ 1,061.20
21510 00	Surgery	13.51	13.51	\$ 945.70	\$ 945.70
21550 00	Surgery	8.02	4.60	\$ 561.40	\$ 322.00
21552 00	Surgery	13.33	13.33	\$ 933.10	\$ 933.10
21554 00	Surgery	21.75	21.75	\$ 1,522.50	\$ 1,522.50
21555 00	Surgery	13.08	9.12	\$ 915.60	\$ 638.40
21556 00	Surgery	15.80	15.80	\$ 1,106.00	\$ 1,106.00
21557 00	Surgery	28.33	28.33	\$ 1,983.10	\$ 1,983.10
21558 00	Surgery	39.84	39.84	\$ 2,788.80	\$ 2,788.80
21600 00	Surgery	16.66	16.66	\$ 1,166.20	\$ 1,166.20
21601 00	Surgery	34.21	34.21	\$ 2,394.70	\$ 2,394.70
21602 00	Surgery	46.06	46.06	\$ 3,224.20	\$ 3,224.20
21603 00	Surgery	50.06	50.06	\$ 3,504.20	\$ 3,504.20
21610 00	Surgery	35.84	35.84	\$ 2,508.80	\$ 2,508.80
21615 00	Surgery	18.23	18.23	\$ 1,276.10	\$ 1,276.10
21616 00	Surgery	21.13	21.13	\$ 1,479.10	\$ 1,479.10

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
21620 00	Surgery	15.05	15.05	\$ 1,053.50	\$ 1,053.50
21627 00	Surgery	16.14	16.14	\$ 1,129.80	\$ 1,129.80
21630 00	Surgery	38.87	38.87	\$ 2,720.90	\$ 2,720.90
21632 00	Surgery	35.93	35.93	\$ 2,515.10	\$ 2,515.10
21685 00	Surgery	29.18	29.18	\$ 2,042.60	\$ 2,042.60
21700 00	Surgery	10.55	10.55	\$ 738.50	\$ 738.50
21705 00	Surgery	15.80	15.80	\$ 1,106.00	\$ 1,106.00
21720 00	Surgery	15.80	15.80	\$ 1,106.00	\$ 1,106.00
21725 00	Surgery	16.15	16.15	\$ 1,130.50	\$ 1,130.50
21740 00	Surgery	30.34	30.34	\$ 2,123.80	\$ 2,123.80
21742 00	Surgery	-	-	\$ 2,507.40	\$ 2,507.40
21743 00	Surgery	-	-	\$ 3,298.40	\$ 3,298.40
21750 00	Surgery	20.06	20.06	\$ 1,404.20	\$ 1,404.20
21811 00	Surgery	17.56	17.56	\$ 1,229.20	\$ 1,229.20
21812 00	Surgery	21.29	21.29	\$ 1,490.30	\$ 1,490.30
21813 00	Surgery	29.18	29.18	\$ 2,042.60	\$ 2,042.60
21820 00	Surgery	4.45	4.36	\$ 311.50	\$ 305.20
21825 00	Surgery	16.36	16.36	\$ 1,145.20	\$ 1,145.20
21899 00	Surgery	0.00	0.00	BR	BR
21920 00	Surgery	7.76	4.59	\$ 543.20	\$ 321.30
21925 00	Surgery	14.83	11.21	\$ 1,038.10	\$ 784.70
21930 00	Surgery	15.12	10.82	\$ 1,058.40	\$ 757.40
21931 00	Surgery	14.02	14.02	\$ 981.40	\$ 981.40
21932 00	Surgery	19.77	19.77	\$ 1,383.90	\$ 1,383.90
21933 00	Surgery	22.03	22.03	\$ 1,542.10	\$ 1,542.10
21935 00	Surgery	30.48	30.48	\$ 2,133.60	\$ 2,133.60
21936 00	Surgery	41.99	41.99	\$ 2,939.30	\$ 2,939.30
22010 00	Surgery	28.79	28.79	\$ 2,015.30	\$ 2,015.30
22015 00	Surgery	28.26	28.26	\$ 1,978.20	\$ 1,978.20
22100 00	Surgery	25.69	25.69	\$ 1,798.30	\$ 1,798.30
22101 00	Surgery	25.53	25.53	\$ 1,787.10	\$ 1,787.10
22102 00	Surgery	23.11	23.11	\$ 1,617.70	\$ 1,617.70
22103 00	Surgery	3.99	3.99	\$ 279.30	\$ 279.30
22110 00	Surgery	31.35	31.35	\$ 2,194.50	\$ 2,194.50
22112 00	Surgery	33.75	33.75	\$ 2,362.50	\$ 2,362.50
22114 00	Surgery	33.75	33.75	\$ 2,362.50	\$ 2,362.50
22116 00	Surgery	4.18	4.18	\$ 292.60	\$ 292.60
22206 00	Surgery	72.57	72.57	\$ 5,079.90	\$ 5,079.90
22207 00	Surgery	71.03	71.03	\$ 4,972.10	\$ 4,972.10
22208 00	Surgery	17.40	17.40	\$ 1,218.00	\$ 1,218.00
22210 00	Surgery	53.04	53.04	\$ 3,712.80	\$ 3,712.80
22212 00	Surgery	44.83	44.83	\$ 3,138.10	\$ 3,138.10
22214 00	Surgery	44.84	44.84	\$ 3,138.80	\$ 3,138.80
22216 00	Surgery	10.70	10.70	\$ 749.00	\$ 749.00
22220 00	Surgery	48.07	48.07	\$ 3,364.90	\$ 3,364.90
22222 00	Surgery	52.25	52.25	\$ 3,657.50	\$ 3,657.50
22224 00	Surgery	47.09	47.09	\$ 3,296.30	\$ 3,296.30
22226 00	Surgery	10.62	10.62	\$ 743.40	\$ 743.40
22310 00	Surgery	9.26	8.84	\$ 648.20	\$ 618.80
22315 00	Surgery	26.20	22.88	\$ 1,834.00	\$ 1,601.60
22318 00	Surgery	48.85	48.85	\$ 3,419.50	\$ 3,419.50
22319 00	Surgery	54.45	54.45	\$ 3,811.50	\$ 3,811.50
22325 00	Surgery	43.64	43.64	\$ 3,054.80	\$ 3,054.80
22326 00	Surgery	44.81	44.81	\$ 3,136.70	\$ 3,136.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
22327 00	Surgery	45.45	45.45	\$ 3,181.50	\$ 3,181.50
22328 00	Surgery	8.28	8.28	\$ 579.60	\$ 579.60
22505 00	Surgery	3.83	3.83	\$ 268.10	\$ 268.10
22510 00	Surgery	56.14	12.65	\$ 3,929.80	\$ 885.50
22511 00	Surgery	56.05	11.92	\$ 3,923.50	\$ 834.40
22512 00	Surgery	22.54	6.06	\$ 1,577.80	\$ 424.20
22513 00	Surgery	179.55	15.01	\$ 12,568.50	\$ 1,050.70
22514 00	Surgery	178.67	13.97	\$ 12,506.90	\$ 977.90
22515 00	Surgery	92.45	6.42	\$ 6,471.50	\$ 449.40
22526 00	Surgery	62.01	9.56	\$ 4,340.70	\$ 669.20
22527 00	Surgery	51.25	4.45	\$ 3,587.50	\$ 311.50
22532 00	Surgery	53.51	53.51	\$ 3,745.70	\$ 3,745.70
22533 00	Surgery	49.06	49.06	\$ 3,434.20	\$ 3,434.20
22534 00	Surgery	10.59	10.59	\$ 741.30	\$ 741.30
22548 00	Surgery	58.34	58.34	\$ 4,083.80	\$ 4,083.80
22551 00	Surgery	50.50	50.50	\$ 3,535.00	\$ 3,535.00
22552 00	Surgery	11.69	11.69	\$ 818.30	\$ 818.30
22554 00	Surgery	37.38	37.38	\$ 2,616.60	\$ 2,616.60
22556 00	Surgery	49.41	49.41	\$ 3,458.70	\$ 3,458.70
22558 00	Surgery	45.34	45.34	\$ 3,173.80	\$ 3,173.80
22585 00	Surgery	9.60	9.60	\$ 672.00	\$ 672.00
22586 00	Surgery	60.36	60.36	\$ 4,225.20	\$ 4,225.20
22590 00	Surgery	47.11	47.11	\$ 3,297.70	\$ 3,297.70
22595 00	Surgery	45.03	45.03	\$ 3,152.10	\$ 3,152.10
22600 00	Surgery	38.60	38.60	\$ 2,702.00	\$ 2,702.00
22610 00	Surgery	37.93	37.93	\$ 2,655.10	\$ 2,655.10
22612 00	Surgery	47.06	47.06	\$ 3,294.20	\$ 3,294.20
22614 00	Surgery	11.53	11.53	\$ 807.10	\$ 807.10
22630 00	Surgery	46.96	46.96	\$ 3,287.20	\$ 3,287.20
22632 00	Surgery	9.46	9.46	\$ 662.20	\$ 662.20
22633 00	Surgery	54.89	54.89	\$ 3,842.30	\$ 3,842.30
22634 00	Surgery	14.64	14.64	\$ 1,024.80	\$ 1,024.80
22800 00	Surgery	40.29	40.29	\$ 2,820.30	\$ 2,820.30
22802 00	Surgery	62.72	62.72	\$ 4,390.40	\$ 4,390.40
22804 00	Surgery	71.95	71.95	\$ 5,036.50	\$ 5,036.50
22808 00	Surgery	54.17	54.17	\$ 3,791.90	\$ 3,791.90
22810 00	Surgery	59.44	59.44	\$ 4,160.80	\$ 4,160.80
22812 00	Surgery	65.12	65.12	\$ 4,558.40	\$ 4,558.40
22818 00	Surgery	63.62	63.62	\$ 4,453.40	\$ 4,453.40
22819 00	Surgery	73.23	73.23	\$ 5,126.10	\$ 5,126.10
22830 00	Surgery	24.43	24.43	\$ 1,710.10	\$ 1,710.10
22840 00	Surgery	22.38	22.38	\$ 1,566.60	\$ 1,566.60
22841 00	Surgery	-	-	\$ 807.80	\$ 807.80
22842 00	Surgery	22.50	22.50	\$ 1,575.00	\$ 1,575.00
22843 00	Surgery	24.06	24.06	\$ 1,684.20	\$ 1,684.20
22844 00	Surgery	29.02	29.02	\$ 2,031.40	\$ 2,031.40
22845 00	Surgery	21.46	21.46	\$ 1,502.20	\$ 1,502.20
22846 00	Surgery	22.31	22.31	\$ 1,561.70	\$ 1,561.70
22847 00	Surgery	23.61	23.61	\$ 1,652.70	\$ 1,652.70
22848 00	Surgery	10.60	10.60	\$ 742.00	\$ 742.00
22849 00	Surgery	38.79	38.79	\$ 2,715.30	\$ 2,715.30
22850 00	Surgery	21.91	21.91	\$ 1,533.70	\$ 1,533.70
22852 00	Surgery	21.04	21.04	\$ 1,472.80	\$ 1,472.80
22853 00	Surgery	7.61	7.61	\$ 532.70	\$ 532.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
22854 00	Surgery	9.88	9.88	\$ 691.60	\$ 691.60
22855 00	Surgery	32.91	32.91	\$ 2,303.70	\$ 2,303.70
22856 00	Surgery	48.36	48.36	\$ 3,385.20	\$ 3,385.20
22857 00	Surgery	52.27	52.27	\$ 3,658.90	\$ 3,658.90
22858 00	Surgery	14.93	14.93	\$ 1,045.10	\$ 1,045.10
22859 00	Surgery	9.82	9.82	\$ 687.40	\$ 687.40
22861 00	Surgery	68.78	68.78	\$ 4,814.60	\$ 4,814.60
22862 00	Surgery	68.75	68.75	\$ 4,812.50	\$ 4,812.50
22864 00	Surgery	61.42	61.42	\$ 4,299.40	\$ 4,299.40
22865 00	Surgery	67.12	67.12	\$ 4,698.40	\$ 4,698.40
22867 00	Surgery	31.90	31.90	\$ 2,233.00	\$ 2,233.00
22868 00	Surgery	7.18	7.18	\$ 502.60	\$ 502.60
22869 00	Surgery	12.82	12.82	\$ 897.40	\$ 897.40
22870 00	Surgery	3.50	3.50	\$ 245.00	\$ 245.00
22899 00	Surgery	0.00	0.00	BR	BR
22900 00	Surgery	16.86	16.86	\$ 1,180.20	\$ 1,180.20
22901 00	Surgery	19.94	19.94	\$ 1,395.80	\$ 1,395.80
22902 00	Surgery	14.27	9.95	\$ 998.90	\$ 696.50
22903 00	Surgery	13.15	13.15	\$ 920.50	\$ 920.50
22904 00	Surgery	31.37	31.37	\$ 2,195.90	\$ 2,195.90
22905 00	Surgery	39.45	39.45	\$ 2,761.50	\$ 2,761.50
22999 00	Surgery	0.00	0.00	BR	BR
23000 00	Surgery	17.31	11.00	\$ 1,211.70	\$ 770.00
23020 00	Surgery	20.55	20.55	\$ 1,438.50	\$ 1,438.50
23030 00	Surgery	13.32	7.59	\$ 932.40	\$ 531.30
23031 00	Surgery	12.80	6.51	\$ 896.00	\$ 455.70
23035 00	Surgery	20.35	20.35	\$ 1,424.50	\$ 1,424.50
23040 00	Surgery	21.43	21.43	\$ 1,500.10	\$ 1,500.10
23044 00	Surgery	16.90	16.90	\$ 1,183.00	\$ 1,183.00
23065 00	Surgery	6.77	4.74	\$ 473.90	\$ 331.80
23066 00	Surgery	16.94	10.85	\$ 1,185.80	\$ 759.50
23071 00	Surgery	12.54	12.54	\$ 877.80	\$ 877.80
23073 00	Surgery	20.75	20.75	\$ 1,452.50	\$ 1,452.50
23075 00	Surgery	15.69	9.81	\$ 1,098.30	\$ 686.70
23076 00	Surgery	16.20	16.20	\$ 1,134.00	\$ 1,134.00
23077 00	Surgery	33.61	33.61	\$ 2,352.70	\$ 2,352.70
23078 00	Surgery	42.46	42.46	\$ 2,972.20	\$ 2,972.20
23100 00	Surgery	15.12	15.12	\$ 1,058.40	\$ 1,058.40
23101 00	Surgery	13.66	13.66	\$ 956.20	\$ 956.20
23105 00	Surgery	19.08	19.08	\$ 1,335.60	\$ 1,335.60
23106 00	Surgery	15.01	15.01	\$ 1,050.70	\$ 1,050.70
23107 00	Surgery	19.69	19.69	\$ 1,378.30	\$ 1,378.30
23120 00	Surgery	17.51	17.51	\$ 1,225.70	\$ 1,225.70
23125 00	Surgery	21.16	21.16	\$ 1,481.20	\$ 1,481.20
23130 00	Surgery	18.48	18.48	\$ 1,293.60	\$ 1,293.60
23140 00	Surgery	16.58	16.58	\$ 1,160.60	\$ 1,160.60
23145 00	Surgery	20.76	20.76	\$ 1,453.20	\$ 1,453.20
23146 00	Surgery	18.60	18.60	\$ 1,302.00	\$ 1,302.00
23150 00	Surgery	19.74	19.74	\$ 1,381.80	\$ 1,381.80
23155 00	Surgery	23.76	23.76	\$ 1,663.20	\$ 1,663.20
23156 00	Surgery	20.24	20.24	\$ 1,416.80	\$ 1,416.80
23170 00	Surgery	16.85	16.85	\$ 1,179.50	\$ 1,179.50
23172 00	Surgery	17.02	17.02	\$ 1,191.40	\$ 1,191.40
23174 00	Surgery	22.76	22.76	\$ 1,593.20	\$ 1,593.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
23180 00	Surgery	19.85	19.85	\$ 1,389.50	\$ 1,389.50
23182 00	Surgery	20.04	20.04	\$ 1,402.80	\$ 1,402.80
23184 00	Surgery	22.01	22.01	\$ 1,540.70	\$ 1,540.70
23190 00	Surgery	17.17	17.17	\$ 1,201.90	\$ 1,201.90
23195 00	Surgery	22.10	22.10	\$ 1,547.00	\$ 1,547.00
23200 00	Surgery	44.54	44.54	\$ 3,117.80	\$ 3,117.80
23210 00	Surgery	52.25	52.25	\$ 3,657.50	\$ 3,657.50
23220 00	Surgery	57.35	57.35	\$ 4,014.50	\$ 4,014.50
23330 00	Surgery	9.07	4.95	\$ 634.90	\$ 346.50
23333 00	Surgery	14.09	14.09	\$ 986.30	\$ 986.30
23334 00	Surgery	31.47	31.47	\$ 2,202.90	\$ 2,202.90
23335 00	Surgery	37.53	37.53	\$ 2,627.10	\$ 2,627.10
23350 00	Surgery	5.07	1.46	\$ 354.90	\$ 102.20
23395 00	Surgery	37.90	37.90	\$ 2,653.00	\$ 2,653.00
23397 00	Surgery	33.74	33.74	\$ 2,361.80	\$ 2,361.80
23400 00	Surgery	28.91	28.91	\$ 2,023.70	\$ 2,023.70
23405 00	Surgery	18.44	18.44	\$ 1,290.80	\$ 1,290.80
23406 00	Surgery	22.13	22.13	\$ 1,549.10	\$ 1,549.10
23410 00	Surgery	24.38	24.38	\$ 1,706.60	\$ 1,706.60
23412 00	Surgery	25.33	25.33	\$ 1,773.10	\$ 1,773.10
23415 00	Surgery	20.82	20.82	\$ 1,457.40	\$ 1,457.40
23420 00	Surgery	28.95	28.95	\$ 2,026.50	\$ 2,026.50
23430 00	Surgery	22.16	22.16	\$ 1,551.20	\$ 1,551.20
23440 00	Surgery	22.52	22.52	\$ 1,576.40	\$ 1,576.40
23450 00	Surgery	28.13	28.13	\$ 1,969.10	\$ 1,969.10
23455 00	Surgery	29.49	29.49	\$ 2,064.30	\$ 2,064.30
23460 00	Surgery	32.39	32.39	\$ 2,267.30	\$ 2,267.30
23462 00	Surgery	31.69	31.69	\$ 2,218.30	\$ 2,218.30
23465 00	Surgery	33.23	33.23	\$ 2,326.10	\$ 2,326.10
23466 00	Surgery	33.25	33.25	\$ 2,327.50	\$ 2,327.50
23470 00	Surgery	35.55	35.55	\$ 2,488.50	\$ 2,488.50
23472 00	Surgery	42.83	42.83	\$ 2,998.10	\$ 2,998.10
23473 00	Surgery	47.72	47.72	\$ 3,340.40	\$ 3,340.40
23474 00	Surgery	51.49	51.49	\$ 3,604.30	\$ 3,604.30
23480 00	Surgery	24.41	24.41	\$ 1,708.70	\$ 1,708.70
23485 00	Surgery	28.24	28.24	\$ 1,976.80	\$ 1,976.80
23490 00	Surgery	25.60	25.60	\$ 1,792.00	\$ 1,792.00
23491 00	Surgery	30.19	30.19	\$ 2,113.30	\$ 2,113.30
23500 00	Surgery	6.69	6.83	\$ 468.30	\$ 478.10
23505 00	Surgery	10.83	10.06	\$ 758.10	\$ 704.20
23515 00	Surgery	21.43	21.43	\$ 1,500.10	\$ 1,500.10
23520 00	Surgery	7.25	7.15	\$ 507.50	\$ 500.50
23525 00	Surgery	11.91	10.90	\$ 833.70	\$ 763.00
23530 00	Surgery	17.20	17.20	\$ 1,204.00	\$ 1,204.00
23532 00	Surgery	18.69	18.69	\$ 1,308.30	\$ 1,308.30
23540 00	Surgery	7.19	7.08	\$ 503.30	\$ 495.60
23545 00	Surgery	10.58	9.50	\$ 740.60	\$ 665.00
23550 00	Surgery	17.07	17.07	\$ 1,194.90	\$ 1,194.90
23552 00	Surgery	19.50	19.50	\$ 1,365.00	\$ 1,365.00
23570 00	Surgery	7.07	7.28	\$ 494.90	\$ 509.60
23575 00	Surgery	12.36	11.42	\$ 865.20	\$ 799.40
23585 00	Surgery	29.07	29.07	\$ 2,034.90	\$ 2,034.90
23600 00	Surgery	10.04	9.51	\$ 702.80	\$ 665.70
23605 00	Surgery	14.12	12.82	\$ 988.40	\$ 897.40

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
23615 00	Surgery	26.26	26.26	\$ 1,838.20	\$ 1,838.20
23616 00	Surgery	36.60	36.60	\$ 2,562.00	\$ 2,562.00
23620 00	Surgery	8.16	7.84	\$ 571.20	\$ 548.80
23625 00	Surgery	11.57	10.59	\$ 809.90	\$ 741.30
23630 00	Surgery	23.16	23.16	\$ 1,621.20	\$ 1,621.20
23650 00	Surgery	9.84	8.89	\$ 688.80	\$ 622.30
23655 00	Surgery	12.27	12.27	\$ 858.90	\$ 858.90
23660 00	Surgery	17.43	17.43	\$ 1,220.10	\$ 1,220.10
23665 00	Surgery	13.04	12.01	\$ 912.80	\$ 840.70
23670 00	Surgery	25.82	25.82	\$ 1,807.40	\$ 1,807.40
23675 00	Surgery	16.55	15.00	\$ 1,158.50	\$ 1,050.00
23680 00	Surgery	27.55	27.55	\$ 1,928.50	\$ 1,928.50
23700 00	Surgery	5.83	5.83	\$ 408.10	\$ 408.10
23800 00	Surgery	30.50	30.50	\$ 2,135.00	\$ 2,135.00
23802 00	Surgery	38.02	38.02	\$ 2,661.40	\$ 2,661.40
23900 00	Surgery	41.03	41.03	\$ 2,872.10	\$ 2,872.10
23920 00	Surgery	33.30	33.30	\$ 2,331.00	\$ 2,331.00
23921 00	Surgery	14.05	14.05	\$ 983.50	\$ 983.50
23929 00	Surgery	0.00	0.00	BR	BR
23930 00	Surgery	10.91	6.40	\$ 763.70	\$ 448.00
23931 00	Surgery	9.16	4.76	\$ 641.20	\$ 333.20
23935 00	Surgery	15.21	15.21	\$ 1,064.70	\$ 1,064.70
24000 00	Surgery	14.13	14.13	\$ 989.10	\$ 989.10
24006 00	Surgery	21.21	21.21	\$ 1,484.70	\$ 1,484.70
24065 00	Surgery	7.84	4.84	\$ 548.80	\$ 338.80
24066 00	Surgery	18.64	12.49	\$ 1,304.80	\$ 874.30
24071 00	Surgery	12.11	12.11	\$ 847.70	\$ 847.70
24073 00	Surgery	20.63	20.63	\$ 1,444.10	\$ 1,444.10
24075 00	Surgery	16.19	9.83	\$ 1,133.30	\$ 688.10
24076 00	Surgery	16.25	16.25	\$ 1,137.50	\$ 1,137.50
24077 00	Surgery	30.68	30.68	\$ 2,147.60	\$ 2,147.60
24079 00	Surgery	39.29	39.29	\$ 2,750.30	\$ 2,750.30
24100 00	Surgery	12.55	12.55	\$ 878.50	\$ 878.50
24101 00	Surgery	15.05	15.05	\$ 1,053.50	\$ 1,053.50
24102 00	Surgery	18.46	18.46	\$ 1,292.20	\$ 1,292.20
24105 00	Surgery	10.75	10.75	\$ 752.50	\$ 752.50
24110 00	Surgery	17.62	17.62	\$ 1,233.40	\$ 1,233.40
24115 00	Surgery	21.97	21.97	\$ 1,537.90	\$ 1,537.90
24116 00	Surgery	25.59	25.59	\$ 1,791.30	\$ 1,791.30
24120 00	Surgery	15.91	15.91	\$ 1,113.70	\$ 1,113.70
24125 00	Surgery	18.60	18.60	\$ 1,302.00	\$ 1,302.00
24126 00	Surgery	19.42	19.42	\$ 1,359.40	\$ 1,359.40
24130 00	Surgery	15.22	15.22	\$ 1,065.40	\$ 1,065.40
24134 00	Surgery	22.27	22.27	\$ 1,558.90	\$ 1,558.90
24136 00	Surgery	18.88	18.88	\$ 1,321.60	\$ 1,321.60
24138 00	Surgery	20.51	20.51	\$ 1,435.70	\$ 1,435.70
24140 00	Surgery	20.96	20.96	\$ 1,467.20	\$ 1,467.20
24145 00	Surgery	17.76	17.76	\$ 1,243.20	\$ 1,243.20
24147 00	Surgery	18.76	18.76	\$ 1,313.20	\$ 1,313.20
24149 00	Surgery	34.93	34.93	\$ 2,445.10	\$ 2,445.10
24150 00	Surgery	45.73	45.73	\$ 3,201.10	\$ 3,201.10
24152 00	Surgery	39.77	39.77	\$ 2,783.90	\$ 2,783.90
24155 00	Surgery	25.35	25.35	\$ 1,774.50	\$ 1,774.50
24160 00	Surgery	37.07	37.07	\$ 2,594.90	\$ 2,594.90

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
24164 00	Surgery	21.57	21.57	\$ 1,509.90	\$ 1,509.90
24200 00	Surgery	6.59	4.20	\$ 461.30	\$ 294.00
24201 00	Surgery	16.48	10.92	\$ 1,153.60	\$ 764.40
24220 00	Surgery	5.83	1.94	\$ 408.10	\$ 135.80
24300 00	Surgery	13.02	13.02	\$ 911.40	\$ 911.40
24301 00	Surgery	22.34	22.34	\$ 1,563.80	\$ 1,563.80
24305 00	Surgery	17.27	17.27	\$ 1,208.90	\$ 1,208.90
24310 00	Surgery	14.22	14.22	\$ 995.40	\$ 995.40
24320 00	Surgery	23.23	23.23	\$ 1,626.10	\$ 1,626.10
24330 00	Surgery	21.40	21.40	\$ 1,498.00	\$ 1,498.00
24331 00	Surgery	23.39	23.39	\$ 1,637.30	\$ 1,637.30
24332 00	Surgery	18.37	18.37	\$ 1,285.90	\$ 1,285.90
24340 00	Surgery	18.45	18.45	\$ 1,291.50	\$ 1,291.50
24341 00	Surgery	22.15	22.15	\$ 1,550.50	\$ 1,550.50
24342 00	Surgery	23.07	23.07	\$ 1,614.90	\$ 1,614.90
24343 00	Surgery	21.27	21.27	\$ 1,488.90	\$ 1,488.90
24344 00	Surgery	32.49	32.49	\$ 2,274.30	\$ 2,274.30
24345 00	Surgery	21.17	21.17	\$ 1,481.90	\$ 1,481.90
24346 00	Surgery	32.79	32.79	\$ 2,295.30	\$ 2,295.30
24357 00	Surgery	12.50	12.50	\$ 875.00	\$ 875.00
24358 00	Surgery	15.79	15.79	\$ 1,105.30	\$ 1,105.30
24359 00	Surgery	19.73	19.73	\$ 1,381.10	\$ 1,381.10
24360 00	Surgery	26.87	26.87	\$ 1,880.90	\$ 1,880.90
24361 00	Surgery	29.96	29.96	\$ 2,097.20	\$ 2,097.20
24362 00	Surgery	31.52	31.52	\$ 2,206.40	\$ 2,206.40
24363 00	Surgery	42.82	42.82	\$ 2,997.40	\$ 2,997.40
24365 00	Surgery	19.14	19.14	\$ 1,339.80	\$ 1,339.80
24366 00	Surgery	20.30	20.30	\$ 1,421.00	\$ 1,421.00
24370 00	Surgery	45.50	45.50	\$ 3,185.00	\$ 3,185.00
24371 00	Surgery	52.27	52.27	\$ 3,658.90	\$ 3,658.90
24400 00	Surgery	24.56	24.56	\$ 1,719.20	\$ 1,719.20
24410 00	Surgery	31.43	31.43	\$ 2,200.10	\$ 2,200.10
24420 00	Surgery	31.84	31.84	\$ 2,228.80	\$ 2,228.80
24430 00	Surgery	31.30	31.30	\$ 2,191.00	\$ 2,191.00
24435 00	Surgery	32.06	32.06	\$ 2,244.20	\$ 2,244.20
24470 00	Surgery	20.06	20.06	\$ 1,404.20	\$ 1,404.20
24495 00	Surgery	24.23	24.23	\$ 1,696.10	\$ 1,696.10
24498 00	Surgery	25.77	25.77	\$ 1,803.90	\$ 1,803.90
24500 00	Surgery	10.89	10.05	\$ 762.30	\$ 703.50
24505 00	Surgery	15.14	13.59	\$ 1,059.80	\$ 951.30
24515 00	Surgery	26.21	26.21	\$ 1,834.70	\$ 1,834.70
24516 00	Surgery	25.55	25.55	\$ 1,788.50	\$ 1,788.50
24530 00	Surgery	11.50	10.56	\$ 805.00	\$ 739.20
24535 00	Surgery	18.54	17.03	\$ 1,297.80	\$ 1,192.10
24538 00	Surgery	23.64	23.64	\$ 1,654.80	\$ 1,654.80
24545 00	Surgery	27.58	27.58	\$ 1,930.60	\$ 1,930.60
24546 00	Surgery	30.77	30.77	\$ 2,153.90	\$ 2,153.90
24560 00	Surgery	10.03	8.88	\$ 702.10	\$ 621.60
24565 00	Surgery	16.25	14.83	\$ 1,137.50	\$ 1,038.10
24566 00	Surgery	21.48	21.48	\$ 1,503.60	\$ 1,503.60
24575 00	Surgery	21.80	21.80	\$ 1,526.00	\$ 1,526.00
24576 00	Surgery	10.58	9.43	\$ 740.60	\$ 660.10
24577 00	Surgery	16.71	15.24	\$ 1,169.70	\$ 1,066.80
24579 00	Surgery	24.78	24.78	\$ 1,734.60	\$ 1,734.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
24582 00	Surgery	24.32	24.32	\$ 1,702.40	\$ 1,702.40
24586 00	Surgery	32.25	32.25	\$ 2,257.50	\$ 2,257.50
24587 00	Surgery	32.33	32.33	\$ 2,263.10	\$ 2,263.10
24600 00	Surgery	11.27	10.20	\$ 788.90	\$ 714.00
24605 00	Surgery	14.33	14.33	\$ 1,003.10	\$ 1,003.10
24615 00	Surgery	21.25	21.25	\$ 1,487.50	\$ 1,487.50
24620 00	Surgery	16.87	16.87	\$ 1,180.90	\$ 1,180.90
24635 00	Surgery	20.10	20.10	\$ 1,407.00	\$ 1,407.00
24640 00	Surgery	3.11	2.38	\$ 217.70	\$ 166.60
24650 00	Surgery	7.93	7.37	\$ 555.10	\$ 515.90
24655 00	Surgery	13.45	12.13	\$ 941.50	\$ 849.10
24665 00	Surgery	19.61	19.61	\$ 1,372.70	\$ 1,372.70
24666 00	Surgery	21.79	21.79	\$ 1,525.30	\$ 1,525.30
24670 00	Surgery	8.82	8.07	\$ 617.40	\$ 564.90
24675 00	Surgery	13.97	12.65	\$ 977.90	\$ 885.50
24685 00	Surgery	19.48	19.48	\$ 1,363.60	\$ 1,363.60
24800 00	Surgery	24.81	24.81	\$ 1,736.70	\$ 1,736.70
24802 00	Surgery	29.81	29.81	\$ 2,086.70	\$ 2,086.70
24900 00	Surgery	21.98	21.98	\$ 1,538.60	\$ 1,538.60
24920 00	Surgery	21.83	21.83	\$ 1,528.10	\$ 1,528.10
24925 00	Surgery	16.99	16.99	\$ 1,189.30	\$ 1,189.30
24930 00	Surgery	23.04	23.04	\$ 1,612.80	\$ 1,612.80
24931 00	Surgery	27.67	27.67	\$ 1,936.90	\$ 1,936.90
24935 00	Surgery	36.49	36.49	\$ 2,554.30	\$ 2,554.30
24940 00	Surgery	-	-	\$ 2,253.30	\$ 2,253.30
24999 00	Surgery	0.00	0.00	BR	BR
25000 00	Surgery	10.30	10.30	\$ 721.00	\$ 721.00
25001 00	Surgery	10.34	10.34	\$ 723.80	\$ 723.80
25020 00	Surgery	22.53	22.53	\$ 1,577.10	\$ 1,577.10
25023 00	Surgery	39.66	39.66	\$ 2,776.20	\$ 2,776.20
25024 00	Surgery	23.28	23.28	\$ 1,629.60	\$ 1,629.60
25025 00	Surgery	34.99	34.99	\$ 2,449.30	\$ 2,449.30
25028 00	Surgery	21.15	21.15	\$ 1,480.50	\$ 1,480.50
25031 00	Surgery	11.03	11.03	\$ 772.10	\$ 772.10
25035 00	Surgery	17.47	17.47	\$ 1,222.90	\$ 1,222.90
25040 00	Surgery	16.67	16.67	\$ 1,166.90	\$ 1,166.90
25065 00	Surgery	7.72	4.68	\$ 540.40	\$ 327.60
25066 00	Surgery	10.92	10.92	\$ 764.40	\$ 764.40
25071 00	Surgery	12.64	12.64	\$ 884.80	\$ 884.80
25073 00	Surgery	15.93	15.93	\$ 1,115.10	\$ 1,115.10
25075 00	Surgery	15.76	9.40	\$ 1,103.20	\$ 658.00
25076 00	Surgery	15.40	15.40	\$ 1,078.00	\$ 1,078.00
25077 00	Surgery	26.49	26.49	\$ 1,854.30	\$ 1,854.30
25078 00	Surgery	34.51	34.51	\$ 2,415.70	\$ 2,415.70
25085 00	Surgery	13.38	13.38	\$ 936.60	\$ 936.60
25100 00	Surgery	10.49	10.49	\$ 734.30	\$ 734.30
25101 00	Surgery	12.11	12.11	\$ 847.70	\$ 847.70
25105 00	Surgery	14.52	14.52	\$ 1,016.40	\$ 1,016.40
25107 00	Surgery	18.37	18.37	\$ 1,285.90	\$ 1,285.90
25109 00	Surgery	15.96	15.96	\$ 1,117.20	\$ 1,117.20
25110 00	Surgery	10.37	10.37	\$ 725.90	\$ 725.90
25111 00	Surgery	9.68	9.68	\$ 677.60	\$ 677.60
25112 00	Surgery	11.65	11.65	\$ 815.50	\$ 815.50
25115 00	Surgery	22.44	22.44	\$ 1,570.80	\$ 1,570.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
25116 00	Surgery	17.95	17.95	\$ 1,256.50	\$ 1,256.50
25118 00	Surgery	11.43	11.43	\$ 800.10	\$ 800.10
25119 00	Surgery	15.02	15.02	\$ 1,051.40	\$ 1,051.40
25120 00	Surgery	14.97	14.97	\$ 1,047.90	\$ 1,047.90
25125 00	Surgery	17.78	17.78	\$ 1,244.60	\$ 1,244.60
25126 00	Surgery	17.91	17.91	\$ 1,253.70	\$ 1,253.70
25130 00	Surgery	13.47	13.47	\$ 942.90	\$ 942.90
25135 00	Surgery	16.75	16.75	\$ 1,172.50	\$ 1,172.50
25136 00	Surgery	14.90	14.90	\$ 1,043.00	\$ 1,043.00
25145 00	Surgery	15.58	15.58	\$ 1,090.60	\$ 1,090.60
25150 00	Surgery	16.94	16.94	\$ 1,185.80	\$ 1,185.80
25151 00	Surgery	17.43	17.43	\$ 1,220.10	\$ 1,220.10
25170 00	Surgery	43.49	43.49	\$ 3,044.30	\$ 3,044.30
25210 00	Surgery	14.68	14.68	\$ 1,027.60	\$ 1,027.60
25215 00	Surgery	18.43	18.43	\$ 1,290.10	\$ 1,290.10
25230 00	Surgery	12.92	12.92	\$ 904.40	\$ 904.40
25240 00	Surgery	12.82	12.82	\$ 897.40	\$ 897.40
25246 00	Surgery	6.01	2.13	\$ 420.70	\$ 149.10
25248 00	Surgery	12.55	12.55	\$ 878.50	\$ 878.50
25250 00	Surgery	15.97	15.97	\$ 1,117.90	\$ 1,117.90
25251 00	Surgery	21.44	21.44	\$ 1,500.80	\$ 1,500.80
25259 00	Surgery	12.87	12.87	\$ 900.90	\$ 900.90
25260 00	Surgery	18.91	18.91	\$ 1,323.70	\$ 1,323.70
25263 00	Surgery	18.94	18.94	\$ 1,325.80	\$ 1,325.80
25265 00	Surgery	22.34	22.34	\$ 1,563.80	\$ 1,563.80
25270 00	Surgery	14.74	14.74	\$ 1,031.80	\$ 1,031.80
25272 00	Surgery	16.73	16.73	\$ 1,171.10	\$ 1,171.10
25274 00	Surgery	19.79	19.79	\$ 1,385.30	\$ 1,385.30
25275 00	Surgery	20.01	20.01	\$ 1,400.70	\$ 1,400.70
25280 00	Surgery	16.89	16.89	\$ 1,182.30	\$ 1,182.30
25290 00	Surgery	13.02	13.02	\$ 911.40	\$ 911.40
25295 00	Surgery	15.72	15.72	\$ 1,100.40	\$ 1,100.40
25300 00	Surgery	20.59	20.59	\$ 1,441.30	\$ 1,441.30
25301 00	Surgery	19.14	19.14	\$ 1,339.80	\$ 1,339.80
25310 00	Surgery	18.47	18.47	\$ 1,292.90	\$ 1,292.90
25312 00	Surgery	21.29	21.29	\$ 1,490.30	\$ 1,490.30
25315 00	Surgery	22.93	22.93	\$ 1,605.10	\$ 1,605.10
25316 00	Surgery	27.27	27.27	\$ 1,908.90	\$ 1,908.90
25320 00	Surgery	29.21	29.21	\$ 2,044.70	\$ 2,044.70
25332 00	Surgery	25.10	25.10	\$ 1,757.00	\$ 1,757.00
25335 00	Surgery	28.12	28.12	\$ 1,968.40	\$ 1,968.40
25337 00	Surgery	26.29	26.29	\$ 1,840.30	\$ 1,840.30
25350 00	Surgery	20.08	20.08	\$ 1,405.60	\$ 1,405.60
25355 00	Surgery	22.80	22.80	\$ 1,596.00	\$ 1,596.00
25360 00	Surgery	19.53	19.53	\$ 1,367.10	\$ 1,367.10
25365 00	Surgery	27.30	27.30	\$ 1,911.00	\$ 1,911.00
25370 00	Surgery	30.11	30.11	\$ 2,107.70	\$ 2,107.70
25375 00	Surgery	28.39	28.39	\$ 1,987.30	\$ 1,987.30
25390 00	Surgery	22.86	22.86	\$ 1,600.20	\$ 1,600.20
25391 00	Surgery	29.63	29.63	\$ 2,074.10	\$ 2,074.10
25392 00	Surgery	30.14	30.14	\$ 2,109.80	\$ 2,109.80
25393 00	Surgery	33.54	33.54	\$ 2,347.80	\$ 2,347.80
25394 00	Surgery	23.36	23.36	\$ 1,635.20	\$ 1,635.20
25400 00	Surgery	23.86	23.86	\$ 1,670.20	\$ 1,670.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
25405 00	Surgery	30.81	30.81	\$ 2,156.70	\$ 2,156.70
25415 00	Surgery	28.81	28.81	\$ 2,016.70	\$ 2,016.70
25420 00	Surgery	34.63	34.63	\$ 2,424.10	\$ 2,424.10
25425 00	Surgery	28.69	28.69	\$ 2,008.30	\$ 2,008.30
25426 00	Surgery	33.35	33.35	\$ 2,334.50	\$ 2,334.50
25430 00	Surgery	21.80	21.80	\$ 1,526.00	\$ 1,526.00
25431 00	Surgery	23.45	23.45	\$ 1,641.50	\$ 1,641.50
25440 00	Surgery	22.82	22.82	\$ 1,597.40	\$ 1,597.40
25441 00	Surgery	27.91	27.91	\$ 1,953.70	\$ 1,953.70
25442 00	Surgery	24.07	24.07	\$ 1,684.90	\$ 1,684.90
25443 00	Surgery	23.39	23.39	\$ 1,637.30	\$ 1,637.30
25444 00	Surgery	24.64	24.64	\$ 1,724.80	\$ 1,724.80
25445 00	Surgery	21.39	21.39	\$ 1,497.30	\$ 1,497.30
25446 00	Surgery	34.68	34.68	\$ 2,427.60	\$ 2,427.60
25447 00	Surgery	24.68	24.68	\$ 1,727.60	\$ 1,727.60
25449 00	Surgery	30.66	30.66	\$ 2,146.20	\$ 2,146.20
25450 00	Surgery	18.45	18.45	\$ 1,291.50	\$ 1,291.50
25455 00	Surgery	21.80	21.80	\$ 1,526.00	\$ 1,526.00
25490 00	Surgery	21.43	21.43	\$ 1,500.10	\$ 1,500.10
25491 00	Surgery	22.03	22.03	\$ 1,542.10	\$ 1,542.10
25492 00	Surgery	26.99	26.99	\$ 1,889.30	\$ 1,889.30
25500 00	Surgery	8.57	7.74	\$ 599.90	\$ 541.80
25505 00	Surgery	15.18	13.77	\$ 1,062.60	\$ 963.90
25515 00	Surgery	19.95	19.95	\$ 1,396.50	\$ 1,396.50
25520 00	Surgery	17.33	16.33	\$ 1,213.10	\$ 1,143.10
25525 00	Surgery	23.45	23.45	\$ 1,641.50	\$ 1,641.50
25526 00	Surgery	28.44	28.44	\$ 1,990.80	\$ 1,990.80
25530 00	Surgery	7.93	7.28	\$ 555.10	\$ 509.60
25535 00	Surgery	14.90	13.73	\$ 1,043.00	\$ 961.10
25545 00	Surgery	18.62	18.62	\$ 1,303.40	\$ 1,303.40
25560 00	Surgery	8.74	7.79	\$ 611.80	\$ 545.30
25565 00	Surgery	15.62	13.99	\$ 1,093.40	\$ 979.30
25574 00	Surgery	20.10	20.10	\$ 1,407.00	\$ 1,407.00
25575 00	Surgery	26.88	26.88	\$ 1,881.60	\$ 1,881.60
25600 00	Surgery	10.19	9.75	\$ 713.30	\$ 682.50
25605 00	Surgery	16.23	15.34	\$ 1,136.10	\$ 1,073.80
25606 00	Surgery	19.91	19.91	\$ 1,393.70	\$ 1,393.70
25607 00	Surgery	21.98	21.98	\$ 1,538.60	\$ 1,538.60
25608 00	Surgery	24.60	24.60	\$ 1,722.00	\$ 1,722.00
25609 00	Surgery	31.22	31.22	\$ 2,185.40	\$ 2,185.40
25622 00	Surgery	9.26	8.55	\$ 648.20	\$ 598.50
25624 00	Surgery	14.77	13.38	\$ 1,033.90	\$ 936.60
25628 00	Surgery	21.43	21.43	\$ 1,500.10	\$ 1,500.10
25630 00	Surgery	9.20	8.55	\$ 644.00	\$ 598.50
25635 00	Surgery	14.02	12.72	\$ 981.40	\$ 890.40
25645 00	Surgery	17.08	17.08	\$ 1,195.60	\$ 1,195.60
25650 00	Surgery	9.95	9.20	\$ 696.50	\$ 644.00
25651 00	Surgery	14.60	14.60	\$ 1,022.00	\$ 1,022.00
25652 00	Surgery	18.57	18.57	\$ 1,299.90	\$ 1,299.90
25660 00	Surgery	13.46	13.46	\$ 942.20	\$ 942.20
25670 00	Surgery	18.17	18.17	\$ 1,271.90	\$ 1,271.90
25671 00	Surgery	15.83	15.83	\$ 1,108.10	\$ 1,108.10
25675 00	Surgery	13.52	12.21	\$ 946.40	\$ 854.70
25676 00	Surgery	18.81	18.81	\$ 1,316.70	\$ 1,316.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
25680 00	Surgery	15.89	15.89	\$ 1,112.30	\$ 1,112.30
25685 00	Surgery	21.91	21.91	\$ 1,533.70	\$ 1,533.70
25690 00	Surgery	14.74	14.74	\$ 1,031.80	\$ 1,031.80
25695 00	Surgery	18.95	18.95	\$ 1,326.50	\$ 1,326.50
25800 00	Surgery	21.77	21.77	\$ 1,523.90	\$ 1,523.90
25805 00	Surgery	25.24	25.24	\$ 1,766.80	\$ 1,766.80
25810 00	Surgery	25.66	25.66	\$ 1,796.20	\$ 1,796.20
25820 00	Surgery	19.43	19.43	\$ 1,360.10	\$ 1,360.10
25825 00	Surgery	23.69	23.69	\$ 1,658.30	\$ 1,658.30
25830 00	Surgery	31.09	31.09	\$ 2,176.30	\$ 2,176.30
25900 00	Surgery	21.32	21.32	\$ 1,492.40	\$ 1,492.40
25905 00	Surgery	20.94	20.94	\$ 1,465.80	\$ 1,465.80
25907 00	Surgery	18.35	18.35	\$ 1,284.50	\$ 1,284.50
25909 00	Surgery	20.46	20.46	\$ 1,432.20	\$ 1,432.20
25915 00	Surgery	34.62	34.62	\$ 2,423.40	\$ 2,423.40
25920 00	Surgery	21.89	21.89	\$ 1,532.30	\$ 1,532.30
25922 00	Surgery	19.41	19.41	\$ 1,358.70	\$ 1,358.70
25924 00	Surgery	21.40	21.40	\$ 1,498.00	\$ 1,498.00
25927 00	Surgery	26.10	26.10	\$ 1,827.00	\$ 1,827.00
25929 00	Surgery	17.90	17.90	\$ 1,253.00	\$ 1,253.00
25931 00	Surgery	24.20	24.20	\$ 1,694.00	\$ 1,694.00
25999 00	Surgery	0.00	0.00	BR	BR
26010 00	Surgery	10.55	4.18	\$ 738.50	\$ 292.60
26011 00	Surgery	14.73	5.51	\$ 1,031.10	\$ 385.70
26020 00	Surgery	16.59	16.59	\$ 1,161.30	\$ 1,161.30
26025 00	Surgery	12.56	12.56	\$ 879.20	\$ 879.20
26030 00	Surgery	14.63	14.63	\$ 1,024.10	\$ 1,024.10
26034 00	Surgery	16.46	16.46	\$ 1,152.20	\$ 1,152.20
26035 00	Surgery	25.61	25.61	\$ 1,792.70	\$ 1,792.70
26037 00	Surgery	16.69	16.69	\$ 1,168.30	\$ 1,168.30
26040 00	Surgery	9.43	9.43	\$ 660.10	\$ 660.10
26045 00	Surgery	14.10	14.10	\$ 987.00	\$ 987.00
26055 00	Surgery	17.95	8.69	\$ 1,256.50	\$ 608.30
26060 00	Surgery	7.66	7.66	\$ 536.20	\$ 536.20
26070 00	Surgery	9.58	9.58	\$ 670.60	\$ 670.60
26075 00	Surgery	10.09	10.09	\$ 706.30	\$ 706.30
26080 00	Surgery	11.91	11.91	\$ 833.70	\$ 833.70
26100 00	Surgery	10.16	10.16	\$ 711.20	\$ 711.20
26105 00	Surgery	10.23	10.23	\$ 716.10	\$ 716.10
26110 00	Surgery	9.73	9.73	\$ 681.10	\$ 681.10
26111 00	Surgery	12.35	12.35	\$ 864.50	\$ 864.50
26113 00	Surgery	16.24	16.24	\$ 1,136.80	\$ 1,136.80
26115 00	Surgery	16.57	9.85	\$ 1,159.90	\$ 689.50
26116 00	Surgery	15.61	15.61	\$ 1,092.70	\$ 1,092.70
26117 00	Surgery	21.92	21.92	\$ 1,534.40	\$ 1,534.40
26118 00	Surgery	31.32	31.32	\$ 2,192.40	\$ 2,192.40
26121 00	Surgery	17.85	17.85	\$ 1,249.50	\$ 1,249.50
26123 00	Surgery	24.86	24.86	\$ 1,740.20	\$ 1,740.20
26125 00	Surgery	7.93	7.93	\$ 555.10	\$ 555.10
26130 00	Surgery	14.04	14.04	\$ 982.80	\$ 982.80
26135 00	Surgery	16.54	16.54	\$ 1,157.80	\$ 1,157.80
26140 00	Surgery	15.15	15.15	\$ 1,060.50	\$ 1,060.50
26145 00	Surgery	15.38	15.38	\$ 1,076.60	\$ 1,076.60
26160 00	Surgery	18.67	9.41	\$ 1,306.90	\$ 658.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
26170 00	Surgery	12.19	12.19	\$ 853.30	\$ 853.30
26180 00	Surgery	13.40	13.40	\$ 938.00	\$ 938.00
26185 00	Surgery	16.61	16.61	\$ 1,162.70	\$ 1,162.70
26200 00	Surgery	13.40	13.40	\$ 938.00	\$ 938.00
26205 00	Surgery	18.10	18.10	\$ 1,267.00	\$ 1,267.00
26210 00	Surgery	13.34	13.34	\$ 933.80	\$ 933.80
26215 00	Surgery	16.95	16.95	\$ 1,186.50	\$ 1,186.50
26230 00	Surgery	14.91	14.91	\$ 1,043.70	\$ 1,043.70
26235 00	Surgery	14.67	14.67	\$ 1,026.90	\$ 1,026.90
26236 00	Surgery	13.19	13.19	\$ 923.30	\$ 923.30
26250 00	Surgery	31.58	31.58	\$ 2,210.60	\$ 2,210.60
26260 00	Surgery	23.69	23.69	\$ 1,658.30	\$ 1,658.30
26262 00	Surgery	18.76	18.76	\$ 1,313.20	\$ 1,313.20
26320 00	Surgery	10.46	10.46	\$ 732.20	\$ 732.20
26340 00	Surgery	10.53	10.53	\$ 737.10	\$ 737.10
26341 00	Surgery	3.50	2.33	\$ 245.00	\$ 163.10
26350 00	Surgery	22.67	22.67	\$ 1,586.90	\$ 1,586.90
26352 00	Surgery	25.25	25.25	\$ 1,767.50	\$ 1,767.50
26356 00	Surgery	23.69	23.69	\$ 1,658.30	\$ 1,658.30
26357 00	Surgery	26.59	26.59	\$ 1,861.30	\$ 1,861.30
26358 00	Surgery	29.36	29.36	\$ 2,055.20	\$ 2,055.20
26370 00	Surgery	23.84	23.84	\$ 1,668.80	\$ 1,668.80
26372 00	Surgery	27.79	27.79	\$ 1,945.30	\$ 1,945.30
26373 00	Surgery	26.76	26.76	\$ 1,873.20	\$ 1,873.20
26390 00	Surgery	26.58	26.58	\$ 1,860.60	\$ 1,860.60
26392 00	Surgery	30.36	30.36	\$ 2,125.20	\$ 2,125.20
26410 00	Surgery	18.30	18.30	\$ 1,281.00	\$ 1,281.00
26412 00	Surgery	21.77	21.77	\$ 1,523.90	\$ 1,523.90
26415 00	Surgery	25.84	25.84	\$ 1,808.80	\$ 1,808.80
26416 00	Surgery	27.92	27.92	\$ 1,954.40	\$ 1,954.40
26418 00	Surgery	18.97	18.97	\$ 1,327.90	\$ 1,327.90
26420 00	Surgery	22.60	22.60	\$ 1,582.00	\$ 1,582.00
26426 00	Surgery	15.02	15.02	\$ 1,051.40	\$ 1,051.40
26428 00	Surgery	24.20	24.20	\$ 1,694.00	\$ 1,694.00
26432 00	Surgery	16.56	16.56	\$ 1,159.20	\$ 1,159.20
26433 00	Surgery	17.41	17.41	\$ 1,218.70	\$ 1,218.70
26434 00	Surgery	21.16	21.16	\$ 1,481.20	\$ 1,481.20
26437 00	Surgery	20.23	20.23	\$ 1,416.10	\$ 1,416.10
26440 00	Surgery	19.82	19.82	\$ 1,387.40	\$ 1,387.40
26442 00	Surgery	29.84	29.84	\$ 2,088.80	\$ 2,088.80
26445 00	Surgery	18.53	18.53	\$ 1,297.10	\$ 1,297.10
26449 00	Surgery	20.73	20.73	\$ 1,451.10	\$ 1,451.10
26450 00	Surgery	14.09	14.09	\$ 986.30	\$ 986.30
26455 00	Surgery	13.93	13.93	\$ 975.10	\$ 975.10
26460 00	Surgery	13.71	13.71	\$ 959.70	\$ 959.70
26471 00	Surgery	20.03	20.03	\$ 1,402.10	\$ 1,402.10
26474 00	Surgery	19.82	19.82	\$ 1,387.40	\$ 1,387.40
26476 00	Surgery	19.59	19.59	\$ 1,371.30	\$ 1,371.30
26477 00	Surgery	18.99	18.99	\$ 1,329.30	\$ 1,329.30
26478 00	Surgery	20.13	20.13	\$ 1,409.10	\$ 1,409.10
26479 00	Surgery	20.55	20.55	\$ 1,438.50	\$ 1,438.50
26480 00	Surgery	23.82	23.82	\$ 1,667.40	\$ 1,667.40
26483 00	Surgery	26.36	26.36	\$ 1,845.20	\$ 1,845.20
26485 00	Surgery	25.29	25.29	\$ 1,770.30	\$ 1,770.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
26489 00	Surgery	29.26	29.26	\$ 2,048.20	\$ 2,048.20
26490 00	Surgery	25.43	25.43	\$ 1,780.10	\$ 1,780.10
26492 00	Surgery	28.06	28.06	\$ 1,964.20	\$ 1,964.20
26494 00	Surgery	25.52	25.52	\$ 1,786.40	\$ 1,786.40
26496 00	Surgery	27.44	27.44	\$ 1,920.80	\$ 1,920.80
26497 00	Surgery	27.41	27.41	\$ 1,918.70	\$ 1,918.70
26498 00	Surgery	35.57	35.57	\$ 2,489.90	\$ 2,489.90
26499 00	Surgery	26.38	26.38	\$ 1,846.60	\$ 1,846.60
26500 00	Surgery	20.29	20.29	\$ 1,420.30	\$ 1,420.30
26502 00	Surgery	22.95	22.95	\$ 1,606.50	\$ 1,606.50
26508 00	Surgery	20.51	20.51	\$ 1,435.70	\$ 1,435.70
26510 00	Surgery	19.49	19.49	\$ 1,364.30	\$ 1,364.30
26516 00	Surgery	22.54	22.54	\$ 1,577.80	\$ 1,577.80
26517 00	Surgery	26.24	26.24	\$ 1,836.80	\$ 1,836.80
26518 00	Surgery	26.59	26.59	\$ 1,861.30	\$ 1,861.30
26520 00	Surgery	20.77	20.77	\$ 1,453.90	\$ 1,453.90
26525 00	Surgery	20.84	20.84	\$ 1,458.80	\$ 1,458.80
26530 00	Surgery	16.14	16.14	\$ 1,129.80	\$ 1,129.80
26531 00	Surgery	18.80	18.80	\$ 1,316.00	\$ 1,316.00
26535 00	Surgery	13.02	13.02	\$ 911.40	\$ 911.40
26536 00	Surgery	22.72	22.72	\$ 1,590.40	\$ 1,590.40
26540 00	Surgery	21.22	21.22	\$ 1,485.40	\$ 1,485.40
26541 00	Surgery	25.21	25.21	\$ 1,764.70	\$ 1,764.70
26542 00	Surgery	21.90	21.90	\$ 1,533.00	\$ 1,533.00
26545 00	Surgery	22.16	22.16	\$ 1,551.20	\$ 1,551.20
26546 00	Surgery	31.17	31.17	\$ 2,181.90	\$ 2,181.90
26548 00	Surgery	24.16	24.16	\$ 1,691.20	\$ 1,691.20
26550 00	Surgery	49.69	49.69	\$ 3,478.30	\$ 3,478.30
26551 00	Surgery	98.20	98.20	\$ 6,874.00	\$ 6,874.00
26553 00	Surgery	97.54	97.54	\$ 6,827.80	\$ 6,827.80
26554 00	Surgery	113.47	113.47	\$ 7,942.90	\$ 7,942.90
26555 00	Surgery	41.82	41.82	\$ 2,927.40	\$ 2,927.40
26556 00	Surgery	101.41	101.41	\$ 7,098.70	\$ 7,098.70
26560 00	Surgery	19.35	19.35	\$ 1,354.50	\$ 1,354.50
26561 00	Surgery	29.71	29.71	\$ 2,079.70	\$ 2,079.70
26562 00	Surgery	41.34	41.34	\$ 2,893.80	\$ 2,893.80
26565 00	Surgery	21.76	21.76	\$ 1,523.20	\$ 1,523.20
26567 00	Surgery	21.82	21.82	\$ 1,527.40	\$ 1,527.40
26568 00	Surgery	28.27	28.27	\$ 1,978.90	\$ 1,978.90
26580 00	Surgery	46.22	46.22	\$ 3,235.40	\$ 3,235.40
26587 00	Surgery	31.04	31.04	\$ 2,172.80	\$ 2,172.80
26590 00	Surgery	43.04	43.04	\$ 3,012.80	\$ 3,012.80
26591 00	Surgery	14.81	14.81	\$ 1,036.70	\$ 1,036.70
26593 00	Surgery	19.57	19.57	\$ 1,369.90	\$ 1,369.90
26596 00	Surgery	24.67	24.67	\$ 1,726.90	\$ 1,726.90
26600 00	Surgery	9.06	8.62	\$ 634.20	\$ 603.40
26605 00	Surgery	9.98	8.98	\$ 698.60	\$ 628.60
26607 00	Surgery	15.35	15.35	\$ 1,074.50	\$ 1,074.50
26608 00	Surgery	14.42	14.42	\$ 1,009.40	\$ 1,009.40
26615 00	Surgery	17.15	17.15	\$ 1,200.50	\$ 1,200.50
26641 00	Surgery	12.63	11.51	\$ 884.10	\$ 805.70
26645 00	Surgery	13.06	11.89	\$ 914.20	\$ 832.30
26650 00	Surgery	14.41	14.41	\$ 1,008.70	\$ 1,008.70
26665 00	Surgery	18.58	18.58	\$ 1,300.60	\$ 1,300.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
26670 00	Surgery	10.53	9.41	\$ 737.10	\$ 658.70
26675 00	Surgery	13.91	12.69	\$ 973.70	\$ 888.30
26676 00	Surgery	15.23	15.23	\$ 1,066.10	\$ 1,066.10
26685 00	Surgery	17.18	17.18	\$ 1,202.60	\$ 1,202.60
26686 00	Surgery	18.62	18.62	\$ 1,303.40	\$ 1,303.40
26700 00	Surgery	10.19	9.37	\$ 713.30	\$ 655.90
26705 00	Surgery	12.75	11.56	\$ 892.50	\$ 809.20
26706 00	Surgery	13.37	13.37	\$ 935.90	\$ 935.90
26715 00	Surgery	17.09	17.09	\$ 1,196.30	\$ 1,196.30
26720 00	Surgery	6.02	5.66	\$ 421.40	\$ 396.20
26725 00	Surgery	10.30	9.16	\$ 721.00	\$ 641.20
26727 00	Surgery	14.19	14.19	\$ 993.30	\$ 993.30
26735 00	Surgery	17.72	17.72	\$ 1,240.40	\$ 1,240.40
26740 00	Surgery	7.00	6.63	\$ 490.00	\$ 464.10
26742 00	Surgery	11.27	10.11	\$ 788.90	\$ 707.70
26746 00	Surgery	22.09	22.09	\$ 1,546.30	\$ 1,546.30
26750 00	Surgery	5.63	5.67	\$ 394.10	\$ 396.90
26755 00	Surgery	9.64	8.27	\$ 674.80	\$ 578.90
26756 00	Surgery	12.73	12.73	\$ 891.10	\$ 891.10
26765 00	Surgery	14.98	14.98	\$ 1,048.60	\$ 1,048.60
26770 00	Surgery	8.60	7.82	\$ 602.00	\$ 547.40
26775 00	Surgery	11.82	10.60	\$ 827.40	\$ 742.00
26776 00	Surgery	13.49	13.49	\$ 944.30	\$ 944.30
26785 00	Surgery	16.29	16.29	\$ 1,140.30	\$ 1,140.30
26820 00	Surgery	25.16	25.16	\$ 1,761.20	\$ 1,761.20
26841 00	Surgery	23.41	23.41	\$ 1,638.70	\$ 1,638.70
26842 00	Surgery	25.22	25.22	\$ 1,765.40	\$ 1,765.40
26843 00	Surgery	23.77	23.77	\$ 1,663.90	\$ 1,663.90
26844 00	Surgery	26.07	26.07	\$ 1,824.90	\$ 1,824.90
26850 00	Surgery	22.26	22.26	\$ 1,558.20	\$ 1,558.20
26852 00	Surgery	25.16	25.16	\$ 1,761.20	\$ 1,761.20
26860 00	Surgery	18.58	18.58	\$ 1,300.60	\$ 1,300.60
26861 00	Surgery	3.00	3.00	\$ 210.00	\$ 210.00
26862 00	Surgery	23.19	23.19	\$ 1,623.30	\$ 1,623.30
26863 00	Surgery	6.69	6.69	\$ 468.30	\$ 468.30
26910 00	Surgery	23.06	23.06	\$ 1,614.20	\$ 1,614.20
26951 00	Surgery	21.17	21.17	\$ 1,481.90	\$ 1,481.90
26952 00	Surgery	20.72	20.72	\$ 1,450.40	\$ 1,450.40
26989 00	Surgery	0.00	0.00	BR	BR
26990 00	Surgery	20.44	20.44	\$ 1,430.80	\$ 1,430.80
26991 00	Surgery	21.20	15.60	\$ 1,484.00	\$ 1,092.00
26992 00	Surgery	30.07	30.07	\$ 2,104.90	\$ 2,104.90
27000 00	Surgery	11.96	11.96	\$ 837.20	\$ 837.20
27001 00	Surgery	16.12	16.12	\$ 1,128.40	\$ 1,128.40
27003 00	Surgery	17.88	17.88	\$ 1,251.60	\$ 1,251.60
27005 00	Surgery	21.52	21.52	\$ 1,506.40	\$ 1,506.40
27006 00	Surgery	21.29	21.29	\$ 1,490.30	\$ 1,490.30
27025 00	Surgery	27.42	27.42	\$ 1,919.40	\$ 1,919.40
27027 00	Surgery	26.29	26.29	\$ 1,840.30	\$ 1,840.30
27030 00	Surgery	27.83	27.83	\$ 1,948.10	\$ 1,948.10
27033 00	Surgery	28.86	28.86	\$ 2,020.20	\$ 2,020.20
27035 00	Surgery	33.90	33.90	\$ 2,373.00	\$ 2,373.00
27036 00	Surgery	30.24	30.24	\$ 2,116.80	\$ 2,116.80
27040 00	Surgery	10.19	5.84	\$ 713.30	\$ 408.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
27041 00	Surgery	21.08	21.08	\$ 1,475.60	\$ 1,475.60
27043 00	Surgery	13.99	13.99	\$ 979.30	\$ 979.30
27045 00	Surgery	21.85	21.85	\$ 1,529.50	\$ 1,529.50
27047 00	Surgery	14.94	10.75	\$ 1,045.80	\$ 752.50
27048 00	Surgery	18.15	18.15	\$ 1,270.50	\$ 1,270.50
27049 00	Surgery	39.99	39.99	\$ 2,799.30	\$ 2,799.30
27050 00	Surgery	12.11	12.11	\$ 847.70	\$ 847.70
27052 00	Surgery	17.23	17.23	\$ 1,206.10	\$ 1,206.10
27054 00	Surgery	20.48	20.48	\$ 1,433.60	\$ 1,433.60
27057 00	Surgery	29.97	29.97	\$ 2,097.90	\$ 2,097.90
27059 00	Surgery	53.64	53.64	\$ 3,754.80	\$ 3,754.80
27060 00	Surgery	13.90	13.90	\$ 973.00	\$ 973.00
27062 00	Surgery	13.59	13.59	\$ 951.30	\$ 951.30
27065 00	Surgery	15.69	15.69	\$ 1,098.30	\$ 1,098.30
27066 00	Surgery	24.25	24.25	\$ 1,697.50	\$ 1,697.50
27067 00	Surgery	30.75	30.75	\$ 2,152.50	\$ 2,152.50
27070 00	Surgery	26.54	26.54	\$ 1,857.80	\$ 1,857.80
27071 00	Surgery	29.10	29.10	\$ 2,037.00	\$ 2,037.00
27075 00	Surgery	61.57	61.57	\$ 4,309.90	\$ 4,309.90
27076 00	Surgery	74.41	74.41	\$ 5,208.70	\$ 5,208.70
27077 00	Surgery	82.99	82.99	\$ 5,809.30	\$ 5,809.30
27078 00	Surgery	60.71	60.71	\$ 4,249.70	\$ 4,249.70
27080 00	Surgery	15.26	15.26	\$ 1,068.20	\$ 1,068.20
27086 00	Surgery	9.38	5.00	\$ 656.60	\$ 350.00
27087 00	Surgery	18.31	18.31	\$ 1,281.70	\$ 1,281.70
27090 00	Surgery	24.70	24.70	\$ 1,729.00	\$ 1,729.00
27091 00	Surgery	47.15	47.15	\$ 3,300.50	\$ 3,300.50
27093 00	Surgery	7.23	1.98	\$ 506.10	\$ 138.60
27095 00	Surgery	9.75	2.44	\$ 682.50	\$ 170.80
27096 00	Surgery	4.85	2.41	\$ 339.50	\$ 168.70
27097 00	Surgery	20.39	20.39	\$ 1,427.30	\$ 1,427.30
27098 00	Surgery	20.74	20.74	\$ 1,451.80	\$ 1,451.80
27100 00	Surgery	24.71	24.71	\$ 1,729.70	\$ 1,729.70
27105 00	Surgery	25.91	25.91	\$ 1,813.70	\$ 1,813.70
27110 00	Surgery	28.87	28.87	\$ 2,020.90	\$ 2,020.90
27111 00	Surgery	26.88	26.88	\$ 1,881.60	\$ 1,881.60
27120 00	Surgery	38.50	38.50	\$ 2,695.00	\$ 2,695.00
27122 00	Surgery	32.76	32.76	\$ 2,293.20	\$ 2,293.20
27125 00	Surgery	33.54	33.54	\$ 2,347.80	\$ 2,347.80
27130 00	Surgery	38.02	38.02	\$ 2,661.40	\$ 2,661.40
27132 00	Surgery	49.43	49.43	\$ 3,460.10	\$ 3,460.10
27134 00	Surgery	56.32	56.32	\$ 3,942.40	\$ 3,942.40
27137 00	Surgery	43.36	43.36	\$ 3,035.20	\$ 3,035.20
27138 00	Surgery	45.07	45.07	\$ 3,154.90	\$ 3,154.90
27140 00	Surgery	26.56	26.56	\$ 1,859.20	\$ 1,859.20
27146 00	Surgery	37.95	37.95	\$ 2,656.50	\$ 2,656.50
27147 00	Surgery	43.31	43.31	\$ 3,031.70	\$ 3,031.70
27151 00	Surgery	46.80	46.80	\$ 3,276.00	\$ 3,276.00
27156 00	Surgery	50.42	50.42	\$ 3,529.40	\$ 3,529.40
27158 00	Surgery	41.46	41.46	\$ 2,902.20	\$ 2,902.20
27161 00	Surgery	36.20	36.20	\$ 2,534.00	\$ 2,534.00
27165 00	Surgery	40.86	40.86	\$ 2,860.20	\$ 2,860.20
27170 00	Surgery	34.56	34.56	\$ 2,419.20	\$ 2,419.20
27175 00	Surgery	19.83	19.83	\$ 1,388.10	\$ 1,388.10

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
27176 00	Surgery	27.42	27.42	\$ 1,919.40	\$ 1,919.40
27177 00	Surgery	33.11	33.11	\$ 2,317.70	\$ 2,317.70
27178 00	Surgery	27.42	27.42	\$ 1,919.40	\$ 1,919.40
27179 00	Surgery	29.10	29.10	\$ 2,037.00	\$ 2,037.00
27181 00	Surgery	33.21	33.21	\$ 2,324.70	\$ 2,324.70
27185 00	Surgery	21.40	21.40	\$ 1,498.00	\$ 1,498.00
27187 00	Surgery	29.62	29.62	\$ 2,073.40	\$ 2,073.40
27197 00	Surgery	3.99	3.99	\$ 279.30	\$ 279.30
27198 00	Surgery	9.46	9.46	\$ 662.20	\$ 662.20
27200 00	Surgery	5.64	5.66	\$ 394.80	\$ 396.20
27202 00	Surgery	15.71	15.71	\$ 1,099.70	\$ 1,099.70
27215 00	Surgery	17.78	17.78	\$ 1,244.60	\$ 1,244.60
27216 00	Surgery	26.28	26.28	\$ 1,839.60	\$ 1,839.60
27217 00	Surgery	24.70	24.70	\$ 1,729.00	\$ 1,729.00
27218 00	Surgery	33.90	33.90	\$ 2,373.00	\$ 2,373.00
27220 00	Surgery	12.51	12.32	\$ 875.70	\$ 862.40
27222 00	Surgery	29.25	29.25	\$ 2,047.50	\$ 2,047.50
27226 00	Surgery	31.31	31.31	\$ 2,191.70	\$ 2,191.70
27227 00	Surgery	48.83	48.83	\$ 3,418.10	\$ 3,418.10
27228 00	Surgery	55.50	55.50	\$ 3,885.00	\$ 3,885.00
27230 00	Surgery	14.57	14.28	\$ 1,019.90	\$ 999.60
27232 00	Surgery	21.95	21.95	\$ 1,536.50	\$ 1,536.50
27235 00	Surgery	26.96	26.96	\$ 1,887.20	\$ 1,887.20
27236 00	Surgery	35.37	35.37	\$ 2,475.90	\$ 2,475.90
27238 00	Surgery	13.98	13.98	\$ 978.60	\$ 978.60
27240 00	Surgery	28.50	28.50	\$ 1,995.00	\$ 1,995.00
27244 00	Surgery	36.38	36.38	\$ 2,546.60	\$ 2,546.60
27245 00	Surgery	36.35	36.35	\$ 2,544.50	\$ 2,544.50
27246 00	Surgery	11.71	11.56	\$ 819.70	\$ 809.20
27248 00	Surgery	22.20	22.20	\$ 1,554.00	\$ 1,554.00
27250 00	Surgery	5.33	5.33	\$ 373.10	\$ 373.10
27252 00	Surgery	22.48	22.48	\$ 1,573.60	\$ 1,573.60
27253 00	Surgery	27.95	27.95	\$ 1,956.50	\$ 1,956.50
27254 00	Surgery	37.71	37.71	\$ 2,639.70	\$ 2,639.70
27256 00	Surgery	9.15	7.07	\$ 640.50	\$ 494.90
27257 00	Surgery	10.69	10.69	\$ 748.30	\$ 748.30
27258 00	Surgery	33.00	33.00	\$ 2,310.00	\$ 2,310.00
27259 00	Surgery	45.67	45.67	\$ 3,196.90	\$ 3,196.90
27265 00	Surgery	12.28	12.28	\$ 859.60	\$ 859.60
27266 00	Surgery	17.46	17.46	\$ 1,222.20	\$ 1,222.20
27267 00	Surgery	13.18	13.18	\$ 922.60	\$ 922.60
27268 00	Surgery	16.25	16.25	\$ 1,137.50	\$ 1,137.50
27269 00	Surgery	36.74	36.74	\$ 2,571.80	\$ 2,571.80
27275 00	Surgery	5.44	5.44	\$ 380.80	\$ 380.80
27279 00	Surgery	24.86	24.86	\$ 1,740.20	\$ 1,740.20
27280 00	Surgery	40.43	40.43	\$ 2,830.10	\$ 2,830.10
27282 00	Surgery	25.59	25.59	\$ 1,791.30	\$ 1,791.30
27284 00	Surgery	47.46	47.46	\$ 3,322.20	\$ 3,322.20
27286 00	Surgery	48.60	48.60	\$ 3,402.00	\$ 3,402.00
27290 00	Surgery	48.12	48.12	\$ 3,368.40	\$ 3,368.40
27295 00	Surgery	37.45	37.45	\$ 2,621.50	\$ 2,621.50
27299 00	Surgery	0.00	0.00	BR	BR
27301 00	Surgery	20.19	15.10	\$ 1,413.30	\$ 1,057.00
27303 00	Surgery	19.03	19.03	\$ 1,332.10	\$ 1,332.10

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
27305 00	Surgery	14.43	14.43	\$ 1,010.10	\$ 1,010.10
27306 00	Surgery	10.06	10.06	\$ 704.20	\$ 704.20
27307 00	Surgery	12.42	12.42	\$ 869.40	\$ 869.40
27310 00	Surgery	21.80	21.80	\$ 1,526.00	\$ 1,526.00
27323 00	Surgery	8.19	5.13	\$ 573.30	\$ 359.10
27324 00	Surgery	12.13	12.13	\$ 849.10	\$ 849.10
27325 00	Surgery	16.87	16.87	\$ 1,180.90	\$ 1,180.90
27326 00	Surgery	15.62	15.62	\$ 1,093.40	\$ 1,093.40
27327 00	Surgery	15.23	9.38	\$ 1,066.10	\$ 656.60
27328 00	Surgery	18.54	18.54	\$ 1,297.80	\$ 1,297.80
27329 00	Surgery	30.92	30.92	\$ 2,164.40	\$ 2,164.40
27330 00	Surgery	12.62	12.62	\$ 883.40	\$ 883.40
27331 00	Surgery	14.22	14.22	\$ 995.40	\$ 995.40
27332 00	Surgery	19.25	19.25	\$ 1,347.50	\$ 1,347.50
27333 00	Surgery	17.58	17.58	\$ 1,230.60	\$ 1,230.60
27334 00	Surgery	20.44	20.44	\$ 1,430.80	\$ 1,430.80
27335 00	Surgery	22.81	22.81	\$ 1,596.70	\$ 1,596.70
27337 00	Surgery	12.52	12.52	\$ 876.40	\$ 876.40
27339 00	Surgery	22.48	22.48	\$ 1,573.60	\$ 1,573.60
27340 00	Surgery	11.21	11.21	\$ 784.70	\$ 784.70
27345 00	Surgery	14.51	14.51	\$ 1,015.70	\$ 1,015.70
27347 00	Surgery	15.70	15.70	\$ 1,099.00	\$ 1,099.00
27350 00	Surgery	19.52	19.52	\$ 1,366.40	\$ 1,366.40
27355 00	Surgery	18.16	18.16	\$ 1,271.20	\$ 1,271.20
27356 00	Surgery	22.04	22.04	\$ 1,542.80	\$ 1,542.80
27357 00	Surgery	24.41	24.41	\$ 1,708.70	\$ 1,708.70
27358 00	Surgery	8.11	8.11	\$ 567.70	\$ 567.70
27360 00	Surgery	27.05	27.05	\$ 1,893.50	\$ 1,893.50
27364 00	Surgery	46.32	46.32	\$ 3,242.40	\$ 3,242.40
27365 00	Surgery	60.67	60.67	\$ 4,246.90	\$ 4,246.90
27369 00	Surgery	5.31	1.17	\$ 371.70	\$ 81.90
27372 00	Surgery	17.85	11.98	\$ 1,249.50	\$ 838.60
27380 00	Surgery	18.69	18.69	\$ 1,308.30	\$ 1,308.30
27381 00	Surgery	24.57	24.57	\$ 1,719.90	\$ 1,719.90
27385 00	Surgery	18.21	18.21	\$ 1,274.70	\$ 1,274.70
27386 00	Surgery	25.66	25.66	\$ 1,796.20	\$ 1,796.20
27390 00	Surgery	13.42	13.42	\$ 939.40	\$ 939.40
27391 00	Surgery	16.60	16.60	\$ 1,162.00	\$ 1,162.00
27392 00	Surgery	21.25	21.25	\$ 1,487.50	\$ 1,487.50
27393 00	Surgery	14.99	14.99	\$ 1,049.30	\$ 1,049.30
27394 00	Surgery	19.53	19.53	\$ 1,367.10	\$ 1,367.10
27395 00	Surgery	26.23	26.23	\$ 1,836.10	\$ 1,836.10
27396 00	Surgery	18.45	18.45	\$ 1,291.50	\$ 1,291.50
27397 00	Surgery	27.19	27.19	\$ 1,903.30	\$ 1,903.30
27400 00	Surgery	20.75	20.75	\$ 1,452.50	\$ 1,452.50
27403 00	Surgery	19.23	19.23	\$ 1,346.10	\$ 1,346.10
27405 00	Surgery	20.18	20.18	\$ 1,412.60	\$ 1,412.60
27407 00	Surgery	23.74	23.74	\$ 1,661.80	\$ 1,661.80
27409 00	Surgery	28.76	28.76	\$ 2,013.20	\$ 2,013.20
27412 00	Surgery	48.78	48.78	\$ 3,414.60	\$ 3,414.60
27415 00	Surgery	40.66	40.66	\$ 2,846.20	\$ 2,846.20
27416 00	Surgery	29.12	29.12	\$ 2,038.40	\$ 2,038.40
27418 00	Surgery	24.74	24.74	\$ 1,731.80	\$ 1,731.80
27420 00	Surgery	22.11	22.11	\$ 1,547.70	\$ 1,547.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
27422 00	Surgery	22.12	22.12	\$ 1,548.40	\$ 1,548.40
27424 00	Surgery	22.31	22.31	\$ 1,561.70	\$ 1,561.70
27425 00	Surgery	13.55	13.55	\$ 948.50	\$ 948.50
27427 00	Surgery	21.17	21.17	\$ 1,481.90	\$ 1,481.90
27428 00	Surgery	33.17	33.17	\$ 2,321.90	\$ 2,321.90
27429 00	Surgery	37.33	37.33	\$ 2,613.10	\$ 2,613.10
27430 00	Surgery	22.12	22.12	\$ 1,548.40	\$ 1,548.40
27435 00	Surgery	23.95	23.95	\$ 1,676.50	\$ 1,676.50
27437 00	Surgery	19.68	19.68	\$ 1,377.60	\$ 1,377.60
27438 00	Surgery	24.98	24.98	\$ 1,748.60	\$ 1,748.60
27440 00	Surgery	23.74	23.74	\$ 1,661.80	\$ 1,661.80
27441 00	Surgery	24.51	24.51	\$ 1,715.70	\$ 1,715.70
27442 00	Surgery	25.89	25.89	\$ 1,812.30	\$ 1,812.30
27443 00	Surgery	24.28	24.28	\$ 1,699.60	\$ 1,699.60
27445 00	Surgery	37.18	37.18	\$ 2,602.60	\$ 2,602.60
27446 00	Surgery	34.18	34.18	\$ 2,392.60	\$ 2,392.60
27447 00	Surgery	37.98	37.98	\$ 2,658.60	\$ 2,658.60
27448 00	Surgery	24.08	24.08	\$ 1,685.60	\$ 1,685.60
27450 00	Surgery	30.06	30.06	\$ 2,104.20	\$ 2,104.20
27454 00	Surgery	38.32	38.32	\$ 2,682.40	\$ 2,682.40
27455 00	Surgery	28.63	28.63	\$ 2,004.10	\$ 2,004.10
27457 00	Surgery	28.55	28.55	\$ 1,998.50	\$ 1,998.50
27465 00	Surgery	36.99	36.99	\$ 2,589.30	\$ 2,589.30
27466 00	Surgery	35.14	35.14	\$ 2,459.80	\$ 2,459.80
27468 00	Surgery	39.75	39.75	\$ 2,782.50	\$ 2,782.50
27470 00	Surgery	34.98	34.98	\$ 2,448.60	\$ 2,448.60
27472 00	Surgery	37.46	37.46	\$ 2,622.20	\$ 2,622.20
27475 00	Surgery	19.79	19.79	\$ 1,385.30	\$ 1,385.30
27477 00	Surgery	21.86	21.86	\$ 1,530.20	\$ 1,530.20
27479 00	Surgery	27.30	27.30	\$ 1,911.00	\$ 1,911.00
27485 00	Surgery	20.03	20.03	\$ 1,402.10	\$ 1,402.10
27486 00	Surgery	41.56	41.56	\$ 2,909.20	\$ 2,909.20
27487 00	Surgery	51.85	51.85	\$ 3,629.50	\$ 3,629.50
27488 00	Surgery	35.56	35.56	\$ 2,489.20	\$ 2,489.20
27495 00	Surgery	33.53	33.53	\$ 2,347.10	\$ 2,347.10
27496 00	Surgery	16.37	16.37	\$ 1,145.90	\$ 1,145.90
27497 00	Surgery	17.32	17.32	\$ 1,212.40	\$ 1,212.40
27498 00	Surgery	19.59	19.59	\$ 1,371.30	\$ 1,371.30
27499 00	Surgery	20.90	20.90	\$ 1,463.00	\$ 1,463.00
27500 00	Surgery	15.61	14.35	\$ 1,092.70	\$ 1,004.50
27501 00	Surgery	15.17	14.88	\$ 1,061.90	\$ 1,041.60
27502 00	Surgery	22.60	22.60	\$ 1,582.00	\$ 1,582.00
27503 00	Surgery	23.78	23.78	\$ 1,664.60	\$ 1,664.60
27506 00	Surgery	39.62	39.62	\$ 2,773.40	\$ 2,773.40
27507 00	Surgery	28.72	28.72	\$ 2,010.40	\$ 2,010.40
27508 00	Surgery	15.75	14.93	\$ 1,102.50	\$ 1,045.10
27509 00	Surgery	20.28	20.28	\$ 1,419.60	\$ 1,419.60
27510 00	Surgery	20.22	20.22	\$ 1,415.40	\$ 1,415.40
27511 00	Surgery	29.54	29.54	\$ 2,067.80	\$ 2,067.80
27513 00	Surgery	36.65	36.65	\$ 2,565.50	\$ 2,565.50
27514 00	Surgery	28.68	28.68	\$ 2,007.60	\$ 2,007.60
27516 00	Surgery	15.54	14.52	\$ 1,087.80	\$ 1,016.40
27517 00	Surgery	20.54	20.54	\$ 1,437.80	\$ 1,437.80
27519 00	Surgery	26.46	26.46	\$ 1,852.20	\$ 1,852.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
27520 00	Surgery	9.80	9.06	\$ 686.00	\$ 634.20
27524 00	Surgery	22.43	22.43	\$ 1,570.10	\$ 1,570.10
27530 00	Surgery	9.28	8.72	\$ 649.60	\$ 610.40
27532 00	Surgery	18.56	17.31	\$ 1,299.20	\$ 1,211.70
27535 00	Surgery	26.63	26.63	\$ 1,864.10	\$ 1,864.10
27536 00	Surgery	35.18	35.18	\$ 2,462.60	\$ 2,462.60
27538 00	Surgery	14.62	13.58	\$ 1,023.40	\$ 950.60
27540 00	Surgery	24.21	24.21	\$ 1,694.70	\$ 1,694.70
27550 00	Surgery	15.46	14.20	\$ 1,082.20	\$ 994.00
27552 00	Surgery	18.93	18.93	\$ 1,325.10	\$ 1,325.10
27556 00	Surgery	26.04	26.04	\$ 1,822.80	\$ 1,822.80
27557 00	Surgery	31.03	31.03	\$ 2,172.10	\$ 2,172.10
27558 00	Surgery	35.27	35.27	\$ 2,468.90	\$ 2,468.90
27560 00	Surgery	11.10	10.12	\$ 777.00	\$ 708.40
27562 00	Surgery	14.67	14.67	\$ 1,026.90	\$ 1,026.90
27566 00	Surgery	26.54	26.54	\$ 1,857.80	\$ 1,857.80
27570 00	Surgery	4.54	4.54	\$ 317.80	\$ 317.80
27580 00	Surgery	43.86	43.86	\$ 3,070.20	\$ 3,070.20
27590 00	Surgery	23.38	23.38	\$ 1,636.60	\$ 1,636.60
27591 00	Surgery	28.65	28.65	\$ 2,005.50	\$ 2,005.50
27592 00	Surgery	19.91	19.91	\$ 1,393.70	\$ 1,393.70
27594 00	Surgery	15.11	15.11	\$ 1,057.70	\$ 1,057.70
27596 00	Surgery	21.23	21.23	\$ 1,486.10	\$ 1,486.10
27598 00	Surgery	20.82	20.82	\$ 1,457.40	\$ 1,457.40
27599 00	Surgery	0.00	0.00	BR	BR
27600 00	Surgery	12.02	12.02	\$ 841.40	\$ 841.40
27601 00	Surgery	13.32	13.32	\$ 932.40	\$ 932.40
27602 00	Surgery	14.26	14.26	\$ 998.20	\$ 998.20
27603 00	Surgery	15.94	11.68	\$ 1,115.80	\$ 817.60
27604 00	Surgery	13.39	9.51	\$ 937.30	\$ 665.70
27605 00	Surgery	9.89	5.38	\$ 692.30	\$ 376.60
27606 00	Surgery	8.08	8.08	\$ 565.60	\$ 565.60
27607 00	Surgery	17.71	17.71	\$ 1,239.70	\$ 1,239.70
27610 00	Surgery	19.25	19.25	\$ 1,347.50	\$ 1,347.50
27612 00	Surgery	16.57	16.57	\$ 1,159.90	\$ 1,159.90
27613 00	Surgery	7.55	4.73	\$ 528.50	\$ 331.10
27614 00	Surgery	17.41	12.24	\$ 1,218.70	\$ 856.80
27615 00	Surgery	30.35	30.35	\$ 2,124.50	\$ 2,124.50
27616 00	Surgery	37.63	37.63	\$ 2,634.10	\$ 2,634.10
27618 00	Surgery	14.76	9.10	\$ 1,033.20	\$ 637.00
27619 00	Surgery	13.69	13.69	\$ 958.30	\$ 958.30
27620 00	Surgery	13.38	13.38	\$ 936.60	\$ 936.60
27625 00	Surgery	17.04	17.04	\$ 1,192.80	\$ 1,192.80
27626 00	Surgery	17.86	17.86	\$ 1,250.20	\$ 1,250.20
27630 00	Surgery	16.18	10.64	\$ 1,132.60	\$ 744.80
27632 00	Surgery	12.28	12.28	\$ 859.60	\$ 859.60
27634 00	Surgery	20.07	20.07	\$ 1,404.90	\$ 1,404.90
27635 00	Surgery	17.22	17.22	\$ 1,205.40	\$ 1,205.40
27637 00	Surgery	21.84	21.84	\$ 1,528.80	\$ 1,528.80
27638 00	Surgery	22.29	22.29	\$ 1,560.30	\$ 1,560.30
27640 00	Surgery	24.70	24.70	\$ 1,729.00	\$ 1,729.00
27641 00	Surgery	19.35	19.35	\$ 1,354.50	\$ 1,354.50
27645 00	Surgery	52.25	52.25	\$ 3,657.50	\$ 3,657.50
27646 00	Surgery	45.41	45.41	\$ 3,178.70	\$ 3,178.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
27647 00	Surgery	29.27	29.27	\$ 2,048.90	\$ 2,048.90
27648 00	Surgery	6.63	1.50	\$ 464.10	\$ 105.00
27650 00	Surgery	19.55	19.55	\$ 1,368.50	\$ 1,368.50
27652 00	Surgery	19.51	19.51	\$ 1,365.70	\$ 1,365.70
27654 00	Surgery	21.13	21.13	\$ 1,479.10	\$ 1,479.10
27656 00	Surgery	16.40	10.46	\$ 1,148.00	\$ 732.20
27658 00	Surgery	10.93	10.93	\$ 765.10	\$ 765.10
27659 00	Surgery	13.93	13.93	\$ 975.10	\$ 975.10
27664 00	Surgery	10.84	10.84	\$ 758.80	\$ 758.80
27665 00	Surgery	12.54	12.54	\$ 877.80	\$ 877.80
27675 00	Surgery	14.58	14.58	\$ 1,020.60	\$ 1,020.60
27676 00	Surgery	18.05	18.05	\$ 1,263.50	\$ 1,263.50
27680 00	Surgery	12.40	12.40	\$ 868.00	\$ 868.00
27681 00	Surgery	15.10	15.10	\$ 1,057.00	\$ 1,057.00
27685 00	Surgery	19.52	13.75	\$ 1,366.40	\$ 962.50
27686 00	Surgery	15.79	15.79	\$ 1,105.30	\$ 1,105.30
27687 00	Surgery	13.45	13.45	\$ 941.50	\$ 941.50
27690 00	Surgery	19.00	19.00	\$ 1,330.00	\$ 1,330.00
27691 00	Surgery	22.08	22.08	\$ 1,545.60	\$ 1,545.60
27692 00	Surgery	2.97	2.97	\$ 207.90	\$ 207.90
27695 00	Surgery	14.23	14.23	\$ 996.10	\$ 996.10
27696 00	Surgery	16.26	16.26	\$ 1,138.20	\$ 1,138.20
27698 00	Surgery	18.89	18.89	\$ 1,322.30	\$ 1,322.30
27700 00	Surgery	18.15	18.15	\$ 1,270.50	\$ 1,270.50
27702 00	Surgery	28.55	28.55	\$ 1,998.50	\$ 1,998.50
27703 00	Surgery	32.84	32.84	\$ 2,298.80	\$ 2,298.80
27704 00	Surgery	16.96	16.96	\$ 1,187.20	\$ 1,187.20
27705 00	Surgery	22.55	22.55	\$ 1,578.50	\$ 1,578.50
27707 00	Surgery	12.02	12.02	\$ 841.40	\$ 841.40
27709 00	Surgery	33.88	33.88	\$ 2,371.60	\$ 2,371.60
27712 00	Surgery	32.69	32.69	\$ 2,288.30	\$ 2,288.30
27715 00	Surgery	31.86	31.86	\$ 2,230.20	\$ 2,230.20
27720 00	Surgery	25.99	25.99	\$ 1,819.30	\$ 1,819.30
27722 00	Surgery	26.61	26.61	\$ 1,862.70	\$ 1,862.70
27724 00	Surgery	37.16	37.16	\$ 2,601.20	\$ 2,601.20
27725 00	Surgery	36.02	36.02	\$ 2,521.40	\$ 2,521.40
27726 00	Surgery	28.46	28.46	\$ 1,992.20	\$ 1,992.20
27727 00	Surgery	30.84	30.84	\$ 2,158.80	\$ 2,158.80
27730 00	Surgery	17.57	17.57	\$ 1,229.90	\$ 1,229.90
27732 00	Surgery	13.54	13.54	\$ 947.80	\$ 947.80
27734 00	Surgery	19.62	19.62	\$ 1,373.40	\$ 1,373.40
27740 00	Surgery	21.10	21.10	\$ 1,477.00	\$ 1,477.00
27742 00	Surgery	23.12	23.12	\$ 1,618.40	\$ 1,618.40
27745 00	Surgery	22.53	22.53	\$ 1,577.10	\$ 1,577.10
27750 00	Surgery	10.45	9.70	\$ 731.50	\$ 679.00
27752 00	Surgery	16.06	14.70	\$ 1,124.20	\$ 1,029.00
27756 00	Surgery	17.29	17.29	\$ 1,210.30	\$ 1,210.30
27758 00	Surgery	26.65	26.65	\$ 1,865.50	\$ 1,865.50
27759 00	Surgery	29.61	29.61	\$ 2,072.70	\$ 2,072.70
27760 00	Surgery	10.00	9.24	\$ 700.00	\$ 646.80
27762 00	Surgery	14.49	13.12	\$ 1,014.30	\$ 918.40
27766 00	Surgery	18.01	18.01	\$ 1,260.70	\$ 1,260.70
27767 00	Surgery	8.79	8.71	\$ 615.30	\$ 609.70
27768 00	Surgery	13.40	13.40	\$ 938.00	\$ 938.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
27769 00	Surgery	21.68	21.68	\$ 1,517.60	\$ 1,517.60
27780 00	Surgery	9.33	8.59	\$ 653.10	\$ 601.30
27781 00	Surgery	13.10	12.06	\$ 917.00	\$ 844.20
27784 00	Surgery	21.05	21.05	\$ 1,473.50	\$ 1,473.50
27786 00	Surgery	9.46	8.68	\$ 662.20	\$ 607.60
27788 00	Surgery	12.77	11.56	\$ 893.90	\$ 809.20
27792 00	Surgery	19.21	19.21	\$ 1,344.70	\$ 1,344.70
27808 00	Surgery	10.10	9.21	\$ 707.00	\$ 644.70
27810 00	Surgery	14.17	12.77	\$ 991.90	\$ 893.90
27814 00	Surgery	22.74	22.74	\$ 1,591.80	\$ 1,591.80
27816 00	Surgery	9.96	8.85	\$ 697.20	\$ 619.50
27818 00	Surgery	14.68	13.11	\$ 1,027.60	\$ 917.70
27822 00	Surgery	26.17	26.17	\$ 1,831.90	\$ 1,831.90
27823 00	Surgery	29.39	29.39	\$ 2,057.30	\$ 2,057.30
27824 00	Surgery	9.55	9.15	\$ 668.50	\$ 640.50
27825 00	Surgery	16.26	14.68	\$ 1,138.20	\$ 1,027.60
27826 00	Surgery	25.53	25.53	\$ 1,787.10	\$ 1,787.10
27827 00	Surgery	33.41	33.41	\$ 2,338.70	\$ 2,338.70
27828 00	Surgery	39.61	39.61	\$ 2,772.70	\$ 2,772.70
27829 00	Surgery	21.16	21.16	\$ 1,481.20	\$ 1,481.20
27830 00	Surgery	11.76	10.84	\$ 823.20	\$ 758.80
27831 00	Surgery	12.27	12.27	\$ 858.90	\$ 858.90
27832 00	Surgery	22.54	22.54	\$ 1,577.80	\$ 1,577.80
27840 00	Surgery	11.46	11.46	\$ 802.20	\$ 802.20
27842 00	Surgery	14.84	14.84	\$ 1,038.80	\$ 1,038.80
27846 00	Surgery	21.51	21.51	\$ 1,505.70	\$ 1,505.70
27848 00	Surgery	23.50	23.50	\$ 1,645.00	\$ 1,645.00
27860 00	Surgery	4.91	4.91	\$ 343.70	\$ 343.70
27870 00	Surgery	29.98	29.98	\$ 2,098.60	\$ 2,098.60
27871 00	Surgery	20.52	20.52	\$ 1,436.40	\$ 1,436.40
27880 00	Surgery	26.72	26.72	\$ 1,870.40	\$ 1,870.40
27881 00	Surgery	25.37	25.37	\$ 1,775.90	\$ 1,775.90
27882 00	Surgery	17.59	17.59	\$ 1,231.30	\$ 1,231.30
27884 00	Surgery	17.17	17.17	\$ 1,201.90	\$ 1,201.90
27886 00	Surgery	19.32	19.32	\$ 1,352.40	\$ 1,352.40
27888 00	Surgery	19.26	19.26	\$ 1,348.20	\$ 1,348.20
27889 00	Surgery	18.89	18.89	\$ 1,322.30	\$ 1,322.30
27892 00	Surgery	15.94	15.94	\$ 1,115.80	\$ 1,115.80
27893 00	Surgery	18.29	18.29	\$ 1,280.30	\$ 1,280.30
27894 00	Surgery	24.32	24.32	\$ 1,702.40	\$ 1,702.40
27899 00	Surgery	0.00	0.00	BR	BR
28001 00	Surgery	5.17	2.85	\$ 361.90	\$ 199.50
28002 00	Surgery	7.43	4.16	\$ 520.10	\$ 291.20
28003 00	Surgery	11.38	7.72	\$ 796.60	\$ 540.40
28005 00	Surgery	16.87	16.87	\$ 1,180.90	\$ 1,180.90
28008 00	Surgery	12.67	8.65	\$ 886.90	\$ 605.50
28010 00	Surgery	6.85	6.08	\$ 479.50	\$ 425.60
28011 00	Surgery	9.25	8.21	\$ 647.50	\$ 574.70
28020 00	Surgery	16.35	10.93	\$ 1,144.50	\$ 765.10
28022 00	Surgery	14.41	9.61	\$ 1,008.70	\$ 672.70
28024 00	Surgery	13.47	8.93	\$ 942.90	\$ 625.10
28035 00	Surgery	15.52	10.47	\$ 1,086.40	\$ 732.90
28039 00	Surgery	14.54	10.24	\$ 1,017.80	\$ 716.80
28041 00	Surgery	13.25	13.25	\$ 927.50	\$ 927.50

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
28043 00	Surgery	11.34	7.63	\$ 793.80	\$ 534.10
28045 00	Surgery	14.12	10.14	\$ 988.40	\$ 709.80
28046 00	Surgery	20.96	20.96	\$ 1,467.20	\$ 1,467.20
28047 00	Surgery	30.44	30.44	\$ 2,130.80	\$ 2,130.80
28050 00	Surgery	12.27	8.15	\$ 858.90	\$ 570.50
28052 00	Surgery	11.52	7.49	\$ 806.40	\$ 524.30
28054 00	Surgery	10.83	6.85	\$ 758.10	\$ 479.50
28055 00	Surgery	11.23	11.23	\$ 786.10	\$ 786.10
28060 00	Surgery	15.40	10.63	\$ 1,078.00	\$ 744.10
28062 00	Surgery	16.81	11.77	\$ 1,176.70	\$ 823.90
28070 00	Surgery	15.25	10.23	\$ 1,067.50	\$ 716.10
28072 00	Surgery	14.53	9.56	\$ 1,017.10	\$ 669.20
28080 00	Surgery	15.73	11.07	\$ 1,101.10	\$ 774.90
28086 00	Surgery	15.92	10.51	\$ 1,114.40	\$ 735.70
28088 00	Surgery	13.49	8.47	\$ 944.30	\$ 592.90
28090 00	Surgery	13.73	9.03	\$ 961.10	\$ 632.10
28092 00	Surgery	12.37	7.91	\$ 865.90	\$ 553.70
28100 00	Surgery	18.24	12.41	\$ 1,276.80	\$ 868.70
28102 00	Surgery	18.22	18.22	\$ 1,275.40	\$ 1,275.40
28103 00	Surgery	11.39	11.39	\$ 797.30	\$ 797.30
28104 00	Surgery	15.50	10.38	\$ 1,085.00	\$ 726.60
28106 00	Surgery	12.51	12.51	\$ 875.70	\$ 875.70
28107 00	Surgery	14.88	10.14	\$ 1,041.60	\$ 709.80
28108 00	Surgery	12.83	8.45	\$ 898.10	\$ 591.50
28110 00	Surgery	13.59	8.54	\$ 951.30	\$ 597.80
28111 00	Surgery	14.23	9.46	\$ 996.10	\$ 662.20
28112 00	Surgery	14.30	9.20	\$ 1,001.00	\$ 644.00
28113 00	Surgery	17.25	12.48	\$ 1,207.50	\$ 873.60
28114 00	Surgery	31.54	24.68	\$ 2,207.80	\$ 1,727.60
28116 00	Surgery	22.85	17.22	\$ 1,599.50	\$ 1,205.40
28118 00	Surgery	17.86	12.42	\$ 1,250.20	\$ 869.40
28119 00	Surgery	15.55	10.70	\$ 1,088.50	\$ 749.00
28120 00	Surgery	19.95	14.67	\$ 1,396.50	\$ 1,026.90
28122 00	Surgery	17.45	12.87	\$ 1,221.50	\$ 900.90
28124 00	Surgery	14.05	9.77	\$ 983.50	\$ 683.90
28126 00	Surgery	11.50	7.27	\$ 805.00	\$ 508.90
28130 00	Surgery	18.10	18.10	\$ 1,267.00	\$ 1,267.00
28140 00	Surgery	17.06	12.68	\$ 1,194.20	\$ 887.60
28150 00	Surgery	12.32	8.15	\$ 862.40	\$ 570.50
28153 00	Surgery	12.04	7.77	\$ 842.80	\$ 543.90
28160 00	Surgery	12.16	7.86	\$ 851.20	\$ 550.20
28171 00	Surgery	32.80	32.80	\$ 2,296.00	\$ 2,296.00
28173 00	Surgery	21.27	21.27	\$ 1,488.90	\$ 1,488.90
28175 00	Surgery	13.74	13.74	\$ 961.80	\$ 961.80
28190 00	Surgery	7.23	3.89	\$ 506.10	\$ 272.30
28192 00	Surgery	13.61	9.12	\$ 952.70	\$ 638.40
28193 00	Surgery	15.42	10.75	\$ 1,079.40	\$ 752.50
28200 00	Surgery	14.70	9.65	\$ 1,029.00	\$ 675.50
28202 00	Surgery	17.58	12.57	\$ 1,230.60	\$ 879.90
28208 00	Surgery	14.30	9.41	\$ 1,001.00	\$ 658.70
28210 00	Surgery	17.32	12.32	\$ 1,212.40	\$ 862.40
28220 00	Surgery	13.30	8.94	\$ 931.00	\$ 625.80
28222 00	Surgery	15.39	10.59	\$ 1,077.30	\$ 741.30
28225 00	Surgery	12.27	7.77	\$ 858.90	\$ 543.90

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
28226 00	Surgery	18.44	11.85	\$ 1,290.80	\$ 829.50
28230 00	Surgery	12.78	8.33	\$ 894.60	\$ 583.10
28232 00	Surgery	11.19	7.06	\$ 783.30	\$ 494.20
28234 00	Surgery	12.06	7.84	\$ 844.20	\$ 548.80
28238 00	Surgery	19.84	14.41	\$ 1,388.80	\$ 1,008.70
28240 00	Surgery	13.15	8.62	\$ 920.50	\$ 603.40
28250 00	Surgery	17.17	11.95	\$ 1,201.90	\$ 836.50
28260 00	Surgery	21.01	15.55	\$ 1,470.70	\$ 1,088.50
28261 00	Surgery	35.73	27.83	\$ 2,501.10	\$ 1,948.10
28262 00	Surgery	41.45	33.35	\$ 2,901.50	\$ 2,334.50
28264 00	Surgery	26.80	20.51	\$ 1,876.00	\$ 1,435.70
28270 00	Surgery	14.38	9.80	\$ 1,006.60	\$ 686.00
28272 00	Surgery	11.33	7.35	\$ 793.10	\$ 514.50
28280 00	Surgery	15.11	10.23	\$ 1,057.70	\$ 716.10
28285 00	Surgery	15.86	11.28	\$ 1,110.20	\$ 789.60
28286 00	Surgery	13.05	8.71	\$ 913.50	\$ 609.70
28288 00	Surgery	17.87	12.77	\$ 1,250.90	\$ 893.90
28289 00	Surgery	20.34	13.49	\$ 1,423.80	\$ 944.30
28291 00	Surgery	20.93	14.41	\$ 1,465.10	\$ 1,008.70
28292 00	Surgery	20.51	14.13	\$ 1,435.70	\$ 989.10
28295 00	Surgery	32.50	18.21	\$ 2,275.00	\$ 1,274.70
28296 00	Surgery	26.38	15.04	\$ 1,846.60	\$ 1,052.80
28297 00	Surgery	30.82	17.80	\$ 2,157.40	\$ 1,246.00
28298 00	Surgery	24.68	14.78	\$ 1,727.60	\$ 1,034.60
28299 00	Surgery	29.88	17.30	\$ 2,091.60	\$ 1,211.00
28300 00	Surgery	19.23	19.23	\$ 1,346.10	\$ 1,346.10
28302 00	Surgery	21.32	21.32	\$ 1,492.40	\$ 1,492.40
28304 00	Surgery	24.49	18.06	\$ 1,714.30	\$ 1,264.20
28305 00	Surgery	20.05	20.05	\$ 1,403.50	\$ 1,403.50
28306 00	Surgery	17.92	11.88	\$ 1,254.40	\$ 831.60
28307 00	Surgery	23.43	15.38	\$ 1,640.10	\$ 1,076.60
28308 00	Surgery	16.86	11.34	\$ 1,180.20	\$ 793.80
28309 00	Surgery	26.35	26.35	\$ 1,844.50	\$ 1,844.50
28310 00	Surgery	16.11	10.63	\$ 1,127.70	\$ 744.10
28312 00	Surgery	15.33	9.67	\$ 1,073.10	\$ 676.90
28313 00	Surgery	15.61	10.58	\$ 1,092.70	\$ 740.60
28315 00	Surgery	14.21	9.62	\$ 994.70	\$ 673.40
28320 00	Surgery	18.04	18.04	\$ 1,262.80	\$ 1,262.80
28322 00	Surgery	23.25	17.04	\$ 1,627.50	\$ 1,192.80
28340 00	Surgery	16.70	11.99	\$ 1,169.00	\$ 839.30
28341 00	Surgery	19.35	14.28	\$ 1,354.50	\$ 999.60
28344 00	Surgery	12.35	8.16	\$ 864.50	\$ 571.20
28345 00	Surgery	15.12	10.63	\$ 1,058.40	\$ 744.10
28360 00	Surgery	32.64	32.64	\$ 2,284.80	\$ 2,284.80
28400 00	Surgery	7.39	6.85	\$ 517.30	\$ 479.50
28405 00	Surgery	11.62	10.47	\$ 813.40	\$ 732.90
28406 00	Surgery	16.85	16.85	\$ 1,179.50	\$ 1,179.50
28415 00	Surgery	33.45	33.45	\$ 2,341.50	\$ 2,341.50
28420 00	Surgery	38.65	38.65	\$ 2,705.50	\$ 2,705.50
28430 00	Surgery	7.19	6.30	\$ 503.30	\$ 441.00
28435 00	Surgery	11.08	9.82	\$ 775.60	\$ 687.40
28436 00	Surgery	14.89	14.89	\$ 1,042.30	\$ 1,042.30
28445 00	Surgery	30.28	30.28	\$ 2,119.60	\$ 2,119.60
28446 00	Surgery	36.32	36.32	\$ 2,542.40	\$ 2,542.40

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
28450 00	Surgery	6.31	5.70	\$ 441.70	\$ 399.00
28455 00	Surgery	8.66	7.71	\$ 606.20	\$ 539.70
28456 00	Surgery	11.15	11.15	\$ 780.50	\$ 780.50
28465 00	Surgery	18.89	18.89	\$ 1,322.30	\$ 1,322.30
28470 00	Surgery	6.51	6.12	\$ 455.70	\$ 428.40
28475 00	Surgery	7.60	6.69	\$ 532.00	\$ 468.30
28476 00	Surgery	11.62	11.62	\$ 813.40	\$ 813.40
28485 00	Surgery	16.65	16.65	\$ 1,165.50	\$ 1,165.50
28490 00	Surgery	4.20	3.69	\$ 294.00	\$ 258.30
28495 00	Surgery	5.31	4.41	\$ 371.70	\$ 308.70
28496 00	Surgery	13.40	7.25	\$ 938.00	\$ 507.50
28505 00	Surgery	19.55	14.72	\$ 1,368.50	\$ 1,030.40
28510 00	Surgery	3.56	3.52	\$ 249.20	\$ 246.40
28515 00	Surgery	4.85	4.22	\$ 339.50	\$ 295.40
28525 00	Surgery	16.86	11.96	\$ 1,180.20	\$ 837.20
28530 00	Surgery	3.36	2.91	\$ 235.20	\$ 203.70
28531 00	Surgery	9.76	5.30	\$ 683.20	\$ 371.00
28540 00	Surgery	5.78	5.18	\$ 404.60	\$ 362.60
28545 00	Surgery	9.26	8.10	\$ 648.20	\$ 567.00
28546 00	Surgery	17.58	10.46	\$ 1,230.60	\$ 732.20
28555 00	Surgery	25.52	19.48	\$ 1,786.40	\$ 1,363.60
28570 00	Surgery	7.01	5.86	\$ 490.70	\$ 410.20
28575 00	Surgery	11.33	10.15	\$ 793.10	\$ 710.50
28576 00	Surgery	11.46	11.46	\$ 802.20	\$ 802.20
28585 00	Surgery	26.19	20.58	\$ 1,833.30	\$ 1,440.60
28600 00	Surgery	6.43	5.48	\$ 450.10	\$ 383.60
28605 00	Surgery	10.23	9.11	\$ 716.10	\$ 637.70
28606 00	Surgery	11.29	11.29	\$ 790.30	\$ 790.30
28615 00	Surgery	24.55	24.55	\$ 1,718.50	\$ 1,718.50
28630 00	Surgery	4.55	3.26	\$ 318.50	\$ 228.20
28635 00	Surgery	5.15	3.91	\$ 360.50	\$ 273.70
28636 00	Surgery	9.32	5.89	\$ 652.40	\$ 412.30
28645 00	Surgery	19.24	14.29	\$ 1,346.80	\$ 1,000.30
28660 00	Surgery	3.65	2.75	\$ 255.50	\$ 192.50
28665 00	Surgery	4.45	3.72	\$ 311.50	\$ 260.40
28666 00	Surgery	5.26	5.26	\$ 368.20	\$ 368.20
28675 00	Surgery	17.09	12.14	\$ 1,196.30	\$ 849.80
28705 00	Surgery	36.16	36.16	\$ 2,531.20	\$ 2,531.20
28715 00	Surgery	27.84	27.84	\$ 1,948.80	\$ 1,948.80
28725 00	Surgery	23.01	23.01	\$ 1,610.70	\$ 1,610.70
28730 00	Surgery	21.66	21.66	\$ 1,516.20	\$ 1,516.20
28735 00	Surgery	23.14	23.14	\$ 1,619.80	\$ 1,619.80
28737 00	Surgery	20.28	20.28	\$ 1,419.60	\$ 1,419.60
28740 00	Surgery	24.54	18.24	\$ 1,717.80	\$ 1,276.80
28750 00	Surgery	23.26	17.10	\$ 1,628.20	\$ 1,197.00
28755 00	Surgery	15.02	9.86	\$ 1,051.40	\$ 690.20
28760 00	Surgery	22.55	16.71	\$ 1,578.50	\$ 1,169.70
28800 00	Surgery	15.61	15.61	\$ 1,092.70	\$ 1,092.70
28805 00	Surgery	20.95	20.95	\$ 1,466.50	\$ 1,466.50
28810 00	Surgery	12.54	12.54	\$ 877.80	\$ 877.80
28820 00	Surgery	8.92	5.25	\$ 624.40	\$ 367.50
28825 00	Surgery	8.75	5.10	\$ 612.50	\$ 357.00
28890 00	Surgery	9.11	6.44	\$ 637.70	\$ 450.80
28899 00	Surgery	0.00	0.00	BR	BR

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
29000 00	Surgery	10.32	5.79	\$ 722.40	\$ 405.30
29010 00	Surgery	7.95	4.68	\$ 556.50	\$ 327.60
29015 00	Surgery	8.56	5.28	\$ 599.20	\$ 369.60
29035 00	Surgery	7.47	4.19	\$ 522.90	\$ 293.30
29040 00	Surgery	8.52	5.04	\$ 596.40	\$ 352.80
29044 00	Surgery	8.35	4.87	\$ 584.50	\$ 340.90
29046 00	Surgery	9.17	5.49	\$ 641.90	\$ 384.30
29049 00	Surgery	2.91	2.05	\$ 203.70	\$ 143.50
29055 00	Surgery	6.50	4.02	\$ 455.00	\$ 281.40
29058 00	Surgery	3.61	2.74	\$ 252.70	\$ 191.80
29065 00	Surgery	2.83	2.01	\$ 198.10	\$ 140.70
29075 00	Surgery	2.54	1.81	\$ 177.80	\$ 126.70
29085 00	Surgery	2.80	1.98	\$ 196.00	\$ 138.60
29086 00	Surgery	2.23	1.44	\$ 156.10	\$ 100.80
29105 00	Surgery	2.39	1.22	\$ 167.30	\$ 85.40
29125 00	Surgery	1.92	1.17	\$ 134.40	\$ 81.90
29126 00	Surgery	2.26	1.44	\$ 158.20	\$ 100.80
29130 00	Surgery	1.21	0.86	\$ 84.70	\$ 60.20
29131 00	Surgery	1.55	1.01	\$ 108.50	\$ 70.70
29200 00	Surgery	0.98	0.55	\$ 68.60	\$ 38.50
29240 00	Surgery	0.89	0.54	\$ 62.30	\$ 37.80
29260 00	Surgery	0.88	0.57	\$ 61.60	\$ 39.90
29280 00	Surgery	0.87	0.58	\$ 60.90	\$ 40.60
29305 00	Surgery	7.21	4.62	\$ 504.70	\$ 323.40
29325 00	Surgery	7.97	5.18	\$ 557.90	\$ 362.60
29345 00	Surgery	3.97	2.92	\$ 277.90	\$ 204.40
29355 00	Surgery	4.16	3.12	\$ 291.20	\$ 218.40
29358 00	Surgery	4.68	3.02	\$ 327.60	\$ 211.40
29365 00	Surgery	3.60	2.56	\$ 252.00	\$ 179.20
29405 00	Surgery	2.33	1.70	\$ 163.10	\$ 119.00
29425 00	Surgery	2.20	1.58	\$ 154.00	\$ 110.60
29435 00	Surgery	3.29	2.34	\$ 230.30	\$ 163.80
29440 00	Surgery	1.24	0.82	\$ 86.80	\$ 57.40
29445 00	Surgery	3.77	2.91	\$ 263.90	\$ 203.70
29450 00	Surgery	4.28	3.35	\$ 299.60	\$ 234.50
29505 00	Surgery	2.55	1.50	\$ 178.50	\$ 105.00
29515 00	Surgery	2.08	1.44	\$ 145.60	\$ 100.80
29520 00	Surgery	1.04	0.54	\$ 72.80	\$ 37.80
29530 00	Surgery	0.89	0.53	\$ 62.30	\$ 37.10
29540 00	Surgery	0.82	0.52	\$ 57.40	\$ 36.40
29550 00	Surgery	0.56	0.33	\$ 39.20	\$ 23.10
29580 00	Surgery	1.90	0.79	\$ 133.00	\$ 55.30
29581 00	Surgery	2.66	0.80	\$ 186.20	\$ 56.00
29584 00	Surgery	2.46	0.46	\$ 172.20	\$ 32.20
29700 00	Surgery	1.81	0.97	\$ 126.70	\$ 67.90
29705 00	Surgery	1.85	1.31	\$ 129.50	\$ 91.70
29710 00	Surgery	3.57	2.43	\$ 249.90	\$ 170.10
29720 00	Surgery	2.47	1.26	\$ 172.90	\$ 88.20
29730 00	Surgery	1.87	1.30	\$ 130.90	\$ 91.00
29740 00	Surgery	2.90	2.04	\$ 203.00	\$ 142.80
29750 00	Surgery	3.13	2.27	\$ 219.10	\$ 158.90
29799 00	Surgery	0.00	0.00	BR	BR
29800 00	Surgery	15.79	15.79	\$ 1,105.30	\$ 1,105.30
29804 00	Surgery	17.76	17.76	\$ 1,243.20	\$ 1,243.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
29805 00	Surgery	13.96	13.96	\$ 977.20	\$ 977.20
29806 00	Surgery	31.44	31.44	\$ 2,200.80	\$ 2,200.80
29807 00	Surgery	30.67	30.67	\$ 2,146.90	\$ 2,146.90
29819 00	Surgery	17.48	17.48	\$ 1,223.60	\$ 1,223.60
29820 00	Surgery	15.98	15.98	\$ 1,118.60	\$ 1,118.60
29821 00	Surgery	17.71	17.71	\$ 1,239.70	\$ 1,239.70
29822 00	Surgery	16.12	16.12	\$ 1,128.40	\$ 1,128.40
29823 00	Surgery	17.64	17.64	\$ 1,234.80	\$ 1,234.80
29824 00	Surgery	20.15	20.15	\$ 1,410.50	\$ 1,410.50
29825 00	Surgery	17.48	17.48	\$ 1,223.60	\$ 1,223.60
29826 00	Surgery	5.10	5.10	\$ 357.00	\$ 357.00
29827 00	Surgery	31.71	31.71	\$ 2,219.70	\$ 2,219.70
29828 00	Surgery	27.22	27.22	\$ 1,905.40	\$ 1,905.40
29830 00	Surgery	13.54	13.54	\$ 947.80	\$ 947.80
29834 00	Surgery	14.66	14.66	\$ 1,026.20	\$ 1,026.20
29835 00	Surgery	15.19	15.19	\$ 1,063.30	\$ 1,063.30
29836 00	Surgery	17.43	17.43	\$ 1,220.10	\$ 1,220.10
29837 00	Surgery	15.77	15.77	\$ 1,103.90	\$ 1,103.90
29838 00	Surgery	17.67	17.67	\$ 1,236.90	\$ 1,236.90
29840 00	Surgery	13.42	13.42	\$ 939.40	\$ 939.40
29843 00	Surgery	14.50	14.50	\$ 1,015.00	\$ 1,015.00
29844 00	Surgery	14.86	14.86	\$ 1,040.20	\$ 1,040.20
29845 00	Surgery	17.42	17.42	\$ 1,219.40	\$ 1,219.40
29846 00	Surgery	15.54	15.54	\$ 1,087.80	\$ 1,087.80
29847 00	Surgery	16.21	16.21	\$ 1,134.70	\$ 1,134.70
29848 00	Surgery	15.20	15.20	\$ 1,064.00	\$ 1,064.00
29850 00	Surgery	18.56	18.56	\$ 1,299.20	\$ 1,299.20
29851 00	Surgery	27.58	27.58	\$ 1,930.60	\$ 1,930.60
29855 00	Surgery	23.22	23.22	\$ 1,625.40	\$ 1,625.40
29856 00	Surgery	29.46	29.46	\$ 2,062.20	\$ 2,062.20
29860 00	Surgery	19.11	19.11	\$ 1,337.70	\$ 1,337.70
29861 00	Surgery	21.34	21.34	\$ 1,493.80	\$ 1,493.80
29862 00	Surgery	24.21	24.21	\$ 1,694.70	\$ 1,694.70
29863 00	Surgery	24.12	24.12	\$ 1,688.40	\$ 1,688.40
29866 00	Surgery	31.23	31.23	\$ 2,186.10	\$ 2,186.10
29867 00	Surgery	37.90	37.90	\$ 2,653.00	\$ 2,653.00
29868 00	Surgery	49.40	49.40	\$ 3,458.00	\$ 3,458.00
29870 00	Surgery	16.51	12.12	\$ 1,155.70	\$ 848.40
29871 00	Surgery	15.32	15.32	\$ 1,072.40	\$ 1,072.40
29873 00	Surgery	16.02	16.02	\$ 1,121.40	\$ 1,121.40
29874 00	Surgery	15.96	15.96	\$ 1,117.20	\$ 1,117.20
29875 00	Surgery	14.78	14.78	\$ 1,034.60	\$ 1,034.60
29876 00	Surgery	19.43	19.43	\$ 1,360.10	\$ 1,360.10
29877 00	Surgery	18.49	18.49	\$ 1,294.30	\$ 1,294.30
29879 00	Surgery	19.67	19.67	\$ 1,376.90	\$ 1,376.90
29880 00	Surgery	16.73	16.73	\$ 1,171.10	\$ 1,171.10
29881 00	Surgery	16.12	16.12	\$ 1,128.40	\$ 1,128.40
29882 00	Surgery	20.47	20.47	\$ 1,432.90	\$ 1,432.90
29883 00	Surgery	24.97	24.97	\$ 1,747.90	\$ 1,747.90
29884 00	Surgery	18.39	18.39	\$ 1,287.30	\$ 1,287.30
29885 00	Surgery	22.49	22.49	\$ 1,574.30	\$ 1,574.30
29886 00	Surgery	18.92	18.92	\$ 1,324.40	\$ 1,324.40
29887 00	Surgery	22.39	22.39	\$ 1,567.30	\$ 1,567.30
29888 00	Surgery	28.99	28.99	\$ 2,029.30	\$ 2,029.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
29889 00	Surgery	36.31	36.31	\$ 2,541.70	\$ 2,541.70
29891 00	Surgery	19.87	19.87	\$ 1,390.90	\$ 1,390.90
29892 00	Surgery	18.82	18.82	\$ 1,317.40	\$ 1,317.40
29893 00	Surgery	19.72	12.75	\$ 1,380.40	\$ 892.50
29894 00	Surgery	14.96	14.96	\$ 1,047.20	\$ 1,047.20
29895 00	Surgery	13.87	13.87	\$ 970.90	\$ 970.90
29897 00	Surgery	14.59	14.59	\$ 1,021.30	\$ 1,021.30
29898 00	Surgery	16.63	16.63	\$ 1,164.10	\$ 1,164.10
29899 00	Surgery	30.11	30.11	\$ 2,107.70	\$ 2,107.70
29900 00	Surgery	15.00	15.00	\$ 1,050.00	\$ 1,050.00
29901 00	Surgery	16.10	16.10	\$ 1,127.00	\$ 1,127.00
29902 00	Surgery	17.07	17.07	\$ 1,194.90	\$ 1,194.90
29904 00	Surgery	19.00	19.00	\$ 1,330.00	\$ 1,330.00
29905 00	Surgery	15.08	15.08	\$ 1,055.60	\$ 1,055.60
29906 00	Surgery	19.35	19.35	\$ 1,354.50	\$ 1,354.50
29907 00	Surgery	26.05	26.05	\$ 1,823.50	\$ 1,823.50
29914 00	Surgery	29.61	29.61	\$ 2,072.70	\$ 2,072.70
29915 00	Surgery	30.47	30.47	\$ 2,132.90	\$ 2,132.90
29916 00	Surgery	30.27	30.27	\$ 2,118.90	\$ 2,118.90
29999 00	Surgery	0.00	0.00	BR	BR
30000 00	Surgery	8.13	3.56	\$ 569.10	\$ 249.20
30020 00	Surgery	8.21	3.60	\$ 574.70	\$ 252.00
30100 00	Surgery	4.27	1.98	\$ 298.90	\$ 138.60
30110 00	Surgery	7.49	3.90	\$ 524.30	\$ 273.00
30115 00	Surgery	14.10	14.10	\$ 987.00	\$ 987.00
30117 00	Surgery	29.62	9.88	\$ 2,073.40	\$ 691.60
30118 00	Surgery	23.84	23.84	\$ 1,668.80	\$ 1,668.80
30120 00	Surgery	15.15	12.42	\$ 1,060.50	\$ 869.40
30124 00	Surgery	9.09	9.09	\$ 636.30	\$ 636.30
30125 00	Surgery	19.73	19.73	\$ 1,381.10	\$ 1,381.10
30130 00	Surgery	12.61	12.61	\$ 882.70	\$ 882.70
30140 00	Surgery	8.88	5.23	\$ 621.60	\$ 366.10
30150 00	Surgery	24.17	24.17	\$ 1,691.90	\$ 1,691.90
30160 00	Surgery	24.51	24.51	\$ 1,715.70	\$ 1,715.70
30200 00	Surgery	3.32	1.73	\$ 232.40	\$ 121.10
30210 00	Surgery	4.53	3.04	\$ 317.10	\$ 212.80
30220 00	Surgery	9.27	3.77	\$ 648.90	\$ 263.90
30300 00	Surgery	6.34	3.70	\$ 443.80	\$ 259.00
30310 00	Surgery	6.27	6.27	\$ 438.90	\$ 438.90
30320 00	Surgery	14.73	14.73	\$ 1,031.10	\$ 1,031.10
30400 00	Surgery	37.22	37.22	\$ 2,605.40	\$ 2,605.40
30410 00	Surgery	42.74	42.74	\$ 2,991.80	\$ 2,991.80
30420 00	Surgery	43.78	43.78	\$ 3,064.60	\$ 3,064.60
30430 00	Surgery	32.60	32.60	\$ 2,282.00	\$ 2,282.00
30435 00	Surgery	40.52	40.52	\$ 2,836.40	\$ 2,836.40
30450 00	Surgery	52.73	52.73	\$ 3,691.10	\$ 3,691.10
30460 00	Surgery	24.85	24.85	\$ 1,739.50	\$ 1,739.50
30462 00	Surgery	47.90	47.90	\$ 3,353.00	\$ 3,353.00
30465 00	Surgery	30.91	30.91	\$ 2,163.70	\$ 2,163.70
30468 00	Surgery	79.50	4.94	\$ 5,565.00	\$ 345.80
30520 00	Surgery	20.31	20.31	\$ 1,421.70	\$ 1,421.70
30540 00	Surgery	22.29	22.29	\$ 1,560.30	\$ 1,560.30
30545 00	Surgery	30.25	30.25	\$ 2,117.50	\$ 2,117.50
30560 00	Surgery	9.88	4.52	\$ 691.60	\$ 316.40

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
30580 00	Surgery	18.25	13.59	\$ 1,277.50	\$ 951.30
30600 00	Surgery	15.37	11.28	\$ 1,075.90	\$ 789.60
30620 00	Surgery	20.46	20.46	\$ 1,432.20	\$ 1,432.20
30630 00	Surgery	20.20	20.20	\$ 1,414.00	\$ 1,414.00
30801 00	Surgery	6.63	4.61	\$ 464.10	\$ 322.70
30802 00	Surgery	8.39	6.11	\$ 587.30	\$ 427.70
30901 00	Surgery	4.76	1.67	\$ 333.20	\$ 116.90
30903 00	Surgery	7.45	2.27	\$ 521.50	\$ 158.90
30905 00	Surgery	10.66	3.11	\$ 746.20	\$ 217.70
30906 00	Surgery	11.19	4.00	\$ 783.30	\$ 280.00
30915 00	Surgery	18.09	18.09	\$ 1,266.30	\$ 1,266.30
30920 00	Surgery	26.23	26.23	\$ 1,836.10	\$ 1,836.10
30930 00	Surgery	3.48	3.48	\$ 243.60	\$ 243.60
30999 00	Surgery	0.00	0.00	BR	BR
31000 00	Surgery	5.52	3.23	\$ 386.40	\$ 226.10
31002 00	Surgery	5.82	5.82	\$ 407.40	\$ 407.40
31020 00	Surgery	13.79	11.13	\$ 965.30	\$ 779.10
31030 00	Surgery	19.09	15.29	\$ 1,336.30	\$ 1,070.30
31032 00	Surgery	17.79	17.79	\$ 1,245.30	\$ 1,245.30
31040 00	Surgery	24.21	24.21	\$ 1,694.70	\$ 1,694.70
31050 00	Surgery	15.60	15.60	\$ 1,092.00	\$ 1,092.00
31051 00	Surgery	20.96	20.96	\$ 1,467.20	\$ 1,467.20
31070 00	Surgery	14.37	14.37	\$ 1,005.90	\$ 1,005.90
31075 00	Surgery	24.95	24.95	\$ 1,746.50	\$ 1,746.50
31080 00	Surgery	32.82	32.82	\$ 2,297.40	\$ 2,297.40
31081 00	Surgery	35.13	35.13	\$ 2,459.10	\$ 2,459.10
31084 00	Surgery	36.37	36.37	\$ 2,545.90	\$ 2,545.90
31085 00	Surgery	37.46	37.46	\$ 2,622.20	\$ 2,622.20
31086 00	Surgery	35.40	35.40	\$ 2,478.00	\$ 2,478.00
31087 00	Surgery	33.61	33.61	\$ 2,352.70	\$ 2,352.70
31090 00	Surgery	33.55	33.55	\$ 2,348.50	\$ 2,348.50
31200 00	Surgery	18.73	18.73	\$ 1,311.10	\$ 1,311.10
31201 00	Surgery	24.05	24.05	\$ 1,683.50	\$ 1,683.50
31205 00	Surgery	27.99	27.99	\$ 1,959.30	\$ 1,959.30
31225 00	Surgery	53.66	53.66	\$ 3,756.20	\$ 3,756.20
31230 00	Surgery	59.74	59.74	\$ 4,181.80	\$ 4,181.80
31231 00	Surgery	5.66	1.87	\$ 396.20	\$ 130.90
31233 00	Surgery	8.24	3.96	\$ 576.80	\$ 277.20
31235 00	Surgery	9.35	4.65	\$ 654.50	\$ 325.50
31237 00	Surgery	7.63	4.68	\$ 534.10	\$ 327.60
31238 00	Surgery	7.45	4.90	\$ 521.50	\$ 343.00
31239 00	Surgery	17.89	17.89	\$ 1,252.30	\$ 1,252.30
31240 00	Surgery	4.65	4.65	\$ 325.50	\$ 325.50
31241 00	Surgery	13.05	13.05	\$ 913.50	\$ 913.50
31253 00	Surgery	14.71	14.71	\$ 1,029.70	\$ 1,029.70
31254 00	Surgery	13.18	7.14	\$ 922.60	\$ 499.80
31255 00	Surgery	9.53	9.53	\$ 667.10	\$ 667.10
31256 00	Surgery	5.27	5.27	\$ 368.90	\$ 368.90
31257 00	Surgery	13.09	13.09	\$ 916.30	\$ 916.30
31259 00	Surgery	13.86	13.86	\$ 970.20	\$ 970.20
31267 00	Surgery	7.79	7.79	\$ 545.30	\$ 545.30
31276 00	Surgery	11.10	11.10	\$ 777.00	\$ 777.00
31287 00	Surgery	5.92	5.92	\$ 414.40	\$ 414.40
31288 00	Surgery	6.89	6.89	\$ 482.30	\$ 482.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
31290 00	Surgery	33.97	33.97	\$ 2,377.90	\$ 2,377.90
31291 00	Surgery	35.73	35.73	\$ 2,501.10	\$ 2,501.10
31292 00	Surgery	29.54	29.54	\$ 2,067.80	\$ 2,067.80
31293 00	Surgery	31.91	31.91	\$ 2,233.70	\$ 2,233.70
31294 00	Surgery	36.44	36.44	\$ 2,550.80	\$ 2,550.80
31295 00	Surgery	51.85	4.64	\$ 3,629.50	\$ 324.80
31296 00	Surgery	52.58	5.25	\$ 3,680.60	\$ 367.50
31297 00	Surgery	51.42	4.21	\$ 3,599.40	\$ 294.70
31298 00	Surgery	97.68	7.51	\$ 6,837.60	\$ 525.70
31299 00	Surgery	0.00	0.00	BR	BR
31300 00	Surgery	37.35	37.35	\$ 2,614.50	\$ 2,614.50
31360 00	Surgery	61.10	61.10	\$ 4,277.00	\$ 4,277.00
31365 00	Surgery	75.29	75.29	\$ 5,270.30	\$ 5,270.30
31367 00	Surgery	64.75	64.75	\$ 4,532.50	\$ 4,532.50
31368 00	Surgery	71.64	71.64	\$ 5,014.80	\$ 5,014.80
31370 00	Surgery	60.86	60.86	\$ 4,260.20	\$ 4,260.20
31375 00	Surgery	57.84	57.84	\$ 4,048.80	\$ 4,048.80
31380 00	Surgery	57.03	57.03	\$ 3,992.10	\$ 3,992.10
31382 00	Surgery	62.46	62.46	\$ 4,372.20	\$ 4,372.20
31390 00	Surgery	83.20	83.20	\$ 5,824.00	\$ 5,824.00
31395 00	Surgery	87.43	87.43	\$ 6,120.10	\$ 6,120.10
31400 00	Surgery	30.24	30.24	\$ 2,116.80	\$ 2,116.80
31420 00	Surgery	24.77	24.77	\$ 1,733.90	\$ 1,733.90
31500 00	Surgery	4.15	4.15	\$ 290.50	\$ 290.50
31502 00	Surgery	1.03	1.03	\$ 72.10	\$ 72.10
31505 00	Surgery	2.73	1.44	\$ 191.10	\$ 100.80
31510 00	Surgery	6.41	3.52	\$ 448.70	\$ 246.40
31511 00	Surgery	6.34	3.88	\$ 443.80	\$ 271.60
31512 00	Surgery	6.44	3.77	\$ 450.80	\$ 263.90
31513 00	Surgery	3.82	3.82	\$ 267.40	\$ 267.40
31515 00	Surgery	6.41	3.27	\$ 448.70	\$ 228.90
31520 00	Surgery	4.55	4.55	\$ 318.50	\$ 318.50
31525 00	Surgery	7.47	4.69	\$ 522.90	\$ 328.30
31526 00	Surgery	4.59	4.59	\$ 321.30	\$ 321.30
31527 00	Surgery	5.69	5.69	\$ 398.30	\$ 398.30
31528 00	Surgery	4.20	4.20	\$ 294.00	\$ 294.00
31529 00	Surgery	4.72	4.72	\$ 330.40	\$ 330.40
31530 00	Surgery	5.84	5.84	\$ 408.80	\$ 408.80
31531 00	Surgery	6.18	6.18	\$ 432.60	\$ 432.60
31535 00	Surgery	5.52	5.52	\$ 386.40	\$ 386.40
31536 00	Surgery	6.16	6.16	\$ 431.20	\$ 431.20
31540 00	Surgery	7.08	7.08	\$ 495.60	\$ 495.60
31541 00	Surgery	7.70	7.70	\$ 539.00	\$ 539.00
31545 00	Surgery	10.59	10.59	\$ 741.30	\$ 741.30
31546 00	Surgery	16.07	16.07	\$ 1,124.90	\$ 1,124.90
31551 00	Surgery	45.91	45.91	\$ 3,213.70	\$ 3,213.70
31552 00	Surgery	44.36	44.36	\$ 3,105.20	\$ 3,105.20
31553 00	Surgery	50.26	50.26	\$ 3,518.20	\$ 3,518.20
31554 00	Surgery	50.29	50.29	\$ 3,520.30	\$ 3,520.30
31560 00	Surgery	9.14	9.14	\$ 639.80	\$ 639.80
31561 00	Surgery	10.01	10.01	\$ 700.70	\$ 700.70
31570 00	Surgery	10.21	6.72	\$ 714.70	\$ 470.40
31571 00	Surgery	7.28	7.28	\$ 509.60	\$ 509.60
31572 00	Surgery	15.99	5.28	\$ 1,119.30	\$ 369.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
31573 00	Surgery	8.58	4.34	\$ 600.60	\$ 303.80
31574 00	Surgery	29.16	4.35	\$ 2,041.20	\$ 304.50
31575 00	Surgery	3.85	1.97	\$ 269.50	\$ 137.90
31576 00	Surgery	8.04	3.47	\$ 562.80	\$ 242.90
31577 00	Surgery	8.24	3.97	\$ 576.80	\$ 277.90
31578 00	Surgery	9.16	4.35	\$ 641.20	\$ 304.50
31579 00	Surgery	5.91	3.49	\$ 413.70	\$ 244.30
31580 00	Surgery	38.46	38.46	\$ 2,692.20	\$ 2,692.20
31584 00	Surgery	42.34	42.34	\$ 2,963.80	\$ 2,963.80
31587 00	Surgery	36.00	36.00	\$ 2,520.00	\$ 2,520.00
31590 00	Surgery	27.68	27.68	\$ 1,937.60	\$ 1,937.60
31591 00	Surgery	32.83	32.83	\$ 2,298.10	\$ 2,298.10
31592 00	Surgery	51.54	51.54	\$ 3,607.80	\$ 3,607.80
31599 00	Surgery	0.00	0.00	BR	BR
31600 00	Surgery	9.02	9.02	\$ 631.40	\$ 631.40
31601 00	Surgery	13.20	13.20	\$ 924.00	\$ 924.00
31603 00	Surgery	9.46	9.46	\$ 662.20	\$ 662.20
31605 00	Surgery	9.82	9.82	\$ 687.40	\$ 687.40
31610 00	Surgery	28.67	28.67	\$ 2,006.90	\$ 2,006.90
31611 00	Surgery	16.05	16.05	\$ 1,123.50	\$ 1,123.50
31612 00	Surgery	2.79	1.41	\$ 195.30	\$ 98.70
31613 00	Surgery	12.79	12.79	\$ 895.30	\$ 895.30
31614 00	Surgery	21.30	21.30	\$ 1,491.00	\$ 1,491.00
31615 00	Surgery	5.16	3.38	\$ 361.20	\$ 236.60
31622 00	Surgery	7.41	3.85	\$ 518.70	\$ 269.50
31623 00	Surgery	8.33	3.87	\$ 583.10	\$ 270.90
31624 00	Surgery	7.68	3.91	\$ 537.60	\$ 273.70
31625 00	Surgery	10.65	4.57	\$ 745.50	\$ 319.90
31626 00	Surgery	24.51	5.74	\$ 1,715.70	\$ 401.80
31627 00	Surgery	34.35	2.82	\$ 2,404.50	\$ 197.40
31628 00	Surgery	11.31	5.13	\$ 791.70	\$ 359.10
31629 00	Surgery	13.88	5.44	\$ 971.60	\$ 380.80
31630 00	Surgery	5.79	5.79	\$ 405.30	\$ 405.30
31631 00	Surgery	6.61	6.61	\$ 462.70	\$ 462.70
31632 00	Surgery	1.92	1.44	\$ 134.40	\$ 100.80
31633 00	Surgery	2.38	1.84	\$ 166.60	\$ 128.80
31634 00	Surgery	48.50	5.59	\$ 3,395.00	\$ 391.30
31635 00	Surgery	8.80	5.12	\$ 616.00	\$ 358.40
31636 00	Surgery	6.35	6.35	\$ 444.50	\$ 444.50
31637 00	Surgery	2.25	2.25	\$ 157.50	\$ 157.50
31638 00	Surgery	7.22	7.22	\$ 505.40	\$ 505.40
31640 00	Surgery	7.27	7.27	\$ 508.90	\$ 508.90
31641 00	Surgery	7.47	7.47	\$ 522.90	\$ 522.90
31643 00	Surgery	5.12	5.12	\$ 358.40	\$ 358.40
31645 00	Surgery	8.20	4.28	\$ 574.00	\$ 299.60
31646 00	Surgery	4.14	4.14	\$ 289.80	\$ 289.80
31647 00	Surgery	6.03	6.03	\$ 422.10	\$ 422.10
31648 00	Surgery	5.78	5.78	\$ 404.60	\$ 404.60
31649 00	Surgery	1.96	1.96	\$ 137.20	\$ 137.20
31651 00	Surgery	2.22	2.22	\$ 155.40	\$ 155.40
31652 00	Surgery	39.50	6.46	\$ 2,765.00	\$ 452.20
31653 00	Surgery	41.00	7.16	\$ 2,870.00	\$ 501.20
31654 00	Surgery	3.63	1.95	\$ 254.10	\$ 136.50
31660 00	Surgery	5.74	5.74	\$ 401.80	\$ 401.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
31661 00	Surgery	6.02	6.02	\$ 421.40	\$ 421.40
31717 00	Surgery	8.85	3.12	\$ 619.50	\$ 218.40
31720 00	Surgery	1.74	1.74	\$ 121.80	\$ 121.80
31725 00	Surgery	2.32	2.32	\$ 162.40	\$ 162.40
31730 00	Surgery	33.79	4.42	\$ 2,365.30	\$ 309.40
31750 00	Surgery	40.70	40.70	\$ 2,849.00	\$ 2,849.00
31755 00	Surgery	51.93	51.93	\$ 3,635.10	\$ 3,635.10
31760 00	Surgery	40.46	40.46	\$ 2,832.20	\$ 2,832.20
31766 00	Surgery	52.16	52.16	\$ 3,651.20	\$ 3,651.20
31770 00	Surgery	39.02	39.02	\$ 2,731.40	\$ 2,731.40
31775 00	Surgery	41.11	41.11	\$ 2,877.70	\$ 2,877.70
31780 00	Surgery	34.91	34.91	\$ 2,443.70	\$ 2,443.70
31781 00	Surgery	42.48	42.48	\$ 2,973.60	\$ 2,973.60
31785 00	Surgery	31.80	31.80	\$ 2,226.00	\$ 2,226.00
31786 00	Surgery	42.38	42.38	\$ 2,966.60	\$ 2,966.60
31800 00	Surgery	21.28	21.28	\$ 1,489.60	\$ 1,489.60
31805 00	Surgery	24.13	24.13	\$ 1,689.10	\$ 1,689.10
31820 00	Surgery	13.35	9.85	\$ 934.50	\$ 689.50
31825 00	Surgery	18.29	14.37	\$ 1,280.30	\$ 1,005.90
31830 00	Surgery	14.90	10.89	\$ 1,043.00	\$ 762.30
31899 00	Surgery	0.00	0.00	BR	BR
32035 00	Surgery	21.72	21.72	\$ 1,520.40	\$ 1,520.40
32036 00	Surgery	23.39	23.39	\$ 1,637.30	\$ 1,637.30
32096 00	Surgery	23.52	23.52	\$ 1,646.40	\$ 1,646.40
32097 00	Surgery	23.57	23.57	\$ 1,649.90	\$ 1,649.90
32098 00	Surgery	22.33	22.33	\$ 1,563.10	\$ 1,563.10
32100 00	Surgery	23.84	23.84	\$ 1,668.80	\$ 1,668.80
32110 00	Surgery	43.39	43.39	\$ 3,037.30	\$ 3,037.30
32120 00	Surgery	25.70	25.70	\$ 1,799.00	\$ 1,799.00
32124 00	Surgery	27.26	27.26	\$ 1,908.20	\$ 1,908.20
32140 00	Surgery	29.14	29.14	\$ 2,039.80	\$ 2,039.80
32141 00	Surgery	44.71	44.71	\$ 3,129.70	\$ 3,129.70
32150 00	Surgery	29.76	29.76	\$ 2,083.20	\$ 2,083.20
32151 00	Surgery	29.56	29.56	\$ 2,069.20	\$ 2,069.20
32160 00	Surgery	23.46	23.46	\$ 1,642.20	\$ 1,642.20
32200 00	Surgery	33.54	33.54	\$ 2,347.80	\$ 2,347.80
32215 00	Surgery	23.53	23.53	\$ 1,647.10	\$ 1,647.10
32220 00	Surgery	46.99	46.99	\$ 3,289.30	\$ 3,289.30
32225 00	Surgery	29.39	29.39	\$ 2,057.30	\$ 2,057.30
32310 00	Surgery	27.08	27.08	\$ 1,895.60	\$ 1,895.60
32320 00	Surgery	47.22	47.22	\$ 3,305.40	\$ 3,305.40
32400 00	Surgery	4.98	2.48	\$ 348.60	\$ 173.60
32408 00	Surgery	26.52	4.45	\$ 1,856.40	\$ 311.50
32440 00	Surgery	46.19	46.19	\$ 3,233.30	\$ 3,233.30
32442 00	Surgery	89.57	89.57	\$ 6,269.90	\$ 6,269.90
32445 00	Surgery	103.51	103.51	\$ 7,245.70	\$ 7,245.70
32480 00	Surgery	43.55	43.55	\$ 3,048.50	\$ 3,048.50
32482 00	Surgery	46.60	46.60	\$ 3,262.00	\$ 3,262.00
32484 00	Surgery	42.18	42.18	\$ 2,952.60	\$ 2,952.60
32486 00	Surgery	68.67	68.67	\$ 4,806.90	\$ 4,806.90
32488 00	Surgery	70.17	70.17	\$ 4,911.90	\$ 4,911.90
32491 00	Surgery	43.29	43.29	\$ 3,030.30	\$ 3,030.30
32501 00	Surgery	7.10	7.10	\$ 497.00	\$ 497.00
32503 00	Surgery	52.70	52.70	\$ 3,689.00	\$ 3,689.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
32504 00	Surgery	60.02	60.02	\$ 4,201.40	\$ 4,201.40
32505 00	Surgery	27.41	27.41	\$ 1,918.70	\$ 1,918.70
32506 00	Surgery	4.59	4.59	\$ 321.30	\$ 321.30
32507 00	Surgery	4.59	4.59	\$ 321.30	\$ 321.30
32540 00	Surgery	50.79	50.79	\$ 3,555.30	\$ 3,555.30
32550 00	Surgery	24.64	5.99	\$ 1,724.80	\$ 419.30
32551 00	Surgery	4.61	4.61	\$ 322.70	\$ 322.70
32552 00	Surgery	5.42	4.62	\$ 379.40	\$ 323.40
32553 00	Surgery	15.59	5.13	\$ 1,091.30	\$ 359.10
32554 00	Surgery	7.21	2.62	\$ 504.70	\$ 183.40
32555 00	Surgery	9.66	3.21	\$ 676.20	\$ 224.70
32556 00	Surgery	23.01	3.63	\$ 1,610.70	\$ 254.10
32557 00	Surgery	20.50	4.36	\$ 1,435.00	\$ 305.20
32560 00	Surgery	7.92	2.26	\$ 554.40	\$ 158.20
32561 00	Surgery	2.81	2.00	\$ 196.70	\$ 140.00
32562 00	Surgery	2.49	1.75	\$ 174.30	\$ 122.50
32601 00	Surgery	9.03	9.03	\$ 632.10	\$ 632.10
32604 00	Surgery	14.03	14.03	\$ 982.10	\$ 982.10
32606 00	Surgery	13.54	13.54	\$ 947.80	\$ 947.80
32607 00	Surgery	9.02	9.02	\$ 631.40	\$ 631.40
32608 00	Surgery	11.10	11.10	\$ 777.00	\$ 777.00
32609 00	Surgery	7.50	7.50	\$ 525.00	\$ 525.00
32650 00	Surgery	19.66	19.66	\$ 1,376.20	\$ 1,376.20
32651 00	Surgery	32.21	32.21	\$ 2,254.70	\$ 2,254.70
32652 00	Surgery	48.83	48.83	\$ 3,418.10	\$ 3,418.10
32653 00	Surgery	31.17	31.17	\$ 2,181.90	\$ 2,181.90
32654 00	Surgery	34.23	34.23	\$ 2,396.10	\$ 2,396.10
32655 00	Surgery	28.13	28.13	\$ 1,969.10	\$ 1,969.10
32656 00	Surgery	23.68	23.68	\$ 1,657.60	\$ 1,657.60
32658 00	Surgery	21.04	21.04	\$ 1,472.80	\$ 1,472.80
32659 00	Surgery	21.55	21.55	\$ 1,508.50	\$ 1,508.50
32661 00	Surgery	23.51	23.51	\$ 1,645.70	\$ 1,645.70
32662 00	Surgery	26.28	26.28	\$ 1,839.60	\$ 1,839.60
32663 00	Surgery	41.09	41.09	\$ 2,876.30	\$ 2,876.30
32664 00	Surgery	24.95	24.95	\$ 1,746.50	\$ 1,746.50
32665 00	Surgery	36.17	36.17	\$ 2,531.90	\$ 2,531.90
32666 00	Surgery	25.60	25.60	\$ 1,792.00	\$ 1,792.00
32667 00	Surgery	4.60	4.60	\$ 322.00	\$ 322.00
32668 00	Surgery	4.61	4.61	\$ 322.70	\$ 322.70
32669 00	Surgery	39.43	39.43	\$ 2,760.10	\$ 2,760.10
32670 00	Surgery	47.11	47.11	\$ 3,297.70	\$ 3,297.70
32671 00	Surgery	52.00	52.00	\$ 3,640.00	\$ 3,640.00
32672 00	Surgery	44.61	44.61	\$ 3,122.70	\$ 3,122.70
32673 00	Surgery	35.70	35.70	\$ 2,499.00	\$ 2,499.00
32674 00	Surgery	6.30	6.30	\$ 441.00	\$ 441.00
32701 00	Surgery	6.25	6.25	\$ 437.50	\$ 437.50
32800 00	Surgery	27.81	27.81	\$ 1,946.70	\$ 1,946.70
32810 00	Surgery	26.52	26.52	\$ 1,856.40	\$ 1,856.40
32815 00	Surgery	82.26	82.26	\$ 5,758.20	\$ 5,758.20
32820 00	Surgery	39.16	39.16	\$ 2,741.20	\$ 2,741.20
32850 00	Surgery	0.00	0.00	BR	BR
32851 00	Surgery	95.96	95.96	\$ 6,717.20	\$ 6,717.20
32852 00	Surgery	104.02	104.02	\$ 7,281.40	\$ 7,281.40
32853 00	Surgery	134.02	134.02	\$ 9,381.40	\$ 9,381.40

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
32854 00	Surgery	142.07	142.07	\$ 9,944.90	\$ 9,944.90
32855 00	Surgery	-	-	\$ 584.50	\$ 584.50
32856 00	Surgery	-	-	\$ 718.20	\$ 718.20
32900 00	Surgery	41.63	41.63	\$ 2,914.10	\$ 2,914.10
32905 00	Surgery	39.20	39.20	\$ 2,744.00	\$ 2,744.00
32906 00	Surgery	48.36	48.36	\$ 3,385.20	\$ 3,385.20
32940 00	Surgery	36.24	36.24	\$ 2,536.80	\$ 2,536.80
32960 00	Surgery	3.73	2.65	\$ 261.10	\$ 185.50
32994 00	Surgery	153.54	12.72	\$ 10,747.80	\$ 890.40
32997 00	Surgery	9.95	9.95	\$ 696.50	\$ 696.50
32998 00	Surgery	96.99	12.70	\$ 6,789.30	\$ 889.00
32999 00	Surgery	0.00	0.00	BR	BR
33016 00	Surgery	6.90	6.90	\$ 483.00	\$ 483.00
33017 00	Surgery	7.22	7.22	\$ 505.40	\$ 505.40
33018 00	Surgery	8.53	8.53	\$ 597.10	\$ 597.10
33019 00	Surgery	6.31	6.31	\$ 441.70	\$ 441.70
33020 00	Surgery	24.38	24.38	\$ 1,706.60	\$ 1,706.60
33025 00	Surgery	22.62	22.62	\$ 1,583.40	\$ 1,583.40
33030 00	Surgery	58.75	58.75	\$ 4,112.50	\$ 4,112.50
33031 00	Surgery	72.61	72.61	\$ 5,082.70	\$ 5,082.70
33050 00	Surgery	29.58	29.58	\$ 2,070.60	\$ 2,070.60
33120 00	Surgery	61.38	61.38	\$ 4,296.60	\$ 4,296.60
33130 00	Surgery	40.16	40.16	\$ 2,811.20	\$ 2,811.20
33140 00	Surgery	45.73	45.73	\$ 3,201.10	\$ 3,201.10
33141 00	Surgery	3.86	3.86	\$ 270.20	\$ 270.20
33202 00	Surgery	22.68	22.68	\$ 1,587.60	\$ 1,587.60
33203 00	Surgery	23.76	23.76	\$ 1,663.20	\$ 1,663.20
33206 00	Surgery	13.50	13.50	\$ 945.00	\$ 945.00
33207 00	Surgery	14.17	14.17	\$ 991.90	\$ 991.90
33208 00	Surgery	15.37	15.37	\$ 1,075.90	\$ 1,075.90
33210 00	Surgery	4.76	4.76	\$ 333.20	\$ 333.20
33211 00	Surgery	4.98	4.98	\$ 348.60	\$ 348.60
33212 00	Surgery	9.56	9.56	\$ 669.20	\$ 669.20
33213 00	Surgery	9.97	9.97	\$ 697.90	\$ 697.90
33214 00	Surgery	14.19	14.19	\$ 993.30	\$ 993.30
33215 00	Surgery	9.17	9.17	\$ 641.90	\$ 641.90
33216 00	Surgery	11.03	11.03	\$ 772.10	\$ 772.10
33217 00	Surgery	10.93	10.93	\$ 765.10	\$ 765.10
33218 00	Surgery	11.54	11.54	\$ 807.80	\$ 807.80
33220 00	Surgery	11.18	11.18	\$ 782.60	\$ 782.60
33221 00	Surgery	10.70	10.70	\$ 749.00	\$ 749.00
33222 00	Surgery	10.16	10.16	\$ 711.20	\$ 711.20
33223 00	Surgery	12.15	12.15	\$ 850.50	\$ 850.50
33224 00	Surgery	15.17	15.17	\$ 1,061.90	\$ 1,061.90
33225 00	Surgery	13.78	13.78	\$ 964.60	\$ 964.60
33226 00	Surgery	14.54	14.54	\$ 1,017.80	\$ 1,017.80
33227 00	Surgery	10.06	10.06	\$ 704.20	\$ 704.20
33228 00	Surgery	10.53	10.53	\$ 737.10	\$ 737.10
33229 00	Surgery	11.12	11.12	\$ 778.40	\$ 778.40
33230 00	Surgery	11.39	11.39	\$ 797.30	\$ 797.30
33231 00	Surgery	11.83	11.83	\$ 828.10	\$ 828.10
33233 00	Surgery	6.93	6.93	\$ 485.10	\$ 485.10
33234 00	Surgery	14.37	14.37	\$ 1,005.90	\$ 1,005.90
33235 00	Surgery	18.89	18.89	\$ 1,322.30	\$ 1,322.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
33236 00	Surgery	23.10	23.10	\$ 1,617.00	\$ 1,617.00
33237 00	Surgery	24.78	24.78	\$ 1,734.60	\$ 1,734.60
33238 00	Surgery	27.95	27.95	\$ 1,956.50	\$ 1,956.50
33240 00	Surgery	10.87	10.87	\$ 760.90	\$ 760.90
33241 00	Surgery	6.39	6.39	\$ 447.30	\$ 447.30
33243 00	Surgery	40.41	40.41	\$ 2,828.70	\$ 2,828.70
33244 00	Surgery	25.68	25.68	\$ 1,797.60	\$ 1,797.60
33249 00	Surgery	27.14	27.14	\$ 1,899.80	\$ 1,899.80
33250 00	Surgery	42.78	42.78	\$ 2,994.60	\$ 2,994.60
33251 00	Surgery	47.77	47.77	\$ 3,343.90	\$ 3,343.90
33254 00	Surgery	40.02	40.02	\$ 2,801.40	\$ 2,801.40
33255 00	Surgery	47.77	47.77	\$ 3,343.90	\$ 3,343.90
33256 00	Surgery	56.60	56.60	\$ 3,962.00	\$ 3,962.00
33257 00	Surgery	17.10	17.10	\$ 1,197.00	\$ 1,197.00
33258 00	Surgery	19.10	19.10	\$ 1,337.00	\$ 1,337.00
33259 00	Surgery	24.86	24.86	\$ 1,740.20	\$ 1,740.20
33261 00	Surgery	47.34	47.34	\$ 3,313.80	\$ 3,313.80
33262 00	Surgery	11.08	11.08	\$ 775.60	\$ 775.60
33263 00	Surgery	11.52	11.52	\$ 806.40	\$ 806.40
33264 00	Surgery	12.00	12.00	\$ 840.00	\$ 840.00
33265 00	Surgery	39.98	39.98	\$ 2,798.60	\$ 2,798.60
33266 00	Surgery	54.04	54.04	\$ 3,782.80	\$ 3,782.80
33267 00	Surgery	30.77	30.77	\$ 2,153.90	\$ 2,153.90
33268 00	Surgery	3.84	3.84	\$ 268.80	\$ 268.80
33269 00	Surgery	24.34	24.34	\$ 1,703.80	\$ 1,703.80
33270 00	Surgery	16.68	16.68	\$ 1,167.60	\$ 1,167.60
33271 00	Surgery	13.38	13.38	\$ 936.60	\$ 936.60
33272 00	Surgery	10.29	10.29	\$ 720.30	\$ 720.30
33273 00	Surgery	11.80	11.80	\$ 826.00	\$ 826.00
33274 00	Surgery	14.26	14.26	\$ 998.20	\$ 998.20
33275 00	Surgery	14.85	14.85	\$ 1,039.50	\$ 1,039.50
33285 00	Surgery	137.12	2.58	\$ 9,598.40	\$ 180.60
33286 00	Surgery	3.99	2.55	\$ 279.30	\$ 178.50
33289 00	Surgery	9.83	9.83	\$ 688.10	\$ 688.10
33300 00	Surgery	71.67	71.67	\$ 5,016.90	\$ 5,016.90
33305 00	Surgery	119.82	119.82	\$ 8,387.40	\$ 8,387.40
33310 00	Surgery	34.39	34.39	\$ 2,407.30	\$ 2,407.30
33315 00	Surgery	56.29	56.29	\$ 3,940.30	\$ 3,940.30
33320 00	Surgery	31.01	31.01	\$ 2,170.70	\$ 2,170.70
33321 00	Surgery	34.95	34.95	\$ 2,446.50	\$ 2,446.50
33322 00	Surgery	40.84	40.84	\$ 2,858.80	\$ 2,858.80
33330 00	Surgery	41.86	41.86	\$ 2,930.20	\$ 2,930.20
33335 00	Surgery	54.87	54.87	\$ 3,840.90	\$ 3,840.90
33340 00	Surgery	23.13	23.13	\$ 1,619.10	\$ 1,619.10
33361 00	Surgery	35.50	35.50	\$ 2,485.00	\$ 2,485.00
33362 00	Surgery	38.70	38.70	\$ 2,709.00	\$ 2,709.00
33363 00	Surgery	40.12	40.12	\$ 2,808.40	\$ 2,808.40
33364 00	Surgery	40.08	40.08	\$ 2,805.60	\$ 2,805.60
33365 00	Surgery	41.86	41.86	\$ 2,930.20	\$ 2,930.20
33366 00	Surgery	46.13	46.13	\$ 3,229.10	\$ 3,229.10
33367 00	Surgery	17.94	17.94	\$ 1,255.80	\$ 1,255.80
33368 00	Surgery	21.74	21.74	\$ 1,521.80	\$ 1,521.80
33369 00	Surgery	28.68	28.68	\$ 2,007.60	\$ 2,007.60
33370 00	Surgery	3.90	3.90	\$ 273.00	\$ 273.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
33390 00	Surgery	56.58	56.58	\$ 3,960.60	\$ 3,960.60
33391 00	Surgery	67.27	67.27	\$ 4,708.90	\$ 4,708.90
33404 00	Surgery	51.36	51.36	\$ 3,595.20	\$ 3,595.20
33405 00	Surgery	66.61	66.61	\$ 4,662.70	\$ 4,662.70
33406 00	Surgery	84.31	84.31	\$ 5,901.70	\$ 5,901.70
33410 00	Surgery	74.51	74.51	\$ 5,215.70	\$ 5,215.70
33411 00	Surgery	98.35	98.35	\$ 6,884.50	\$ 6,884.50
33412 00	Surgery	92.30	92.30	\$ 6,461.00	\$ 6,461.00
33413 00	Surgery	94.57	94.57	\$ 6,619.90	\$ 6,619.90
33414 00	Surgery	62.95	62.95	\$ 4,406.50	\$ 4,406.50
33415 00	Surgery	59.50	59.50	\$ 4,165.00	\$ 4,165.00
33416 00	Surgery	59.35	59.35	\$ 4,154.50	\$ 4,154.50
33417 00	Surgery	48.97	48.97	\$ 3,427.90	\$ 3,427.90
33418 00	Surgery	52.83	52.83	\$ 3,698.10	\$ 3,698.10
33419 00	Surgery	12.44	12.44	\$ 870.80	\$ 870.80
33420 00	Surgery	42.63	42.63	\$ 2,984.10	\$ 2,984.10
33422 00	Surgery	48.87	48.87	\$ 3,420.90	\$ 3,420.90
33425 00	Surgery	80.10	80.10	\$ 5,607.00	\$ 5,607.00
33426 00	Surgery	69.85	69.85	\$ 4,889.50	\$ 4,889.50
33427 00	Surgery	71.49	71.49	\$ 5,004.30	\$ 5,004.30
33430 00	Surgery	82.19	82.19	\$ 5,753.30	\$ 5,753.30
33440 00	Surgery	99.87	99.87	\$ 6,990.90	\$ 6,990.90
33460 00	Surgery	70.40	70.40	\$ 4,928.00	\$ 4,928.00
33463 00	Surgery	90.04	90.04	\$ 6,302.80	\$ 6,302.80
33464 00	Surgery	71.48	71.48	\$ 5,003.60	\$ 5,003.60
33465 00	Surgery	80.72	80.72	\$ 5,650.40	\$ 5,650.40
33468 00	Surgery	71.80	71.80	\$ 5,026.00	\$ 5,026.00
33471 00	Surgery	38.91	38.91	\$ 2,723.70	\$ 2,723.70
33474 00	Surgery	63.92	63.92	\$ 4,474.40	\$ 4,474.40
33475 00	Surgery	68.09	68.09	\$ 4,766.30	\$ 4,766.30
33476 00	Surgery	44.74	44.74	\$ 3,131.80	\$ 3,131.80
33477 00	Surgery	39.78	39.78	\$ 2,784.60	\$ 2,784.60
33478 00	Surgery	46.21	46.21	\$ 3,234.70	\$ 3,234.70
33496 00	Surgery	48.92	48.92	\$ 3,424.40	\$ 3,424.40
33500 00	Surgery	45.86	45.86	\$ 3,210.20	\$ 3,210.20
33501 00	Surgery	32.83	32.83	\$ 2,298.10	\$ 2,298.10
33502 00	Surgery	37.57	37.57	\$ 2,629.90	\$ 2,629.90
33503 00	Surgery	39.02	39.02	\$ 2,731.40	\$ 2,731.40
33504 00	Surgery	43.10	43.10	\$ 3,017.00	\$ 3,017.00
33505 00	Surgery	60.37	60.37	\$ 4,225.90	\$ 4,225.90
33506 00	Surgery	60.14	60.14	\$ 4,209.80	\$ 4,209.80
33507 00	Surgery	50.46	50.46	\$ 3,532.20	\$ 3,532.20
33508 00	Surgery	0.48	0.48	\$ 33.60	\$ 33.60
33509 00	Surgery	5.07	5.07	\$ 354.90	\$ 354.90
33510 00	Surgery	56.78	56.78	\$ 3,974.60	\$ 3,974.60
33511 00	Surgery	62.33	62.33	\$ 4,363.10	\$ 4,363.10
33512 00	Surgery	71.07	71.07	\$ 4,974.90	\$ 4,974.90
33513 00	Surgery	72.77	72.77	\$ 5,093.90	\$ 5,093.90
33514 00	Surgery	76.57	76.57	\$ 5,359.90	\$ 5,359.90
33516 00	Surgery	79.29	79.29	\$ 5,550.30	\$ 5,550.30
33517 00	Surgery	5.50	5.50	\$ 385.00	\$ 385.00
33518 00	Surgery	12.03	12.03	\$ 842.10	\$ 842.10
33519 00	Surgery	15.94	15.94	\$ 1,115.80	\$ 1,115.80
33521 00	Surgery	19.11	19.11	\$ 1,337.70	\$ 1,337.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
33522 00	Surgery	21.45	21.45	\$ 1,501.50	\$ 1,501.50
33523 00	Surgery	24.27	24.27	\$ 1,698.90	\$ 1,698.90
33530 00	Surgery	15.37	15.37	\$ 1,075.90	\$ 1,075.90
33533 00	Surgery	54.94	54.94	\$ 3,845.80	\$ 3,845.80
33534 00	Surgery	64.49	64.49	\$ 4,514.30	\$ 4,514.30
33535 00	Surgery	71.79	71.79	\$ 5,025.30	\$ 5,025.30
33536 00	Surgery	77.32	77.32	\$ 5,412.40	\$ 5,412.40
33542 00	Surgery	76.75	76.75	\$ 5,372.50	\$ 5,372.50
33545 00	Surgery	90.01	90.01	\$ 6,300.70	\$ 6,300.70
33548 00	Surgery	87.16	87.16	\$ 6,101.20	\$ 6,101.20
33572 00	Surgery	6.74	6.74	\$ 471.80	\$ 471.80
33600 00	Surgery	50.46	50.46	\$ 3,532.20	\$ 3,532.20
33602 00	Surgery	48.99	48.99	\$ 3,429.30	\$ 3,429.30
33606 00	Surgery	52.20	52.20	\$ 3,654.00	\$ 3,654.00
33608 00	Surgery	52.85	52.85	\$ 3,699.50	\$ 3,699.50
33610 00	Surgery	52.13	52.13	\$ 3,649.10	\$ 3,649.10
33611 00	Surgery	57.17	57.17	\$ 4,001.90	\$ 4,001.90
33612 00	Surgery	58.68	58.68	\$ 4,107.60	\$ 4,107.60
33615 00	Surgery	58.62	58.62	\$ 4,103.40	\$ 4,103.40
33617 00	Surgery	63.46	63.46	\$ 4,442.20	\$ 4,442.20
33619 00	Surgery	80.62	80.62	\$ 5,643.40	\$ 5,643.40
33620 00	Surgery	48.33	48.33	\$ 3,383.10	\$ 3,383.10
33621 00	Surgery	27.30	27.30	\$ 1,911.00	\$ 1,911.00
33622 00	Surgery	100.45	100.45	\$ 7,031.50	\$ 7,031.50
33641 00	Surgery	48.06	48.06	\$ 3,364.20	\$ 3,364.20
33645 00	Surgery	50.78	50.78	\$ 3,554.60	\$ 3,554.60
33647 00	Surgery	53.26	53.26	\$ 3,728.20	\$ 3,728.20
33660 00	Surgery	51.47	51.47	\$ 3,602.90	\$ 3,602.90
33665 00	Surgery	56.07	56.07	\$ 3,924.90	\$ 3,924.90
33670 00	Surgery	57.78	57.78	\$ 4,044.60	\$ 4,044.60
33675 00	Surgery	57.76	57.76	\$ 4,043.20	\$ 4,043.20
33676 00	Surgery	59.29	59.29	\$ 4,150.30	\$ 4,150.30
33677 00	Surgery	61.57	61.57	\$ 4,309.90	\$ 4,309.90
33681 00	Surgery	54.15	54.15	\$ 3,790.50	\$ 3,790.50
33684 00	Surgery	55.34	55.34	\$ 3,873.80	\$ 3,873.80
33688 00	Surgery	55.19	55.19	\$ 3,863.30	\$ 3,863.30
33690 00	Surgery	35.33	35.33	\$ 2,473.10	\$ 2,473.10
33692 00	Surgery	57.31	57.31	\$ 4,011.70	\$ 4,011.70
33694 00	Surgery	57.17	57.17	\$ 4,001.90	\$ 4,001.90
33697 00	Surgery	60.21	60.21	\$ 4,214.70	\$ 4,214.70
33702 00	Surgery	45.44	45.44	\$ 3,180.80	\$ 3,180.80
33710 00	Surgery	60.12	60.12	\$ 4,208.40	\$ 4,208.40
33720 00	Surgery	45.48	45.48	\$ 3,183.60	\$ 3,183.60
33724 00	Surgery	45.10	45.10	\$ 3,157.00	\$ 3,157.00
33726 00	Surgery	59.54	59.54	\$ 4,167.80	\$ 4,167.80
33730 00	Surgery	58.86	58.86	\$ 4,120.20	\$ 4,120.20
33732 00	Surgery	48.41	48.41	\$ 3,388.70	\$ 3,388.70
33735 00	Surgery	38.14	38.14	\$ 2,669.80	\$ 2,669.80
33736 00	Surgery	41.38	41.38	\$ 2,896.60	\$ 2,896.60
33737 00	Surgery	38.17	38.17	\$ 2,671.90	\$ 2,671.90
33741 00	Surgery	22.11	22.11	\$ 1,547.70	\$ 1,547.70
33745 00	Surgery	31.57	31.57	\$ 2,209.90	\$ 2,209.90
33746 00	Surgery	12.62	12.62	\$ 883.40	\$ 883.40
33750 00	Surgery	37.13	37.13	\$ 2,599.10	\$ 2,599.10

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
33755 00	Surgery	38.74	38.74	\$ 2,711.80	\$ 2,711.80
33762 00	Surgery	37.69	37.69	\$ 2,638.30	\$ 2,638.30
33764 00	Surgery	38.74	38.74	\$ 2,711.80	\$ 2,711.80
33766 00	Surgery	39.16	39.16	\$ 2,741.20	\$ 2,741.20
33767 00	Surgery	41.81	41.81	\$ 2,926.70	\$ 2,926.70
33768 00	Surgery	12.18	12.18	\$ 852.60	\$ 852.60
33770 00	Surgery	61.99	61.99	\$ 4,339.30	\$ 4,339.30
33771 00	Surgery	63.77	63.77	\$ 4,463.90	\$ 4,463.90
33774 00	Surgery	52.84	52.84	\$ 3,698.80	\$ 3,698.80
33775 00	Surgery	54.44	54.44	\$ 3,810.80	\$ 3,810.80
33776 00	Surgery	57.55	57.55	\$ 4,028.50	\$ 4,028.50
33777 00	Surgery	55.53	55.53	\$ 3,887.10	\$ 3,887.10
33778 00	Surgery	68.92	68.92	\$ 4,824.40	\$ 4,824.40
33779 00	Surgery	68.08	68.08	\$ 4,765.60	\$ 4,765.60
33780 00	Surgery	69.35	69.35	\$ 4,854.50	\$ 4,854.50
33781 00	Surgery	67.70	67.70	\$ 4,739.00	\$ 4,739.00
33782 00	Surgery	94.50	94.50	\$ 6,615.00	\$ 6,615.00
33783 00	Surgery	102.09	102.09	\$ 7,146.30	\$ 7,146.30
33786 00	Surgery	66.76	66.76	\$ 4,673.20	\$ 4,673.20
33788 00	Surgery	45.03	45.03	\$ 3,152.10	\$ 3,152.10
33800 00	Surgery	28.96	28.96	\$ 2,027.20	\$ 2,027.20
33802 00	Surgery	31.93	31.93	\$ 2,235.10	\$ 2,235.10
33803 00	Surgery	33.87	33.87	\$ 2,370.90	\$ 2,370.90
33813 00	Surgery	36.48	36.48	\$ 2,553.60	\$ 2,553.60
33814 00	Surgery	44.78	44.78	\$ 3,134.60	\$ 3,134.60
33820 00	Surgery	28.43	28.43	\$ 1,990.10	\$ 1,990.10
33822 00	Surgery	30.00	30.00	\$ 2,100.00	\$ 2,100.00
33824 00	Surgery	34.73	34.73	\$ 2,431.10	\$ 2,431.10
33840 00	Surgery	36.46	36.46	\$ 2,552.20	\$ 2,552.20
33845 00	Surgery	39.24	39.24	\$ 2,746.80	\$ 2,746.80
33851 00	Surgery	37.43	37.43	\$ 2,620.10	\$ 2,620.10
33852 00	Surgery	41.15	41.15	\$ 2,880.50	\$ 2,880.50
33853 00	Surgery	53.82	53.82	\$ 3,767.40	\$ 3,767.40
33858 00	Surgery	99.49	99.49	\$ 6,964.30	\$ 6,964.30
33859 00	Surgery	71.50	71.50	\$ 5,005.00	\$ 5,005.00
33863 00	Surgery	92.21	92.21	\$ 6,454.70	\$ 6,454.70
33864 00	Surgery	94.35	94.35	\$ 6,604.50	\$ 6,604.50
33866 00	Surgery	26.99	26.99	\$ 1,889.30	\$ 1,889.30
33871 00	Surgery	95.49	95.49	\$ 6,684.30	\$ 6,684.30
33875 00	Surgery	79.88	79.88	\$ 5,591.60	\$ 5,591.60
33877 00	Surgery	105.91	105.91	\$ 7,413.70	\$ 7,413.70
33880 00	Surgery	52.45	52.45	\$ 3,671.50	\$ 3,671.50
33881 00	Surgery	44.96	44.96	\$ 3,147.20	\$ 3,147.20
33883 00	Surgery	32.58	32.58	\$ 2,280.60	\$ 2,280.60
33884 00	Surgery	11.55	11.55	\$ 808.50	\$ 808.50
33886 00	Surgery	28.23	28.23	\$ 1,976.10	\$ 1,976.10
33889 00	Surgery	23.25	23.25	\$ 1,627.50	\$ 1,627.50
33891 00	Surgery	28.18	28.18	\$ 1,972.60	\$ 1,972.60
33894 00	Surgery	28.48	28.48	\$ 1,993.60	\$ 1,993.60
33895 00	Surgery	22.66	22.66	\$ 1,586.20	\$ 1,586.20
33897 00	Surgery	16.87	16.87	\$ 1,180.90	\$ 1,180.90
33910 00	Surgery	77.16	77.16	\$ 5,401.20	\$ 5,401.20
33915 00	Surgery	40.46	40.46	\$ 2,832.20	\$ 2,832.20
33916 00	Surgery	122.34	122.34	\$ 8,563.80	\$ 8,563.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
33917 00	Surgery	42.85	42.85	\$ 2,999.50	\$ 2,999.50
33920 00	Surgery	53.13	53.13	\$ 3,719.10	\$ 3,719.10
33922 00	Surgery	40.84	40.84	\$ 2,858.80	\$ 2,858.80
33924 00	Surgery	8.34	8.34	\$ 583.80	\$ 583.80
33925 00	Surgery	50.32	50.32	\$ 3,522.40	\$ 3,522.40
33926 00	Surgery	70.75	70.75	\$ 4,952.50	\$ 4,952.50
33927 00	Surgery	74.58	74.58	\$ 5,220.60	\$ 5,220.60
33928 00	Surgery	-	-	\$ 5,425.70	\$ 5,425.70
33929 00	Surgery	-	-	\$ 3,497.90	\$ 3,497.90
33930 00	Surgery	0.00	0.00	BR	BR
33933 00	Surgery	-	-	\$ 835.80	\$ 835.80
33935 00	Surgery	144.61	144.61	\$ 10,122.70	\$ 10,122.70
33940 00	Surgery	0.00	0.00	BR	BR
33944 00	Surgery	-	-	\$ 693.70	\$ 693.70
33945 00	Surgery	142.49	142.49	\$ 9,974.30	\$ 9,974.30
33946 00	Surgery	9.08	9.08	\$ 635.60	\$ 635.60
33947 00	Surgery	10.04	10.04	\$ 702.80	\$ 702.80
33948 00	Surgery	6.98	6.98	\$ 488.60	\$ 488.60
33949 00	Surgery	6.77	6.77	\$ 473.90	\$ 473.90
33951 00	Surgery	12.41	12.41	\$ 868.70	\$ 868.70
33952 00	Surgery	12.53	12.53	\$ 877.10	\$ 877.10
33953 00	Surgery	13.88	13.88	\$ 971.60	\$ 971.60
33954 00	Surgery	13.99	13.99	\$ 979.30	\$ 979.30
33955 00	Surgery	24.25	24.25	\$ 1,697.50	\$ 1,697.50
33956 00	Surgery	24.44	24.44	\$ 1,710.80	\$ 1,710.80
33957 00	Surgery	5.41	5.41	\$ 378.70	\$ 378.70
33958 00	Surgery	5.41	5.41	\$ 378.70	\$ 378.70
33959 00	Surgery	6.85	6.85	\$ 479.50	\$ 479.50
33962 00	Surgery	6.85	6.85	\$ 479.50	\$ 479.50
33963 00	Surgery	13.69	13.69	\$ 958.30	\$ 958.30
33964 00	Surgery	14.44	14.44	\$ 1,010.80	\$ 1,010.80
33965 00	Surgery	5.41	5.41	\$ 378.70	\$ 378.70
33966 00	Surgery	6.92	6.92	\$ 484.40	\$ 484.40
33967 00	Surgery	7.59	7.59	\$ 531.30	\$ 531.30
33968 00	Surgery	0.97	0.97	\$ 67.90	\$ 67.90
33969 00	Surgery	7.97	7.97	\$ 557.90	\$ 557.90
33970 00	Surgery	10.38	10.38	\$ 726.60	\$ 726.60
33971 00	Surgery	20.83	20.83	\$ 1,458.10	\$ 1,458.10
33973 00	Surgery	14.71	14.71	\$ 1,029.70	\$ 1,029.70
33974 00	Surgery	26.21	26.21	\$ 1,834.70	\$ 1,834.70
33975 00	Surgery	38.11	38.11	\$ 2,667.70	\$ 2,667.70
33976 00	Surgery	46.40	46.40	\$ 3,248.00	\$ 3,248.00
33977 00	Surgery	32.79	32.79	\$ 2,295.30	\$ 2,295.30
33978 00	Surgery	38.96	38.96	\$ 2,727.20	\$ 2,727.20
33979 00	Surgery	56.91	56.91	\$ 3,983.70	\$ 3,983.70
33980 00	Surgery	52.06	52.06	\$ 3,644.20	\$ 3,644.20
33981 00	Surgery	24.32	24.32	\$ 1,702.40	\$ 1,702.40
33982 00	Surgery	57.15	57.15	\$ 4,000.50	\$ 4,000.50
33983 00	Surgery	67.53	67.53	\$ 4,727.10	\$ 4,727.10
33984 00	Surgery	8.31	8.31	\$ 581.70	\$ 581.70
33985 00	Surgery	15.03	15.03	\$ 1,052.10	\$ 1,052.10
33986 00	Surgery	15.32	15.32	\$ 1,072.40	\$ 1,072.40
33987 00	Surgery	6.11	6.11	\$ 427.70	\$ 427.70
33988 00	Surgery	22.75	22.75	\$ 1,592.50	\$ 1,592.50

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
33989 00	Surgery	14.44	14.44	\$ 1,010.80	\$ 1,010.80
33990 00	Surgery	10.60	10.60	\$ 742.00	\$ 742.00
33991 00	Surgery	13.89	13.89	\$ 972.30	\$ 972.30
33992 00	Surgery	5.54	5.54	\$ 387.80	\$ 387.80
33993 00	Surgery	4.87	4.87	\$ 340.90	\$ 340.90
33995 00	Surgery	10.59	10.59	\$ 741.30	\$ 741.30
33997 00	Surgery	4.71	4.71	\$ 329.70	\$ 329.70
33999 00	Surgery	0.00	0.00	BR	BR
34001 00	Surgery	26.81	26.81	\$ 1,876.70	\$ 1,876.70
34051 00	Surgery	29.25	29.25	\$ 2,047.50	\$ 2,047.50
34101 00	Surgery	17.54	17.54	\$ 1,227.80	\$ 1,227.80
34111 00	Surgery	17.63	17.63	\$ 1,234.10	\$ 1,234.10
34151 00	Surgery	40.81	40.81	\$ 2,856.70	\$ 2,856.70
34201 00	Surgery	30.00	30.00	\$ 2,100.00	\$ 2,100.00
34203 00	Surgery	27.84	27.84	\$ 1,948.80	\$ 1,948.80
34401 00	Surgery	43.56	43.56	\$ 3,049.20	\$ 3,049.20
34421 00	Surgery	20.39	20.39	\$ 1,427.30	\$ 1,427.30
34451 00	Surgery	42.07	42.07	\$ 2,944.90	\$ 2,944.90
34471 00	Surgery	31.64	31.64	\$ 2,214.80	\$ 2,214.80
34490 00	Surgery	19.15	19.15	\$ 1,340.50	\$ 1,340.50
34501 00	Surgery	26.21	26.21	\$ 1,834.70	\$ 1,834.70
34502 00	Surgery	45.25	45.25	\$ 3,167.50	\$ 3,167.50
34510 00	Surgery	29.94	29.94	\$ 2,095.80	\$ 2,095.80
34520 00	Surgery	29.00	29.00	\$ 2,030.00	\$ 2,030.00
34530 00	Surgery	27.63	27.63	\$ 1,934.10	\$ 1,934.10
34701 00	Surgery	36.35	36.35	\$ 2,544.50	\$ 2,544.50
34702 00	Surgery	54.15	54.15	\$ 3,790.50	\$ 3,790.50
34703 00	Surgery	40.27	40.27	\$ 2,818.90	\$ 2,818.90
34704 00	Surgery	66.90	66.90	\$ 4,683.00	\$ 4,683.00
34705 00	Surgery	44.74	44.74	\$ 3,131.80	\$ 3,131.80
34706 00	Surgery	66.81	66.81	\$ 4,676.70	\$ 4,676.70
34707 00	Surgery	33.90	33.90	\$ 2,373.00	\$ 2,373.00
34708 00	Surgery	54.11	54.11	\$ 3,787.70	\$ 3,787.70
34709 00	Surgery	9.43	9.43	\$ 660.10	\$ 660.10
34710 00	Surgery	23.30	23.30	\$ 1,631.00	\$ 1,631.00
34711 00	Surgery	8.62	8.62	\$ 603.40	\$ 603.40
34712 00	Surgery	19.18	19.18	\$ 1,342.60	\$ 1,342.60
34713 00	Surgery	3.61	3.61	\$ 252.70	\$ 252.70
34714 00	Surgery	7.88	7.88	\$ 551.60	\$ 551.60
34715 00	Surgery	8.76	8.76	\$ 613.20	\$ 613.20
34716 00	Surgery	10.86	10.86	\$ 760.20	\$ 760.20
34717 00	Surgery	13.02	13.02	\$ 911.40	\$ 911.40
34718 00	Surgery	36.19	36.19	\$ 2,533.30	\$ 2,533.30
34808 00	Surgery	5.81	5.81	\$ 406.70	\$ 406.70
34812 00	Surgery	6.03	6.03	\$ 422.10	\$ 422.10
34813 00	Surgery	6.91	6.91	\$ 483.70	\$ 483.70
34820 00	Surgery	9.85	9.85	\$ 689.50	\$ 689.50
34830 00	Surgery	51.61	51.61	\$ 3,612.70	\$ 3,612.70
34831 00	Surgery	56.39	56.39	\$ 3,947.30	\$ 3,947.30
34832 00	Surgery	55.49	55.49	\$ 3,884.30	\$ 3,884.30
34833 00	Surgery	11.49	11.49	\$ 804.30	\$ 804.30
34834 00	Surgery	3.78	3.78	\$ 264.60	\$ 264.60
34839 00	Surgery	0.00	0.00	Bundled Code	Bundled Code
34841 00	Surgery	-	-	\$ 3,177.30	\$ 3,177.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
34842 00	Surgery	-	-	\$ 3,479.00	\$ 3,479.00
34843 00	Surgery	-	-	\$ 3,816.40	\$ 3,816.40
34844 00	Surgery	-	-	\$ 4,224.50	\$ 4,224.50
34845 00	Surgery	-	-	\$ 3,652.60	\$ 3,652.60
34846 00	Surgery	-	-	\$ 3,889.90	\$ 3,889.90
34847 00	Surgery	-	-	\$ 4,118.10	\$ 4,118.10
34848 00	Surgery	-	-	\$ 4,407.90	\$ 4,407.90
35001 00	Surgery	33.05	33.05	\$ 2,313.50	\$ 2,313.50
35002 00	Surgery	33.35	33.35	\$ 2,334.50	\$ 2,334.50
35005 00	Surgery	29.23	29.23	\$ 2,046.10	\$ 2,046.10
35011 00	Surgery	29.66	29.66	\$ 2,076.20	\$ 2,076.20
35013 00	Surgery	37.07	37.07	\$ 2,594.90	\$ 2,594.90
35021 00	Surgery	37.07	37.07	\$ 2,594.90	\$ 2,594.90
35022 00	Surgery	42.41	42.41	\$ 2,968.70	\$ 2,968.70
35045 00	Surgery	28.61	28.61	\$ 2,002.70	\$ 2,002.70
35081 00	Surgery	50.69	50.69	\$ 3,548.30	\$ 3,548.30
35082 00	Surgery	63.55	63.55	\$ 4,448.50	\$ 4,448.50
35091 00	Surgery	52.41	52.41	\$ 3,668.70	\$ 3,668.70
35092 00	Surgery	76.35	76.35	\$ 5,344.50	\$ 5,344.50
35102 00	Surgery	54.98	54.98	\$ 3,848.60	\$ 3,848.60
35103 00	Surgery	64.97	64.97	\$ 4,547.90	\$ 4,547.90
35111 00	Surgery	38.93	38.93	\$ 2,725.10	\$ 2,725.10
35112 00	Surgery	47.84	47.84	\$ 3,348.80	\$ 3,348.80
35121 00	Surgery	46.29	46.29	\$ 3,240.30	\$ 3,240.30
35122 00	Surgery	55.35	55.35	\$ 3,874.50	\$ 3,874.50
35131 00	Surgery	40.11	40.11	\$ 2,807.70	\$ 2,807.70
35132 00	Surgery	47.84	47.84	\$ 3,348.80	\$ 3,348.80
35141 00	Surgery	32.17	32.17	\$ 2,251.90	\$ 2,251.90
35142 00	Surgery	38.79	38.79	\$ 2,715.30	\$ 2,715.30
35151 00	Surgery	36.27	36.27	\$ 2,538.90	\$ 2,538.90
35152 00	Surgery	40.93	40.93	\$ 2,865.10	\$ 2,865.10
35180 00	Surgery	23.03	23.03	\$ 1,612.10	\$ 1,612.10
35182 00	Surgery	52.61	52.61	\$ 3,682.70	\$ 3,682.70
35184 00	Surgery	28.29	28.29	\$ 1,980.30	\$ 1,980.30
35188 00	Surgery	38.10	38.10	\$ 2,667.00	\$ 2,667.00
35189 00	Surgery	44.19	44.19	\$ 3,093.30	\$ 3,093.30
35190 00	Surgery	22.55	22.55	\$ 1,578.50	\$ 1,578.50
35201 00	Surgery	27.68	27.68	\$ 1,937.60	\$ 1,937.60
35206 00	Surgery	23.06	23.06	\$ 1,614.20	\$ 1,614.20
35207 00	Surgery	22.35	22.35	\$ 1,564.50	\$ 1,564.50
35211 00	Surgery	41.04	41.04	\$ 2,872.80	\$ 2,872.80
35216 00	Surgery	61.39	61.39	\$ 4,297.30	\$ 4,297.30
35221 00	Surgery	43.44	43.44	\$ 3,040.80	\$ 3,040.80
35226 00	Surgery	24.46	24.46	\$ 1,712.20	\$ 1,712.20
35231 00	Surgery	36.64	36.64	\$ 2,564.80	\$ 2,564.80
35236 00	Surgery	29.41	29.41	\$ 2,058.70	\$ 2,058.70
35241 00	Surgery	42.22	42.22	\$ 2,955.40	\$ 2,955.40
35246 00	Surgery	45.94	45.94	\$ 3,215.80	\$ 3,215.80
35251 00	Surgery	51.05	51.05	\$ 3,573.50	\$ 3,573.50
35256 00	Surgery	29.86	29.86	\$ 2,090.20	\$ 2,090.20
35261 00	Surgery	28.73	28.73	\$ 2,011.10	\$ 2,011.10
35266 00	Surgery	25.37	25.37	\$ 1,775.90	\$ 1,775.90
35271 00	Surgery	40.64	40.64	\$ 2,844.80	\$ 2,844.80
35276 00	Surgery	42.88	42.88	\$ 3,001.60	\$ 3,001.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
35281 00	Surgery	47.61	47.61	\$ 3,332.70	\$ 3,332.70
35286 00	Surgery	27.40	27.40	\$ 1,918.00	\$ 1,918.00
35301 00	Surgery	33.15	33.15	\$ 2,320.50	\$ 2,320.50
35302 00	Surgery	32.88	32.88	\$ 2,301.60	\$ 2,301.60
35303 00	Surgery	36.17	36.17	\$ 2,531.90	\$ 2,531.90
35304 00	Surgery	37.37	37.37	\$ 2,615.90	\$ 2,615.90
35305 00	Surgery	35.95	35.95	\$ 2,516.50	\$ 2,516.50
35306 00	Surgery	13.03	13.03	\$ 912.10	\$ 912.10
35311 00	Surgery	45.70	45.70	\$ 3,199.00	\$ 3,199.00
35321 00	Surgery	26.21	26.21	\$ 1,834.70	\$ 1,834.70
35331 00	Surgery	42.53	42.53	\$ 2,977.10	\$ 2,977.10
35341 00	Surgery	40.60	40.60	\$ 2,842.00	\$ 2,842.00
35351 00	Surgery	37.76	37.76	\$ 2,643.20	\$ 2,643.20
35355 00	Surgery	30.18	30.18	\$ 2,112.60	\$ 2,112.60
35361 00	Surgery	44.57	44.57	\$ 3,119.90	\$ 3,119.90
35363 00	Surgery	47.56	47.56	\$ 3,329.20	\$ 3,329.20
35371 00	Surgery	23.92	23.92	\$ 1,674.40	\$ 1,674.40
35372 00	Surgery	28.56	28.56	\$ 1,999.20	\$ 1,999.20
35390 00	Surgery	4.64	4.64	\$ 324.80	\$ 324.80
35400 00	Surgery	4.33	4.33	\$ 303.10	\$ 303.10
35500 00	Surgery	9.31	9.31	\$ 651.70	\$ 651.70
35501 00	Surgery	42.72	42.72	\$ 2,990.40	\$ 2,990.40
35506 00	Surgery	37.31	37.31	\$ 2,611.70	\$ 2,611.70
35508 00	Surgery	38.87	38.87	\$ 2,720.90	\$ 2,720.90
35509 00	Surgery	41.35	41.35	\$ 2,894.50	\$ 2,894.50
35510 00	Surgery	36.01	36.01	\$ 2,520.70	\$ 2,520.70
35511 00	Surgery	32.81	32.81	\$ 2,296.70	\$ 2,296.70
35512 00	Surgery	35.29	35.29	\$ 2,470.30	\$ 2,470.30
35515 00	Surgery	38.87	38.87	\$ 2,720.90	\$ 2,720.90
35516 00	Surgery	35.73	35.73	\$ 2,501.10	\$ 2,501.10
35518 00	Surgery	33.44	33.44	\$ 2,340.80	\$ 2,340.80
35521 00	Surgery	35.98	35.98	\$ 2,518.60	\$ 2,518.60
35522 00	Surgery	34.27	34.27	\$ 2,398.90	\$ 2,398.90
35523 00	Surgery	37.59	37.59	\$ 2,631.30	\$ 2,631.30
35525 00	Surgery	33.24	33.24	\$ 2,326.80	\$ 2,326.80
35526 00	Surgery	50.83	50.83	\$ 3,558.10	\$ 3,558.10
35531 00	Surgery	57.09	57.09	\$ 3,996.30	\$ 3,996.30
35533 00	Surgery	44.13	44.13	\$ 3,089.10	\$ 3,089.10
35535 00	Surgery	55.71	55.71	\$ 3,899.70	\$ 3,899.70
35536 00	Surgery	49.50	49.50	\$ 3,465.00	\$ 3,465.00
35537 00	Surgery	61.00	61.00	\$ 4,270.00	\$ 4,270.00
35538 00	Surgery	68.35	68.35	\$ 4,784.50	\$ 4,784.50
35539 00	Surgery	64.15	64.15	\$ 4,490.50	\$ 4,490.50
35540 00	Surgery	71.50	71.50	\$ 5,005.00	\$ 5,005.00
35556 00	Surgery	40.95	40.95	\$ 2,866.50	\$ 2,866.50
35558 00	Surgery	36.12	36.12	\$ 2,528.40	\$ 2,528.40
35560 00	Surgery	49.93	49.93	\$ 3,495.10	\$ 3,495.10
35563 00	Surgery	38.77	38.77	\$ 2,713.90	\$ 2,713.90
35565 00	Surgery	38.42	38.42	\$ 2,689.40	\$ 2,689.40
35566 00	Surgery	48.84	48.84	\$ 3,418.80	\$ 3,418.80
35570 00	Surgery	43.16	43.16	\$ 3,021.20	\$ 3,021.20
35571 00	Surgery	38.85	38.85	\$ 2,719.50	\$ 2,719.50
35572 00	Surgery	10.06	10.06	\$ 704.20	\$ 704.20
35583 00	Surgery	42.19	42.19	\$ 2,953.30	\$ 2,953.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
35585 00	Surgery	48.94	48.94	\$ 3,425.80	\$ 3,425.80
35587 00	Surgery	39.68	39.68	\$ 2,777.60	\$ 2,777.60
35600 00	Surgery	5.47	5.47	\$ 382.90	\$ 382.90
35601 00	Surgery	41.11	41.11	\$ 2,877.70	\$ 2,877.70
35606 00	Surgery	34.34	34.34	\$ 2,403.80	\$ 2,403.80
35612 00	Surgery	30.63	30.63	\$ 2,144.10	\$ 2,144.10
35616 00	Surgery	32.25	32.25	\$ 2,257.50	\$ 2,257.50
35621 00	Surgery	32.18	32.18	\$ 2,252.60	\$ 2,252.60
35623 00	Surgery	38.51	38.51	\$ 2,695.70	\$ 2,695.70
35626 00	Surgery	46.88	46.88	\$ 3,281.60	\$ 3,281.60
35631 00	Surgery	54.11	54.11	\$ 3,787.70	\$ 3,787.70
35632 00	Surgery	52.90	52.90	\$ 3,703.00	\$ 3,703.00
35633 00	Surgery	58.02	58.02	\$ 4,061.40	\$ 4,061.40
35634 00	Surgery	51.77	51.77	\$ 3,623.90	\$ 3,623.90
35636 00	Surgery	46.71	46.71	\$ 3,269.70	\$ 3,269.70
35637 00	Surgery	48.56	48.56	\$ 3,399.20	\$ 3,399.20
35638 00	Surgery	50.83	50.83	\$ 3,558.10	\$ 3,558.10
35642 00	Surgery	28.97	28.97	\$ 2,027.90	\$ 2,027.90
35645 00	Surgery	27.77	27.77	\$ 1,943.90	\$ 1,943.90
35646 00	Surgery	50.02	50.02	\$ 3,501.40	\$ 3,501.40
35647 00	Surgery	45.41	45.41	\$ 3,178.70	\$ 3,178.70
35650 00	Surgery	29.94	29.94	\$ 2,095.80	\$ 2,095.80
35654 00	Surgery	40.04	40.04	\$ 2,802.80	\$ 2,802.80
35656 00	Surgery	31.55	31.55	\$ 2,208.50	\$ 2,208.50
35661 00	Surgery	31.79	31.79	\$ 2,225.30	\$ 2,225.30
35663 00	Surgery	35.69	35.69	\$ 2,498.30	\$ 2,498.30
35665 00	Surgery	34.34	34.34	\$ 2,403.80	\$ 2,403.80
35666 00	Surgery	37.84	37.84	\$ 2,648.80	\$ 2,648.80
35671 00	Surgery	33.37	33.37	\$ 2,335.90	\$ 2,335.90
35681 00	Surgery	2.33	2.33	\$ 163.10	\$ 163.10
35682 00	Surgery	10.34	10.34	\$ 723.80	\$ 723.80
35683 00	Surgery	11.98	11.98	\$ 838.60	\$ 838.60
35685 00	Surgery	5.79	5.79	\$ 405.30	\$ 405.30
35686 00	Surgery	4.72	4.72	\$ 330.40	\$ 330.40
35691 00	Surgery	27.75	27.75	\$ 1,942.50	\$ 1,942.50
35693 00	Surgery	24.50	24.50	\$ 1,715.00	\$ 1,715.00
35694 00	Surgery	28.98	28.98	\$ 2,028.60	\$ 2,028.60
35695 00	Surgery	30.07	30.07	\$ 2,104.90	\$ 2,104.90
35697 00	Surgery	4.29	4.29	\$ 300.30	\$ 300.30
35700 00	Surgery	4.44	4.44	\$ 310.80	\$ 310.80
35701 00	Surgery	12.88	12.88	\$ 901.60	\$ 901.60
35702 00	Surgery	11.98	11.98	\$ 838.60	\$ 838.60
35703 00	Surgery	12.32	12.32	\$ 862.40	\$ 862.40
35800 00	Surgery	21.51	21.51	\$ 1,505.70	\$ 1,505.70
35820 00	Surgery	59.04	59.04	\$ 4,132.80	\$ 4,132.80
35840 00	Surgery	35.75	35.75	\$ 2,502.50	\$ 2,502.50
35860 00	Surgery	24.67	24.67	\$ 1,726.90	\$ 1,726.90
35870 00	Surgery	36.57	36.57	\$ 2,559.90	\$ 2,559.90
35875 00	Surgery	17.44	17.44	\$ 1,220.80	\$ 1,220.80
35876 00	Surgery	27.69	27.69	\$ 1,938.30	\$ 1,938.30
35879 00	Surgery	27.05	27.05	\$ 1,893.50	\$ 1,893.50
35881 00	Surgery	29.97	29.97	\$ 2,097.90	\$ 2,097.90
35883 00	Surgery	35.24	35.24	\$ 2,466.80	\$ 2,466.80
35884 00	Surgery	36.30	36.30	\$ 2,541.00	\$ 2,541.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
35901 00	Surgery	13.98	13.98	\$ 978.60	\$ 978.60
35903 00	Surgery	16.68	16.68	\$ 1,167.60	\$ 1,167.60
35905 00	Surgery	49.23	49.23	\$ 3,446.10	\$ 3,446.10
35907 00	Surgery	55.89	55.89	\$ 3,912.30	\$ 3,912.30
36000 00	Surgery	0.00	0.00	Bundled Code	Bundled Code
36002 00	Surgery	4.46	3.03	\$ 312.20	\$ 212.10
36005 00	Surgery	7.94	1.39	\$ 555.80	\$ 97.30
36010 00	Surgery	16.89	3.18	\$ 1,182.30	\$ 222.60
36011 00	Surgery	25.25	4.58	\$ 1,767.50	\$ 320.60
36012 00	Surgery	25.83	5.06	\$ 1,808.10	\$ 354.20
36013 00	Surgery	24.17	3.62	\$ 1,691.90	\$ 253.40
36014 00	Surgery	24.49	4.40	\$ 1,714.30	\$ 308.00
36015 00	Surgery	26.45	4.96	\$ 1,851.50	\$ 347.20
36100 00	Surgery	16.78	4.50	\$ 1,174.60	\$ 315.00
36140 00	Surgery	15.89	2.61	\$ 1,112.30	\$ 182.70
36160 00	Surgery	17.22	3.62	\$ 1,205.40	\$ 253.40
36200 00	Surgery	18.43	4.07	\$ 1,290.10	\$ 284.90
36215 00	Surgery	31.94	6.20	\$ 2,235.80	\$ 434.00
36216 00	Surgery	32.84	7.88	\$ 2,298.80	\$ 551.60
36217 00	Surgery	54.39	9.54	\$ 3,807.30	\$ 667.80
36218 00	Surgery	6.16	1.50	\$ 431.20	\$ 105.00
36221 00	Surgery	30.70	5.90	\$ 2,149.00	\$ 413.00
36222 00	Surgery	37.06	8.33	\$ 2,594.20	\$ 583.10
36223 00	Surgery	49.05	9.44	\$ 3,433.50	\$ 660.80
36224 00	Surgery	61.54	10.63	\$ 4,307.80	\$ 744.10
36225 00	Surgery	46.56	9.39	\$ 3,259.20	\$ 657.30
36226 00	Surgery	59.34	10.56	\$ 4,153.80	\$ 739.20
36227 00	Surgery	7.05	3.49	\$ 493.50	\$ 244.30
36228 00	Surgery	38.25	7.14	\$ 2,677.50	\$ 499.80
36245 00	Surgery	38.45	6.86	\$ 2,691.50	\$ 480.20
36246 00	Surgery	25.78	7.37	\$ 1,804.60	\$ 515.90
36247 00	Surgery	44.09	8.69	\$ 3,086.30	\$ 608.30
36248 00	Surgery	3.55	1.40	\$ 248.50	\$ 98.00
36251 00	Surgery	39.87	7.48	\$ 2,790.90	\$ 523.60
36252 00	Surgery	42.98	10.47	\$ 3,008.60	\$ 732.90
36253 00	Surgery	62.31	10.30	\$ 4,361.70	\$ 721.00
36254 00	Surgery	61.64	12.01	\$ 4,314.80	\$ 840.70
36260 00	Surgery	19.60	19.60	\$ 1,372.00	\$ 1,372.00
36261 00	Surgery	12.29	12.29	\$ 860.30	\$ 860.30
36262 00	Surgery	9.38	9.38	\$ 656.60	\$ 656.60
36299 00	Surgery	0.00	0.00	BR	BR
36400 00	Surgery	0.81	0.56	\$ 56.70	\$ 39.20
36405 00	Surgery	0.70	0.44	\$ 49.00	\$ 30.80
36406 00	Surgery	0.51	0.26	\$ 35.70	\$ 18.20
36410 00	Surgery	0.52	0.27	\$ 36.40	\$ 18.90
36415 00	Surgery	-	-	\$ 6.30	\$ 6.30
36416 00	Surgery	0.00	0.00	Bundled Code	Bundled Code
36420 00	Surgery	1.39	1.39	\$ 97.30	\$ 97.30
36425 00	Surgery	1.18	1.18	\$ 82.60	\$ 82.60
36430 00	Surgery	1.13	1.13	\$ 79.10	\$ 79.10
36440 00	Surgery	1.49	1.49	\$ 104.30	\$ 104.30
36450 00	Surgery	5.03	5.03	\$ 352.10	\$ 352.10
36455 00	Surgery	3.69	3.69	\$ 258.30	\$ 258.30
36456 00	Surgery	2.86	2.86	\$ 200.20	\$ 200.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
36460 00	Surgery	10.14	10.14	\$ 709.80	\$ 709.80
36465 00	Surgery	40.70	3.46	\$ 2,849.00	\$ 242.20
36466 00	Surgery	44.99	4.50	\$ 3,149.30	\$ 315.00
36468 00	Surgery	0.00	0.00	BR	BR
36470 00	Surgery	3.44	1.11	\$ 240.80	\$ 77.70
36471 00	Surgery	5.98	2.21	\$ 418.60	\$ 154.70
36473 00	Surgery	37.95	5.24	\$ 2,656.50	\$ 366.80
36474 00	Surgery	7.85	2.61	\$ 549.50	\$ 182.70
36475 00	Surgery	33.38	8.13	\$ 2,336.60	\$ 569.10
36476 00	Surgery	8.69	3.94	\$ 608.30	\$ 275.80
36478 00	Surgery	30.44	8.11	\$ 2,130.80	\$ 567.70
36479 00	Surgery	9.11	3.98	\$ 637.70	\$ 278.60
36481 00	Surgery	53.68	9.38	\$ 3,757.60	\$ 656.60
36482 00	Surgery	51.84	5.26	\$ 3,628.80	\$ 368.20
36483 00	Surgery	4.08	2.62	\$ 285.60	\$ 183.40
36500 00	Surgery	5.31	5.31	\$ 371.70	\$ 371.70
36510 00	Surgery	2.53	1.57	\$ 177.10	\$ 109.90
36511 00	Surgery	3.19	3.19	\$ 223.30	\$ 223.30
36512 00	Surgery	3.12	3.12	\$ 218.40	\$ 218.40
36513 00	Surgery	3.11	3.11	\$ 217.70	\$ 217.70
36514 00	Surgery	17.16	2.74	\$ 1,201.20	\$ 191.80
36516 00	Surgery	54.65	2.49	\$ 3,825.50	\$ 174.30
36522 00	Surgery	41.83	2.83	\$ 2,928.10	\$ 198.10
36555 00	Surgery	5.74	2.48	\$ 401.80	\$ 173.60
36556 00	Surgery	6.50	2.47	\$ 455.00	\$ 172.90
36557 00	Surgery	36.33	9.53	\$ 2,543.10	\$ 667.10
36558 00	Surgery	25.82	7.59	\$ 1,807.40	\$ 531.30
36560 00	Surgery	38.66	11.39	\$ 2,706.20	\$ 797.30
36561 00	Surgery	30.65	9.81	\$ 2,145.50	\$ 686.70
36563 00	Surgery	34.89	10.80	\$ 2,442.30	\$ 756.00
36565 00	Surgery	25.53	9.92	\$ 1,787.10	\$ 694.40
36566 00	Surgery	133.68	10.58	\$ 9,357.60	\$ 740.60
36568 00	Surgery	2.67	2.67	\$ 186.90	\$ 186.90
36569 00	Surgery	2.74	2.74	\$ 191.80	\$ 191.80
36570 00	Surgery	45.79	9.88	\$ 3,205.30	\$ 691.60
36571 00	Surgery	39.85	9.26	\$ 2,789.50	\$ 648.20
36572 00	Surgery	11.48	2.35	\$ 803.60	\$ 164.50
36573 00	Surgery	11.86	2.46	\$ 830.20	\$ 172.20
36575 00	Surgery	4.55	0.99	\$ 318.50	\$ 69.30
36576 00	Surgery	10.62	5.44	\$ 743.40	\$ 380.80
36578 00	Surgery	13.42	5.98	\$ 939.40	\$ 418.60
36580 00	Surgery	5.82	1.92	\$ 407.40	\$ 134.40
36581 00	Surgery	24.28	5.36	\$ 1,699.60	\$ 375.20
36582 00	Surgery	27.46	8.47	\$ 1,922.20	\$ 592.90
36583 00	Surgery	36.03	9.78	\$ 2,522.10	\$ 684.60
36584 00	Surgery	10.17	1.71	\$ 711.90	\$ 119.70
36585 00	Surgery	36.25	8.32	\$ 2,537.50	\$ 582.40
36589 00	Surgery	4.95	4.03	\$ 346.50	\$ 282.10
36590 00	Surgery	6.71	5.61	\$ 469.70	\$ 392.70
36591 00	Surgery	0.79	0.79	\$ 55.30	\$ 55.30
36592 00	Surgery	0.88	0.88	\$ 61.60	\$ 61.60
36593 00	Surgery	0.97	0.97	\$ 67.90	\$ 67.90
36595 00	Surgery	18.38	5.29	\$ 1,286.60	\$ 370.30
36596 00	Surgery	3.41	1.29	\$ 238.70	\$ 90.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
36597 00	Surgery	3.32	1.74	\$ 232.40	\$ 121.80
36598 00	Surgery	3.69	1.06	\$ 258.30	\$ 74.20
36600 00	Surgery	0.85	0.46	\$ 59.50	\$ 32.20
36620 00	Surgery	1.29	1.29	\$ 90.30	\$ 90.30
36625 00	Surgery	3.10	3.10	\$ 217.00	\$ 217.00
36640 00	Surgery	3.38	3.38	\$ 236.60	\$ 236.60
36660 00	Surgery	2.01	2.01	\$ 140.70	\$ 140.70
36680 00	Surgery	1.74	1.74	\$ 121.80	\$ 121.80
36800 00	Surgery	3.57	3.57	\$ 249.90	\$ 249.90
36810 00	Surgery	6.18	6.18	\$ 432.60	\$ 432.60
36815 00	Surgery	3.96	3.96	\$ 277.20	\$ 277.20
36818 00	Surgery	20.26	20.26	\$ 1,418.20	\$ 1,418.20
36819 00	Surgery	21.48	21.48	\$ 1,503.60	\$ 1,503.60
36820 00	Surgery	21.13	21.13	\$ 1,479.10	\$ 1,479.10
36821 00	Surgery	19.47	19.47	\$ 1,362.90	\$ 1,362.90
36823 00	Surgery	41.84	41.84	\$ 2,928.80	\$ 2,928.80
36825 00	Surgery	23.34	23.34	\$ 1,633.80	\$ 1,633.80
36830 00	Surgery	19.60	19.60	\$ 1,372.00	\$ 1,372.00
36831 00	Surgery	18.08	18.08	\$ 1,265.60	\$ 1,265.60
36832 00	Surgery	22.22	22.22	\$ 1,555.40	\$ 1,555.40
36833 00	Surgery	23.76	23.76	\$ 1,663.20	\$ 1,663.20
36835 00	Surgery	14.30	14.30	\$ 1,001.00	\$ 1,001.00
36838 00	Surgery	33.53	33.53	\$ 2,347.10	\$ 2,347.10
36860 00	Surgery	7.02	3.27	\$ 491.40	\$ 228.90
36861 00	Surgery	4.10	4.10	\$ 287.00	\$ 287.00
36901 00	Surgery	21.77	4.91	\$ 1,523.90	\$ 343.70
36902 00	Surgery	37.41	6.98	\$ 2,618.70	\$ 488.60
36903 00	Surgery	134.68	9.20	\$ 9,427.60	\$ 644.00
36904 00	Surgery	55.86	10.69	\$ 3,910.20	\$ 748.30
36905 00	Surgery	70.83	12.92	\$ 4,958.10	\$ 904.40
36906 00	Surgery	170.31	14.85	\$ 11,921.70	\$ 1,039.50
36907 00	Surgery	18.25	4.25	\$ 1,277.50	\$ 297.50
36908 00	Surgery	44.22	6.03	\$ 3,095.40	\$ 422.10
36909 00	Surgery	60.38	5.87	\$ 4,226.60	\$ 410.90
37140 00	Surgery	69.11	69.11	\$ 4,837.70	\$ 4,837.70
37145 00	Surgery	64.12	64.12	\$ 4,488.40	\$ 4,488.40
37160 00	Surgery	65.84	65.84	\$ 4,608.80	\$ 4,608.80
37180 00	Surgery	63.26	63.26	\$ 4,428.20	\$ 4,428.20
37181 00	Surgery	69.11	69.11	\$ 4,837.70	\$ 4,837.70
37182 00	Surgery	23.58	23.58	\$ 1,650.60	\$ 1,650.60
37183 00	Surgery	183.15	10.81	\$ 12,820.50	\$ 756.70
37184 00	Surgery	53.30	12.56	\$ 3,731.00	\$ 879.20
37185 00	Surgery	14.56	4.74	\$ 1,019.20	\$ 331.80
37186 00	Surgery	36.98	7.11	\$ 2,588.60	\$ 497.70
37187 00	Surgery	53.40	11.43	\$ 3,738.00	\$ 800.10
37188 00	Surgery	45.62	8.09	\$ 3,193.40	\$ 566.30
37191 00	Surgery	63.55	6.43	\$ 4,448.50	\$ 450.10
37192 00	Surgery	39.52	10.09	\$ 2,766.40	\$ 706.30
37193 00	Surgery	46.26	10.08	\$ 3,238.20	\$ 705.60
37195 00	Surgery	-	-	\$ 1,798.30	\$ 1,798.30
37197 00	Surgery	48.39	8.72	\$ 3,387.30	\$ 610.40
37200 00	Surgery	6.21	6.21	\$ 434.70	\$ 434.70
37211 00	Surgery	11.25	11.25	\$ 787.50	\$ 787.50
37212 00	Surgery	9.81	9.81	\$ 686.70	\$ 686.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
37213 00	Surgery	6.75	6.75	\$ 472.50	\$ 472.50
37214 00	Surgery	3.54	3.54	\$ 247.80	\$ 247.80
37215 00	Surgery	29.15	29.15	\$ 2,040.50	\$ 2,040.50
37216 00	Surgery	28.60	28.60	\$ 2,002.00	\$ 2,002.00
37217 00	Surgery	31.67	31.67	\$ 2,216.90	\$ 2,216.90
37218 00	Surgery	23.95	23.95	\$ 1,676.50	\$ 1,676.50
37220 00	Surgery	78.27	11.70	\$ 5,478.90	\$ 819.00
37221 00	Surgery	96.58	14.42	\$ 6,760.60	\$ 1,009.40
37222 00	Surgery	18.92	5.43	\$ 1,324.40	\$ 380.10
37223 00	Surgery	39.91	6.21	\$ 2,793.70	\$ 434.70
37224 00	Surgery	91.57	12.97	\$ 6,409.90	\$ 907.90
37225 00	Surgery	276.03	17.52	\$ 19,322.10	\$ 1,226.40
37226 00	Surgery	257.50	15.17	\$ 18,025.00	\$ 1,061.90
37227 00	Surgery	353.69	20.99	\$ 24,758.30	\$ 1,469.30
37228 00	Surgery	130.22	15.80	\$ 9,115.40	\$ 1,106.00
37229 00	Surgery	279.39	20.31	\$ 19,557.30	\$ 1,421.70
37230 00	Surgery	281.17	20.33	\$ 19,681.90	\$ 1,423.10
37231 00	Surgery	366.87	21.48	\$ 25,680.90	\$ 1,503.60
37232 00	Surgery	25.40	5.80	\$ 1,778.00	\$ 406.00
37233 00	Surgery	31.83	9.45	\$ 2,228.10	\$ 661.50
37234 00	Surgery	113.28	8.26	\$ 7,929.60	\$ 578.20
37235 00	Surgery	121.24	11.18	\$ 8,486.80	\$ 782.60
37236 00	Surgery	85.82	12.90	\$ 6,007.40	\$ 903.00
37237 00	Surgery	40.18	6.17	\$ 2,812.60	\$ 431.90
37238 00	Surgery	107.53	8.93	\$ 7,527.10	\$ 625.10
37239 00	Surgery	53.15	4.40	\$ 3,720.50	\$ 308.00
37241 00	Surgery	146.05	12.51	\$ 10,223.50	\$ 875.70
37242 00	Surgery	223.29	13.79	\$ 15,630.30	\$ 965.30
37243 00	Surgery	269.36	16.16	\$ 18,855.20	\$ 1,131.20
37244 00	Surgery	205.61	19.13	\$ 14,392.70	\$ 1,339.10
37246 00	Surgery	56.85	10.13	\$ 3,979.50	\$ 709.10
37247 00	Surgery	16.87	4.96	\$ 1,180.90	\$ 347.20
37248 00	Surgery	42.34	8.65	\$ 2,963.80	\$ 605.50
37249 00	Surgery	13.60	4.23	\$ 952.00	\$ 296.10
37252 00	Surgery	29.65	2.59	\$ 2,075.50	\$ 181.30
37253 00	Surgery	5.07	2.05	\$ 354.90	\$ 143.50
37500 00	Surgery	18.53	18.53	\$ 1,297.10	\$ 1,297.10
37501 00	Surgery	0.00	0.00	BR	BR
37565 00	Surgery	21.53	21.53	\$ 1,507.10	\$ 1,507.10
37600 00	Surgery	21.73	21.73	\$ 1,521.10	\$ 1,521.10
37605 00	Surgery	21.65	21.65	\$ 1,515.50	\$ 1,515.50
37606 00	Surgery	21.68	21.68	\$ 1,517.60	\$ 1,517.60
37607 00	Surgery	11.02	11.02	\$ 771.40	\$ 771.40
37609 00	Surgery	9.43	6.05	\$ 660.10	\$ 423.50
37615 00	Surgery	15.93	15.93	\$ 1,115.10	\$ 1,115.10
37616 00	Surgery	32.52	32.52	\$ 2,276.40	\$ 2,276.40
37617 00	Surgery	38.86	38.86	\$ 2,720.20	\$ 2,720.20
37618 00	Surgery	11.54	11.54	\$ 807.80	\$ 807.80
37619 00	Surgery	51.41	51.41	\$ 3,598.70	\$ 3,598.70
37650 00	Surgery	13.52	13.52	\$ 946.40	\$ 946.40
37660 00	Surgery	39.16	39.16	\$ 2,741.20	\$ 2,741.20
37700 00	Surgery	7.24	7.24	\$ 506.80	\$ 506.80
37718 00	Surgery	11.56	11.56	\$ 809.20	\$ 809.20
37722 00	Surgery	13.79	13.79	\$ 965.30	\$ 965.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
37735 00	Surgery	17.10	17.10	\$ 1,197.00	\$ 1,197.00
37760 00	Surgery	16.94	16.94	\$ 1,185.80	\$ 1,185.80
37761 00	Surgery	15.79	15.79	\$ 1,105.30	\$ 1,105.30
37765 00	Surgery	12.89	7.97	\$ 902.30	\$ 557.90
37766 00	Surgery	15.01	9.76	\$ 1,050.70	\$ 683.20
37780 00	Surgery	6.93	6.93	\$ 485.10	\$ 485.10
37785 00	Surgery	10.65	7.57	\$ 745.50	\$ 529.90
37788 00	Surgery	36.88	36.88	\$ 2,581.60	\$ 2,581.60
37790 00	Surgery	14.20	14.20	\$ 994.00	\$ 994.00
37799 00	Surgery	0.00	0.00	BR	BR
38100 00	Surgery	34.25	34.25	\$ 2,397.50	\$ 2,397.50
38101 00	Surgery	34.74	34.74	\$ 2,431.80	\$ 2,431.80
38102 00	Surgery	7.72	7.72	\$ 540.40	\$ 540.40
38115 00	Surgery	38.53	38.53	\$ 2,697.10	\$ 2,697.10
38120 00	Surgery	31.51	31.51	\$ 2,205.70	\$ 2,205.70
38129 00	Surgery	0.00	0.00	BR	BR
38200 00	Surgery	3.82	3.82	\$ 267.40	\$ 267.40
38204 00	Surgery	0.00	0.00	Bundled Code	Bundled Code
38205 00	Surgery	2.51	2.51	\$ 175.70	\$ 175.70
38206 00	Surgery	2.48	2.48	\$ 173.60	\$ 173.60
38207 00	Surgery	1.31	1.31	\$ 91.70	\$ 91.70
38208 00	Surgery	0.83	0.83	\$ 58.10	\$ 58.10
38209 00	Surgery	0.35	0.35	\$ 24.50	\$ 24.50
38210 00	Surgery	2.30	2.30	\$ 161.00	\$ 161.00
38211 00	Surgery	2.08	2.08	\$ 145.60	\$ 145.60
38212 00	Surgery	1.39	1.39	\$ 97.30	\$ 97.30
38213 00	Surgery	0.35	0.35	\$ 24.50	\$ 24.50
38214 00	Surgery	1.20	1.20	\$ 84.00	\$ 84.00
38215 00	Surgery	1.39	1.39	\$ 97.30	\$ 97.30
38220 00	Surgery	4.64	1.99	\$ 324.80	\$ 139.30
38221 00	Surgery	4.83	2.07	\$ 338.10	\$ 144.90
38222 00	Surgery	5.23	2.23	\$ 366.10	\$ 156.10
38230 00	Surgery	6.00	6.00	\$ 420.00	\$ 420.00
38232 00	Surgery	5.81	5.81	\$ 406.70	\$ 406.70
38240 00	Surgery	7.11	7.11	\$ 497.70	\$ 497.70
38241 00	Surgery	5.24	5.24	\$ 366.80	\$ 366.80
38242 00	Surgery	3.70	3.70	\$ 259.00	\$ 259.00
38243 00	Surgery	3.60	3.60	\$ 252.00	\$ 252.00
38300 00	Surgery	10.31	6.26	\$ 721.70	\$ 438.20
38305 00	Surgery	14.77	14.77	\$ 1,033.90	\$ 1,033.90
38308 00	Surgery	13.79	13.79	\$ 965.30	\$ 965.30
38380 00	Surgery	16.88	16.88	\$ 1,181.60	\$ 1,181.60
38381 00	Surgery	23.66	23.66	\$ 1,656.20	\$ 1,656.20
38382 00	Surgery	20.27	20.27	\$ 1,418.90	\$ 1,418.90
38500 00	Surgery	10.13	7.61	\$ 709.10	\$ 532.70
38505 00	Surgery	5.33	2.50	\$ 373.10	\$ 175.00
38510 00	Surgery	15.83	12.42	\$ 1,108.10	\$ 869.40
38520 00	Surgery	13.86	13.86	\$ 970.20	\$ 970.20
38525 00	Surgery	13.15	13.15	\$ 920.50	\$ 920.50
38530 00	Surgery	16.69	16.69	\$ 1,168.30	\$ 1,168.30
38531 00	Surgery	13.29	13.29	\$ 930.30	\$ 930.30
38542 00	Surgery	15.51	15.51	\$ 1,085.70	\$ 1,085.70
38550 00	Surgery	15.65	15.65	\$ 1,095.50	\$ 1,095.50
38555 00	Surgery	30.67	30.67	\$ 2,146.90	\$ 2,146.90

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
38562 00	Surgery	20.91	20.91	\$ 1,463.70	\$ 1,463.70
38564 00	Surgery	20.98	20.98	\$ 1,468.60	\$ 1,468.60
38570 00	Surgery	15.24	15.24	\$ 1,066.80	\$ 1,066.80
38571 00	Surgery	19.42	19.42	\$ 1,359.40	\$ 1,359.40
38572 00	Surgery	26.78	26.78	\$ 1,874.60	\$ 1,874.60
38573 00	Surgery	34.61	34.61	\$ 2,422.70	\$ 2,422.70
38589 00	Surgery	0.00	0.00	BR	BR
38700 00	Surgery	23.90	23.90	\$ 1,673.00	\$ 1,673.00
38720 00	Surgery	39.68	39.68	\$ 2,777.60	\$ 2,777.60
38724 00	Surgery	42.88	42.88	\$ 3,001.60	\$ 3,001.60
38740 00	Surgery	20.91	20.91	\$ 1,463.70	\$ 1,463.70
38745 00	Surgery	26.28	26.28	\$ 1,839.60	\$ 1,839.60
38746 00	Surgery	6.30	6.30	\$ 441.00	\$ 441.00
38747 00	Surgery	7.89	7.89	\$ 552.30	\$ 552.30
38760 00	Surgery	24.82	24.82	\$ 1,737.40	\$ 1,737.40
38765 00	Surgery	38.82	38.82	\$ 2,717.40	\$ 2,717.40
38770 00	Surgery	23.66	23.66	\$ 1,656.20	\$ 1,656.20
38780 00	Surgery	30.68	30.68	\$ 2,147.60	\$ 2,147.60
38790 00	Surgery	2.38	2.38	\$ 166.60	\$ 166.60
38792 00	Surgery	2.46	0.97	\$ 172.20	\$ 67.90
38794 00	Surgery	8.59	8.59	\$ 601.30	\$ 601.30
38900 00	Surgery	4.08	4.08	\$ 285.60	\$ 285.60
38999 00	Surgery	0.00	0.00	BR	BR
39000 00	Surgery	14.77	14.77	\$ 1,033.90	\$ 1,033.90
39010 00	Surgery	23.23	23.23	\$ 1,626.10	\$ 1,626.10
39200 00	Surgery	25.61	25.61	\$ 1,792.70	\$ 1,792.70
39220 00	Surgery	33.37	33.37	\$ 2,335.90	\$ 2,335.90
39401 00	Surgery	9.05	9.05	\$ 633.50	\$ 633.50
39402 00	Surgery	11.82	11.82	\$ 827.40	\$ 827.40
39499 00	Surgery	0.00	0.00	BR	BR
39501 00	Surgery	25.37	25.37	\$ 1,775.90	\$ 1,775.90
39503 00	Surgery	170.74	170.74	\$ 11,951.80	\$ 11,951.80
39540 00	Surgery	25.63	25.63	\$ 1,794.10	\$ 1,794.10
39541 00	Surgery	27.92	27.92	\$ 1,954.40	\$ 1,954.40
39545 00	Surgery	26.47	26.47	\$ 1,852.90	\$ 1,852.90
39560 00	Surgery	23.71	23.71	\$ 1,659.70	\$ 1,659.70
39561 00	Surgery	36.86	36.86	\$ 2,580.20	\$ 2,580.20
39599 00	Surgery	0.00	0.00	BR	BR
40490 00	Surgery	3.65	2.01	\$ 255.50	\$ 140.70
40500 00	Surgery	15.68	10.87	\$ 1,097.60	\$ 760.90
40510 00	Surgery	14.67	10.32	\$ 1,026.90	\$ 722.40
40520 00	Surgery	15.05	10.54	\$ 1,053.50	\$ 737.80
40525 00	Surgery	16.33	16.33	\$ 1,143.10	\$ 1,143.10
40527 00	Surgery	18.57	18.57	\$ 1,299.90	\$ 1,299.90
40530 00	Surgery	16.73	12.04	\$ 1,171.10	\$ 842.80
40650 00	Surgery	14.41	9.25	\$ 1,008.70	\$ 647.50
40652 00	Surgery	15.44	10.60	\$ 1,080.80	\$ 742.00
40654 00	Surgery	17.40	12.55	\$ 1,218.00	\$ 878.50
40700 00	Surgery	29.78	29.78	\$ 2,084.60	\$ 2,084.60
40701 00	Surgery	35.17	35.17	\$ 2,461.90	\$ 2,461.90
40702 00	Surgery	29.53	29.53	\$ 2,067.10	\$ 2,067.10
40720 00	Surgery	30.31	30.31	\$ 2,121.70	\$ 2,121.70
40761 00	Surgery	31.89	31.89	\$ 2,232.30	\$ 2,232.30
40799 00	Surgery	0.00	0.00	BR	BR

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
40800 00	Surgery	6.11	3.50	\$ 427.70	\$ 245.00
40801 00	Surgery	8.63	5.79	\$ 604.10	\$ 405.30
40804 00	Surgery	5.61	3.30	\$ 392.70	\$ 231.00
40805 00	Surgery	8.48	5.80	\$ 593.60	\$ 406.00
40806 00	Surgery	2.98	0.83	\$ 208.60	\$ 58.10
40808 00	Surgery	5.05	2.56	\$ 353.50	\$ 179.20
40810 00	Surgery	6.50	3.61	\$ 455.00	\$ 252.70
40812 00	Surgery	8.56	5.47	\$ 599.20	\$ 382.90
40814 00	Surgery	11.15	8.37	\$ 780.50	\$ 585.90
40816 00	Surgery	11.96	8.92	\$ 837.20	\$ 624.40
40818 00	Surgery	10.98	7.88	\$ 768.60	\$ 551.60
40819 00	Surgery	8.03	5.84	\$ 562.10	\$ 408.80
40820 00	Surgery	7.90	5.00	\$ 553.00	\$ 350.00
40830 00	Surgery	7.06	4.39	\$ 494.20	\$ 307.30
40831 00	Surgery	9.32	6.15	\$ 652.40	\$ 430.50
40840 00	Surgery	25.85	18.75	\$ 1,809.50	\$ 1,312.50
40842 00	Surgery	27.79	20.05	\$ 1,945.30	\$ 1,403.50
40843 00	Surgery	35.78	25.77	\$ 2,504.60	\$ 1,803.90
40844 00	Surgery	44.79	34.80	\$ 3,135.30	\$ 2,436.00
40845 00	Surgery	44.26	35.80	\$ 3,098.20	\$ 2,506.00
40899 00	Surgery	0.00	0.00	BR	BR
41000 00	Surgery	4.53	3.14	\$ 317.10	\$ 219.80
41005 00	Surgery	6.45	3.20	\$ 451.50	\$ 224.00
41006 00	Surgery	10.81	7.06	\$ 756.70	\$ 494.20
41007 00	Surgery	9.78	6.44	\$ 684.60	\$ 450.80
41008 00	Surgery	11.63	7.51	\$ 814.10	\$ 525.70
41009 00	Surgery	12.58	8.31	\$ 880.60	\$ 581.70
41010 00	Surgery	6.59	3.26	\$ 461.30	\$ 228.20
41015 00	Surgery	11.88	8.78	\$ 831.60	\$ 614.60
41016 00	Surgery	14.10	10.26	\$ 987.00	\$ 718.20
41017 00	Surgery	13.90	10.10	\$ 973.00	\$ 707.00
41018 00	Surgery	15.57	11.75	\$ 1,089.90	\$ 822.50
41019 00	Surgery	14.20	14.20	\$ 994.00	\$ 994.00
41100 00	Surgery	5.63	3.17	\$ 394.10	\$ 221.90
41105 00	Surgery	5.62	3.24	\$ 393.40	\$ 226.80
41108 00	Surgery	5.03	2.66	\$ 352.10	\$ 186.20
41110 00	Surgery	6.91	3.84	\$ 483.70	\$ 268.80
41112 00	Surgery	10.14	7.18	\$ 709.80	\$ 502.60
41113 00	Surgery	10.91	7.85	\$ 763.70	\$ 549.50
41114 00	Surgery	18.12	18.12	\$ 1,268.40	\$ 1,268.40
41115 00	Surgery	7.90	4.33	\$ 553.00	\$ 303.10
41116 00	Surgery	10.05	6.36	\$ 703.50	\$ 445.20
41120 00	Surgery	31.78	31.78	\$ 2,224.60	\$ 2,224.60
41130 00	Surgery	39.10	39.10	\$ 2,737.00	\$ 2,737.00
41135 00	Surgery	64.13	64.13	\$ 4,489.10	\$ 4,489.10
41140 00	Surgery	64.84	64.84	\$ 4,538.80	\$ 4,538.80
41145 00	Surgery	81.72	81.72	\$ 5,720.40	\$ 5,720.40
41150 00	Surgery	65.20	65.20	\$ 4,564.00	\$ 4,564.00
41153 00	Surgery	70.92	70.92	\$ 4,964.40	\$ 4,964.40
41155 00	Surgery	88.66	88.66	\$ 6,206.20	\$ 6,206.20
41250 00	Surgery	8.53	4.52	\$ 597.10	\$ 316.40
41251 00	Surgery	9.39	5.35	\$ 657.30	\$ 374.50
41252 00	Surgery	9.86	6.16	\$ 690.20	\$ 431.20
41510 00	Surgery	13.63	13.63	\$ 954.10	\$ 954.10

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
41512 00	Surgery	19.99	19.99	\$ 1,399.30	\$ 1,399.30
41520 00	Surgery	10.98	7.42	\$ 768.60	\$ 519.40
41530 00	Surgery	28.36	11.41	\$ 1,985.20	\$ 798.70
41599 00	Surgery	0.00	0.00	BR	BR
41800 00	Surgery	8.77	4.54	\$ 613.90	\$ 317.80
41805 00	Surgery	9.44	5.90	\$ 660.80	\$ 413.00
41806 00	Surgery	12.41	8.32	\$ 868.70	\$ 582.40
41820 00	Surgery	-	-	\$ 514.50	\$ 514.50
41821 00	Surgery	-	-	\$ 115.50	\$ 115.50
41822 00	Surgery	10.60	5.91	\$ 742.00	\$ 413.70
41823 00	Surgery	15.79	10.76	\$ 1,105.30	\$ 753.20
41825 00	Surgery	6.59	3.52	\$ 461.30	\$ 246.40
41826 00	Surgery	9.13	5.86	\$ 639.10	\$ 410.20
41827 00	Surgery	13.01	8.49	\$ 910.70	\$ 594.30
41828 00	Surgery	10.53	6.56	\$ 737.10	\$ 459.20
41830 00	Surgery	14.04	9.32	\$ 982.80	\$ 652.40
41850 00	Surgery	-	-	\$ 257.60	\$ 257.60
41870 00	Surgery	-	-	\$ 642.60	\$ 642.60
41872 00	Surgery	14.04	8.92	\$ 982.80	\$ 624.40
41874 00	Surgery	11.56	7.18	\$ 809.20	\$ 502.60
41899 00	Surgery	0.00	0.00	BR	BR
42000 00	Surgery	4.83	3.18	\$ 338.10	\$ 222.60
42100 00	Surgery	4.40	3.23	\$ 308.00	\$ 226.10
42104 00	Surgery	6.49	3.97	\$ 454.30	\$ 277.90
42106 00	Surgery	7.73	4.83	\$ 541.10	\$ 338.10
42107 00	Surgery	13.74	9.81	\$ 961.80	\$ 686.70
42120 00	Surgery	30.02	30.02	\$ 2,101.40	\$ 2,101.40
42140 00	Surgery	9.39	4.75	\$ 657.30	\$ 332.50
42145 00	Surgery	20.42	20.42	\$ 1,429.40	\$ 1,429.40
42160 00	Surgery	6.99	4.22	\$ 489.30	\$ 295.40
42180 00	Surgery	7.67	5.51	\$ 536.90	\$ 385.70
42182 00	Surgery	9.92	7.64	\$ 694.40	\$ 534.80
42200 00	Surgery	27.50	27.50	\$ 1,925.00	\$ 1,925.00
42205 00	Surgery	28.62	28.62	\$ 2,003.40	\$ 2,003.40
42210 00	Surgery	31.96	31.96	\$ 2,237.20	\$ 2,237.20
42215 00	Surgery	20.85	20.85	\$ 1,459.50	\$ 1,459.50
42220 00	Surgery	17.17	17.17	\$ 1,201.90	\$ 1,201.90
42225 00	Surgery	29.40	29.40	\$ 2,058.00	\$ 2,058.00
42226 00	Surgery	27.02	27.02	\$ 1,891.40	\$ 1,891.40
42227 00	Surgery	25.18	25.18	\$ 1,762.60	\$ 1,762.60
42235 00	Surgery	22.15	22.15	\$ 1,550.50	\$ 1,550.50
42260 00	Surgery	25.65	19.81	\$ 1,795.50	\$ 1,386.70
42280 00	Surgery	5.31	3.21	\$ 371.70	\$ 224.70
42281 00	Surgery	6.75	4.75	\$ 472.50	\$ 332.50
42299 00	Surgery	0.00	0.00	BR	BR
42300 00	Surgery	6.45	4.59	\$ 451.50	\$ 321.30
42305 00	Surgery	12.62	12.62	\$ 883.40	\$ 883.40
42310 00	Surgery	5.13	3.97	\$ 359.10	\$ 277.90
42320 00	Surgery	7.85	5.28	\$ 549.50	\$ 369.60
42330 00	Surgery	6.97	4.88	\$ 487.90	\$ 341.60
42335 00	Surgery	12.99	7.71	\$ 909.30	\$ 539.70
42340 00	Surgery	16.00	10.16	\$ 1,120.00	\$ 711.20
42400 00	Surgery	2.95	1.55	\$ 206.50	\$ 108.50
42405 00	Surgery	9.04	6.69	\$ 632.80	\$ 468.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
42408 00	Surgery	16.35	10.26	\$ 1,144.50	\$ 718.20
42409 00	Surgery	11.91	6.80	\$ 833.70	\$ 476.00
42410 00	Surgery	18.66	18.66	\$ 1,306.20	\$ 1,306.20
42415 00	Surgery	31.30	31.30	\$ 2,191.00	\$ 2,191.00
42420 00	Surgery	35.08	35.08	\$ 2,455.60	\$ 2,455.60
42425 00	Surgery	24.81	24.81	\$ 1,736.70	\$ 1,736.70
42426 00	Surgery	39.91	39.91	\$ 2,793.70	\$ 2,793.70
42440 00	Surgery	12.30	12.30	\$ 861.00	\$ 861.00
42450 00	Surgery	14.12	10.82	\$ 988.40	\$ 757.40
42500 00	Surgery	13.45	10.26	\$ 941.50	\$ 718.20
42505 00	Surgery	17.16	13.63	\$ 1,201.20	\$ 954.10
42507 00	Surgery	14.73	14.73	\$ 1,031.10	\$ 1,031.10
42509 00	Surgery	24.33	24.33	\$ 1,703.10	\$ 1,703.10
42510 00	Surgery	18.08	18.08	\$ 1,265.60	\$ 1,265.60
42550 00	Surgery	4.77	1.80	\$ 333.90	\$ 126.00
42600 00	Surgery	16.38	10.52	\$ 1,146.60	\$ 736.40
42650 00	Surgery	2.23	1.71	\$ 156.10	\$ 119.70
42660 00	Surgery	3.47	2.58	\$ 242.90	\$ 180.60
42665 00	Surgery	11.33	6.36	\$ 793.10	\$ 445.20
42699 00	Surgery	0.00	0.00	BR	BR
42700 00	Surgery	5.76	4.00	\$ 403.20	\$ 280.00
42720 00	Surgery	13.36	11.42	\$ 935.20	\$ 799.40
42725 00	Surgery	23.64	23.64	\$ 1,654.80	\$ 1,654.80
42800 00	Surgery	4.73	3.42	\$ 331.10	\$ 239.40
42804 00	Surgery	6.48	3.63	\$ 453.60	\$ 254.10
42806 00	Surgery	7.20	4.16	\$ 504.00	\$ 291.20
42808 00	Surgery	6.91	4.89	\$ 483.70	\$ 342.30
42809 00	Surgery	6.08	3.74	\$ 425.60	\$ 261.80
42810 00	Surgery	11.63	8.34	\$ 814.10	\$ 583.80
42815 00	Surgery	16.05	16.05	\$ 1,123.50	\$ 1,123.50
42820 00	Surgery	8.61	8.61	\$ 602.70	\$ 602.70
42821 00	Surgery	8.99	8.99	\$ 629.30	\$ 629.30
42825 00	Surgery	7.94	7.94	\$ 555.80	\$ 555.80
42826 00	Surgery	7.56	7.56	\$ 529.20	\$ 529.20
42830 00	Surgery	6.28	6.28	\$ 439.60	\$ 439.60
42831 00	Surgery	6.82	6.82	\$ 477.40	\$ 477.40
42835 00	Surgery	5.84	5.84	\$ 408.80	\$ 408.80
42836 00	Surgery	7.22	7.22	\$ 505.40	\$ 505.40
42842 00	Surgery	30.16	30.16	\$ 2,111.20	\$ 2,111.20
42844 00	Surgery	40.91	40.91	\$ 2,863.70	\$ 2,863.70
42845 00	Surgery	65.50	65.50	\$ 4,585.00	\$ 4,585.00
42860 00	Surgery	5.71	5.71	\$ 399.70	\$ 399.70
42870 00	Surgery	17.68	17.68	\$ 1,237.60	\$ 1,237.60
42890 00	Surgery	42.22	42.22	\$ 2,955.40	\$ 2,955.40
42892 00	Surgery	55.66	55.66	\$ 3,896.20	\$ 3,896.20
42894 00	Surgery	70.23	70.23	\$ 4,916.10	\$ 4,916.10
42900 00	Surgery	9.80	9.80	\$ 686.00	\$ 686.00
42950 00	Surgery	23.89	23.89	\$ 1,672.30	\$ 1,672.30
42953 00	Surgery	28.61	28.61	\$ 2,002.70	\$ 2,002.70
42955 00	Surgery	22.70	22.70	\$ 1,589.00	\$ 1,589.00
42960 00	Surgery	4.78	4.78	\$ 334.60	\$ 334.60
42961 00	Surgery	12.43	12.43	\$ 870.10	\$ 870.10
42962 00	Surgery	15.27	15.27	\$ 1,068.90	\$ 1,068.90
42970 00	Surgery	12.21	12.21	\$ 854.70	\$ 854.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
42971 00	Surgery	13.45	13.45	\$ 941.50	\$ 941.50
42972 00	Surgery	15.02	15.02	\$ 1,051.40	\$ 1,051.40
42975 00	Surgery	3.32	3.32	\$ 232.40	\$ 232.40
42999 00	Surgery	0.00	0.00	BR	BR
43020 00	Surgery	16.92	16.92	\$ 1,184.40	\$ 1,184.40
43030 00	Surgery	15.50	15.50	\$ 1,085.00	\$ 1,085.00
43045 00	Surgery	38.46	38.46	\$ 2,692.20	\$ 2,692.20
43100 00	Surgery	18.82	18.82	\$ 1,317.40	\$ 1,317.40
43101 00	Surgery	29.72	29.72	\$ 2,080.40	\$ 2,080.40
43107 00	Surgery	87.60	87.60	\$ 6,132.00	\$ 6,132.00
43108 00	Surgery	130.53	130.53	\$ 9,137.10	\$ 9,137.10
43112 00	Surgery	102.09	102.09	\$ 7,146.30	\$ 7,146.30
43113 00	Surgery	127.55	127.55	\$ 8,928.50	\$ 8,928.50
43116 00	Surgery	145.94	145.94	\$ 10,215.80	\$ 10,215.80
43117 00	Surgery	95.76	95.76	\$ 6,703.20	\$ 6,703.20
43118 00	Surgery	106.48	106.48	\$ 7,453.60	\$ 7,453.60
43121 00	Surgery	83.95	83.95	\$ 5,876.50	\$ 5,876.50
43122 00	Surgery	75.50	75.50	\$ 5,285.00	\$ 5,285.00
43123 00	Surgery	132.23	132.23	\$ 9,256.10	\$ 9,256.10
43124 00	Surgery	111.82	111.82	\$ 7,827.40	\$ 7,827.40
43130 00	Surgery	23.53	23.53	\$ 1,647.10	\$ 1,647.10
43135 00	Surgery	43.27	43.27	\$ 3,028.90	\$ 3,028.90
43180 00	Surgery	16.17	16.17	\$ 1,131.90	\$ 1,131.90
43191 00	Surgery	4.55	4.55	\$ 318.50	\$ 318.50
43192 00	Surgery	4.98	4.98	\$ 348.60	\$ 348.60
43193 00	Surgery	4.97	4.97	\$ 347.90	\$ 347.90
43194 00	Surgery	5.68	5.68	\$ 397.60	\$ 397.60
43195 00	Surgery	5.41	5.41	\$ 378.70	\$ 378.70
43196 00	Surgery	5.73	5.73	\$ 401.10	\$ 401.10
43197 00	Surgery	5.80	2.43	\$ 406.00	\$ 170.10
43198 00	Surgery	6.40	2.89	\$ 448.00	\$ 202.30
43200 00	Surgery	8.06	2.57	\$ 564.20	\$ 179.90
43201 00	Surgery	7.95	3.03	\$ 556.50	\$ 212.10
43202 00	Surgery	11.07	3.02	\$ 774.90	\$ 211.40
43204 00	Surgery	3.94	3.94	\$ 275.80	\$ 275.80
43205 00	Surgery	4.10	4.10	\$ 287.00	\$ 287.00
43206 00	Surgery	9.24	3.89	\$ 646.80	\$ 272.30
43210 00	Surgery	12.68	12.68	\$ 887.60	\$ 887.60
43211 00	Surgery	6.85	6.85	\$ 479.50	\$ 479.50
43212 00	Surgery	5.55	5.55	\$ 388.50	\$ 388.50
43213 00	Surgery	38.64	7.61	\$ 2,704.80	\$ 532.70
43214 00	Surgery	5.65	5.65	\$ 395.50	\$ 395.50
43215 00	Surgery	12.14	4.15	\$ 849.80	\$ 290.50
43216 00	Surgery	12.70	3.90	\$ 889.00	\$ 273.00
43217 00	Surgery	12.96	4.68	\$ 907.20	\$ 327.60
43220 00	Surgery	28.28	3.45	\$ 1,979.60	\$ 241.50
43226 00	Surgery	11.86	3.82	\$ 830.20	\$ 267.40
43227 00	Surgery	18.49	4.82	\$ 1,294.30	\$ 337.40
43229 00	Surgery	22.15	5.75	\$ 1,550.50	\$ 402.50
43231 00	Surgery	4.64	4.64	\$ 324.80	\$ 324.80
43232 00	Surgery	5.83	5.83	\$ 408.10	\$ 408.10
43233 00	Surgery	6.73	6.73	\$ 471.10	\$ 471.10
43235 00	Surgery	9.09	3.59	\$ 636.30	\$ 251.30
43236 00	Surgery	12.40	4.02	\$ 868.00	\$ 281.40

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
43237 00	Surgery	5.73	5.73	\$ 401.10	\$ 401.10
43238 00	Surgery	6.78	6.78	\$ 474.60	\$ 474.60
43239 00	Surgery	11.63	4.04	\$ 814.10	\$ 282.80
43240 00	Surgery	11.45	11.45	\$ 801.50	\$ 801.50
43241 00	Surgery	4.17	4.17	\$ 291.90	\$ 291.90
43242 00	Surgery	7.69	7.69	\$ 538.30	\$ 538.30
43243 00	Surgery	6.93	6.93	\$ 485.10	\$ 485.10
43244 00	Surgery	7.16	7.16	\$ 501.20	\$ 501.20
43245 00	Surgery	18.50	5.14	\$ 1,295.00	\$ 359.80
43246 00	Surgery	5.87	5.87	\$ 410.90	\$ 410.90
43247 00	Surgery	11.75	5.18	\$ 822.50	\$ 362.60
43248 00	Surgery	12.71	4.85	\$ 889.70	\$ 339.50
43249 00	Surgery	34.11	4.49	\$ 2,387.70	\$ 314.30
43250 00	Surgery	13.97	4.98	\$ 977.90	\$ 348.60
43251 00	Surgery	15.31	5.73	\$ 1,071.70	\$ 401.10
43252 00	Surgery	10.33	4.92	\$ 723.10	\$ 344.40
43253 00	Surgery	7.68	7.68	\$ 537.60	\$ 537.60
43254 00	Surgery	7.92	7.92	\$ 554.40	\$ 554.40
43255 00	Surgery	19.48	5.87	\$ 1,363.60	\$ 410.90
43257 00	Surgery	6.84	6.84	\$ 478.80	\$ 478.80
43259 00	Surgery	6.59	6.59	\$ 461.30	\$ 461.30
43260 00	Surgery	9.43	9.43	\$ 660.10	\$ 660.10
43261 00	Surgery	9.89	9.89	\$ 692.30	\$ 692.30
43262 00	Surgery	10.46	10.46	\$ 732.20	\$ 732.20
43263 00	Surgery	10.46	10.46	\$ 732.20	\$ 732.20
43264 00	Surgery	10.64	10.64	\$ 744.80	\$ 744.80
43265 00	Surgery	12.69	12.69	\$ 888.30	\$ 888.30
43266 00	Surgery	6.38	6.38	\$ 446.60	\$ 446.60
43270 00	Surgery	22.70	6.55	\$ 1,589.00	\$ 458.50
43273 00	Surgery	3.49	3.49	\$ 244.30	\$ 244.30
43274 00	Surgery	13.53	13.53	\$ 947.10	\$ 947.10
43275 00	Surgery	11.00	11.00	\$ 770.00	\$ 770.00
43276 00	Surgery	14.09	14.09	\$ 986.30	\$ 986.30
43277 00	Surgery	11.07	11.07	\$ 774.90	\$ 774.90
43278 00	Surgery	12.67	12.67	\$ 886.90	\$ 886.90
43279 00	Surgery	38.22	38.22	\$ 2,675.40	\$ 2,675.40
43280 00	Surgery	32.15	32.15	\$ 2,250.50	\$ 2,250.50
43281 00	Surgery	45.82	45.82	\$ 3,207.40	\$ 3,207.40
43282 00	Surgery	51.51	51.51	\$ 3,605.70	\$ 3,605.70
43283 00	Surgery	4.68	4.68	\$ 327.60	\$ 327.60
43284 00	Surgery	19.49	19.49	\$ 1,364.30	\$ 1,364.30
43285 00	Surgery	20.07	20.07	\$ 1,404.90	\$ 1,404.90
43286 00	Surgery	93.82	93.82	\$ 6,567.40	\$ 6,567.40
43287 00	Surgery	104.60	104.60	\$ 7,322.00	\$ 7,322.00
43288 00	Surgery	110.21	110.21	\$ 7,714.70	\$ 7,714.70
43289 00	Surgery	0.00	0.00	BR	BR
43300 00	Surgery	18.52	18.52	\$ 1,296.40	\$ 1,296.40
43305 00	Surgery	32.37	32.37	\$ 2,265.90	\$ 2,265.90
43310 00	Surgery	43.66	43.66	\$ 3,056.20	\$ 3,056.20
43312 00	Surgery	46.69	46.69	\$ 3,268.30	\$ 3,268.30
43313 00	Surgery	86.36	86.36	\$ 6,045.20	\$ 6,045.20
43314 00	Surgery	92.69	92.69	\$ 6,488.30	\$ 6,488.30
43320 00	Surgery	41.72	41.72	\$ 2,920.40	\$ 2,920.40
43325 00	Surgery	40.59	40.59	\$ 2,841.30	\$ 2,841.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
43327 00	Surgery	24.44	24.44	\$ 1,710.80	\$ 1,710.80
43328 00	Surgery	33.12	33.12	\$ 2,318.40	\$ 2,318.40
43330 00	Surgery	39.92	39.92	\$ 2,794.40	\$ 2,794.40
43331 00	Surgery	39.48	39.48	\$ 2,763.60	\$ 2,763.60
43332 00	Surgery	34.23	34.23	\$ 2,396.10	\$ 2,396.10
43333 00	Surgery	37.38	37.38	\$ 2,616.60	\$ 2,616.60
43334 00	Surgery	36.71	36.71	\$ 2,569.70	\$ 2,569.70
43335 00	Surgery	39.28	39.28	\$ 2,749.60	\$ 2,749.60
43336 00	Surgery	42.69	42.69	\$ 2,988.30	\$ 2,988.30
43337 00	Surgery	45.49	45.49	\$ 3,184.30	\$ 3,184.30
43338 00	Surgery	3.38	3.38	\$ 236.60	\$ 236.60
43340 00	Surgery	41.21	41.21	\$ 2,884.70	\$ 2,884.70
43341 00	Surgery	41.28	41.28	\$ 2,889.60	\$ 2,889.60
43351 00	Surgery	38.91	38.91	\$ 2,723.70	\$ 2,723.70
43352 00	Surgery	31.49	31.49	\$ 2,204.30	\$ 2,204.30
43360 00	Surgery	66.17	66.17	\$ 4,631.90	\$ 4,631.90
43361 00	Surgery	80.31	80.31	\$ 5,621.70	\$ 5,621.70
43400 00	Surgery	45.46	45.46	\$ 3,182.20	\$ 3,182.20
43405 00	Surgery	42.99	42.99	\$ 3,009.30	\$ 3,009.30
43410 00	Surgery	30.45	30.45	\$ 2,131.50	\$ 2,131.50
43415 00	Surgery	75.37	75.37	\$ 5,275.90	\$ 5,275.90
43420 00	Surgery	30.07	30.07	\$ 2,104.90	\$ 2,104.90
43425 00	Surgery	42.50	42.50	\$ 2,975.00	\$ 2,975.00
43450 00	Surgery	5.71	2.32	\$ 399.70	\$ 162.40
43453 00	Surgery	25.22	2.53	\$ 1,765.40	\$ 177.10
43460 00	Surgery	6.20	6.20	\$ 434.00	\$ 434.00
43496 00	Surgery	-	-	\$ 4,377.10	\$ 4,377.10
43497 00	Surgery	23.40	23.40	\$ 1,638.00	\$ 1,638.00
43499 00	Surgery	0.00	0.00	BR	BR
43500 00	Surgery	23.49	23.49	\$ 1,644.30	\$ 1,644.30
43501 00	Surgery	40.29	40.29	\$ 2,820.30	\$ 2,820.30
43502 00	Surgery	45.57	45.57	\$ 3,189.90	\$ 3,189.90
43510 00	Surgery	28.41	28.41	\$ 1,988.70	\$ 1,988.70
43520 00	Surgery	20.65	20.65	\$ 1,445.50	\$ 1,445.50
43605 00	Surgery	25.01	25.01	\$ 1,750.70	\$ 1,750.70
43610 00	Surgery	29.22	29.22	\$ 2,045.40	\$ 2,045.40
43611 00	Surgery	36.41	36.41	\$ 2,548.70	\$ 2,548.70
43620 00	Surgery	59.15	59.15	\$ 4,140.50	\$ 4,140.50
43621 00	Surgery	67.60	67.60	\$ 4,732.00	\$ 4,732.00
43622 00	Surgery	68.88	68.88	\$ 4,821.60	\$ 4,821.60
43631 00	Surgery	43.21	43.21	\$ 3,024.70	\$ 3,024.70
43632 00	Surgery	60.52	60.52	\$ 4,236.40	\$ 4,236.40
43633 00	Surgery	57.22	57.22	\$ 4,005.40	\$ 4,005.40
43634 00	Surgery	63.36	63.36	\$ 4,435.20	\$ 4,435.20
43635 00	Surgery	3.33	3.33	\$ 233.10	\$ 233.10
43640 00	Surgery	35.61	35.61	\$ 2,492.70	\$ 2,492.70
43641 00	Surgery	36.02	36.02	\$ 2,521.40	\$ 2,521.40
43644 00	Surgery	51.80	51.80	\$ 3,626.00	\$ 3,626.00
43645 00	Surgery	54.79	54.79	\$ 3,835.30	\$ 3,835.30
43647 00	Surgery	-	-	\$ 1,288.00	\$ 1,288.00
43648 00	Surgery	-	-	\$ 1,206.80	\$ 1,206.80
43651 00	Surgery	19.65	19.65	\$ 1,375.50	\$ 1,375.50
43652 00	Surgery	22.90	22.90	\$ 1,603.00	\$ 1,603.00
43653 00	Surgery	17.31	17.31	\$ 1,211.70	\$ 1,211.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
43659 00	Surgery	0.00	0.00	BR	BR
43752 00	Surgery	1.18	1.18	\$ 82.60	\$ 82.60
43753 00	Surgery	0.65	0.65	\$ 45.50	\$ 45.50
43754 00	Surgery	6.95	1.06	\$ 486.50	\$ 74.20
43755 00	Surgery	6.23	1.74	\$ 436.10	\$ 121.80
43756 00	Surgery	8.67	1.49	\$ 606.90	\$ 104.30
43757 00	Surgery	11.59	2.23	\$ 811.30	\$ 156.10
43761 00	Surgery	3.69	3.06	\$ 258.30	\$ 214.20
43762 00	Surgery	7.01	1.09	\$ 490.70	\$ 76.30
43763 00	Surgery	10.58	2.50	\$ 740.60	\$ 175.00
43770 00	Surgery	33.73	33.73	\$ 2,361.10	\$ 2,361.10
43771 00	Surgery	38.25	38.25	\$ 2,677.50	\$ 2,677.50
43772 00	Surgery	28.39	28.39	\$ 1,987.30	\$ 1,987.30
43773 00	Surgery	38.25	38.25	\$ 2,677.50	\$ 2,677.50
43774 00	Surgery	28.71	28.71	\$ 2,009.70	\$ 2,009.70
43775 00	Surgery	33.03	33.03	\$ 2,312.10	\$ 2,312.10
43800 00	Surgery	27.80	27.80	\$ 1,946.00	\$ 1,946.00
43810 00	Surgery	30.39	30.39	\$ 2,127.30	\$ 2,127.30
43820 00	Surgery	40.08	40.08	\$ 2,805.60	\$ 2,805.60
43825 00	Surgery	39.19	39.19	\$ 2,743.30	\$ 2,743.30
43830 00	Surgery	21.03	21.03	\$ 1,472.10	\$ 1,472.10
43831 00	Surgery	18.34	18.34	\$ 1,283.80	\$ 1,283.80
43832 00	Surgery	31.17	31.17	\$ 2,181.90	\$ 2,181.90
43840 00	Surgery	40.55	40.55	\$ 2,838.50	\$ 2,838.50
43842 00	Surgery	33.82	33.82	\$ 2,367.40	\$ 2,367.40
43843 00	Surgery	38.40	38.40	\$ 2,688.00	\$ 2,688.00
43845 00	Surgery	58.29	58.29	\$ 4,080.30	\$ 4,080.30
43846 00	Surgery	49.35	49.35	\$ 3,454.50	\$ 3,454.50
43847 00	Surgery	54.02	54.02	\$ 3,781.40	\$ 3,781.40
43848 00	Surgery	57.55	57.55	\$ 4,028.50	\$ 4,028.50
43860 00	Surgery	48.78	48.78	\$ 3,414.60	\$ 3,414.60
43865 00	Surgery	51.04	51.04	\$ 3,572.80	\$ 3,572.80
43870 00	Surgery	21.21	21.21	\$ 1,484.70	\$ 1,484.70
43880 00	Surgery	47.69	47.69	\$ 3,338.30	\$ 3,338.30
43881 00	Surgery	-	-	\$ 1,400.70	\$ 1,400.70
43882 00	Surgery	-	-	\$ 1,579.90	\$ 1,579.90
43886 00	Surgery	11.04	11.04	\$ 772.80	\$ 772.80
43887 00	Surgery	9.93	9.93	\$ 695.10	\$ 695.10
43888 00	Surgery	13.97	13.97	\$ 977.90	\$ 977.90
43999 00	Surgery	0.00	0.00	BR	BR
44005 00	Surgery	32.55	32.55	\$ 2,278.50	\$ 2,278.50
44010 00	Surgery	25.45	25.45	\$ 1,781.50	\$ 1,781.50
44015 00	Surgery	4.20	4.20	\$ 294.00	\$ 294.00
44020 00	Surgery	29.10	29.10	\$ 2,037.00	\$ 2,037.00
44021 00	Surgery	28.95	28.95	\$ 2,026.50	\$ 2,026.50
44025 00	Surgery	29.23	29.23	\$ 2,046.10	\$ 2,046.10
44050 00	Surgery	27.92	27.92	\$ 1,954.40	\$ 1,954.40
44055 00	Surgery	44.31	44.31	\$ 3,101.70	\$ 3,101.70
44100 00	Surgery	3.13	3.13	\$ 219.10	\$ 219.10
44110 00	Surgery	25.18	25.18	\$ 1,762.60	\$ 1,762.60
44111 00	Surgery	29.12	29.12	\$ 2,038.40	\$ 2,038.40
44120 00	Surgery	36.36	36.36	\$ 2,545.20	\$ 2,545.20
44121 00	Surgery	7.12	7.12	\$ 498.40	\$ 498.40
44125 00	Surgery	34.99	34.99	\$ 2,449.30	\$ 2,449.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
44126 00	Surgery	73.61	73.61	\$ 5,152.70	\$ 5,152.70
44127 00	Surgery	85.00	85.00	\$ 5,950.00	\$ 5,950.00
44128 00	Surgery	7.20	7.20	\$ 504.00	\$ 504.00
44130 00	Surgery	39.16	39.16	\$ 2,741.20	\$ 2,741.20
44132 00	Surgery	0.00	0.00	BR	BR
44133 00	Surgery	0.00	0.00	BR	BR
44135 00	Surgery	0.00	0.00	BR	BR
44136 00	Surgery	0.00	0.00	BR	BR
44137 00	Surgery	-	-	\$ 2,331.70	\$ 2,331.70
44139 00	Surgery	3.57	3.57	\$ 249.90	\$ 249.90
44140 00	Surgery	39.93	39.93	\$ 2,795.10	\$ 2,795.10
44141 00	Surgery	54.04	54.04	\$ 3,782.80	\$ 3,782.80
44143 00	Surgery	49.25	49.25	\$ 3,447.50	\$ 3,447.50
44144 00	Surgery	52.38	52.38	\$ 3,666.60	\$ 3,666.60
44145 00	Surgery	48.89	48.89	\$ 3,422.30	\$ 3,422.30
44146 00	Surgery	62.26	62.26	\$ 4,358.20	\$ 4,358.20
44147 00	Surgery	57.29	57.29	\$ 4,010.30	\$ 4,010.30
44150 00	Surgery	55.04	55.04	\$ 3,852.80	\$ 3,852.80
44151 00	Surgery	64.25	64.25	\$ 4,497.50	\$ 4,497.50
44155 00	Surgery	61.26	61.26	\$ 4,288.20	\$ 4,288.20
44156 00	Surgery	68.72	68.72	\$ 4,810.40	\$ 4,810.40
44157 00	Surgery	65.25	65.25	\$ 4,567.50	\$ 4,567.50
44158 00	Surgery	66.86	66.86	\$ 4,680.20	\$ 4,680.20
44160 00	Surgery	36.91	36.91	\$ 2,583.70	\$ 2,583.70
44180 00	Surgery	27.43	27.43	\$ 1,920.10	\$ 1,920.10
44186 00	Surgery	19.47	19.47	\$ 1,362.90	\$ 1,362.90
44187 00	Surgery	32.41	32.41	\$ 2,268.70	\$ 2,268.70
44188 00	Surgery	36.13	36.13	\$ 2,529.10	\$ 2,529.10
44202 00	Surgery	41.25	41.25	\$ 2,887.50	\$ 2,887.50
44203 00	Surgery	7.11	7.11	\$ 497.70	\$ 497.70
44204 00	Surgery	45.55	45.55	\$ 3,188.50	\$ 3,188.50
44205 00	Surgery	39.55	39.55	\$ 2,768.50	\$ 2,768.50
44206 00	Surgery	51.65	51.65	\$ 3,615.50	\$ 3,615.50
44207 00	Surgery	53.55	53.55	\$ 3,748.50	\$ 3,748.50
44208 00	Surgery	58.28	58.28	\$ 4,079.60	\$ 4,079.60
44210 00	Surgery	52.23	52.23	\$ 3,656.10	\$ 3,656.10
44211 00	Surgery	62.03	62.03	\$ 4,342.10	\$ 4,342.10
44212 00	Surgery	59.76	59.76	\$ 4,183.20	\$ 4,183.20
44213 00	Surgery	5.52	5.52	\$ 386.40	\$ 386.40
44227 00	Surgery	49.23	49.23	\$ 3,446.10	\$ 3,446.10
44238 00	Surgery	0.00	0.00	BR	BR
44300 00	Surgery	25.11	25.11	\$ 1,757.70	\$ 1,757.70
44310 00	Surgery	30.86	30.86	\$ 2,160.20	\$ 2,160.20
44312 00	Surgery	17.78	17.78	\$ 1,244.60	\$ 1,244.60
44314 00	Surgery	29.82	29.82	\$ 2,087.40	\$ 2,087.40
44316 00	Surgery	42.25	42.25	\$ 2,957.50	\$ 2,957.50
44320 00	Surgery	35.67	35.67	\$ 2,496.90	\$ 2,496.90
44322 00	Surgery	30.23	30.23	\$ 2,116.10	\$ 2,116.10
44340 00	Surgery	18.65	18.65	\$ 1,305.50	\$ 1,305.50
44345 00	Surgery	31.17	31.17	\$ 2,181.90	\$ 2,181.90
44346 00	Surgery	35.09	35.09	\$ 2,456.30	\$ 2,456.30
44360 00	Surgery	4.19	4.19	\$ 293.30	\$ 293.30
44361 00	Surgery	4.64	4.64	\$ 324.80	\$ 324.80
44363 00	Surgery	5.61	5.61	\$ 392.70	\$ 392.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
44364 00	Surgery	5.97	5.97	\$ 417.90	\$ 417.90
44365 00	Surgery	5.31	5.31	\$ 371.70	\$ 371.70
44366 00	Surgery	6.99	6.99	\$ 489.30	\$ 489.30
44369 00	Surgery	7.17	7.17	\$ 501.90	\$ 501.90
44370 00	Surgery	7.79	7.79	\$ 545.30	\$ 545.30
44372 00	Surgery	7.01	7.01	\$ 490.70	\$ 490.70
44373 00	Surgery	5.61	5.61	\$ 392.70	\$ 392.70
44376 00	Surgery	8.31	8.31	\$ 581.70	\$ 581.70
44377 00	Surgery	8.74	8.74	\$ 611.80	\$ 611.80
44378 00	Surgery	11.25	11.25	\$ 787.50	\$ 787.50
44379 00	Surgery	11.97	11.97	\$ 837.90	\$ 837.90
44380 00	Surgery	5.98	1.65	\$ 418.60	\$ 115.50
44381 00	Surgery	30.43	2.46	\$ 2,130.10	\$ 172.20
44382 00	Surgery	9.24	2.13	\$ 646.80	\$ 149.10
44384 00	Surgery	4.52	4.52	\$ 316.40	\$ 316.40
44385 00	Surgery	6.55	2.13	\$ 458.50	\$ 149.10
44386 00	Surgery	9.62	2.62	\$ 673.40	\$ 183.40
44388 00	Surgery	9.61	4.58	\$ 672.70	\$ 320.60
44389 00	Surgery	12.63	5.03	\$ 884.10	\$ 352.10
44390 00	Surgery	12.30	6.13	\$ 861.00	\$ 429.10
44391 00	Surgery	19.77	6.75	\$ 1,383.90	\$ 472.50
44392 00	Surgery	11.74	5.84	\$ 821.80	\$ 408.80
44394 00	Surgery	13.39	6.62	\$ 937.30	\$ 463.40
44401 00	Surgery	75.16	7.07	\$ 5,261.20	\$ 494.90
44402 00	Surgery	7.65	7.65	\$ 535.50	\$ 535.50
44403 00	Surgery	8.88	8.88	\$ 621.60	\$ 621.60
44404 00	Surgery	12.97	5.04	\$ 907.90	\$ 352.80
44405 00	Surgery	17.20	5.35	\$ 1,204.00	\$ 374.50
44406 00	Surgery	6.69	6.69	\$ 468.30	\$ 468.30
44407 00	Surgery	8.06	8.06	\$ 564.20	\$ 564.20
44408 00	Surgery	6.75	6.75	\$ 472.50	\$ 472.50
44500 00	Surgery	0.57	0.57	\$ 39.90	\$ 39.90
44602 00	Surgery	41.85	41.85	\$ 2,929.50	\$ 2,929.50
44603 00	Surgery	47.96	47.96	\$ 3,357.20	\$ 3,357.20
44604 00	Surgery	31.32	31.32	\$ 2,192.40	\$ 2,192.40
44605 00	Surgery	38.63	38.63	\$ 2,704.10	\$ 2,704.10
44615 00	Surgery	31.88	31.88	\$ 2,231.60	\$ 2,231.60
44620 00	Surgery	25.65	25.65	\$ 1,795.50	\$ 1,795.50
44625 00	Surgery	29.93	29.93	\$ 2,095.10	\$ 2,095.10
44626 00	Surgery	47.31	47.31	\$ 3,311.70	\$ 3,311.70
44640 00	Surgery	41.47	41.47	\$ 2,902.90	\$ 2,902.90
44650 00	Surgery	42.79	42.79	\$ 2,995.30	\$ 2,995.30
44660 00	Surgery	39.31	39.31	\$ 2,751.70	\$ 2,751.70
44661 00	Surgery	45.74	45.74	\$ 3,201.80	\$ 3,201.80
44680 00	Surgery	32.18	32.18	\$ 2,252.60	\$ 2,252.60
44700 00	Surgery	29.50	29.50	\$ 2,065.00	\$ 2,065.00
44701 00	Surgery	5.03	5.03	\$ 352.10	\$ 352.10
44705 00	Surgery	3.26	2.08	\$ 228.20	\$ 145.60
44715 00	Surgery	-	-	\$ 721.70	\$ 721.70
44720 00	Surgery	8.13	8.13	\$ 569.10	\$ 569.10
44721 00	Surgery	11.37	11.37	\$ 795.90	\$ 795.90
44799 00	Surgery	0.00	0.00	BR	BR
44800 00	Surgery	22.99	22.99	\$ 1,609.30	\$ 1,609.30
44820 00	Surgery	25.47	25.47	\$ 1,782.90	\$ 1,782.90

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
44850 00	Surgery	22.40	22.40	\$ 1,568.00	\$ 1,568.00
44899 00	Surgery	0.00	0.00	BR	BR
44900 00	Surgery	23.49	23.49	\$ 1,644.30	\$ 1,644.30
44950 00	Surgery	19.18	19.18	\$ 1,342.60	\$ 1,342.60
44955 00	Surgery	2.46	2.46	\$ 172.20	\$ 172.20
44960 00	Surgery	26.24	26.24	\$ 1,836.80	\$ 1,836.80
44970 00	Surgery	18.01	18.01	\$ 1,260.70	\$ 1,260.70
44979 00	Surgery	0.00	0.00	BR	BR
45000 00	Surgery	12.74	12.74	\$ 891.80	\$ 891.80
45005 00	Surgery	9.76	5.03	\$ 683.20	\$ 352.10
45020 00	Surgery	17.09	17.09	\$ 1,196.30	\$ 1,196.30
45100 00	Surgery	8.97	8.97	\$ 627.90	\$ 627.90
45108 00	Surgery	11.19	11.19	\$ 783.30	\$ 783.30
45110 00	Surgery	53.86	53.86	\$ 3,770.20	\$ 3,770.20
45111 00	Surgery	32.25	32.25	\$ 2,257.50	\$ 2,257.50
45112 00	Surgery	54.52	54.52	\$ 3,816.40	\$ 3,816.40
45113 00	Surgery	54.81	54.81	\$ 3,836.70	\$ 3,836.70
45114 00	Surgery	54.21	54.21	\$ 3,794.70	\$ 3,794.70
45116 00	Surgery	45.32	45.32	\$ 3,172.40	\$ 3,172.40
45119 00	Surgery	55.21	55.21	\$ 3,864.70	\$ 3,864.70
45120 00	Surgery	47.78	47.78	\$ 3,344.60	\$ 3,344.60
45121 00	Surgery	52.16	52.16	\$ 3,651.20	\$ 3,651.20
45123 00	Surgery	32.96	32.96	\$ 2,307.20	\$ 2,307.20
45126 00	Surgery	80.78	80.78	\$ 5,654.60	\$ 5,654.60
45130 00	Surgery	31.95	31.95	\$ 2,236.50	\$ 2,236.50
45135 00	Surgery	38.06	38.06	\$ 2,664.20	\$ 2,664.20
45136 00	Surgery	52.46	52.46	\$ 3,672.20	\$ 3,672.20
45150 00	Surgery	12.68	12.68	\$ 887.60	\$ 887.60
45160 00	Surgery	30.67	30.67	\$ 2,146.90	\$ 2,146.90
45171 00	Surgery	18.46	18.46	\$ 1,292.20	\$ 1,292.20
45172 00	Surgery	24.56	24.56	\$ 1,719.20	\$ 1,719.20
45190 00	Surgery	21.06	21.06	\$ 1,474.20	\$ 1,474.20
45300 00	Surgery	3.89	1.40	\$ 272.30	\$ 98.00
45303 00	Surgery	29.71	2.49	\$ 2,079.70	\$ 174.30
45305 00	Surgery	5.53	2.14	\$ 387.10	\$ 149.80
45307 00	Surgery	6.58	2.98	\$ 460.60	\$ 208.60
45308 00	Surgery	6.29	2.50	\$ 440.30	\$ 175.00
45309 00	Surgery	6.48	2.64	\$ 453.60	\$ 184.80
45315 00	Surgery	7.00	3.14	\$ 490.00	\$ 219.80
45317 00	Surgery	6.70	3.24	\$ 469.00	\$ 226.80
45320 00	Surgery	6.88	3.11	\$ 481.60	\$ 217.70
45321 00	Surgery	3.06	3.06	\$ 214.20	\$ 214.20
45327 00	Surgery	3.46	3.46	\$ 242.20	\$ 242.20
45330 00	Surgery	5.67	1.64	\$ 396.90	\$ 114.80
45331 00	Surgery	8.84	2.09	\$ 618.80	\$ 146.30
45332 00	Surgery	8.50	3.08	\$ 595.00	\$ 215.60
45333 00	Surgery	10.17	2.75	\$ 711.90	\$ 192.50
45334 00	Surgery	15.37	3.44	\$ 1,075.90	\$ 240.80
45335 00	Surgery	9.00	1.93	\$ 630.00	\$ 135.10
45337 00	Surgery	3.36	3.36	\$ 235.20	\$ 235.20
45338 00	Surgery	9.17	3.52	\$ 641.90	\$ 246.40
45340 00	Surgery	14.31	2.29	\$ 1,001.70	\$ 160.30
45341 00	Surgery	3.63	3.63	\$ 254.10	\$ 254.10
45342 00	Surgery	4.96	4.96	\$ 347.20	\$ 347.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
45346 00	Surgery	72.82	4.69	\$ 5,097.40	\$ 328.30
45347 00	Surgery	4.51	4.51	\$ 315.70	\$ 315.70
45349 00	Surgery	5.80	5.80	\$ 406.00	\$ 406.00
45350 00	Surgery	21.04	2.95	\$ 1,472.80	\$ 206.50
45378 00	Surgery	10.32	5.40	\$ 722.40	\$ 378.00
45379 00	Surgery	13.25	7.00	\$ 927.50	\$ 490.00
45380 00	Surgery	13.30	5.86	\$ 931.00	\$ 410.20
45381 00	Surgery	13.57	5.86	\$ 949.90	\$ 410.20
45382 00	Surgery	20.59	7.59	\$ 1,441.30	\$ 531.30
45384 00	Surgery	14.97	6.70	\$ 1,047.90	\$ 469.00
45385 00	Surgery	13.83	7.45	\$ 968.10	\$ 521.50
45386 00	Surgery	18.90	6.18	\$ 1,323.00	\$ 432.60
45388 00	Surgery	77.61	7.91	\$ 5,432.70	\$ 553.70
45389 00	Surgery	8.48	8.48	\$ 593.60	\$ 593.60
45390 00	Surgery	9.71	9.71	\$ 679.70	\$ 679.70
45391 00	Surgery	7.54	7.54	\$ 527.80	\$ 527.80
45392 00	Surgery	8.88	8.88	\$ 621.60	\$ 621.60
45393 00	Surgery	7.40	7.40	\$ 518.00	\$ 518.00
45395 00	Surgery	57.69	57.69	\$ 4,038.30	\$ 4,038.30
45397 00	Surgery	62.67	62.67	\$ 4,386.90	\$ 4,386.90
45398 00	Surgery	25.74	6.89	\$ 1,801.80	\$ 482.30
45399 00	Surgery	0.00	0.00	BR	BR
45400 00	Surgery	33.43	33.43	\$ 2,340.10	\$ 2,340.10
45402 00	Surgery	44.68	44.68	\$ 3,127.60	\$ 3,127.60
45499 00	Surgery	0.00	0.00	BR	BR
45500 00	Surgery	17.13	17.13	\$ 1,199.10	\$ 1,199.10
45505 00	Surgery	17.95	17.95	\$ 1,256.50	\$ 1,256.50
45520 00	Surgery	4.92	1.18	\$ 344.40	\$ 82.60
45540 00	Surgery	31.18	31.18	\$ 2,182.60	\$ 2,182.60
45541 00	Surgery	28.06	28.06	\$ 1,964.20	\$ 1,964.20
45550 00	Surgery	43.12	43.12	\$ 3,018.40	\$ 3,018.40
45560 00	Surgery	20.48	20.48	\$ 1,433.60	\$ 1,433.60
45562 00	Surgery	33.92	33.92	\$ 2,374.40	\$ 2,374.40
45563 00	Surgery	49.64	49.64	\$ 3,474.80	\$ 3,474.80
45800 00	Surgery	38.06	38.06	\$ 2,664.20	\$ 2,664.20
45805 00	Surgery	43.98	43.98	\$ 3,078.60	\$ 3,078.60
45820 00	Surgery	38.16	38.16	\$ 2,671.20	\$ 2,671.20
45825 00	Surgery	46.07	46.07	\$ 3,224.90	\$ 3,224.90
45900 00	Surgery	6.36	6.36	\$ 445.20	\$ 445.20
45905 00	Surgery	5.02	5.02	\$ 351.40	\$ 351.40
45910 00	Surgery	5.74	5.74	\$ 401.80	\$ 401.80
45915 00	Surgery	10.68	6.85	\$ 747.60	\$ 479.50
45990 00	Surgery	3.10	3.10	\$ 217.00	\$ 217.00
45999 00	Surgery	0.00	0.00	BR	BR
46020 00	Surgery	3.42	3.42	\$ 239.40	\$ 239.40
46030 00	Surgery	7.82	2.57	\$ 547.40	\$ 179.90
46040 00	Surgery	16.79	12.73	\$ 1,175.30	\$ 891.10
46045 00	Surgery	13.16	13.16	\$ 921.20	\$ 921.20
46050 00	Surgery	7.19	2.98	\$ 503.30	\$ 208.60
46060 00	Surgery	14.52	14.52	\$ 1,016.40	\$ 1,016.40
46070 00	Surgery	8.20	8.20	\$ 574.00	\$ 574.00
46080 00	Surgery	8.73	4.69	\$ 611.10	\$ 328.30
46083 00	Surgery	6.36	3.27	\$ 445.20	\$ 228.90
46200 00	Surgery	14.34	10.06	\$ 1,003.80	\$ 704.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
46220 00	Surgery	7.62	3.59	\$ 533.40	\$ 251.30
46221 00	Surgery	8.61	5.78	\$ 602.70	\$ 404.60
46230 00	Surgery	9.42	5.11	\$ 659.40	\$ 357.70
46250 00	Surgery	14.50	9.54	\$ 1,015.00	\$ 667.80
46255 00	Surgery	15.78	10.66	\$ 1,104.60	\$ 746.20
46257 00	Surgery	12.38	12.38	\$ 866.60	\$ 866.60
46258 00	Surgery	14.44	14.44	\$ 1,010.80	\$ 1,010.80
46260 00	Surgery	14.44	14.44	\$ 1,010.80	\$ 1,010.80
46261 00	Surgery	15.78	15.78	\$ 1,104.60	\$ 1,104.60
46262 00	Surgery	17.64	17.64	\$ 1,234.80	\$ 1,234.80
46270 00	Surgery	16.19	11.97	\$ 1,133.30	\$ 837.90
46275 00	Surgery	17.05	12.61	\$ 1,193.50	\$ 882.70
46280 00	Surgery	14.35	14.35	\$ 1,004.50	\$ 1,004.50
46285 00	Surgery	16.96	12.59	\$ 1,187.20	\$ 881.30
46288 00	Surgery	16.62	16.62	\$ 1,163.40	\$ 1,163.40
46320 00	Surgery	6.46	3.36	\$ 452.20	\$ 235.20
46500 00	Surgery	9.58	5.55	\$ 670.60	\$ 388.50
46505 00	Surgery	9.50	7.52	\$ 665.00	\$ 526.40
46600 00	Surgery	3.66	1.20	\$ 256.20	\$ 84.00
46601 00	Surgery	4.56	2.80	\$ 319.20	\$ 196.00
46604 00	Surgery	20.94	1.96	\$ 1,465.80	\$ 137.20
46606 00	Surgery	8.68	2.22	\$ 607.60	\$ 155.40
46607 00	Surgery	6.36	3.74	\$ 445.20	\$ 261.80
46608 00	Surgery	9.09	2.50	\$ 636.30	\$ 175.00
46610 00	Surgery	8.57	2.37	\$ 599.90	\$ 165.90
46611 00	Surgery	6.94	2.37	\$ 485.80	\$ 165.90
46612 00	Surgery	10.45	2.83	\$ 731.50	\$ 198.10
46614 00	Surgery	5.13	1.86	\$ 359.10	\$ 130.20
46615 00	Surgery	5.51	2.69	\$ 385.70	\$ 188.30
46700 00	Surgery	19.52	19.52	\$ 1,366.40	\$ 1,366.40
46705 00	Surgery	17.19	17.19	\$ 1,203.30	\$ 1,203.30
46706 00	Surgery	5.35	5.35	\$ 374.50	\$ 374.50
46707 00	Surgery	15.18	15.18	\$ 1,062.60	\$ 1,062.60
46710 00	Surgery	33.29	33.29	\$ 2,330.30	\$ 2,330.30
46712 00	Surgery	66.35	66.35	\$ 4,644.50	\$ 4,644.50
46715 00	Surgery	16.74	16.74	\$ 1,171.80	\$ 1,171.80
46716 00	Surgery	36.94	36.94	\$ 2,585.80	\$ 2,585.80
46730 00	Surgery	59.39	59.39	\$ 4,157.30	\$ 4,157.30
46735 00	Surgery	68.32	68.32	\$ 4,782.40	\$ 4,782.40
46740 00	Surgery	64.78	64.78	\$ 4,534.60	\$ 4,534.60
46742 00	Surgery	74.82	74.82	\$ 5,237.40	\$ 5,237.40
46744 00	Surgery	105.47	105.47	\$ 7,382.90	\$ 7,382.90
46746 00	Surgery	116.18	116.18	\$ 8,132.60	\$ 8,132.60
46748 00	Surgery	125.88	125.88	\$ 8,811.60	\$ 8,811.60
46750 00	Surgery	22.28	22.28	\$ 1,559.60	\$ 1,559.60
46751 00	Surgery	20.13	20.13	\$ 1,409.10	\$ 1,409.10
46753 00	Surgery	18.64	18.64	\$ 1,304.80	\$ 1,304.80
46754 00	Surgery	10.38	7.10	\$ 726.60	\$ 497.00
46760 00	Surgery	32.53	32.53	\$ 2,277.10	\$ 2,277.10
46761 00	Surgery	27.16	27.16	\$ 1,901.20	\$ 1,901.20
46900 00	Surgery	7.14	4.03	\$ 499.80	\$ 282.10
46910 00	Surgery	8.00	4.00	\$ 560.00	\$ 280.00
46916 00	Surgery	7.82	4.15	\$ 547.40	\$ 290.50
46917 00	Surgery	13.22	3.76	\$ 925.40	\$ 263.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
46922 00	Surgery	9.55	4.07	\$ 668.50	\$ 284.90
46924 00	Surgery	16.69	5.31	\$ 1,168.30	\$ 371.70
46930 00	Surgery	6.56	4.55	\$ 459.20	\$ 318.50
46940 00	Surgery	8.00	4.26	\$ 560.00	\$ 298.20
46942 00	Surgery	7.62	3.82	\$ 533.40	\$ 267.40
46945 00	Surgery	10.16	10.16	\$ 711.20	\$ 711.20
46946 00	Surgery	11.45	11.45	\$ 801.50	\$ 801.50
46947 00	Surgery	11.60	11.60	\$ 812.00	\$ 812.00
46948 00	Surgery	13.37	13.37	\$ 935.90	\$ 935.90
46999 00	Surgery	0.00	0.00	BR	BR
47000 00	Surgery	9.19	2.55	\$ 643.30	\$ 178.50
47001 00	Surgery	3.06	3.06	\$ 214.20	\$ 214.20
47010 00	Surgery	36.26	36.26	\$ 2,538.20	\$ 2,538.20
47015 00	Surgery	34.89	34.89	\$ 2,442.30	\$ 2,442.30
47100 00	Surgery	25.39	25.39	\$ 1,777.30	\$ 1,777.30
47120 00	Surgery	69.46	69.46	\$ 4,862.20	\$ 4,862.20
47122 00	Surgery	102.10	102.10	\$ 7,147.00	\$ 7,147.00
47125 00	Surgery	91.48	91.48	\$ 6,403.60	\$ 6,403.60
47130 00	Surgery	98.14	98.14	\$ 6,869.80	\$ 6,869.80
47133 00	Surgery	0.00	0.00	BR	BR
47135 00	Surgery	159.98	159.98	\$ 11,198.60	\$ 11,198.60
47140 00	Surgery	106.20	106.20	\$ 7,434.00	\$ 7,434.00
47141 00	Surgery	126.95	126.95	\$ 8,886.50	\$ 8,886.50
47142 00	Surgery	139.51	139.51	\$ 9,765.70	\$ 9,765.70
47143 00	Surgery	-	-	\$ 761.60	\$ 761.60
47144 00	Surgery	-	-	\$ 971.60	\$ 971.60
47145 00	Surgery	-	-	\$ 1,000.30	\$ 1,000.30
47146 00	Surgery	9.72	9.72	\$ 680.40	\$ 680.40
47147 00	Surgery	11.29	11.29	\$ 790.30	\$ 790.30
47300 00	Surgery	33.85	33.85	\$ 2,369.50	\$ 2,369.50
47350 00	Surgery	40.81	40.81	\$ 2,856.70	\$ 2,856.70
47360 00	Surgery	56.02	56.02	\$ 3,921.40	\$ 3,921.40
47361 00	Surgery	89.68	89.68	\$ 6,277.60	\$ 6,277.60
47362 00	Surgery	42.56	42.56	\$ 2,979.20	\$ 2,979.20
47370 00	Surgery	37.31	37.31	\$ 2,611.70	\$ 2,611.70
47371 00	Surgery	37.63	37.63	\$ 2,634.10	\$ 2,634.10
47379 00	Surgery	0.00	0.00	BR	BR
47380 00	Surgery	43.08	43.08	\$ 3,015.60	\$ 3,015.60
47381 00	Surgery	44.24	44.24	\$ 3,096.80	\$ 3,096.80
47382 00	Surgery	114.26	21.36	\$ 7,998.20	\$ 1,495.20
47383 00	Surgery	185.51	12.97	\$ 12,985.70	\$ 907.90
47399 00	Surgery	0.00	0.00	BR	BR
47400 00	Surgery	64.23	64.23	\$ 4,496.10	\$ 4,496.10
47420 00	Surgery	39.82	39.82	\$ 2,787.40	\$ 2,787.40
47425 00	Surgery	40.91	40.91	\$ 2,863.70	\$ 2,863.70
47460 00	Surgery	38.02	38.02	\$ 2,661.40	\$ 2,661.40
47480 00	Surgery	26.15	26.15	\$ 1,830.50	\$ 1,830.50
47490 00	Surgery	9.75	9.75	\$ 682.50	\$ 682.50
47531 00	Surgery	13.19	2.03	\$ 923.30	\$ 142.10
47532 00	Surgery	25.99	6.12	\$ 1,819.30	\$ 428.40
47533 00	Surgery	36.14	7.66	\$ 2,529.80	\$ 536.20
47534 00	Surgery	39.37	10.67	\$ 2,755.90	\$ 746.90
47535 00	Surgery	27.50	5.66	\$ 1,925.00	\$ 396.20
47536 00	Surgery	19.74	3.80	\$ 1,381.80	\$ 266.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
47537 00	Surgery	15.30	2.79	\$ 1,071.00	\$ 195.30
47538 00	Surgery	118.56	6.77	\$ 8,299.20	\$ 473.90
47539 00	Surgery	131.42	12.21	\$ 9,199.40	\$ 854.70
47540 00	Surgery	133.11	12.70	\$ 9,317.70	\$ 889.00
47541 00	Surgery	35.75	9.66	\$ 2,502.50	\$ 676.20
47542 00	Surgery	15.37	3.91	\$ 1,075.90	\$ 273.70
47543 00	Surgery	12.01	4.13	\$ 840.70	\$ 289.10
47544 00	Surgery	26.07	4.50	\$ 1,824.90	\$ 315.00
47550 00	Surgery	4.88	4.88	\$ 341.60	\$ 341.60
47552 00	Surgery	7.97	7.97	\$ 557.90	\$ 557.90
47553 00	Surgery	8.03	8.03	\$ 562.10	\$ 562.10
47554 00	Surgery	15.27	15.27	\$ 1,068.90	\$ 1,068.90
47555 00	Surgery	9.55	9.55	\$ 668.50	\$ 668.50
47556 00	Surgery	10.83	10.83	\$ 758.10	\$ 758.10
47562 00	Surgery	19.76	19.76	\$ 1,383.20	\$ 1,383.20
47563 00	Surgery	21.50	21.50	\$ 1,505.00	\$ 1,505.00
47564 00	Surgery	33.36	33.36	\$ 2,335.20	\$ 2,335.20
47570 00	Surgery	23.23	23.23	\$ 1,626.10	\$ 1,626.10
47579 00	Surgery	0.00	0.00	BR	BR
47600 00	Surgery	31.93	31.93	\$ 2,235.10	\$ 2,235.10
47605 00	Surgery	33.70	33.70	\$ 2,359.00	\$ 2,359.00
47610 00	Surgery	37.48	37.48	\$ 2,623.60	\$ 2,623.60
47612 00	Surgery	38.10	38.10	\$ 2,667.00	\$ 2,667.00
47620 00	Surgery	41.12	41.12	\$ 2,878.40	\$ 2,878.40
47700 00	Surgery	31.79	31.79	\$ 2,225.30	\$ 2,225.30
47701 00	Surgery	51.96	51.96	\$ 3,637.20	\$ 3,637.20
47711 00	Surgery	46.45	46.45	\$ 3,251.50	\$ 3,251.50
47712 00	Surgery	59.64	59.64	\$ 4,174.80	\$ 4,174.80
47715 00	Surgery	39.83	39.83	\$ 2,788.10	\$ 2,788.10
47720 00	Surgery	34.62	34.62	\$ 2,423.40	\$ 2,423.40
47721 00	Surgery	40.56	40.56	\$ 2,839.20	\$ 2,839.20
47740 00	Surgery	39.34	39.34	\$ 2,753.80	\$ 2,753.80
47741 00	Surgery	44.18	44.18	\$ 3,092.60	\$ 3,092.60
47760 00	Surgery	67.02	67.02	\$ 4,691.40	\$ 4,691.40
47765 00	Surgery	90.41	90.41	\$ 6,328.70	\$ 6,328.70
47780 00	Surgery	73.58	73.58	\$ 5,150.60	\$ 5,150.60
47785 00	Surgery	95.91	95.91	\$ 6,713.70	\$ 6,713.70
47800 00	Surgery	45.83	45.83	\$ 3,208.10	\$ 3,208.10
47801 00	Surgery	33.44	33.44	\$ 2,340.80	\$ 2,340.80
47802 00	Surgery	45.65	45.65	\$ 3,195.50	\$ 3,195.50
47900 00	Surgery	40.77	40.77	\$ 2,853.90	\$ 2,853.90
47999 00	Surgery	0.00	0.00	BR	BR
48000 00	Surgery	56.21	56.21	\$ 3,934.70	\$ 3,934.70
48001 00	Surgery	68.80	68.80	\$ 4,816.00	\$ 4,816.00
48020 00	Surgery	35.31	35.31	\$ 2,471.70	\$ 2,471.70
48100 00	Surgery	26.22	26.22	\$ 1,835.40	\$ 1,835.40
48102 00	Surgery	15.70	6.85	\$ 1,099.00	\$ 479.50
48105 00	Surgery	84.48	84.48	\$ 5,913.60	\$ 5,913.60
48120 00	Surgery	32.92	32.92	\$ 2,304.40	\$ 2,304.40
48140 00	Surgery	46.57	46.57	\$ 3,259.90	\$ 3,259.90
48145 00	Surgery	48.78	48.78	\$ 3,414.60	\$ 3,414.60
48146 00	Surgery	56.41	56.41	\$ 3,948.70	\$ 3,948.70
48148 00	Surgery	37.42	37.42	\$ 2,619.40	\$ 2,619.40
48150 00	Surgery	92.63	92.63	\$ 6,484.10	\$ 6,484.10

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
48152 00	Surgery	86.25	86.25	\$ 6,037.50	\$ 6,037.50
48153 00	Surgery	92.46	92.46	\$ 6,472.20	\$ 6,472.20
48154 00	Surgery	86.63	86.63	\$ 6,064.10	\$ 6,064.10
48155 00	Surgery	54.30	54.30	\$ 3,801.00	\$ 3,801.00
48160 00	Surgery	-	-	\$ 6,517.70	\$ 6,517.70
48400 00	Surgery	3.18	3.18	\$ 222.60	\$ 222.60
48500 00	Surgery	34.47	34.47	\$ 2,412.90	\$ 2,412.90
48510 00	Surgery	32.87	32.87	\$ 2,300.90	\$ 2,300.90
48520 00	Surgery	32.94	32.94	\$ 2,305.80	\$ 2,305.80
48540 00	Surgery	39.09	39.09	\$ 2,736.30	\$ 2,736.30
48545 00	Surgery	40.25	40.25	\$ 2,817.50	\$ 2,817.50
48547 00	Surgery	53.50	53.50	\$ 3,745.00	\$ 3,745.00
48548 00	Surgery	49.94	49.94	\$ 3,495.80	\$ 3,495.80
48550 00	Surgery	0.00	0.00	BR	BR
48551 00	Surgery	-	-	\$ 494.90	\$ 494.90
48552 00	Surgery	6.99	6.99	\$ 489.30	\$ 489.30
48554 00	Surgery	77.53	77.53	\$ 5,427.10	\$ 5,427.10
48556 00	Surgery	38.37	38.37	\$ 2,685.90	\$ 2,685.90
48999 00	Surgery	0.00	0.00	BR	BR
49000 00	Surgery	22.92	22.92	\$ 1,604.40	\$ 1,604.40
49002 00	Surgery	31.06	31.06	\$ 2,174.20	\$ 2,174.20
49010 00	Surgery	27.46	27.46	\$ 1,922.20	\$ 1,922.20
49013 00	Surgery	13.57	13.57	\$ 949.90	\$ 949.90
49014 00	Surgery	11.27	11.27	\$ 788.90	\$ 788.90
49020 00	Surgery	47.45	47.45	\$ 3,321.50	\$ 3,321.50
49040 00	Surgery	30.04	30.04	\$ 2,102.80	\$ 2,102.80
49060 00	Surgery	32.69	32.69	\$ 2,288.30	\$ 2,288.30
49062 00	Surgery	22.96	22.96	\$ 1,607.20	\$ 1,607.20
49082 00	Surgery	6.48	2.16	\$ 453.60	\$ 151.20
49083 00	Surgery	8.97	3.10	\$ 627.90	\$ 217.00
49084 00	Surgery	3.16	3.16	\$ 221.20	\$ 221.20
49180 00	Surgery	5.22	2.41	\$ 365.40	\$ 168.70
49185 00	Surgery	39.58	3.45	\$ 2,770.60	\$ 241.50
49203 00	Surgery	35.53	35.53	\$ 2,487.10	\$ 2,487.10
49204 00	Surgery	45.13	45.13	\$ 3,159.10	\$ 3,159.10
49205 00	Surgery	51.74	51.74	\$ 3,621.80	\$ 3,621.80
49215 00	Surgery	65.70	65.70	\$ 4,599.00	\$ 4,599.00
49250 00	Surgery	17.70	17.70	\$ 1,239.00	\$ 1,239.00
49255 00	Surgery	23.53	23.53	\$ 1,647.10	\$ 1,647.10
49320 00	Surgery	9.79	9.79	\$ 685.30	\$ 685.30
49321 00	Surgery	10.26	10.26	\$ 718.20	\$ 718.20
49322 00	Surgery	11.18	11.18	\$ 782.60	\$ 782.60
49323 00	Surgery	18.88	18.88	\$ 1,321.60	\$ 1,321.60
49324 00	Surgery	11.57	11.57	\$ 809.90	\$ 809.90
49325 00	Surgery	12.36	12.36	\$ 865.20	\$ 865.20
49326 00	Surgery	5.61	5.61	\$ 392.70	\$ 392.70
49327 00	Surgery	3.87	3.87	\$ 270.90	\$ 270.90
49329 00	Surgery	0.00	0.00	BR	BR
49400 00	Surgery	4.54	2.65	\$ 317.80	\$ 185.50
49402 00	Surgery	25.44	25.44	\$ 1,780.80	\$ 1,780.80
49405 00	Surgery	27.41	5.66	\$ 1,918.70	\$ 396.20
49406 00	Surgery	27.40	5.65	\$ 1,918.00	\$ 395.50
49407 00	Surgery	23.06	5.99	\$ 1,614.20	\$ 419.30
49411 00	Surgery	14.58	5.33	\$ 1,020.60	\$ 373.10

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
49412 00	Surgery	2.45	2.45	\$ 171.50	\$ 171.50
49418 00	Surgery	30.52	5.85	\$ 2,136.40	\$ 409.50
49419 00	Surgery	12.63	12.63	\$ 884.10	\$ 884.10
49421 00	Surgery	6.72	6.72	\$ 470.40	\$ 470.40
49422 00	Surgery	6.57	6.57	\$ 459.90	\$ 459.90
49423 00	Surgery	18.46	2.03	\$ 1,292.20	\$ 142.10
49424 00	Surgery	5.66	1.10	\$ 396.20	\$ 77.00
49425 00	Surgery	20.67	20.67	\$ 1,446.90	\$ 1,446.90
49426 00	Surgery	20.08	20.08	\$ 1,405.60	\$ 1,405.60
49427 00	Surgery	1.13	1.13	\$ 79.10	\$ 79.10
49428 00	Surgery	12.87	12.87	\$ 900.90	\$ 900.90
49429 00	Surgery	13.67	13.67	\$ 956.90	\$ 956.90
49435 00	Surgery	3.53	3.53	\$ 247.10	\$ 247.10
49436 00	Surgery	5.62	5.62	\$ 393.40	\$ 393.40
49440 00	Surgery	25.75	5.90	\$ 1,802.50	\$ 413.00
49441 00	Surgery	29.12	6.95	\$ 2,038.40	\$ 486.50
49442 00	Surgery	24.58	5.99	\$ 1,720.60	\$ 419.30
49446 00	Surgery	24.73	4.25	\$ 1,731.10	\$ 297.50
49450 00	Surgery	18.54	1.89	\$ 1,297.80	\$ 132.30
49451 00	Surgery	19.92	2.59	\$ 1,394.40	\$ 181.30
49452 00	Surgery	24.10	3.96	\$ 1,687.00	\$ 277.20
49460 00	Surgery	20.80	1.42	\$ 1,456.00	\$ 99.40
49465 00	Surgery	4.10	0.88	\$ 287.00	\$ 61.60
49491 00	Surgery	23.92	23.92	\$ 1,674.40	\$ 1,674.40
49492 00	Surgery	28.74	28.74	\$ 2,011.80	\$ 2,011.80
49495 00	Surgery	12.23	12.23	\$ 856.10	\$ 856.10
49496 00	Surgery	18.45	18.45	\$ 1,291.50	\$ 1,291.50
49500 00	Surgery	12.45	12.45	\$ 871.50	\$ 871.50
49501 00	Surgery	18.18	18.18	\$ 1,272.60	\$ 1,272.60
49505 00	Surgery	15.66	15.66	\$ 1,096.20	\$ 1,096.20
49507 00	Surgery	17.58	17.58	\$ 1,230.60	\$ 1,230.60
49520 00	Surgery	18.97	18.97	\$ 1,327.90	\$ 1,327.90
49521 00	Surgery	21.43	21.43	\$ 1,500.10	\$ 1,500.10
49525 00	Surgery	17.18	17.18	\$ 1,202.60	\$ 1,202.60
49540 00	Surgery	20.24	20.24	\$ 1,416.80	\$ 1,416.80
49550 00	Surgery	17.26	17.26	\$ 1,208.20	\$ 1,208.20
49553 00	Surgery	18.95	18.95	\$ 1,326.50	\$ 1,326.50
49555 00	Surgery	18.13	18.13	\$ 1,269.10	\$ 1,269.10
49557 00	Surgery	21.68	21.68	\$ 1,517.60	\$ 1,517.60
49560 00	Surgery	22.05	22.05	\$ 1,543.50	\$ 1,543.50
49561 00	Surgery	27.74	27.74	\$ 1,941.80	\$ 1,941.80
49565 00	Surgery	22.95	22.95	\$ 1,606.50	\$ 1,606.50
49566 00	Surgery	27.98	27.98	\$ 1,958.60	\$ 1,958.60
49568 00	Surgery	7.89	7.89	\$ 552.30	\$ 552.30
49570 00	Surgery	12.57	12.57	\$ 879.90	\$ 879.90
49572 00	Surgery	15.56	15.56	\$ 1,089.20	\$ 1,089.20
49580 00	Surgery	10.11	10.11	\$ 707.70	\$ 707.70
49582 00	Surgery	14.57	14.57	\$ 1,019.90	\$ 1,019.90
49585 00	Surgery	13.41	13.41	\$ 938.70	\$ 938.70
49587 00	Surgery	14.32	14.32	\$ 1,002.40	\$ 1,002.40
49590 00	Surgery	17.17	17.17	\$ 1,201.90	\$ 1,201.90
49600 00	Surgery	22.04	22.04	\$ 1,542.80	\$ 1,542.80
49605 00	Surgery	146.41	146.41	\$ 10,248.70	\$ 10,248.70
49606 00	Surgery	33.94	33.94	\$ 2,375.80	\$ 2,375.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
49610 00	Surgery	20.81	20.81	\$ 1,456.70	\$ 1,456.70
49611 00	Surgery	18.33	18.33	\$ 1,283.10	\$ 1,283.10
49650 00	Surgery	12.95	12.95	\$ 906.50	\$ 906.50
49651 00	Surgery	16.91	16.91	\$ 1,183.70	\$ 1,183.70
49652 00	Surgery	22.24	22.24	\$ 1,556.80	\$ 1,556.80
49653 00	Surgery	27.86	27.86	\$ 1,950.20	\$ 1,950.20
49654 00	Surgery	25.23	25.23	\$ 1,766.10	\$ 1,766.10
49655 00	Surgery	30.92	30.92	\$ 2,164.40	\$ 2,164.40
49656 00	Surgery	27.41	27.41	\$ 1,918.70	\$ 1,918.70
49657 00	Surgery	39.35	39.35	\$ 2,754.50	\$ 2,754.50
49659 00	Surgery	0.00	0.00	BR	BR
49900 00	Surgery	24.50	24.50	\$ 1,715.00	\$ 1,715.00
49904 00	Surgery	41.20	41.20	\$ 2,884.00	\$ 2,884.00
49905 00	Surgery	10.42	10.42	\$ 729.40	\$ 729.40
49906 00	Surgery	-	-	\$ 4,920.30	\$ 4,920.30
49999 00	Surgery	0.00	0.00	BR	BR
50010 00	Surgery	20.63	20.63	\$ 1,444.10	\$ 1,444.10
50020 00	Surgery	29.68	29.68	\$ 2,077.60	\$ 2,077.60
50040 00	Surgery	27.04	27.04	\$ 1,892.80	\$ 1,892.80
50045 00	Surgery	27.25	27.25	\$ 1,907.50	\$ 1,907.50
50060 00	Surgery	33.25	33.25	\$ 2,327.50	\$ 2,327.50
50065 00	Surgery	35.25	35.25	\$ 2,467.50	\$ 2,467.50
50070 00	Surgery	34.58	34.58	\$ 2,420.60	\$ 2,420.60
50075 00	Surgery	42.49	42.49	\$ 2,974.30	\$ 2,974.30
50080 00	Surgery	25.36	25.36	\$ 1,775.20	\$ 1,775.20
50081 00	Surgery	37.30	37.30	\$ 2,611.00	\$ 2,611.00
50100 00	Surgery	32.35	32.35	\$ 2,264.50	\$ 2,264.50
50120 00	Surgery	27.73	27.73	\$ 1,941.10	\$ 1,941.10
50125 00	Surgery	28.72	28.72	\$ 2,010.40	\$ 2,010.40
50130 00	Surgery	30.15	30.15	\$ 2,110.50	\$ 2,110.50
50135 00	Surgery	32.74	32.74	\$ 2,291.80	\$ 2,291.80
50200 00	Surgery	15.93	3.70	\$ 1,115.10	\$ 259.00
50205 00	Surgery	22.43	22.43	\$ 1,570.10	\$ 1,570.10
50220 00	Surgery	30.93	30.93	\$ 2,165.10	\$ 2,165.10
50225 00	Surgery	35.19	35.19	\$ 2,463.30	\$ 2,463.30
50230 00	Surgery	37.40	37.40	\$ 2,618.00	\$ 2,618.00
50234 00	Surgery	38.13	38.13	\$ 2,669.10	\$ 2,669.10
50236 00	Surgery	42.78	42.78	\$ 2,994.60	\$ 2,994.60
50240 00	Surgery	38.75	38.75	\$ 2,712.50	\$ 2,712.50
50250 00	Surgery	35.53	35.53	\$ 2,487.10	\$ 2,487.10
50280 00	Surgery	28.13	28.13	\$ 1,969.10	\$ 1,969.10
50290 00	Surgery	26.28	26.28	\$ 1,839.60	\$ 1,839.60
50300 00	Surgery	0.00	0.00	BR	BR
50320 00	Surgery	45.24	45.24	\$ 3,166.80	\$ 3,166.80
50323 00	Surgery	-	-	\$ 431.20	\$ 431.20
50325 00	Surgery	-	-	\$ 412.30	\$ 412.30
50327 00	Surgery	6.41	6.41	\$ 448.70	\$ 448.70
50328 00	Surgery	5.62	5.62	\$ 393.40	\$ 393.40
50329 00	Surgery	5.32	5.32	\$ 372.40	\$ 372.40
50340 00	Surgery	28.58	28.58	\$ 2,000.60	\$ 2,000.60
50360 00	Surgery	72.21	72.21	\$ 5,054.70	\$ 5,054.70
50365 00	Surgery	86.13	86.13	\$ 6,029.10	\$ 6,029.10
50370 00	Surgery	36.15	36.15	\$ 2,530.50	\$ 2,530.50
50380 00	Surgery	60.68	60.68	\$ 4,247.60	\$ 4,247.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
50382 00	Surgery	31.16	7.32	\$ 2,181.20	\$ 512.40
50384 00	Surgery	26.63	6.56	\$ 1,864.10	\$ 459.20
50385 00	Surgery	31.28	6.28	\$ 2,189.60	\$ 439.60
50386 00	Surgery	23.09	4.69	\$ 1,616.30	\$ 328.30
50387 00	Surgery	17.36	2.42	\$ 1,215.20	\$ 169.40
50389 00	Surgery	12.98	1.54	\$ 908.60	\$ 107.80
50390 00	Surgery	2.77	2.77	\$ 193.90	\$ 193.90
50391 00	Surgery	3.69	2.85	\$ 258.30	\$ 199.50
50396 00	Surgery	3.38	3.38	\$ 236.60	\$ 236.60
50400 00	Surgery	33.73	33.73	\$ 2,361.10	\$ 2,361.10
50405 00	Surgery	40.68	40.68	\$ 2,847.60	\$ 2,847.60
50430 00	Surgery	19.41	4.45	\$ 1,358.70	\$ 311.50
50431 00	Surgery	9.98	1.89	\$ 698.60	\$ 132.30
50432 00	Surgery	28.01	5.91	\$ 1,960.70	\$ 413.70
50433 00	Surgery	34.90	7.33	\$ 2,443.00	\$ 513.10
50434 00	Surgery	28.07	5.51	\$ 1,964.90	\$ 385.70
50435 00	Surgery	18.69	2.89	\$ 1,308.30	\$ 202.30
50436 00	Surgery	4.36	4.36	\$ 305.20	\$ 305.20
50437 00	Surgery	7.20	7.20	\$ 504.00	\$ 504.00
50500 00	Surgery	37.07	37.07	\$ 2,594.90	\$ 2,594.90
50520 00	Surgery	34.66	34.66	\$ 2,426.20	\$ 2,426.20
50525 00	Surgery	43.95	43.95	\$ 3,076.50	\$ 3,076.50
50526 00	Surgery	47.05	47.05	\$ 3,293.50	\$ 3,293.50
50540 00	Surgery	33.46	33.46	\$ 2,342.20	\$ 2,342.20
50541 00	Surgery	26.78	26.78	\$ 1,874.60	\$ 1,874.60
50542 00	Surgery	34.08	34.08	\$ 2,385.60	\$ 2,385.60
50543 00	Surgery	43.49	43.49	\$ 3,044.30	\$ 3,044.30
50544 00	Surgery	36.24	36.24	\$ 2,536.80	\$ 2,536.80
50545 00	Surgery	38.94	38.94	\$ 2,725.80	\$ 2,725.80
50546 00	Surgery	35.18	35.18	\$ 2,462.60	\$ 2,462.60
50547 00	Surgery	47.99	47.99	\$ 3,359.30	\$ 3,359.30
50548 00	Surgery	39.16	39.16	\$ 2,741.20	\$ 2,741.20
50549 00	Surgery	0.00	0.00	BR	BR
50551 00	Surgery	10.60	8.53	\$ 742.00	\$ 597.10
50553 00	Surgery	11.36	9.11	\$ 795.20	\$ 637.70
50555 00	Surgery	12.09	9.88	\$ 846.30	\$ 691.60
50557 00	Surgery	12.30	10.01	\$ 861.00	\$ 700.70
50561 00	Surgery	13.94	11.43	\$ 975.80	\$ 800.10
50562 00	Surgery	16.78	16.78	\$ 1,174.60	\$ 1,174.60
50570 00	Surgery	14.22	14.22	\$ 995.40	\$ 995.40
50572 00	Surgery	15.39	15.39	\$ 1,077.30	\$ 1,077.30
50574 00	Surgery	16.36	16.36	\$ 1,145.20	\$ 1,145.20
50575 00	Surgery	20.68	20.68	\$ 1,447.60	\$ 1,447.60
50576 00	Surgery	16.32	16.32	\$ 1,142.40	\$ 1,142.40
50580 00	Surgery	17.58	17.58	\$ 1,230.60	\$ 1,230.60
50590 00	Surgery	21.99	16.72	\$ 1,539.30	\$ 1,170.40
50592 00	Surgery	88.47	9.95	\$ 6,192.90	\$ 696.50
50593 00	Surgery	118.28	13.23	\$ 8,279.60	\$ 926.10
50600 00	Surgery	27.38	27.38	\$ 1,916.60	\$ 1,916.60
50605 00	Surgery	29.80	29.80	\$ 2,086.00	\$ 2,086.00
50606 00	Surgery	14.79	4.00	\$ 1,035.30	\$ 280.00
50610 00	Surgery	27.57	27.57	\$ 1,929.90	\$ 1,929.90
50620 00	Surgery	26.37	26.37	\$ 1,845.90	\$ 1,845.90
50630 00	Surgery	26.07	26.07	\$ 1,824.90	\$ 1,824.90

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
50650 00	Surgery	30.37	30.37	\$ 2,125.90	\$ 2,125.90
50660 00	Surgery	33.35	33.35	\$ 2,334.50	\$ 2,334.50
50684 00	Surgery	3.84	1.46	\$ 268.80	\$ 102.20
50686 00	Surgery	4.24	2.57	\$ 296.80	\$ 179.90
50688 00	Surgery	2.24	2.24	\$ 156.80	\$ 156.80
50690 00	Surgery	3.57	2.02	\$ 249.90	\$ 141.40
50693 00	Surgery	30.75	5.87	\$ 2,152.50	\$ 410.90
50694 00	Surgery	34.40	7.67	\$ 2,408.00	\$ 536.90
50695 00	Surgery	41.33	9.88	\$ 2,893.10	\$ 691.60
50700 00	Surgery	27.06	27.06	\$ 1,894.20	\$ 1,894.20
50705 00	Surgery	57.31	5.09	\$ 4,011.70	\$ 356.30
50706 00	Surgery	25.96	5.23	\$ 1,817.20	\$ 366.10
50715 00	Surgery	35.46	35.46	\$ 2,482.20	\$ 2,482.20
50722 00	Surgery	30.21	30.21	\$ 2,114.70	\$ 2,114.70
50725 00	Surgery	32.14	32.14	\$ 2,249.80	\$ 2,249.80
50727 00	Surgery	15.04	15.04	\$ 1,052.80	\$ 1,052.80
50728 00	Surgery	21.56	21.56	\$ 1,509.20	\$ 1,509.20
50740 00	Surgery	36.59	36.59	\$ 2,561.30	\$ 2,561.30
50750 00	Surgery	33.63	33.63	\$ 2,354.10	\$ 2,354.10
50760 00	Surgery	33.40	33.40	\$ 2,338.00	\$ 2,338.00
50770 00	Surgery	33.63	33.63	\$ 2,354.10	\$ 2,354.10
50780 00	Surgery	32.52	32.52	\$ 2,276.40	\$ 2,276.40
50782 00	Surgery	31.37	31.37	\$ 2,195.90	\$ 2,195.90
50783 00	Surgery	32.89	32.89	\$ 2,302.30	\$ 2,302.30
50785 00	Surgery	35.45	35.45	\$ 2,481.50	\$ 2,481.50
50800 00	Surgery	27.02	27.02	\$ 1,891.40	\$ 1,891.40
50810 00	Surgery	42.01	42.01	\$ 2,940.70	\$ 2,940.70
50815 00	Surgery	35.76	35.76	\$ 2,503.20	\$ 2,503.20
50820 00	Surgery	38.32	38.32	\$ 2,682.40	\$ 2,682.40
50825 00	Surgery	48.02	48.02	\$ 3,361.40	\$ 3,361.40
50830 00	Surgery	52.50	52.50	\$ 3,675.00	\$ 3,675.00
50840 00	Surgery	35.94	35.94	\$ 2,515.80	\$ 2,515.80
50845 00	Surgery	36.64	36.64	\$ 2,564.80	\$ 2,564.80
50860 00	Surgery	27.62	27.62	\$ 1,933.40	\$ 1,933.40
50900 00	Surgery	24.66	24.66	\$ 1,726.20	\$ 1,726.20
50920 00	Surgery	25.76	25.76	\$ 1,803.20	\$ 1,803.20
50930 00	Surgery	32.13	32.13	\$ 2,249.10	\$ 2,249.10
50940 00	Surgery	25.95	25.95	\$ 1,816.50	\$ 1,816.50
50945 00	Surgery	28.36	28.36	\$ 1,985.20	\$ 1,985.20
50947 00	Surgery	40.41	40.41	\$ 2,828.70	\$ 2,828.70
50948 00	Surgery	37.20	37.20	\$ 2,604.00	\$ 2,604.00
50949 00	Surgery	0.00	0.00	BR	BR
50951 00	Surgery	11.11	8.88	\$ 777.70	\$ 621.60
50953 00	Surgery	11.75	9.45	\$ 822.50	\$ 661.50
50955 00	Surgery	12.52	10.19	\$ 876.40	\$ 713.30
50957 00	Surgery	12.63	10.25	\$ 884.10	\$ 717.50
50961 00	Surgery	11.43	9.20	\$ 800.10	\$ 644.00
50970 00	Surgery	10.75	10.75	\$ 752.50	\$ 752.50
50972 00	Surgery	10.39	10.39	\$ 727.30	\$ 727.30
50974 00	Surgery	13.70	13.70	\$ 959.00	\$ 959.00
50976 00	Surgery	13.50	13.50	\$ 945.00	\$ 945.00
50980 00	Surgery	10.33	10.33	\$ 723.10	\$ 723.10
51020 00	Surgery	13.80	13.80	\$ 966.00	\$ 966.00
51030 00	Surgery	13.90	13.90	\$ 973.00	\$ 973.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
51040 00	Surgery	8.55	8.55	\$ 598.50	\$ 598.50
51045 00	Surgery	14.95	14.95	\$ 1,046.50	\$ 1,046.50
51050 00	Surgery	13.82	13.82	\$ 967.40	\$ 967.40
51060 00	Surgery	17.08	17.08	\$ 1,195.60	\$ 1,195.60
51065 00	Surgery	17.01	17.01	\$ 1,190.70	\$ 1,190.70
51080 00	Surgery	11.98	11.98	\$ 838.60	\$ 838.60
51100 00	Surgery	2.19	1.13	\$ 153.30	\$ 79.10
51101 00	Surgery	4.70	1.48	\$ 329.00	\$ 103.60
51102 00	Surgery	7.23	4.21	\$ 506.10	\$ 294.70
51500 00	Surgery	18.68	18.68	\$ 1,307.60	\$ 1,307.60
51520 00	Surgery	17.46	17.46	\$ 1,222.20	\$ 1,222.20
51525 00	Surgery	25.13	25.13	\$ 1,759.10	\$ 1,759.10
51530 00	Surgery	22.55	22.55	\$ 1,578.50	\$ 1,578.50
51535 00	Surgery	22.81	22.81	\$ 1,596.70	\$ 1,596.70
51550 00	Surgery	28.21	28.21	\$ 1,974.70	\$ 1,974.70
51555 00	Surgery	36.89	36.89	\$ 2,582.30	\$ 2,582.30
51565 00	Surgery	37.63	37.63	\$ 2,634.10	\$ 2,634.10
51570 00	Surgery	42.91	42.91	\$ 3,003.70	\$ 3,003.70
51575 00	Surgery	53.11	53.11	\$ 3,717.70	\$ 3,717.70
51580 00	Surgery	55.28	55.28	\$ 3,869.60	\$ 3,869.60
51585 00	Surgery	61.51	61.51	\$ 4,305.70	\$ 4,305.70
51590 00	Surgery	56.33	56.33	\$ 3,943.10	\$ 3,943.10
51595 00	Surgery	63.70	63.70	\$ 4,459.00	\$ 4,459.00
51596 00	Surgery	68.62	68.62	\$ 4,803.40	\$ 4,803.40
51597 00	Surgery	67.03	67.03	\$ 4,692.10	\$ 4,692.10
51600 00	Surgery	6.53	1.28	\$ 457.10	\$ 89.60
51605 00	Surgery	1.13	1.13	\$ 79.10	\$ 79.10
51610 00	Surgery	3.89	1.86	\$ 272.30	\$ 130.20
51700 00	Surgery	2.29	0.90	\$ 160.30	\$ 63.00
51701 00	Surgery	1.33	0.76	\$ 93.10	\$ 53.20
51702 00	Surgery	1.85	0.75	\$ 129.50	\$ 52.50
51703 00	Surgery	4.50	2.24	\$ 315.00	\$ 156.80
51705 00	Surgery	2.88	1.50	\$ 201.60	\$ 105.00
51710 00	Surgery	4.06	2.32	\$ 284.20	\$ 162.40
51715 00	Surgery	11.22	5.82	\$ 785.40	\$ 407.40
51720 00	Surgery	2.59	1.27	\$ 181.30	\$ 88.90
51725 00	Surgery	6.89	6.89	\$ 482.30	\$ 482.30
51725 26	Surgery	2.20	2.20	\$ 154.00	\$ 154.00
51725 TC	Surgery	4.69	4.69	\$ 328.30	\$ 328.30
51726 00	Surgery	9.11	9.11	\$ 637.70	\$ 637.70
51726 26	Surgery	2.45	2.45	\$ 171.50	\$ 171.50
51726 TC	Surgery	6.66	6.66	\$ 466.20	\$ 466.20
51727 00	Surgery	11.00	11.00	\$ 770.00	\$ 770.00
51727 26	Surgery	3.08	3.08	\$ 215.60	\$ 215.60
51727 TC	Surgery	7.92	7.92	\$ 554.40	\$ 554.40
51728 00	Surgery	11.08	11.08	\$ 775.60	\$ 775.60
51728 26	Surgery	3.02	3.02	\$ 211.40	\$ 211.40
51728 TC	Surgery	8.06	8.06	\$ 564.20	\$ 564.20
51729 00	Surgery	11.71	11.71	\$ 819.70	\$ 819.70
51729 26	Surgery	3.66	3.66	\$ 256.20	\$ 256.20
51729 TC	Surgery	8.05	8.05	\$ 563.50	\$ 563.50
51736 00	Surgery	0.39	0.39	\$ 27.30	\$ 27.30
51736 26	Surgery	0.24	0.24	\$ 16.80	\$ 16.80
51736 TC	Surgery	0.15	0.15	\$ 10.50	\$ 10.50

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
51741 00	Surgery	0.41	0.41	\$ 28.70	\$ 28.70
51741 26	Surgery	0.25	0.25	\$ 17.50	\$ 17.50
51741 TC	Surgery	0.16	0.16	\$ 11.20	\$ 11.20
51784 00	Surgery	1.90	1.90	\$ 133.00	\$ 133.00
51784 26	Surgery	1.09	1.09	\$ 76.30	\$ 76.30
51784 TC	Surgery	0.81	0.81	\$ 56.70	\$ 56.70
51785 00	Surgery	13.45	13.45	\$ 941.50	\$ 941.50
51785 26	Surgery	2.73	2.73	\$ 191.10	\$ 191.10
51785 TC	Surgery	10.72	10.72	\$ 750.40	\$ 750.40
51792 00	Surgery	8.21	8.21	\$ 574.70	\$ 574.70
51792 26	Surgery	1.57	1.57	\$ 109.90	\$ 109.90
51792 TC	Surgery	6.64	6.64	\$ 464.80	\$ 464.80
51797 00	Surgery	5.92	5.92	\$ 414.40	\$ 414.40
51797 26	Surgery	1.16	1.16	\$ 81.20	\$ 81.20
51797 TC	Surgery	4.76	4.76	\$ 333.20	\$ 333.20
51798 00	Surgery	0.31	0.31	\$ 21.70	\$ 21.70
51800 00	Surgery	30.31	30.31	\$ 2,121.70	\$ 2,121.70
51820 00	Surgery	31.70	31.70	\$ 2,219.00	\$ 2,219.00
51840 00	Surgery	20.57	20.57	\$ 1,439.90	\$ 1,439.90
51841 00	Surgery	23.74	23.74	\$ 1,661.80	\$ 1,661.80
51845 00	Surgery	17.08	17.08	\$ 1,195.60	\$ 1,195.60
51860 00	Surgery	21.97	21.97	\$ 1,537.90	\$ 1,537.90
51865 00	Surgery	26.35	26.35	\$ 1,844.50	\$ 1,844.50
51880 00	Surgery	13.67	13.67	\$ 956.90	\$ 956.90
51900 00	Surgery	24.10	24.10	\$ 1,687.00	\$ 1,687.00
51920 00	Surgery	22.34	22.34	\$ 1,563.80	\$ 1,563.80
51925 00	Surgery	32.16	32.16	\$ 2,251.20	\$ 2,251.20
51940 00	Surgery	47.86	47.86	\$ 3,350.20	\$ 3,350.20
51960 00	Surgery	40.41	40.41	\$ 2,828.70	\$ 2,828.70
51980 00	Surgery	20.89	20.89	\$ 1,462.30	\$ 1,462.30
51990 00	Surgery	21.83	21.83	\$ 1,528.10	\$ 1,528.10
51992 00	Surgery	24.65	24.65	\$ 1,725.50	\$ 1,725.50
51999 00	Surgery	0.00	0.00	BR	BR
52000 00	Surgery	7.31	2.35	\$ 511.70	\$ 164.50
52001 00	Surgery	13.17	8.32	\$ 921.90	\$ 582.40
52005 00	Surgery	9.21	3.85	\$ 644.70	\$ 269.50
52007 00	Surgery	13.76	4.80	\$ 963.20	\$ 336.00
52010 00	Surgery	11.58	4.78	\$ 810.60	\$ 334.60
52204 00	Surgery	11.53	4.10	\$ 807.10	\$ 287.00
52214 00	Surgery	23.01	5.10	\$ 1,610.70	\$ 357.00
52224 00	Surgery	24.03	5.91	\$ 1,682.10	\$ 413.70
52234 00	Surgery	7.13	7.13	\$ 499.10	\$ 499.10
52235 00	Surgery	8.35	8.35	\$ 584.50	\$ 584.50
52240 00	Surgery	11.36	11.36	\$ 795.20	\$ 795.20
52250 00	Surgery	6.94	6.94	\$ 485.80	\$ 485.80
52260 00	Surgery	6.12	6.12	\$ 428.40	\$ 428.40
52265 00	Surgery	11.39	4.72	\$ 797.30	\$ 330.40
52270 00	Surgery	12.80	5.26	\$ 896.00	\$ 368.20
52275 00	Surgery	16.42	7.20	\$ 1,149.40	\$ 504.00
52276 00	Surgery	7.66	7.66	\$ 536.20	\$ 536.20
52277 00	Surgery	9.36	9.36	\$ 655.20	\$ 655.20
52281 00	Surgery	9.89	4.41	\$ 692.30	\$ 308.70
52282 00	Surgery	9.73	9.73	\$ 681.10	\$ 681.10
52283 00	Surgery	10.66	5.82	\$ 746.20	\$ 407.40

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
52285 00	Surgery	10.55	5.66	\$ 738.50	\$ 396.20
52287 00	Surgery	11.79	4.92	\$ 825.30	\$ 344.40
52290 00	Surgery	7.07	7.07	\$ 494.90	\$ 494.90
52300 00	Surgery	8.10	8.10	\$ 567.00	\$ 567.00
52301 00	Surgery	8.39	8.39	\$ 587.30	\$ 587.30
52305 00	Surgery	8.05	8.05	\$ 563.50	\$ 563.50
52310 00	Surgery	9.60	4.39	\$ 672.00	\$ 307.30
52315 00	Surgery	14.10	7.95	\$ 987.00	\$ 556.50
52317 00	Surgery	27.01	10.05	\$ 1,890.70	\$ 703.50
52318 00	Surgery	13.71	13.71	\$ 959.70	\$ 959.70
52320 00	Surgery	7.14	7.14	\$ 499.80	\$ 499.80
52325 00	Surgery	9.27	9.27	\$ 648.90	\$ 648.90
52327 00	Surgery	7.64	7.64	\$ 534.80	\$ 534.80
52330 00	Surgery	18.34	7.63	\$ 1,283.80	\$ 534.10
52332 00	Surgery	12.23	4.51	\$ 856.10	\$ 315.70
52334 00	Surgery	5.29	5.29	\$ 370.30	\$ 370.30
52341 00	Surgery	8.22	8.22	\$ 575.40	\$ 575.40
52342 00	Surgery	8.95	8.95	\$ 626.50	\$ 626.50
52343 00	Surgery	9.96	9.96	\$ 697.20	\$ 697.20
52344 00	Surgery	10.71	10.71	\$ 749.70	\$ 749.70
52345 00	Surgery	11.42	11.42	\$ 799.40	\$ 799.40
52346 00	Surgery	12.92	12.92	\$ 904.40	\$ 904.40
52351 00	Surgery	8.76	8.76	\$ 613.20	\$ 613.20
52352 00	Surgery	10.25	10.25	\$ 717.50	\$ 717.50
52353 00	Surgery	11.36	11.36	\$ 795.20	\$ 795.20
52354 00	Surgery	12.08	12.08	\$ 845.60	\$ 845.60
52355 00	Surgery	13.52	13.52	\$ 946.40	\$ 946.40
52356 00	Surgery	12.04	12.04	\$ 842.80	\$ 842.80
52400 00	Surgery	13.93	13.93	\$ 975.10	\$ 975.10
52402 00	Surgery	7.71	7.71	\$ 539.70	\$ 539.70
52441 00	Surgery	39.25	6.08	\$ 2,747.50	\$ 425.60
52442 00	Surgery	26.98	1.46	\$ 1,888.60	\$ 102.20
52450 00	Surgery	13.89	13.89	\$ 972.30	\$ 972.30
52500 00	Surgery	14.39	14.39	\$ 1,007.30	\$ 1,007.30
52601 00	Surgery	21.29	21.29	\$ 1,490.30	\$ 1,490.30
52630 00	Surgery	11.86	11.86	\$ 830.20	\$ 830.20
52640 00	Surgery	9.41	9.41	\$ 658.70	\$ 658.70
52647 00	Surgery	47.58	18.99	\$ 3,330.60	\$ 1,329.30
52648 00	Surgery	49.06	20.24	\$ 3,434.20	\$ 1,416.80
52649 00	Surgery	24.15	24.15	\$ 1,690.50	\$ 1,690.50
52700 00	Surgery	12.95	12.95	\$ 906.50	\$ 906.50
53000 00	Surgery	4.34	4.34	\$ 303.80	\$ 303.80
53010 00	Surgery	8.70	8.70	\$ 609.00	\$ 609.00
53020 00	Surgery	2.81	2.81	\$ 196.70	\$ 196.70
53025 00	Surgery	1.97	1.97	\$ 137.90	\$ 137.90
53040 00	Surgery	11.49	11.49	\$ 804.30	\$ 804.30
53060 00	Surgery	5.59	4.88	\$ 391.30	\$ 341.60
53080 00	Surgery	12.34	12.34	\$ 863.80	\$ 863.80
53085 00	Surgery	19.02	19.02	\$ 1,331.40	\$ 1,331.40
53200 00	Surgery	4.64	4.13	\$ 324.80	\$ 289.10
53210 00	Surgery	22.73	22.73	\$ 1,591.10	\$ 1,591.10
53215 00	Surgery	27.12	27.12	\$ 1,898.40	\$ 1,898.40
53220 00	Surgery	13.23	13.23	\$ 926.10	\$ 926.10
53230 00	Surgery	17.91	17.91	\$ 1,253.70	\$ 1,253.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
53235 00	Surgery	18.57	18.57	\$ 1,299.90	\$ 1,299.90
53240 00	Surgery	12.47	12.47	\$ 872.90	\$ 872.90
53250 00	Surgery	11.61	11.61	\$ 812.70	\$ 812.70
53260 00	Surgery	6.11	5.32	\$ 427.70	\$ 372.40
53265 00	Surgery	6.77	5.53	\$ 473.90	\$ 387.10
53270 00	Surgery	6.23	5.41	\$ 436.10	\$ 378.70
53275 00	Surgery	7.73	7.73	\$ 541.10	\$ 541.10
53400 00	Surgery	23.40	23.40	\$ 1,638.00	\$ 1,638.00
53405 00	Surgery	25.52	25.52	\$ 1,786.40	\$ 1,786.40
53410 00	Surgery	28.66	28.66	\$ 2,006.20	\$ 2,006.20
53415 00	Surgery	33.01	33.01	\$ 2,310.70	\$ 2,310.70
53420 00	Surgery	24.60	24.60	\$ 1,722.00	\$ 1,722.00
53425 00	Surgery	27.37	27.37	\$ 1,915.90	\$ 1,915.90
53430 00	Surgery	28.53	28.53	\$ 1,997.10	\$ 1,997.10
53431 00	Surgery	33.64	33.64	\$ 2,354.80	\$ 2,354.80
53440 00	Surgery	22.03	22.03	\$ 1,542.10	\$ 1,542.10
53442 00	Surgery	22.99	22.99	\$ 1,609.30	\$ 1,609.30
53444 00	Surgery	23.21	23.21	\$ 1,624.70	\$ 1,624.70
53445 00	Surgery	22.14	22.14	\$ 1,549.80	\$ 1,549.80
53446 00	Surgery	18.84	18.84	\$ 1,318.80	\$ 1,318.80
53447 00	Surgery	23.61	23.61	\$ 1,652.70	\$ 1,652.70
53448 00	Surgery	37.27	37.27	\$ 2,608.90	\$ 2,608.90
53449 00	Surgery	17.97	17.97	\$ 1,257.90	\$ 1,257.90
53450 00	Surgery	12.00	12.00	\$ 840.00	\$ 840.00
53451 00	Surgery	0.00	0.00	BR	BR
53452 00	Surgery	0.00	0.00	BR	BR
53453 00	Surgery	0.00	0.00	BR	BR
53454 00	Surgery	0.00	0.00	BR	BR
53460 00	Surgery	13.43	13.43	\$ 940.10	\$ 940.10
53500 00	Surgery	22.00	22.00	\$ 1,540.00	\$ 1,540.00
53502 00	Surgery	14.25	14.25	\$ 997.50	\$ 997.50
53505 00	Surgery	14.24	14.24	\$ 996.80	\$ 996.80
53510 00	Surgery	18.53	18.53	\$ 1,297.10	\$ 1,297.10
53515 00	Surgery	23.27	23.27	\$ 1,628.90	\$ 1,628.90
53520 00	Surgery	16.36	16.36	\$ 1,145.20	\$ 1,145.20
53600 00	Surgery	2.61	1.84	\$ 182.70	\$ 128.80
53601 00	Surgery	2.50	1.54	\$ 175.00	\$ 107.80
53605 00	Surgery	1.85	1.85	\$ 129.50	\$ 129.50
53620 00	Surgery	5.16	2.54	\$ 361.20	\$ 177.80
53621 00	Surgery	4.92	2.10	\$ 344.40	\$ 147.00
53660 00	Surgery	2.23	1.21	\$ 156.10	\$ 84.70
53661 00	Surgery	2.19	1.17	\$ 153.30	\$ 81.90
53665 00	Surgery	1.12	1.12	\$ 78.40	\$ 78.40
53850 00	Surgery	43.59	10.38	\$ 3,051.30	\$ 726.60
53852 00	Surgery	42.52	11.13	\$ 2,976.40	\$ 779.10
53854 00	Surgery	51.57	11.14	\$ 3,609.90	\$ 779.80
53855 00	Surgery	20.31	2.40	\$ 1,421.70	\$ 168.00
53860 00	Surgery	74.20	6.47	\$ 5,194.00	\$ 452.90
53899 00	Surgery	0.00	0.00	BR	BR
54000 00	Surgery	4.85	3.24	\$ 339.50	\$ 226.80
54001 00	Surgery	5.87	4.09	\$ 410.90	\$ 286.30
54015 00	Surgery	8.92	8.92	\$ 624.40	\$ 624.40
54050 00	Surgery	4.19	3.07	\$ 293.30	\$ 214.90
54055 00	Surgery	4.01	2.75	\$ 280.70	\$ 192.50

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
54056 00	Surgery	4.21	3.21	\$ 294.70	\$ 224.70
54057 00	Surgery	4.18	2.83	\$ 292.60	\$ 198.10
54060 00	Surgery	5.81	3.84	\$ 406.70	\$ 268.80
54065 00	Surgery	6.55	4.99	\$ 458.50	\$ 349.30
54100 00	Surgery	6.02	3.51	\$ 421.40	\$ 245.70
54105 00	Surgery	8.16	6.21	\$ 571.20	\$ 434.70
54110 00	Surgery	18.38	18.38	\$ 1,286.60	\$ 1,286.60
54111 00	Surgery	23.36	23.36	\$ 1,635.20	\$ 1,635.20
54112 00	Surgery	27.39	27.39	\$ 1,917.30	\$ 1,917.30
54115 00	Surgery	13.44	12.51	\$ 940.80	\$ 875.70
54120 00	Surgery	18.53	18.53	\$ 1,297.10	\$ 1,297.10
54125 00	Surgery	24.03	24.03	\$ 1,682.10	\$ 1,682.10
54130 00	Surgery	34.86	34.86	\$ 2,440.20	\$ 2,440.20
54135 00	Surgery	44.07	44.07	\$ 3,084.90	\$ 3,084.90
54150 00	Surgery	4.42	2.84	\$ 309.40	\$ 198.80
54160 00	Surgery	6.53	4.25	\$ 457.10	\$ 297.50
54161 00	Surgery	5.78	5.78	\$ 404.60	\$ 404.60
54162 00	Surgery	7.64	5.87	\$ 534.80	\$ 410.90
54163 00	Surgery	6.39	6.39	\$ 447.30	\$ 447.30
54164 00	Surgery	5.68	5.68	\$ 397.60	\$ 397.60
54200 00	Surgery	3.40	2.51	\$ 238.00	\$ 175.70
54205 00	Surgery	15.60	15.60	\$ 1,092.00	\$ 1,092.00
54220 00	Surgery	6.52	3.90	\$ 456.40	\$ 273.00
54230 00	Surgery	3.12	2.32	\$ 218.40	\$ 162.40
54231 00	Surgery	4.18	3.36	\$ 292.60	\$ 235.20
54235 00	Surgery	2.58	2.11	\$ 180.60	\$ 147.70
54240 00	Surgery	3.11	3.11	\$ 217.70	\$ 217.70
54240 26	Surgery	1.92	1.92	\$ 134.40	\$ 134.40
54240 TC	Surgery	1.19	1.19	\$ 83.30	\$ 83.30
54250 00	Surgery	3.58	3.58	\$ 250.60	\$ 250.60
54250 26	Surgery	3.16	3.16	\$ 221.20	\$ 221.20
54250 TC	Surgery	0.42	0.42	\$ 29.40	\$ 29.40
54300 00	Surgery	18.96	18.96	\$ 1,327.20	\$ 1,327.20
54304 00	Surgery	21.90	21.90	\$ 1,533.00	\$ 1,533.00
54308 00	Surgery	20.97	20.97	\$ 1,467.90	\$ 1,467.90
54312 00	Surgery	23.93	23.93	\$ 1,675.10	\$ 1,675.10
54316 00	Surgery	29.09	29.09	\$ 2,036.30	\$ 2,036.30
54318 00	Surgery	20.83	20.83	\$ 1,458.10	\$ 1,458.10
54322 00	Surgery	22.86	22.86	\$ 1,600.20	\$ 1,600.20
54324 00	Surgery	28.30	28.30	\$ 1,981.00	\$ 1,981.00
54326 00	Surgery	27.54	27.54	\$ 1,927.80	\$ 1,927.80
54328 00	Surgery	27.38	27.38	\$ 1,916.60	\$ 1,916.60
54332 00	Surgery	29.53	29.53	\$ 2,067.10	\$ 2,067.10
54336 00	Surgery	34.71	34.71	\$ 2,429.70	\$ 2,429.70
54340 00	Surgery	16.70	16.70	\$ 1,169.00	\$ 1,169.00
54344 00	Surgery	27.62	27.62	\$ 1,933.40	\$ 1,933.40
54348 00	Surgery	29.53	29.53	\$ 2,067.10	\$ 2,067.10
54352 00	Surgery	41.29	41.29	\$ 2,890.30	\$ 2,890.30
54360 00	Surgery	21.11	21.11	\$ 1,477.70	\$ 1,477.70
54380 00	Surgery	23.39	23.39	\$ 1,637.30	\$ 1,637.30
54385 00	Surgery	27.24	27.24	\$ 1,906.80	\$ 1,906.80
54390 00	Surgery	36.27	36.27	\$ 2,538.90	\$ 2,538.90
54400 00	Surgery	15.61	15.61	\$ 1,092.70	\$ 1,092.70
54401 00	Surgery	19.44	19.44	\$ 1,360.80	\$ 1,360.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
54405 00	Surgery	23.65	23.65	\$ 1,655.50	\$ 1,655.50
54406 00	Surgery	21.41	21.41	\$ 1,498.70	\$ 1,498.70
54408 00	Surgery	23.15	23.15	\$ 1,620.50	\$ 1,620.50
54410 00	Surgery	25.26	25.26	\$ 1,768.20	\$ 1,768.20
54411 00	Surgery	30.09	30.09	\$ 2,106.30	\$ 2,106.30
54415 00	Surgery	15.58	15.58	\$ 1,090.60	\$ 1,090.60
54416 00	Surgery	21.00	21.00	\$ 1,470.00	\$ 1,470.00
54417 00	Surgery	26.30	26.30	\$ 1,841.00	\$ 1,841.00
54420 00	Surgery	20.58	20.58	\$ 1,440.60	\$ 1,440.60
54430 00	Surgery	18.72	18.72	\$ 1,310.40	\$ 1,310.40
54435 00	Surgery	12.13	12.13	\$ 849.10	\$ 849.10
54437 00	Surgery	19.85	19.85	\$ 1,389.50	\$ 1,389.50
54438 00	Surgery	39.04	39.04	\$ 2,732.80	\$ 2,732.80
54440 00	Surgery	-	-	\$ 1,148.70	\$ 1,148.70
54450 00	Surgery	1.99	1.65	\$ 139.30	\$ 115.50
54500 00	Surgery	2.17	2.17	\$ 151.90	\$ 151.90
54505 00	Surgery	6.13	6.13	\$ 429.10	\$ 429.10
54512 00	Surgery	15.74	15.74	\$ 1,101.80	\$ 1,101.80
54520 00	Surgery	9.64	9.64	\$ 674.80	\$ 674.80
54522 00	Surgery	17.22	17.22	\$ 1,205.40	\$ 1,205.40
54530 00	Surgery	14.91	14.91	\$ 1,043.70	\$ 1,043.70
54535 00	Surgery	21.77	21.77	\$ 1,523.90	\$ 1,523.90
54550 00	Surgery	14.41	14.41	\$ 1,008.70	\$ 1,008.70
54560 00	Surgery	20.12	20.12	\$ 1,408.40	\$ 1,408.40
54600 00	Surgery	13.27	13.27	\$ 928.90	\$ 928.90
54620 00	Surgery	8.73	8.73	\$ 611.10	\$ 611.10
54640 00	Surgery	12.68	12.68	\$ 887.60	\$ 887.60
54650 00	Surgery	20.85	20.85	\$ 1,459.50	\$ 1,459.50
54660 00	Surgery	10.51	10.51	\$ 735.70	\$ 735.70
54670 00	Surgery	12.00	12.00	\$ 840.00	\$ 840.00
54680 00	Surgery	23.06	23.06	\$ 1,614.20	\$ 1,614.20
54690 00	Surgery	19.20	19.20	\$ 1,344.00	\$ 1,344.00
54692 00	Surgery	22.12	22.12	\$ 1,548.40	\$ 1,548.40
54699 00	Surgery	0.00	0.00	BR	BR
54700 00	Surgery	6.25	6.25	\$ 437.50	\$ 437.50
54800 00	Surgery	3.64	3.64	\$ 254.80	\$ 254.80
54830 00	Surgery	10.94	10.94	\$ 765.80	\$ 765.80
54840 00	Surgery	9.46	9.46	\$ 662.20	\$ 662.20
54860 00	Surgery	12.30	12.30	\$ 861.00	\$ 861.00
54861 00	Surgery	16.67	16.67	\$ 1,166.90	\$ 1,166.90
54865 00	Surgery	10.55	10.55	\$ 738.50	\$ 738.50
54900 00	Surgery	23.43	23.43	\$ 1,640.10	\$ 1,640.10
54901 00	Surgery	30.94	30.94	\$ 2,165.80	\$ 2,165.80
55000 00	Surgery	3.58	2.47	\$ 250.60	\$ 172.90
55040 00	Surgery	9.95	9.95	\$ 696.50	\$ 696.50
55041 00	Surgery	15.03	15.03	\$ 1,052.10	\$ 1,052.10
55060 00	Surgery	11.16	11.16	\$ 781.20	\$ 781.20
55100 00	Surgery	6.87	4.92	\$ 480.90	\$ 344.40
55110 00	Surgery	11.43	11.43	\$ 800.10	\$ 800.10
55120 00	Surgery	10.41	10.41	\$ 728.70	\$ 728.70
55150 00	Surgery	14.54	14.54	\$ 1,017.80	\$ 1,017.80
55175 00	Surgery	10.72	10.72	\$ 750.40	\$ 750.40
55180 00	Surgery	20.31	20.31	\$ 1,421.70	\$ 1,421.70
55200 00	Surgery	11.46	8.14	\$ 802.20	\$ 569.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
55250 00	Surgery	10.01	6.70	\$ 700.70	\$ 469.00
55300 00	Surgery	5.41	5.41	\$ 378.70	\$ 378.70
55400 00	Surgery	14.64	14.64	\$ 1,024.80	\$ 1,024.80
55500 00	Surgery	11.60	11.60	\$ 812.00	\$ 812.00
55520 00	Surgery	13.70	13.70	\$ 959.00	\$ 959.00
55530 00	Surgery	10.38	10.38	\$ 726.60	\$ 726.60
55535 00	Surgery	12.64	12.64	\$ 884.80	\$ 884.80
55540 00	Surgery	16.61	16.61	\$ 1,162.70	\$ 1,162.70
55550 00	Surgery	12.61	12.61	\$ 882.70	\$ 882.70
55559 00	Surgery	0.00	0.00	BR	BR
55600 00	Surgery	12.39	12.39	\$ 867.30	\$ 867.30
55605 00	Surgery	15.36	15.36	\$ 1,075.20	\$ 1,075.20
55650 00	Surgery	21.05	21.05	\$ 1,473.50	\$ 1,473.50
55680 00	Surgery	10.19	10.19	\$ 713.30	\$ 713.30
55700 00	Surgery	7.22	3.78	\$ 505.40	\$ 264.60
55705 00	Surgery	7.77	7.77	\$ 543.90	\$ 543.90
55706 00	Surgery	11.01	11.01	\$ 770.70	\$ 770.70
55720 00	Surgery	13.27	13.27	\$ 928.90	\$ 928.90
55725 00	Surgery	17.45	17.45	\$ 1,221.50	\$ 1,221.50
55801 00	Surgery	31.99	31.99	\$ 2,239.30	\$ 2,239.30
55810 00	Surgery	38.16	38.16	\$ 2,671.20	\$ 2,671.20
55812 00	Surgery	46.90	46.90	\$ 3,283.00	\$ 3,283.00
55815 00	Surgery	51.35	51.35	\$ 3,594.50	\$ 3,594.50
55821 00	Surgery	25.51	25.51	\$ 1,785.70	\$ 1,785.70
55831 00	Surgery	27.64	27.64	\$ 1,934.80	\$ 1,934.80
55840 00	Surgery	34.14	34.14	\$ 2,389.80	\$ 2,389.80
55842 00	Surgery	34.15	34.15	\$ 2,390.50	\$ 2,390.50
55845 00	Surgery	39.71	39.71	\$ 2,779.70	\$ 2,779.70
55860 00	Surgery	25.57	25.57	\$ 1,789.90	\$ 1,789.90
55862 00	Surgery	31.99	31.99	\$ 2,239.30	\$ 2,239.30
55865 00	Surgery	38.98	38.98	\$ 2,728.60	\$ 2,728.60
55866 00	Surgery	42.04	42.04	\$ 2,942.80	\$ 2,942.80
55870 00	Surgery	5.16	4.12	\$ 361.20	\$ 288.40
55873 00	Surgery	177.99	22.36	\$ 12,459.30	\$ 1,565.20
55874 00	Surgery	88.88	4.79	\$ 6,221.60	\$ 335.30
55875 00	Surgery	22.69	22.69	\$ 1,588.30	\$ 1,588.30
55876 00	Surgery	4.48	2.96	\$ 313.60	\$ 207.20
55880 00	Surgery	28.67	28.67	\$ 2,006.90	\$ 2,006.90
55899 00	Surgery	0.00	0.00	BR	BR
55920 00	Surgery	13.38	13.38	\$ 936.60	\$ 936.60
55970 00	Surgery	0.00	0.00	BR	BR
55980 00	Surgery	0.00	0.00	BR	BR
56405 00	Surgery	4.47	3.80	\$ 312.90	\$ 266.00
56420 00	Surgery	5.64	3.33	\$ 394.80	\$ 233.10
56440 00	Surgery	5.35	5.35	\$ 374.50	\$ 374.50
56441 00	Surgery	5.54	4.61	\$ 387.80	\$ 322.70
56442 00	Surgery	1.38	1.38	\$ 96.60	\$ 96.60
56501 00	Surgery	5.83	3.97	\$ 408.10	\$ 277.90
56515 00	Surgery	8.37	6.34	\$ 585.90	\$ 443.80
56605 00	Surgery	2.90	1.75	\$ 203.00	\$ 122.50
56606 00	Surgery	1.14	0.86	\$ 79.80	\$ 60.20
56620 00	Surgery	17.51	17.51	\$ 1,225.70	\$ 1,225.70
56625 00	Surgery	19.92	19.92	\$ 1,394.40	\$ 1,394.40
56630 00	Surgery	28.59	28.59	\$ 2,001.30	\$ 2,001.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
56631 00	Surgery	35.20	35.20	\$ 2,464.00	\$ 2,464.00
56632 00	Surgery	42.66	42.66	\$ 2,986.20	\$ 2,986.20
56633 00	Surgery	36.55	36.55	\$ 2,558.50	\$ 2,558.50
56634 00	Surgery	38.41	38.41	\$ 2,688.70	\$ 2,688.70
56637 00	Surgery	44.98	44.98	\$ 3,148.60	\$ 3,148.60
56640 00	Surgery	45.31	45.31	\$ 3,171.70	\$ 3,171.70
56700 00	Surgery	6.07	6.07	\$ 424.90	\$ 424.90
56740 00	Surgery	9.44	9.44	\$ 660.80	\$ 660.80
56800 00	Surgery	7.53	7.53	\$ 527.10	\$ 527.10
56805 00	Surgery	34.77	34.77	\$ 2,433.90	\$ 2,433.90
56810 00	Surgery	8.10	8.10	\$ 567.00	\$ 567.00
56820 00	Surgery	3.74	2.49	\$ 261.80	\$ 174.30
56821 00	Surgery	5.01	3.35	\$ 350.70	\$ 234.50
57000 00	Surgery	6.04	6.04	\$ 422.80	\$ 422.80
57010 00	Surgery	13.67	13.67	\$ 956.90	\$ 956.90
57020 00	Surgery	3.82	2.35	\$ 267.40	\$ 164.50
57022 00	Surgery	5.42	5.42	\$ 379.40	\$ 379.40
57023 00	Surgery	9.55	9.55	\$ 668.50	\$ 668.50
57061 00	Surgery	5.08	3.43	\$ 355.60	\$ 240.10
57065 00	Surgery	7.46	5.54	\$ 522.20	\$ 387.80
57100 00	Surgery	3.10	1.94	\$ 217.00	\$ 135.80
57105 00	Surgery	5.34	4.37	\$ 373.80	\$ 305.90
57106 00	Surgery	16.07	16.07	\$ 1,124.90	\$ 1,124.90
57107 00	Surgery	43.28	43.28	\$ 3,029.60	\$ 3,029.60
57109 00	Surgery	51.32	51.32	\$ 3,592.40	\$ 3,592.40
57110 00	Surgery	26.93	26.93	\$ 1,885.10	\$ 1,885.10
57111 00	Surgery	51.32	51.32	\$ 3,592.40	\$ 3,592.40
57120 00	Surgery	15.84	15.84	\$ 1,108.80	\$ 1,108.80
57130 00	Surgery	6.98	5.17	\$ 488.60	\$ 361.90
57135 00	Surgery	7.46	5.59	\$ 522.20	\$ 391.30
57150 00	Surgery	1.79	0.78	\$ 125.30	\$ 54.60
57155 00	Surgery	11.62	8.29	\$ 813.40	\$ 580.30
57156 00	Surgery	6.73	4.40	\$ 471.10	\$ 308.00
57160 00	Surgery	2.22	1.34	\$ 155.40	\$ 93.80
57170 00	Surgery	2.34	1.40	\$ 163.80	\$ 98.00
57180 00	Surgery	6.05	3.63	\$ 423.50	\$ 254.10
57200 00	Surgery	9.95	9.95	\$ 696.50	\$ 696.50
57210 00	Surgery	11.79	11.79	\$ 825.30	\$ 825.30
57220 00	Surgery	10.38	10.38	\$ 726.60	\$ 726.60
57230 00	Surgery	12.53	12.53	\$ 877.10	\$ 877.10
57240 00	Surgery	18.25	18.25	\$ 1,277.50	\$ 1,277.50
57250 00	Surgery	18.37	18.37	\$ 1,285.90	\$ 1,285.90
57260 00	Surgery	23.19	23.19	\$ 1,623.30	\$ 1,623.30
57265 00	Surgery	25.96	25.96	\$ 1,817.20	\$ 1,817.20
57267 00	Surgery	7.39	7.39	\$ 517.30	\$ 517.30
57268 00	Surgery	15.13	15.13	\$ 1,059.10	\$ 1,059.10
57270 00	Surgery	24.23	24.23	\$ 1,696.10	\$ 1,696.10
57280 00	Surgery	28.73	28.73	\$ 2,011.10	\$ 2,011.10
57282 00	Surgery	20.66	20.66	\$ 1,446.20	\$ 1,446.20
57283 00	Surgery	20.81	20.81	\$ 1,456.70	\$ 1,456.70
57284 00	Surgery	24.78	24.78	\$ 1,734.60	\$ 1,734.60
57285 00	Surgery	20.64	20.64	\$ 1,444.80	\$ 1,444.80
57287 00	Surgery	22.14	22.14	\$ 1,549.80	\$ 1,549.80
57288 00	Surgery	22.08	22.08	\$ 1,545.60	\$ 1,545.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
57289 00	Surgery	23.72	23.72	\$ 1,660.40	\$ 1,660.40
57291 00	Surgery	16.42	16.42	\$ 1,149.40	\$ 1,149.40
57292 00	Surgery	24.70	24.70	\$ 1,729.00	\$ 1,729.00
57295 00	Surgery	14.96	14.96	\$ 1,047.20	\$ 1,047.20
57296 00	Surgery	28.55	28.55	\$ 1,998.50	\$ 1,998.50
57300 00	Surgery	18.35	18.35	\$ 1,284.50	\$ 1,284.50
57305 00	Surgery	29.51	29.51	\$ 2,065.70	\$ 2,065.70
57307 00	Surgery	32.17	32.17	\$ 2,251.90	\$ 2,251.90
57308 00	Surgery	19.65	19.65	\$ 1,375.50	\$ 1,375.50
57310 00	Surgery	14.59	14.59	\$ 1,021.30	\$ 1,021.30
57311 00	Surgery	16.43	16.43	\$ 1,150.10	\$ 1,150.10
57320 00	Surgery	16.87	16.87	\$ 1,180.90	\$ 1,180.90
57330 00	Surgery	22.63	22.63	\$ 1,584.10	\$ 1,584.10
57335 00	Surgery	35.11	35.11	\$ 2,457.70	\$ 2,457.70
57400 00	Surgery	3.86	3.86	\$ 270.20	\$ 270.20
57410 00	Surgery	3.11	3.11	\$ 217.70	\$ 217.70
57415 00	Surgery	5.24	5.24	\$ 366.80	\$ 366.80
57420 00	Surgery	3.94	2.63	\$ 275.80	\$ 184.10
57421 00	Surgery	5.30	3.58	\$ 371.00	\$ 250.60
57423 00	Surgery	27.62	27.62	\$ 1,933.40	\$ 1,933.40
57425 00	Surgery	28.92	28.92	\$ 2,024.40	\$ 2,024.40
57426 00	Surgery	25.95	25.95	\$ 1,816.50	\$ 1,816.50
57452 00	Surgery	3.79	2.67	\$ 265.30	\$ 186.90
57454 00	Surgery	5.07	3.95	\$ 354.90	\$ 276.50
57455 00	Surgery	4.84	3.21	\$ 338.80	\$ 224.70
57456 00	Surgery	4.54	2.98	\$ 317.80	\$ 208.60
57460 00	Surgery	9.57	4.68	\$ 669.90	\$ 327.60
57461 00	Surgery	10.68	5.43	\$ 747.60	\$ 380.10
57465 00	Surgery	1.60	1.24	\$ 112.00	\$ 86.80
57500 00	Surgery	4.70	2.21	\$ 329.00	\$ 154.70
57505 00	Surgery	4.71	3.27	\$ 329.70	\$ 228.90
57510 00	Surgery	5.07	3.33	\$ 354.90	\$ 233.10
57511 00	Surgery	6.06	4.40	\$ 424.20	\$ 308.00
57513 00	Surgery	6.26	4.39	\$ 438.20	\$ 307.30
57520 00	Surgery	10.61	8.82	\$ 742.70	\$ 617.40
57522 00	Surgery	9.12	7.60	\$ 638.40	\$ 532.00
57530 00	Surgery	11.17	11.17	\$ 781.90	\$ 781.90
57531 00	Surgery	54.30	54.30	\$ 3,801.00	\$ 3,801.00
57540 00	Surgery	23.61	23.61	\$ 1,652.70	\$ 1,652.70
57545 00	Surgery	24.87	24.87	\$ 1,740.90	\$ 1,740.90
57550 00	Surgery	12.91	12.91	\$ 903.70	\$ 903.70
57555 00	Surgery	18.49	18.49	\$ 1,294.30	\$ 1,294.30
57556 00	Surgery	17.56	17.56	\$ 1,229.20	\$ 1,229.20
57558 00	Surgery	4.76	3.85	\$ 333.20	\$ 269.50
57700 00	Surgery	10.71	10.71	\$ 749.70	\$ 749.70
57720 00	Surgery	10.03	10.03	\$ 702.10	\$ 702.10
57800 00	Surgery	2.33	1.40	\$ 163.10	\$ 98.00
58100 00	Surgery	3.07	1.88	\$ 214.90	\$ 131.60
58110 00	Surgery	1.48	1.19	\$ 103.60	\$ 83.30
58120 00	Surgery	8.96	6.97	\$ 627.20	\$ 487.90
58140 00	Surgery	27.83	27.83	\$ 1,948.10	\$ 1,948.10
58145 00	Surgery	16.98	16.98	\$ 1,188.60	\$ 1,188.60
58146 00	Surgery	34.40	34.40	\$ 2,408.00	\$ 2,408.00
58150 00	Surgery	30.06	30.06	\$ 2,104.20	\$ 2,104.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
58152 00	Surgery	36.83	36.83	\$ 2,578.10	\$ 2,578.10
58180 00	Surgery	28.51	28.51	\$ 1,995.70	\$ 1,995.70
58200 00	Surgery	39.92	39.92	\$ 2,794.40	\$ 2,794.40
58210 00	Surgery	54.01	54.01	\$ 3,780.70	\$ 3,780.70
58240 00	Surgery	87.21	87.21	\$ 6,104.70	\$ 6,104.70
58260 00	Surgery	25.00	25.00	\$ 1,750.00	\$ 1,750.00
58262 00	Surgery	27.61	27.61	\$ 1,932.70	\$ 1,932.70
58263 00	Surgery	29.59	29.59	\$ 2,071.30	\$ 2,071.30
58267 00	Surgery	31.89	31.89	\$ 2,232.30	\$ 2,232.30
58270 00	Surgery	26.69	26.69	\$ 1,868.30	\$ 1,868.30
58275 00	Surgery	29.46	29.46	\$ 2,062.20	\$ 2,062.20
58280 00	Surgery	31.58	31.58	\$ 2,210.60	\$ 2,210.60
58285 00	Surgery	42.16	42.16	\$ 2,951.20	\$ 2,951.20
58290 00	Surgery	34.28	34.28	\$ 2,399.60	\$ 2,399.60
58291 00	Surgery	37.04	37.04	\$ 2,592.80	\$ 2,592.80
58292 00	Surgery	39.03	39.03	\$ 2,732.10	\$ 2,732.10
58294 00	Surgery	36.26	36.26	\$ 2,538.20	\$ 2,538.20
58300 00	Surgery	3.35	1.49	\$ 234.50	\$ 104.30
58301 00	Surgery	3.32	1.96	\$ 232.40	\$ 137.20
58321 00	Surgery	2.42	1.41	\$ 169.40	\$ 98.70
58322 00	Surgery	2.72	1.71	\$ 190.40	\$ 119.70
58323 00	Surgery	0.44	0.36	\$ 30.80	\$ 25.20
58340 00	Surgery	7.57	1.66	\$ 529.90	\$ 116.20
58345 00	Surgery	8.63	8.63	\$ 604.10	\$ 604.10
58346 00	Surgery	14.56	14.56	\$ 1,019.20	\$ 1,019.20
58350 00	Surgery	4.69	2.86	\$ 328.30	\$ 200.20
58353 00	Surgery	29.04	6.91	\$ 2,032.80	\$ 483.70
58356 00	Surgery	52.16	10.57	\$ 3,651.20	\$ 739.90
58400 00	Surgery	13.84	13.84	\$ 968.80	\$ 968.80
58410 00	Surgery	24.33	24.33	\$ 1,703.10	\$ 1,703.10
58520 00	Surgery	23.84	23.84	\$ 1,668.80	\$ 1,668.80
58540 00	Surgery	27.35	27.35	\$ 1,914.50	\$ 1,914.50
58541 00	Surgery	21.72	21.72	\$ 1,520.40	\$ 1,520.40
58542 00	Surgery	24.75	24.75	\$ 1,732.50	\$ 1,732.50
58543 00	Surgery	25.12	25.12	\$ 1,758.40	\$ 1,758.40
58544 00	Surgery	26.97	26.97	\$ 1,887.90	\$ 1,887.90
58545 00	Surgery	26.80	26.80	\$ 1,876.00	\$ 1,876.00
58546 00	Surgery	33.12	33.12	\$ 2,318.40	\$ 2,318.40
58548 00	Surgery	55.79	55.79	\$ 3,905.30	\$ 3,905.30
58550 00	Surgery	26.22	26.22	\$ 1,835.40	\$ 1,835.40
58552 00	Surgery	29.13	29.13	\$ 2,039.10	\$ 2,039.10
58553 00	Surgery	33.30	33.30	\$ 2,331.00	\$ 2,331.00
58554 00	Surgery	38.75	38.75	\$ 2,712.50	\$ 2,712.50
58555 00	Surgery	11.10	4.44	\$ 777.00	\$ 310.80
58558 00	Surgery	41.57	6.80	\$ 2,909.90	\$ 476.00
58559 00	Surgery	8.40	8.40	\$ 588.00	\$ 588.00
58560 00	Surgery	9.23	9.23	\$ 646.10	\$ 646.10
58561 00	Surgery	10.55	10.55	\$ 738.50	\$ 738.50
58562 00	Surgery	13.19	6.53	\$ 923.30	\$ 457.10
58563 00	Surgery	66.34	7.25	\$ 4,643.80	\$ 507.50
58565 00	Surgery	51.87	13.67	\$ 3,630.90	\$ 956.90
58570 00	Surgery	23.96	23.96	\$ 1,677.20	\$ 1,677.20
58571 00	Surgery	26.99	26.99	\$ 1,889.30	\$ 1,889.30
58572 00	Surgery	30.80	30.80	\$ 2,156.00	\$ 2,156.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
58573 00	Surgery	36.15	36.15	\$ 2,530.50	\$ 2,530.50
58575 00	Surgery	57.37	57.37	\$ 4,015.90	\$ 4,015.90
58578 00	Surgery	0.00	0.00	BR	BR
58579 00	Surgery	0.00	0.00	BR	BR
58600 00	Surgery	11.05	11.05	\$ 773.50	\$ 773.50
58605 00	Surgery	10.08	10.08	\$ 705.60	\$ 705.60
58611 00	Surgery	2.24	2.24	\$ 156.80	\$ 156.80
58615 00	Surgery	7.59	7.59	\$ 531.30	\$ 531.30
58660 00	Surgery	20.30	20.30	\$ 1,421.00	\$ 1,421.00
58661 00	Surgery	19.38	19.38	\$ 1,356.60	\$ 1,356.60
58662 00	Surgery	21.15	21.15	\$ 1,480.50	\$ 1,480.50
58670 00	Surgery	11.09	11.09	\$ 776.30	\$ 776.30
58671 00	Surgery	11.07	11.07	\$ 774.90	\$ 774.90
58672 00	Surgery	21.78	21.78	\$ 1,524.60	\$ 1,524.60
58673 00	Surgery	23.60	23.60	\$ 1,652.00	\$ 1,652.00
58674 00	Surgery	24.21	24.21	\$ 1,694.70	\$ 1,694.70
58679 00	Surgery	0.00	0.00	BR	BR
58700 00	Surgery	23.87	23.87	\$ 1,670.90	\$ 1,670.90
58720 00	Surgery	22.57	22.57	\$ 1,579.90	\$ 1,579.90
58740 00	Surgery	26.84	26.84	\$ 1,878.80	\$ 1,878.80
58750 00	Surgery	27.14	27.14	\$ 1,899.80	\$ 1,899.80
58752 00	Surgery	27.07	27.07	\$ 1,894.90	\$ 1,894.90
58760 00	Surgery	24.49	24.49	\$ 1,714.30	\$ 1,714.30
58770 00	Surgery	25.71	25.71	\$ 1,799.70	\$ 1,799.70
58800 00	Surgery	10.93	9.45	\$ 765.10	\$ 661.50
58805 00	Surgery	12.80	12.80	\$ 896.00	\$ 896.00
58820 00	Surgery	10.16	10.16	\$ 711.20	\$ 711.20
58822 00	Surgery	21.34	21.34	\$ 1,493.80	\$ 1,493.80
58825 00	Surgery	21.19	21.19	\$ 1,483.30	\$ 1,483.30
58900 00	Surgery	13.07	13.07	\$ 914.90	\$ 914.90
58920 00	Surgery	21.33	21.33	\$ 1,493.10	\$ 1,493.10
58925 00	Surgery	22.89	22.89	\$ 1,602.30	\$ 1,602.30
58940 00	Surgery	16.61	16.61	\$ 1,162.70	\$ 1,162.70
58943 00	Surgery	34.72	34.72	\$ 2,430.40	\$ 2,430.40
58950 00	Surgery	34.26	34.26	\$ 2,398.20	\$ 2,398.20
58951 00	Surgery	42.77	42.77	\$ 2,993.90	\$ 2,993.90
58952 00	Surgery	48.84	48.84	\$ 3,418.80	\$ 3,418.80
58953 00	Surgery	59.27	59.27	\$ 4,148.90	\$ 4,148.90
58954 00	Surgery	64.13	64.13	\$ 4,489.10	\$ 4,489.10
58956 00	Surgery	40.27	40.27	\$ 2,818.90	\$ 2,818.90
58957 00	Surgery	47.27	47.27	\$ 3,308.90	\$ 3,308.90
58958 00	Surgery	49.32	49.32	\$ 3,452.40	\$ 3,452.40
58960 00	Surgery	29.55	29.55	\$ 2,068.50	\$ 2,068.50
58970 00	Surgery	7.19	5.78	\$ 503.30	\$ 404.60
58974 00	Surgery	-	-	\$ 304.50	\$ 304.50
58976 00	Surgery	7.69	6.24	\$ 538.30	\$ 436.80
58999 00	Surgery	0.00	0.00	BR	BR
59000 00	Surgery	3.46	2.36	\$ 242.20	\$ 165.20
59001 00	Surgery	5.25	5.25	\$ 367.50	\$ 367.50
59012 00	Surgery	5.92	5.92	\$ 414.40	\$ 414.40
59015 00	Surgery	4.62	3.85	\$ 323.40	\$ 269.50
59020 00	Surgery	2.08	2.08	\$ 145.60	\$ 145.60
59020 26	Surgery	1.09	1.09	\$ 76.30	\$ 76.30
59020 TC	Surgery	0.99	0.99	\$ 69.30	\$ 69.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
59025 00	Surgery	1.42	1.42	\$ 99.40	\$ 99.40
59025 26	Surgery	0.84	0.84	\$ 58.80	\$ 58.80
59025 TC	Surgery	0.58	0.58	\$ 40.60	\$ 40.60
59030 00	Surgery	3.31	3.31	\$ 231.70	\$ 231.70
59050 00	Surgery	1.48	1.48	\$ 103.60	\$ 103.60
59051 00	Surgery	1.23	1.23	\$ 86.10	\$ 86.10
59070 00	Surgery	11.84	9.08	\$ 828.80	\$ 635.60
59072 00	Surgery	15.35	15.35	\$ 1,074.50	\$ 1,074.50
59074 00	Surgery	11.35	9.08	\$ 794.50	\$ 635.60
59076 00	Surgery	15.35	15.35	\$ 1,074.50	\$ 1,074.50
59100 00	Surgery	25.49	25.49	\$ 1,784.30	\$ 1,784.30
59120 00	Surgery	24.33	24.33	\$ 1,703.10	\$ 1,703.10
59121 00	Surgery	24.35	24.35	\$ 1,704.50	\$ 1,704.50
59130 00	Surgery	28.23	28.23	\$ 1,976.10	\$ 1,976.10
59136 00	Surgery	26.80	26.80	\$ 1,876.00	\$ 1,876.00
59140 00	Surgery	12.48	12.48	\$ 873.60	\$ 873.60
59150 00	Surgery	23.62	23.62	\$ 1,653.40	\$ 1,653.40
59151 00	Surgery	23.10	23.10	\$ 1,617.00	\$ 1,617.00
59160 00	Surgery	8.30	5.63	\$ 581.00	\$ 394.10
59200 00	Surgery	3.20	1.31	\$ 224.00	\$ 91.70
59300 00	Surgery	6.96	4.33	\$ 487.20	\$ 303.10
59320 00	Surgery	4.47	4.47	\$ 312.90	\$ 312.90
59325 00	Surgery	7.09	7.09	\$ 496.30	\$ 496.30
59350 00	Surgery	8.21	8.21	\$ 574.70	\$ 574.70
59400 00	Surgery	71.09	71.09	\$ 4,976.30	\$ 4,976.30
59409 00	Surgery	23.73	23.73	\$ 1,661.10	\$ 1,661.10
59410 00	Surgery	31.38	31.38	\$ 2,196.60	\$ 2,196.60
59412 00	Surgery	3.03	3.03	\$ 212.10	\$ 212.10
59414 00	Surgery	2.66	2.66	\$ 186.20	\$ 186.20
59425 00	Surgery	16.62	12.83	\$ 1,163.40	\$ 898.10
59426 00	Surgery	30.36	23.50	\$ 2,125.20	\$ 1,645.00
59430 00	Surgery	7.91	5.32	\$ 553.70	\$ 372.40
59510 00	Surgery	78.50	78.50	\$ 5,495.00	\$ 5,495.00
59514 00	Surgery	26.83	26.83	\$ 1,878.10	\$ 1,878.10
59515 00	Surgery	38.66	38.66	\$ 2,706.20	\$ 2,706.20
59525 00	Surgery	14.22	14.22	\$ 995.40	\$ 995.40
59610 00	Surgery	74.34	74.34	\$ 5,203.80	\$ 5,203.80
59612 00	Surgery	26.79	26.79	\$ 1,875.30	\$ 1,875.30
59614 00	Surgery	33.89	33.89	\$ 2,372.30	\$ 2,372.30
59618 00	Surgery	79.33	79.33	\$ 5,553.10	\$ 5,553.10
59620 00	Surgery	27.74	27.74	\$ 1,941.80	\$ 1,941.80
59622 00	Surgery	40.10	40.10	\$ 2,807.00	\$ 2,807.00
59812 00	Surgery	10.91	9.18	\$ 763.70	\$ 642.60
59820 00	Surgery	13.19	11.50	\$ 923.30	\$ 805.00
59821 00	Surgery	13.00	11.25	\$ 910.00	\$ 787.50
59830 00	Surgery	13.87	13.87	\$ 970.90	\$ 970.90
59840 00	Surgery	7.52	6.65	\$ 526.40	\$ 465.50
59841 00	Surgery	12.81	11.11	\$ 896.70	\$ 777.70
59850 00	Surgery	11.65	11.65	\$ 815.50	\$ 815.50
59851 00	Surgery	12.78	12.78	\$ 894.60	\$ 894.60
59852 00	Surgery	17.62	17.62	\$ 1,233.40	\$ 1,233.40
59855 00	Surgery	12.65	12.65	\$ 885.50	\$ 885.50
59856 00	Surgery	14.80	14.80	\$ 1,036.00	\$ 1,036.00
59857 00	Surgery	17.27	17.27	\$ 1,208.90	\$ 1,208.90

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
59866 00	Surgery	7.02	7.02	\$ 491.40	\$ 491.40
59870 00	Surgery	16.05	16.05	\$ 1,123.50	\$ 1,123.50
59871 00	Surgery	3.90	3.90	\$ 273.00	\$ 273.00
59897 00	Surgery	0.00	0.00	BR	BR
59898 00	Surgery	0.00	0.00	BR	BR
59899 00	Surgery	-	-	\$ 1,066.10	\$ 1,066.10
60000 00	Surgery	5.49	4.61	\$ 384.30	\$ 322.70
60100 00	Surgery	3.24	2.24	\$ 226.80	\$ 156.80
60200 00	Surgery	19.86	19.86	\$ 1,390.20	\$ 1,390.20
60210 00	Surgery	21.03	21.03	\$ 1,472.10	\$ 1,472.10
60212 00	Surgery	30.72	30.72	\$ 2,150.40	\$ 2,150.40
60220 00	Surgery	21.00	21.00	\$ 1,470.00	\$ 1,470.00
60225 00	Surgery	27.85	27.85	\$ 1,949.50	\$ 1,949.50
60240 00	Surgery	27.27	27.27	\$ 1,908.90	\$ 1,908.90
60252 00	Surgery	39.24	39.24	\$ 2,746.80	\$ 2,746.80
60254 00	Surgery	49.47	49.47	\$ 3,462.90	\$ 3,462.90
60260 00	Surgery	32.31	32.31	\$ 2,261.70	\$ 2,261.70
60270 00	Surgery	40.40	40.40	\$ 2,828.00	\$ 2,828.00
60271 00	Surgery	31.31	31.31	\$ 2,191.70	\$ 2,191.70
60280 00	Surgery	13.49	13.49	\$ 944.30	\$ 944.30
60281 00	Surgery	17.66	17.66	\$ 1,236.20	\$ 1,236.20
60300 00	Surgery	3.22	1.43	\$ 225.40	\$ 100.10
60500 00	Surgery	28.84	28.84	\$ 2,018.80	\$ 2,018.80
60502 00	Surgery	38.67	38.67	\$ 2,706.90	\$ 2,706.90
60505 00	Surgery	41.63	41.63	\$ 2,914.10	\$ 2,914.10
60512 00	Surgery	7.13	7.13	\$ 499.10	\$ 499.10
60520 00	Surgery	31.26	31.26	\$ 2,188.20	\$ 2,188.20
60521 00	Surgery	33.08	33.08	\$ 2,315.60	\$ 2,315.60
60522 00	Surgery	40.27	40.27	\$ 2,818.90	\$ 2,818.90
60540 00	Surgery	31.83	31.83	\$ 2,228.10	\$ 2,228.10
60545 00	Surgery	36.93	36.93	\$ 2,585.10	\$ 2,585.10
60600 00	Surgery	40.12	40.12	\$ 2,808.40	\$ 2,808.40
60605 00	Surgery	48.50	48.50	\$ 3,395.00	\$ 3,395.00
60650 00	Surgery	35.22	35.22	\$ 2,465.40	\$ 2,465.40
60659 00	Surgery	0.00	0.00	BR	BR
60699 00	Surgery	0.00	0.00	BR	BR
61000 00	Surgery	3.34	3.34	\$ 233.80	\$ 233.80
61001 00	Surgery	3.18	3.18	\$ 222.60	\$ 222.60
61020 00	Surgery	3.13	3.13	\$ 219.10	\$ 219.10
61026 00	Surgery	3.15	3.15	\$ 220.50	\$ 220.50
61050 00	Surgery	2.35	2.35	\$ 164.50	\$ 164.50
61055 00	Surgery	3.45	3.45	\$ 241.50	\$ 241.50
61070 00	Surgery	1.67	1.67	\$ 116.90	\$ 116.90
61105 00	Surgery	13.81	13.81	\$ 966.70	\$ 966.70
61107 00	Surgery	9.22	9.22	\$ 645.40	\$ 645.40
61108 00	Surgery	26.94	26.94	\$ 1,885.80	\$ 1,885.80
61120 00	Surgery	22.38	22.38	\$ 1,566.60	\$ 1,566.60
61140 00	Surgery	37.84	37.84	\$ 2,648.80	\$ 2,648.80
61150 00	Surgery	40.18	40.18	\$ 2,812.60	\$ 2,812.60
61151 00	Surgery	29.61	29.61	\$ 2,072.70	\$ 2,072.70
61154 00	Surgery	38.04	38.04	\$ 2,662.80	\$ 2,662.80
61156 00	Surgery	36.96	36.96	\$ 2,587.20	\$ 2,587.20
61210 00	Surgery	10.81	10.81	\$ 756.70	\$ 756.70
61215 00	Surgery	15.34	15.34	\$ 1,073.80	\$ 1,073.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
61250 00	Surgery	25.90	25.90	\$ 1,813.00	\$ 1,813.00
61253 00	Surgery	29.61	29.61	\$ 2,072.70	\$ 2,072.70
61304 00	Surgery	48.82	48.82	\$ 3,417.40	\$ 3,417.40
61305 00	Surgery	59.63	59.63	\$ 4,174.10	\$ 4,174.10
61312 00	Surgery	61.49	61.49	\$ 4,304.30	\$ 4,304.30
61313 00	Surgery	58.95	58.95	\$ 4,126.50	\$ 4,126.50
61314 00	Surgery	54.42	54.42	\$ 3,809.40	\$ 3,809.40
61315 00	Surgery	61.33	61.33	\$ 4,293.10	\$ 4,293.10
61316 00	Surgery	2.60	2.60	\$ 182.00	\$ 182.00
61320 00	Surgery	56.25	56.25	\$ 3,937.50	\$ 3,937.50
61321 00	Surgery	63.14	63.14	\$ 4,419.80	\$ 4,419.80
61322 00	Surgery	70.74	70.74	\$ 4,951.80	\$ 4,951.80
61323 00	Surgery	70.86	70.86	\$ 4,960.20	\$ 4,960.20
61330 00	Surgery	53.35	53.35	\$ 3,734.50	\$ 3,734.50
61333 00	Surgery	59.89	59.89	\$ 4,192.30	\$ 4,192.30
61340 00	Surgery	42.84	42.84	\$ 2,998.80	\$ 2,998.80
61343 00	Surgery	65.25	65.25	\$ 4,567.50	\$ 4,567.50
61345 00	Surgery	60.71	60.71	\$ 4,249.70	\$ 4,249.70
61450 00	Surgery	57.05	57.05	\$ 3,993.50	\$ 3,993.50
61458 00	Surgery	59.87	59.87	\$ 4,190.90	\$ 4,190.90
61460 00	Surgery	62.61	62.61	\$ 4,382.70	\$ 4,382.70
61500 00	Surgery	38.71	38.71	\$ 2,709.70	\$ 2,709.70
61501 00	Surgery	33.55	33.55	\$ 2,348.50	\$ 2,348.50
61510 00	Surgery	65.40	65.40	\$ 4,578.00	\$ 4,578.00
61512 00	Surgery	75.82	75.82	\$ 5,307.40	\$ 5,307.40
61514 00	Surgery	56.92	56.92	\$ 3,984.40	\$ 3,984.40
61516 00	Surgery	55.59	55.59	\$ 3,891.30	\$ 3,891.30
61517 00	Surgery	2.58	2.58	\$ 180.60	\$ 180.60
61518 00	Surgery	82.23	82.23	\$ 5,756.10	\$ 5,756.10
61519 00	Surgery	87.15	87.15	\$ 6,100.50	\$ 6,100.50
61520 00	Surgery	110.85	110.85	\$ 7,759.50	\$ 7,759.50
61521 00	Surgery	94.05	94.05	\$ 6,583.50	\$ 6,583.50
61522 00	Surgery	65.03	65.03	\$ 4,552.10	\$ 4,552.10
61524 00	Surgery	61.95	61.95	\$ 4,336.50	\$ 4,336.50
61526 00	Surgery	99.32	99.32	\$ 6,952.40	\$ 6,952.40
61530 00	Surgery	91.12	91.12	\$ 6,378.40	\$ 6,378.40
61531 00	Surgery	36.50	36.50	\$ 2,555.00	\$ 2,555.00
61533 00	Surgery	45.44	45.44	\$ 3,180.80	\$ 3,180.80
61534 00	Surgery	49.16	49.16	\$ 3,441.20	\$ 3,441.20
61535 00	Surgery	29.97	29.97	\$ 2,097.90	\$ 2,097.90
61536 00	Surgery	76.52	76.52	\$ 5,356.40	\$ 5,356.40
61537 00	Surgery	72.94	72.94	\$ 5,105.80	\$ 5,105.80
61538 00	Surgery	78.92	78.92	\$ 5,524.40	\$ 5,524.40
61539 00	Surgery	70.13	70.13	\$ 4,909.10	\$ 4,909.10
61540 00	Surgery	64.67	64.67	\$ 4,526.90	\$ 4,526.90
61541 00	Surgery	63.89	63.89	\$ 4,472.30	\$ 4,472.30
61543 00	Surgery	64.59	64.59	\$ 4,521.30	\$ 4,521.30
61544 00	Surgery	56.41	56.41	\$ 3,948.70	\$ 3,948.70
61545 00	Surgery	94.56	94.56	\$ 6,619.20	\$ 6,619.20
61546 00	Surgery	68.55	68.55	\$ 4,798.50	\$ 4,798.50
61548 00	Surgery	46.66	46.66	\$ 3,266.20	\$ 3,266.20
61550 00	Surgery	35.66	35.66	\$ 2,496.20	\$ 2,496.20
61552 00	Surgery	44.31	44.31	\$ 3,101.70	\$ 3,101.70
61556 00	Surgery	50.84	50.84	\$ 3,558.80	\$ 3,558.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
61557 00	Surgery	50.19	50.19	\$ 3,513.30	\$ 3,513.30
61558 00	Surgery	55.98	55.98	\$ 3,918.60	\$ 3,918.60
61559 00	Surgery	71.30	71.30	\$ 4,991.00	\$ 4,991.00
61563 00	Surgery	58.95	58.95	\$ 4,126.50	\$ 4,126.50
61564 00	Surgery	71.50	71.50	\$ 5,005.00	\$ 5,005.00
61566 00	Surgery	66.58	66.58	\$ 4,660.60	\$ 4,660.60
61567 00	Surgery	75.81	75.81	\$ 5,306.70	\$ 5,306.70
61570 00	Surgery	55.66	55.66	\$ 3,896.20	\$ 3,896.20
61571 00	Surgery	59.22	59.22	\$ 4,145.40	\$ 4,145.40
61575 00	Surgery	74.37	74.37	\$ 5,205.90	\$ 5,205.90
61576 00	Surgery	124.44	124.44	\$ 8,710.80	\$ 8,710.80
61580 00	Surgery	74.57	74.57	\$ 5,219.90	\$ 5,219.90
61581 00	Surgery	84.87	84.87	\$ 5,940.90	\$ 5,940.90
61582 00	Surgery	90.39	90.39	\$ 6,327.30	\$ 6,327.30
61583 00	Surgery	87.18	87.18	\$ 6,102.60	\$ 6,102.60
61584 00	Surgery	86.16	86.16	\$ 6,031.20	\$ 6,031.20
61585 00	Surgery	98.34	98.34	\$ 6,883.80	\$ 6,883.80
61586 00	Surgery	76.40	76.40	\$ 5,348.00	\$ 5,348.00
61590 00	Surgery	90.52	90.52	\$ 6,336.40	\$ 6,336.40
61591 00	Surgery	90.95	90.95	\$ 6,366.50	\$ 6,366.50
61592 00	Surgery	94.63	94.63	\$ 6,624.10	\$ 6,624.10
61595 00	Surgery	71.57	71.57	\$ 5,009.90	\$ 5,009.90
61596 00	Surgery	72.49	72.49	\$ 5,074.30	\$ 5,074.30
61597 00	Surgery	88.87	88.87	\$ 6,220.90	\$ 6,220.90
61598 00	Surgery	85.53	85.53	\$ 5,987.10	\$ 5,987.10
61600 00	Surgery	63.73	63.73	\$ 4,461.10	\$ 4,461.10
61601 00	Surgery	72.81	72.81	\$ 5,096.70	\$ 5,096.70
61605 00	Surgery	64.61	64.61	\$ 4,522.70	\$ 4,522.70
61606 00	Surgery	86.92	86.92	\$ 6,084.40	\$ 6,084.40
61607 00	Surgery	79.31	79.31	\$ 5,551.70	\$ 5,551.70
61608 00	Surgery	97.60	97.60	\$ 6,832.00	\$ 6,832.00
61611 00	Surgery	13.81	13.81	\$ 966.70	\$ 966.70
61613 00	Surgery	98.19	98.19	\$ 6,873.30	\$ 6,873.30
61615 00	Surgery	84.40	84.40	\$ 5,908.00	\$ 5,908.00
61616 00	Surgery	99.53	99.53	\$ 6,967.10	\$ 6,967.10
61618 00	Surgery	38.29	38.29	\$ 2,680.30	\$ 2,680.30
61619 00	Surgery	42.13	42.13	\$ 2,949.10	\$ 2,949.10
61623 00	Surgery	16.95	16.95	\$ 1,186.50	\$ 1,186.50
61624 00	Surgery	33.94	33.94	\$ 2,375.80	\$ 2,375.80
61626 00	Surgery	26.22	26.22	\$ 1,835.40	\$ 1,835.40
61630 00	Surgery	40.26	40.26	\$ 2,818.20	\$ 2,818.20
61635 00	Surgery	42.86	42.86	\$ 3,000.20	\$ 3,000.20
61640 00	Surgery	14.01	14.01	\$ 980.70	\$ 980.70
61641 00	Surgery	4.92	4.92	\$ 344.40	\$ 344.40
61642 00	Surgery	9.84	9.84	\$ 688.80	\$ 688.80
61645 00	Surgery	24.67	24.67	\$ 1,726.90	\$ 1,726.90
61650 00	Surgery	16.90	16.90	\$ 1,183.00	\$ 1,183.00
61651 00	Surgery	7.12	7.12	\$ 498.40	\$ 498.40
61680 00	Surgery	67.17	67.17	\$ 4,701.90	\$ 4,701.90
61682 00	Surgery	123.15	123.15	\$ 8,620.50	\$ 8,620.50
61684 00	Surgery	84.33	84.33	\$ 5,903.10	\$ 5,903.10
61686 00	Surgery	132.92	132.92	\$ 9,304.40	\$ 9,304.40
61690 00	Surgery	64.76	64.76	\$ 4,533.20	\$ 4,533.20
61692 00	Surgery	108.04	108.04	\$ 7,562.80	\$ 7,562.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
61697 00	Surgery	125.01	125.01	\$ 8,750.70	\$ 8,750.70
61698 00	Surgery	136.89	136.89	\$ 9,582.30	\$ 9,582.30
61700 00	Surgery	100.79	100.79	\$ 7,055.30	\$ 7,055.30
61702 00	Surgery	119.05	119.05	\$ 8,333.50	\$ 8,333.50
61703 00	Surgery	40.48	40.48	\$ 2,833.60	\$ 2,833.60
61705 00	Surgery	77.26	77.26	\$ 5,408.20	\$ 5,408.20
61708 00	Surgery	75.57	75.57	\$ 5,289.90	\$ 5,289.90
61710 00	Surgery	63.73	63.73	\$ 4,461.10	\$ 4,461.10
61711 00	Surgery	76.25	76.25	\$ 5,337.50	\$ 5,337.50
61720 00	Surgery	37.89	37.89	\$ 2,652.30	\$ 2,652.30
61735 00	Surgery	47.52	47.52	\$ 3,326.40	\$ 3,326.40
61736 00	Surgery	26.72	26.72	\$ 1,870.40	\$ 1,870.40
61737 00	Surgery	31.83	31.83	\$ 2,228.10	\$ 2,228.10
61750 00	Surgery	41.95	41.95	\$ 2,936.50	\$ 2,936.50
61751 00	Surgery	41.28	41.28	\$ 2,889.60	\$ 2,889.60
61760 00	Surgery	47.24	47.24	\$ 3,306.80	\$ 3,306.80
61770 00	Surgery	48.27	48.27	\$ 3,378.90	\$ 3,378.90
61781 00	Surgery	6.94	6.94	\$ 485.80	\$ 485.80
61782 00	Surgery	5.08	5.08	\$ 355.60	\$ 355.60
61783 00	Surgery	6.85	6.85	\$ 479.50	\$ 479.50
61790 00	Surgery	26.37	26.37	\$ 1,845.90	\$ 1,845.90
61791 00	Surgery	33.60	33.60	\$ 2,352.00	\$ 2,352.00
61796 00	Surgery	30.30	30.30	\$ 2,121.00	\$ 2,121.00
61797 00	Surgery	6.47	6.47	\$ 452.90	\$ 452.90
61798 00	Surgery	41.04	41.04	\$ 2,872.80	\$ 2,872.80
61799 00	Surgery	8.93	8.93	\$ 625.10	\$ 625.10
61800 00	Surgery	4.48	4.48	\$ 313.60	\$ 313.60
61850 00	Surgery	29.41	29.41	\$ 2,058.70	\$ 2,058.70
61860 00	Surgery	46.54	46.54	\$ 3,257.80	\$ 3,257.80
61863 00	Surgery	44.80	44.80	\$ 3,136.00	\$ 3,136.00
61864 00	Surgery	8.33	8.33	\$ 583.10	\$ 583.10
61867 00	Surgery	67.68	67.68	\$ 4,737.60	\$ 4,737.60
61868 00	Surgery	14.71	14.71	\$ 1,029.70	\$ 1,029.70
61880 00	Surgery	17.50	17.50	\$ 1,225.00	\$ 1,225.00
61885 00	Surgery	15.68	15.68	\$ 1,097.60	\$ 1,097.60
61886 00	Surgery	26.09	26.09	\$ 1,826.30	\$ 1,826.30
61888 00	Surgery	11.90	11.90	\$ 833.00	\$ 833.00
62000 00	Surgery	30.85	30.85	\$ 2,159.50	\$ 2,159.50
62005 00	Surgery	37.91	37.91	\$ 2,653.70	\$ 2,653.70
62010 00	Surgery	45.82	45.82	\$ 3,207.40	\$ 3,207.40
62100 00	Surgery	46.86	46.86	\$ 3,280.20	\$ 3,280.20
62115 00	Surgery	50.20	50.20	\$ 3,514.00	\$ 3,514.00
62117 00	Surgery	58.44	58.44	\$ 4,090.80	\$ 4,090.80
62120 00	Surgery	62.26	62.26	\$ 4,358.20	\$ 4,358.20
62121 00	Surgery	46.70	46.70	\$ 3,269.00	\$ 3,269.00
62140 00	Surgery	30.32	30.32	\$ 2,122.40	\$ 2,122.40
62141 00	Surgery	33.94	33.94	\$ 2,375.80	\$ 2,375.80
62142 00	Surgery	26.60	26.60	\$ 1,862.00	\$ 1,862.00
62143 00	Surgery	31.15	31.15	\$ 2,180.50	\$ 2,180.50
62145 00	Surgery	41.76	41.76	\$ 2,923.20	\$ 2,923.20
62146 00	Surgery	37.25	37.25	\$ 2,607.50	\$ 2,607.50
62147 00	Surgery	42.40	42.40	\$ 2,968.00	\$ 2,968.00
62148 00	Surgery	3.73	3.73	\$ 261.10	\$ 261.10
62160 00	Surgery	5.59	5.59	\$ 391.30	\$ 391.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
62161 00	Surgery	45.18	45.18	\$ 3,162.60	\$ 3,162.60
62162 00	Surgery	56.18	56.18	\$ 3,932.60	\$ 3,932.60
62164 00	Surgery	62.29	62.29	\$ 4,360.30	\$ 4,360.30
62165 00	Surgery	45.00	45.00	\$ 3,150.00	\$ 3,150.00
62180 00	Surgery	47.58	47.58	\$ 3,330.60	\$ 3,330.60
62190 00	Surgery	27.75	27.75	\$ 1,942.50	\$ 1,942.50
62192 00	Surgery	29.42	29.42	\$ 2,059.40	\$ 2,059.40
62194 00	Surgery	14.74	14.74	\$ 1,031.80	\$ 1,031.80
62200 00	Surgery	41.00	41.00	\$ 2,870.00	\$ 2,870.00
62201 00	Surgery	36.10	36.10	\$ 2,527.00	\$ 2,527.00
62220 00	Surgery	29.08	29.08	\$ 2,035.60	\$ 2,035.60
62223 00	Surgery	31.00	31.00	\$ 2,170.00	\$ 2,170.00
62225 00	Surgery	15.93	15.93	\$ 1,115.10	\$ 1,115.10
62230 00	Surgery	25.11	25.11	\$ 1,757.70	\$ 1,757.70
62252 00	Surgery	2.44	2.44	\$ 170.80	\$ 170.80
62252 26	Surgery	1.35	1.35	\$ 94.50	\$ 94.50
62252 TC	Surgery	1.09	1.09	\$ 76.30	\$ 76.30
62256 00	Surgery	18.19	18.19	\$ 1,273.30	\$ 1,273.30
62258 00	Surgery	33.19	33.19	\$ 2,323.30	\$ 2,323.30
62263 00	Surgery	19.00	9.20	\$ 1,330.00	\$ 644.00
62264 00	Surgery	13.28	7.15	\$ 929.60	\$ 500.50
62267 00	Surgery	8.05	4.50	\$ 563.50	\$ 315.00
62268 00	Surgery	7.50	7.50	\$ 525.00	\$ 525.00
62269 00	Surgery	7.61	7.61	\$ 532.70	\$ 532.70
62270 00	Surgery	3.77	1.82	\$ 263.90	\$ 127.40
62272 00	Surgery	5.14	2.63	\$ 359.80	\$ 184.10
62273 00	Surgery	5.01	3.31	\$ 350.70	\$ 231.70
62280 00	Surgery	9.85	4.65	\$ 689.50	\$ 325.50
62281 00	Surgery	7.11	4.64	\$ 497.70	\$ 324.80
62282 00	Surgery	9.69	4.20	\$ 678.30	\$ 294.00
62284 00	Surgery	5.83	2.48	\$ 408.10	\$ 173.60
62287 00	Surgery	16.96	16.96	\$ 1,187.20	\$ 1,187.20
62290 00	Surgery	10.83	4.69	\$ 758.10	\$ 328.30
62291 00	Surgery	9.82	4.34	\$ 687.40	\$ 303.80
62292 00	Surgery	16.96	16.96	\$ 1,187.20	\$ 1,187.20
62294 00	Surgery	28.36	28.36	\$ 1,985.20	\$ 1,985.20
62302 00	Surgery	7.84	3.49	\$ 548.80	\$ 244.30
62303 00	Surgery	7.98	3.50	\$ 558.60	\$ 245.00
62304 00	Surgery	7.75	3.44	\$ 542.50	\$ 240.80
62305 00	Surgery	8.45	3.59	\$ 591.50	\$ 251.30
62320 00	Surgery	4.91	2.93	\$ 343.70	\$ 205.10
62321 00	Surgery	7.92	3.14	\$ 554.40	\$ 219.80
62322 00	Surgery	4.17	2.38	\$ 291.90	\$ 166.60
62323 00	Surgery	7.81	2.91	\$ 546.70	\$ 203.70
62324 00	Surgery	4.12	2.62	\$ 288.40	\$ 183.40
62325 00	Surgery	7.67	3.26	\$ 536.90	\$ 228.20
62326 00	Surgery	4.17	2.52	\$ 291.90	\$ 176.40
62327 00	Surgery	7.99	3.07	\$ 559.30	\$ 214.90
62328 00	Surgery	7.27	2.57	\$ 508.90	\$ 179.90
62329 00	Surgery	9.21	3.27	\$ 644.70	\$ 228.90
62350 00	Surgery	11.77	11.77	\$ 823.90	\$ 823.90
62351 00	Surgery	27.08	27.08	\$ 1,895.60	\$ 1,895.60
62355 00	Surgery	8.07	8.07	\$ 564.90	\$ 564.90
62360 00	Surgery	9.61	9.61	\$ 672.70	\$ 672.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
62361 00	Surgery	12.93	12.93	\$ 905.10	\$ 905.10
62362 00	Surgery	11.39	11.39	\$ 797.30	\$ 797.30
62365 00	Surgery	8.77	8.77	\$ 613.90	\$ 613.90
62367 00	Surgery	0.94	0.74	\$ 65.80	\$ 51.80
62368 00	Surgery	1.31	1.03	\$ 91.70	\$ 72.10
62369 00	Surgery	2.76	1.04	\$ 193.20	\$ 72.80
62370 00	Surgery	2.78	1.35	\$ 194.60	\$ 94.50
62380 00	Surgery	-	-	\$ 2,565.50	\$ 2,565.50
63001 00	Surgery	36.69	36.69	\$ 2,568.30	\$ 2,568.30
63003 00	Surgery	36.68	36.68	\$ 2,567.60	\$ 2,567.60
63005 00	Surgery	35.61	35.61	\$ 2,492.70	\$ 2,492.70
63011 00	Surgery	32.55	32.55	\$ 2,278.50	\$ 2,278.50
63012 00	Surgery	35.53	35.53	\$ 2,487.10	\$ 2,487.10
63015 00	Surgery	43.97	43.97	\$ 3,077.90	\$ 3,077.90
63016 00	Surgery	45.32	45.32	\$ 3,172.40	\$ 3,172.40
63017 00	Surgery	37.55	37.55	\$ 2,628.50	\$ 2,628.50
63020 00	Surgery	34.45	34.45	\$ 2,411.50	\$ 2,411.50
63030 00	Surgery	29.00	29.00	\$ 2,030.00	\$ 2,030.00
63035 00	Surgery	5.64	5.64	\$ 394.80	\$ 394.80
63040 00	Surgery	41.04	41.04	\$ 2,872.80	\$ 2,872.80
63042 00	Surgery	38.44	38.44	\$ 2,690.80	\$ 2,690.80
63043 00	Surgery	-	-	\$ 1,250.20	\$ 1,250.20
63044 00	Surgery	-	-	\$ 1,187.20	\$ 1,187.20
63045 00	Surgery	38.28	38.28	\$ 2,679.60	\$ 2,679.60
63046 00	Surgery	36.48	36.48	\$ 2,553.60	\$ 2,553.60
63047 00	Surgery	32.84	32.84	\$ 2,298.80	\$ 2,298.80
63048 00	Surgery	6.21	6.21	\$ 434.70	\$ 434.70
63050 00	Surgery	43.99	43.99	\$ 3,079.30	\$ 3,079.30
63051 00	Surgery	50.35	50.35	\$ 3,524.50	\$ 3,524.50
63052 00	Surgery	7.62	7.62	\$ 533.40	\$ 533.40
63053 00	Surgery	5.70	5.70	\$ 399.00	\$ 399.00
63055 00	Surgery	48.26	48.26	\$ 3,378.20	\$ 3,378.20
63056 00	Surgery	44.32	44.32	\$ 3,102.40	\$ 3,102.40
63057 00	Surgery	9.47	9.47	\$ 662.90	\$ 662.90
63064 00	Surgery	52.82	52.82	\$ 3,697.40	\$ 3,697.40
63066 00	Surgery	6.06	6.06	\$ 424.20	\$ 424.20
63075 00	Surgery	40.37	40.37	\$ 2,825.90	\$ 2,825.90
63076 00	Surgery	7.18	7.18	\$ 502.60	\$ 502.60
63077 00	Surgery	44.58	44.58	\$ 3,120.60	\$ 3,120.60
63078 00	Surgery	6.10	6.10	\$ 427.00	\$ 427.00
63081 00	Surgery	52.17	52.17	\$ 3,651.90	\$ 3,651.90
63082 00	Surgery	7.81	7.81	\$ 546.70	\$ 546.70
63085 00	Surgery	57.17	57.17	\$ 4,001.90	\$ 4,001.90
63086 00	Surgery	5.62	5.62	\$ 393.40	\$ 393.40
63087 00	Surgery	71.29	71.29	\$ 4,990.30	\$ 4,990.30
63088 00	Surgery	7.56	7.56	\$ 529.20	\$ 529.20
63090 00	Surgery	58.06	58.06	\$ 4,064.20	\$ 4,064.20
63091 00	Surgery	5.23	5.23	\$ 366.10	\$ 366.10
63101 00	Surgery	68.99	68.99	\$ 4,829.30	\$ 4,829.30
63102 00	Surgery	67.22	67.22	\$ 4,705.40	\$ 4,705.40
63103 00	Surgery	8.66	8.66	\$ 606.20	\$ 606.20
63170 00	Surgery	47.45	47.45	\$ 3,321.50	\$ 3,321.50
63172 00	Surgery	42.05	42.05	\$ 2,943.50	\$ 2,943.50
63173 00	Surgery	51.36	51.36	\$ 3,595.20	\$ 3,595.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
63185 00	Surgery	33.74	33.74	\$ 2,361.80	\$ 2,361.80
63190 00	Surgery	36.77	36.77	\$ 2,573.90	\$ 2,573.90
63191 00	Surgery	41.15	41.15	\$ 2,880.50	\$ 2,880.50
63197 00	Surgery	50.92	50.92	\$ 3,564.40	\$ 3,564.40
63200 00	Surgery	45.10	45.10	\$ 3,157.00	\$ 3,157.00
63250 00	Surgery	87.96	87.96	\$ 6,157.20	\$ 6,157.20
63251 00	Surgery	89.92	89.92	\$ 6,294.40	\$ 6,294.40
63252 00	Surgery	89.90	89.90	\$ 6,293.00	\$ 6,293.00
63265 00	Surgery	49.62	49.62	\$ 3,473.40	\$ 3,473.40
63266 00	Surgery	51.17	51.17	\$ 3,581.90	\$ 3,581.90
63267 00	Surgery	40.82	40.82	\$ 2,857.40	\$ 2,857.40
63268 00	Surgery	42.21	42.21	\$ 2,954.70	\$ 2,954.70
63270 00	Surgery	61.80	61.80	\$ 4,326.00	\$ 4,326.00
63271 00	Surgery	61.57	61.57	\$ 4,309.90	\$ 4,309.90
63272 00	Surgery	55.67	55.67	\$ 3,896.90	\$ 3,896.90
63273 00	Surgery	55.59	55.59	\$ 3,891.30	\$ 3,891.30
63275 00	Surgery	53.78	53.78	\$ 3,764.60	\$ 3,764.60
63276 00	Surgery	53.18	53.18	\$ 3,722.60	\$ 3,722.60
63277 00	Surgery	46.38	46.38	\$ 3,246.60	\$ 3,246.60
63278 00	Surgery	47.50	47.50	\$ 3,325.00	\$ 3,325.00
63280 00	Surgery	63.00	63.00	\$ 4,410.00	\$ 4,410.00
63281 00	Surgery	62.35	62.35	\$ 4,364.50	\$ 4,364.50
63282 00	Surgery	58.86	58.86	\$ 4,120.20	\$ 4,120.20
63283 00	Surgery	56.63	56.63	\$ 3,964.10	\$ 3,964.10
63285 00	Surgery	77.65	77.65	\$ 5,435.50	\$ 5,435.50
63286 00	Surgery	76.57	76.57	\$ 5,359.90	\$ 5,359.90
63287 00	Surgery	81.42	81.42	\$ 5,699.40	\$ 5,699.40
63290 00	Surgery	82.79	82.79	\$ 5,795.30	\$ 5,795.30
63295 00	Surgery	9.68	9.68	\$ 677.60	\$ 677.60
63300 00	Surgery	53.87	53.87	\$ 3,770.90	\$ 3,770.90
63301 00	Surgery	65.58	65.58	\$ 4,590.60	\$ 4,590.60
63302 00	Surgery	64.80	64.80	\$ 4,536.00	\$ 4,536.00
63303 00	Surgery	68.78	68.78	\$ 4,814.60	\$ 4,814.60
63304 00	Surgery	69.82	69.82	\$ 4,887.40	\$ 4,887.40
63305 00	Surgery	74.27	74.27	\$ 5,198.90	\$ 5,198.90
63306 00	Surgery	72.98	72.98	\$ 5,108.60	\$ 5,108.60
63307 00	Surgery	71.50	71.50	\$ 5,005.00	\$ 5,005.00
63308 00	Surgery	9.39	9.39	\$ 657.30	\$ 657.30
63600 00	Surgery	32.57	32.57	\$ 2,279.90	\$ 2,279.90
63610 00	Surgery	17.12	17.12	\$ 1,198.40	\$ 1,198.40
63620 00	Surgery	33.44	33.44	\$ 2,340.80	\$ 2,340.80
63621 00	Surgery	7.44	7.44	\$ 520.80	\$ 520.80
63650 00	Surgery	70.78	12.17	\$ 4,954.60	\$ 851.90
63655 00	Surgery	24.91	24.91	\$ 1,743.70	\$ 1,743.70
63661 00	Surgery	20.60	9.69	\$ 1,442.00	\$ 678.30
63662 00	Surgery	25.23	25.23	\$ 1,766.10	\$ 1,766.10
63663 00	Surgery	27.07	13.26	\$ 1,894.90	\$ 928.20
63664 00	Surgery	26.25	26.25	\$ 1,837.50	\$ 1,837.50
63685 00	Surgery	10.71	10.71	\$ 749.70	\$ 749.70
63688 00	Surgery	11.03	11.03	\$ 772.10	\$ 772.10
63700 00	Surgery	39.12	39.12	\$ 2,738.40	\$ 2,738.40
63702 00	Surgery	42.75	42.75	\$ 2,992.50	\$ 2,992.50
63704 00	Surgery	49.70	49.70	\$ 3,479.00	\$ 3,479.00
63706 00	Surgery	55.14	55.14	\$ 3,859.80	\$ 3,859.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
63707 00	Surgery	27.89	27.89	\$ 1,952.30	\$ 1,952.30
63709 00	Surgery	33.21	33.21	\$ 2,324.70	\$ 2,324.70
63710 00	Surgery	32.25	32.25	\$ 2,257.50	\$ 2,257.50
63740 00	Surgery	29.42	29.42	\$ 2,059.40	\$ 2,059.40
63741 00	Surgery	20.20	20.20	\$ 1,414.00	\$ 1,414.00
63744 00	Surgery	20.61	20.61	\$ 1,442.70	\$ 1,442.70
63746 00	Surgery	18.25	18.25	\$ 1,277.50	\$ 1,277.50
64400 00	Surgery	3.39	1.49	\$ 237.30	\$ 104.30
64405 00	Surgery	2.24	1.56	\$ 156.80	\$ 109.20
64408 00	Surgery	2.44	1.32	\$ 170.80	\$ 92.40
64415 00	Surgery	3.35	1.84	\$ 234.50	\$ 128.80
64416 00	Surgery	1.86	1.86	\$ 130.20	\$ 130.20
64417 00	Surgery	4.18	1.78	\$ 292.60	\$ 124.60
64418 00	Surgery	2.62	1.65	\$ 183.40	\$ 115.50
64420 00	Surgery	2.90	1.73	\$ 203.00	\$ 121.10
64421 00	Surgery	0.98	0.73	\$ 68.60	\$ 51.10
64425 00	Surgery	3.33	1.61	\$ 233.10	\$ 112.70
64430 00	Surgery	2.94	1.59	\$ 205.80	\$ 111.30
64435 00	Surgery	2.42	1.27	\$ 169.40	\$ 88.90
64445 00	Surgery	3.76	1.57	\$ 263.20	\$ 109.90
64446 00	Surgery	1.72	1.72	\$ 120.40	\$ 120.40
64447 00	Surgery	2.63	1.54	\$ 184.10	\$ 107.80
64448 00	Surgery	1.77	1.77	\$ 123.90	\$ 123.90
64449 00	Surgery	1.80	1.80	\$ 126.00	\$ 126.00
64450 00	Surgery	2.26	1.24	\$ 158.20	\$ 86.80
64451 00	Surgery	6.93	2.39	\$ 485.10	\$ 167.30
64454 00	Surgery	6.74	2.43	\$ 471.80	\$ 170.10
64455 00	Surgery	1.47	0.99	\$ 102.90	\$ 69.30
64461 00	Surgery	4.06	2.30	\$ 284.20	\$ 161.00
64462 00	Surgery	2.16	1.43	\$ 151.20	\$ 100.10
64463 00	Surgery	7.09	2.42	\$ 496.30	\$ 169.40
64479 00	Surgery	8.00	3.84	\$ 560.00	\$ 268.80
64480 00	Surgery	4.06	1.79	\$ 284.20	\$ 125.30
64483 00	Surgery	7.44	3.26	\$ 520.80	\$ 228.20
64484 00	Surgery	3.37	1.51	\$ 235.90	\$ 105.70
64486 00	Surgery	3.36	1.63	\$ 235.20	\$ 114.10
64487 00	Surgery	6.60	1.86	\$ 462.00	\$ 130.20
64488 00	Surgery	4.16	2.01	\$ 291.20	\$ 140.70
64489 00	Surgery	10.82	2.26	\$ 757.40	\$ 158.20
64490 00	Surgery	5.70	3.10	\$ 399.00	\$ 217.00
64491 00	Surgery	2.87	1.74	\$ 200.90	\$ 121.80
64492 00	Surgery	2.88	1.76	\$ 201.60	\$ 123.20
64493 00	Surgery	5.22	2.63	\$ 365.40	\$ 184.10
64494 00	Surgery	2.70	1.50	\$ 189.00	\$ 105.00
64495 00	Surgery	2.69	1.52	\$ 188.30	\$ 106.40
64505 00	Surgery	4.25	3.06	\$ 297.50	\$ 214.20
64510 00	Surgery	4.40	2.25	\$ 308.00	\$ 157.50
64517 00	Surgery	5.76	3.70	\$ 403.20	\$ 259.00
64520 00	Surgery	6.95	2.47	\$ 486.50	\$ 172.90
64530 00	Surgery	7.01	2.76	\$ 490.70	\$ 193.20
64553 00	Surgery	76.68	11.15	\$ 5,367.60	\$ 780.50
64555 00	Surgery	67.21	9.61	\$ 4,704.70	\$ 672.70
64561 00	Surgery	22.57	8.91	\$ 1,579.90	\$ 623.70
64566 00	Surgery	3.58	0.90	\$ 250.60	\$ 63.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
64568 00	Surgery	18.14	18.14	\$ 1,269.80	\$ 1,269.80
64569 00	Surgery	22.86	22.86	\$ 1,600.20	\$ 1,600.20
64570 00	Surgery	21.91	21.91	\$ 1,533.70	\$ 1,533.70
64575 00	Surgery	9.51	9.51	\$ 665.70	\$ 665.70
64580 00	Surgery	9.40	9.40	\$ 658.00	\$ 658.00
64581 00	Surgery	19.32	19.32	\$ 1,352.40	\$ 1,352.40
64582 00	Surgery	25.65	25.65	\$ 1,795.50	\$ 1,795.50
64583 00	Surgery	23.33	23.33	\$ 1,633.10	\$ 1,633.10
64584 00	Surgery	19.66	19.66	\$ 1,376.20	\$ 1,376.20
64585 00	Surgery	7.33	4.22	\$ 513.10	\$ 295.40
64590 00	Surgery	7.90	4.73	\$ 553.00	\$ 331.10
64595 00	Surgery	6.96	3.73	\$ 487.20	\$ 261.10
64600 00	Surgery	13.93	6.76	\$ 975.10	\$ 473.20
64605 00	Surgery	19.23	10.29	\$ 1,346.10	\$ 720.30
64610 00	Surgery	24.02	14.39	\$ 1,681.40	\$ 1,007.30
64611 00	Surgery	3.84	3.29	\$ 268.80	\$ 230.30
64612 00	Surgery	4.03	3.48	\$ 282.10	\$ 243.60
64615 00	Surgery	4.59	3.64	\$ 321.30	\$ 254.80
64616 00	Surgery	4.10	3.23	\$ 287.00	\$ 226.10
64617 00	Surgery	4.84	3.17	\$ 338.80	\$ 221.90
64620 00	Surgery	6.20	5.20	\$ 434.00	\$ 364.00
64624 00	Surgery	11.82	4.29	\$ 827.40	\$ 300.30
64625 00	Surgery	14.32	5.72	\$ 1,002.40	\$ 400.40
64628 00	Surgery	13.58	13.58	\$ 950.60	\$ 950.60
64629 00	Surgery	6.36	6.36	\$ 445.20	\$ 445.20
64630 00	Surgery	7.76	5.72	\$ 543.20	\$ 400.40
64632 00	Surgery	2.66	1.95	\$ 186.20	\$ 136.50
64633 00	Surgery	13.26	5.62	\$ 928.20	\$ 393.40
64634 00	Surgery	7.85	1.96	\$ 549.50	\$ 137.20
64635 00	Surgery	13.38	5.62	\$ 936.60	\$ 393.40
64636 00	Surgery	7.41	1.73	\$ 518.70	\$ 121.10
64640 00	Surgery	7.43	3.48	\$ 520.10	\$ 243.60
64642 00	Surgery	4.52	3.18	\$ 316.40	\$ 222.60
64643 00	Surgery	2.78	2.09	\$ 194.60	\$ 146.30
64644 00	Surgery	5.31	3.46	\$ 371.70	\$ 242.20
64645 00	Surgery	3.61	2.43	\$ 252.70	\$ 170.10
64646 00	Surgery	4.71	3.40	\$ 329.70	\$ 238.00
64647 00	Surgery	5.40	3.96	\$ 378.00	\$ 277.20
64650 00	Surgery	2.64	1.19	\$ 184.80	\$ 83.30
64653 00	Surgery	3.16	1.54	\$ 221.20	\$ 107.80
64680 00	Surgery	10.56	4.72	\$ 739.20	\$ 330.40
64681 00	Surgery	14.19	6.59	\$ 993.30	\$ 461.30
64702 00	Surgery	15.14	15.14	\$ 1,059.80	\$ 1,059.80
64704 00	Surgery	9.58	9.58	\$ 670.60	\$ 670.60
64708 00	Surgery	14.93	14.93	\$ 1,045.10	\$ 1,045.10
64712 00	Surgery	17.69	17.69	\$ 1,238.30	\$ 1,238.30
64713 00	Surgery	23.47	23.47	\$ 1,642.90	\$ 1,642.90
64714 00	Surgery	22.46	22.46	\$ 1,572.20	\$ 1,572.20
64716 00	Surgery	15.19	15.19	\$ 1,063.30	\$ 1,063.30
64718 00	Surgery	17.86	17.86	\$ 1,250.20	\$ 1,250.20
64719 00	Surgery	12.12	12.12	\$ 848.40	\$ 848.40
64721 00	Surgery	13.22	12.97	\$ 925.40	\$ 907.90
64722 00	Surgery	10.70	10.70	\$ 749.00	\$ 749.00
64726 00	Surgery	7.93	7.93	\$ 555.10	\$ 555.10

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
64727 00	Surgery	5.30	5.30	\$ 371.00	\$ 371.00
64732 00	Surgery	13.51	13.51	\$ 945.70	\$ 945.70
64734 00	Surgery	15.27	15.27	\$ 1,068.90	\$ 1,068.90
64736 00	Surgery	9.70	9.70	\$ 679.00	\$ 679.00
64738 00	Surgery	13.27	13.27	\$ 928.90	\$ 928.90
64740 00	Surgery	13.60	13.60	\$ 952.00	\$ 952.00
64742 00	Surgery	14.39	14.39	\$ 1,007.30	\$ 1,007.30
64744 00	Surgery	15.06	15.06	\$ 1,054.20	\$ 1,054.20
64746 00	Surgery	12.84	12.84	\$ 898.80	\$ 898.80
64755 00	Surgery	27.56	27.56	\$ 1,929.20	\$ 1,929.20
64760 00	Surgery	15.61	15.61	\$ 1,092.70	\$ 1,092.70
64763 00	Surgery	15.44	15.44	\$ 1,080.80	\$ 1,080.80
64766 00	Surgery	19.05	19.05	\$ 1,333.50	\$ 1,333.50
64771 00	Surgery	17.16	17.16	\$ 1,201.20	\$ 1,201.20
64772 00	Surgery	16.67	16.67	\$ 1,166.90	\$ 1,166.90
64774 00	Surgery	12.39	12.39	\$ 867.30	\$ 867.30
64776 00	Surgery	11.66	11.66	\$ 816.20	\$ 816.20
64778 00	Surgery	5.32	5.32	\$ 372.40	\$ 372.40
64782 00	Surgery	13.49	13.49	\$ 944.30	\$ 944.30
64783 00	Surgery	6.36	6.36	\$ 445.20	\$ 445.20
64784 00	Surgery	21.58	21.58	\$ 1,510.60	\$ 1,510.60
64786 00	Surgery	30.08	30.08	\$ 2,105.60	\$ 2,105.60
64787 00	Surgery	7.01	7.01	\$ 490.70	\$ 490.70
64788 00	Surgery	12.04	12.04	\$ 842.80	\$ 842.80
64790 00	Surgery	24.88	24.88	\$ 1,741.60	\$ 1,741.60
64792 00	Surgery	31.65	31.65	\$ 2,215.50	\$ 2,215.50
64795 00	Surgery	5.63	5.63	\$ 394.10	\$ 394.10
64802 00	Surgery	25.21	25.21	\$ 1,764.70	\$ 1,764.70
64804 00	Surgery	35.54	35.54	\$ 2,487.80	\$ 2,487.80
64809 00	Surgery	32.46	32.46	\$ 2,272.20	\$ 2,272.20
64818 00	Surgery	23.10	23.10	\$ 1,617.00	\$ 1,617.00
64820 00	Surgery	21.57	21.57	\$ 1,509.90	\$ 1,509.90
64821 00	Surgery	20.49	20.49	\$ 1,434.30	\$ 1,434.30
64822 00	Surgery	20.78	20.78	\$ 1,454.60	\$ 1,454.60
64823 00	Surgery	23.52	23.52	\$ 1,646.40	\$ 1,646.40
64831 00	Surgery	20.56	20.56	\$ 1,439.20	\$ 1,439.20
64832 00	Surgery	9.77	9.77	\$ 683.90	\$ 683.90
64834 00	Surgery	21.95	21.95	\$ 1,536.50	\$ 1,536.50
64835 00	Surgery	24.23	24.23	\$ 1,696.10	\$ 1,696.10
64836 00	Surgery	24.23	24.23	\$ 1,696.10	\$ 1,696.10
64837 00	Surgery	10.71	10.71	\$ 749.70	\$ 749.70
64840 00	Surgery	28.55	28.55	\$ 1,998.50	\$ 1,998.50
64856 00	Surgery	29.93	29.93	\$ 2,095.10	\$ 2,095.10
64857 00	Surgery	31.23	31.23	\$ 2,186.10	\$ 2,186.10
64858 00	Surgery	34.81	34.81	\$ 2,436.70	\$ 2,436.70
64859 00	Surgery	7.29	7.29	\$ 510.30	\$ 510.30
64861 00	Surgery	45.29	45.29	\$ 3,170.30	\$ 3,170.30
64862 00	Surgery	40.63	40.63	\$ 2,844.10	\$ 2,844.10
64864 00	Surgery	25.29	25.29	\$ 1,770.30	\$ 1,770.30
64865 00	Surgery	32.25	32.25	\$ 2,257.50	\$ 2,257.50
64866 00	Surgery	37.00	37.00	\$ 2,590.00	\$ 2,590.00
64868 00	Surgery	29.60	29.60	\$ 2,072.00	\$ 2,072.00
64872 00	Surgery	3.40	3.40	\$ 238.00	\$ 238.00
64874 00	Surgery	5.10	5.10	\$ 357.00	\$ 357.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
64876 00	Surgery	5.77	5.77	\$ 403.90	\$ 403.90
64885 00	Surgery	32.58	32.58	\$ 2,280.60	\$ 2,280.60
64886 00	Surgery	37.91	37.91	\$ 2,653.70	\$ 2,653.70
64890 00	Surgery	31.99	31.99	\$ 2,239.30	\$ 2,239.30
64891 00	Surgery	34.00	34.00	\$ 2,380.00	\$ 2,380.00
64892 00	Surgery	31.11	31.11	\$ 2,177.70	\$ 2,177.70
64893 00	Surgery	33.17	33.17	\$ 2,321.90	\$ 2,321.90
64895 00	Surgery	39.23	39.23	\$ 2,746.10	\$ 2,746.10
64896 00	Surgery	42.26	42.26	\$ 2,958.20	\$ 2,958.20
64897 00	Surgery	37.47	37.47	\$ 2,622.90	\$ 2,622.90
64898 00	Surgery	40.54	40.54	\$ 2,837.80	\$ 2,837.80
64901 00	Surgery	17.48	17.48	\$ 1,223.60	\$ 1,223.60
64902 00	Surgery	20.24	20.24	\$ 1,416.80	\$ 1,416.80
64905 00	Surgery	29.78	29.78	\$ 2,084.60	\$ 2,084.60
64907 00	Surgery	38.47	38.47	\$ 2,692.90	\$ 2,692.90
64910 00	Surgery	22.82	22.82	\$ 1,597.40	\$ 1,597.40
64911 00	Surgery	30.36	30.36	\$ 2,125.20	\$ 2,125.20
64912 00	Surgery	26.31	26.31	\$ 1,841.70	\$ 1,841.70
64913 00	Surgery	5.16	5.16	\$ 361.20	\$ 361.20
64999 00	Surgery	0.00	0.00	BR	BR
65091 00	Surgery	22.16	22.16	\$ 1,551.20	\$ 1,551.20
65093 00	Surgery	21.98	21.98	\$ 1,538.60	\$ 1,538.60
65101 00	Surgery	25.27	25.27	\$ 1,768.90	\$ 1,768.90
65103 00	Surgery	26.04	26.04	\$ 1,822.80	\$ 1,822.80
65105 00	Surgery	28.30	28.30	\$ 1,981.00	\$ 1,981.00
65110 00	Surgery	38.90	38.90	\$ 2,723.00	\$ 2,723.00
65112 00	Surgery	44.48	44.48	\$ 3,113.60	\$ 3,113.60
65114 00	Surgery	46.43	46.43	\$ 3,250.10	\$ 3,250.10
65125 00	Surgery	13.50	8.49	\$ 945.00	\$ 594.30
65130 00	Surgery	25.35	25.35	\$ 1,774.50	\$ 1,774.50
65135 00	Surgery	25.64	25.64	\$ 1,794.80	\$ 1,794.80
65140 00	Surgery	27.53	27.53	\$ 1,927.10	\$ 1,927.10
65150 00	Surgery	20.94	20.94	\$ 1,465.80	\$ 1,465.80
65155 00	Surgery	28.59	28.59	\$ 2,001.30	\$ 2,001.30
65175 00	Surgery	23.19	23.19	\$ 1,623.30	\$ 1,623.30
65205 00	Surgery	0.85	0.85	\$ 59.50	\$ 59.50
65210 00	Surgery	1.14	1.05	\$ 79.80	\$ 73.50
65220 00	Surgery	1.77	1.20	\$ 123.90	\$ 84.00
65222 00	Surgery	1.98	1.46	\$ 138.60	\$ 102.20
65235 00	Surgery	21.25	21.25	\$ 1,487.50	\$ 1,487.50
65260 00	Surgery	28.58	28.58	\$ 2,000.60	\$ 2,000.60
65265 00	Surgery	32.17	32.17	\$ 2,251.90	\$ 2,251.90
65270 00	Surgery	8.49	4.07	\$ 594.30	\$ 284.90
65272 00	Surgery	15.62	10.25	\$ 1,093.40	\$ 717.50
65273 00	Surgery	11.02	11.02	\$ 771.40	\$ 771.40
65275 00	Surgery	17.28	13.39	\$ 1,209.60	\$ 937.30
65280 00	Surgery	19.43	19.43	\$ 1,360.10	\$ 1,360.10
65285 00	Surgery	32.03	32.03	\$ 2,242.10	\$ 2,242.10
65286 00	Surgery	20.61	14.37	\$ 1,442.70	\$ 1,005.90
65290 00	Surgery	14.20	14.20	\$ 994.00	\$ 994.00
65400 00	Surgery	20.22	17.44	\$ 1,415.40	\$ 1,220.80
65410 00	Surgery	4.18	2.94	\$ 292.60	\$ 205.80
65420 00	Surgery	15.94	10.98	\$ 1,115.80	\$ 768.60
65426 00	Surgery	19.77	13.82	\$ 1,383.90	\$ 967.40

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
65430 00	Surgery	3.35	2.93	\$ 234.50	\$ 205.10
65435 00	Surgery	2.40	2.00	\$ 168.00	\$ 140.00
65436 00	Surgery	11.25	10.68	\$ 787.50	\$ 747.60
65450 00	Surgery	9.53	9.30	\$ 667.10	\$ 651.00
65600 00	Surgery	12.87	9.82	\$ 900.90	\$ 687.40
65710 00	Surgery	33.22	33.22	\$ 2,325.40	\$ 2,325.40
65730 00	Surgery	36.41	36.41	\$ 2,548.70	\$ 2,548.70
65750 00	Surgery	36.70	36.70	\$ 2,569.00	\$ 2,569.00
65755 00	Surgery	36.53	36.53	\$ 2,557.10	\$ 2,557.10
65756 00	Surgery	34.06	34.06	\$ 2,384.20	\$ 2,384.20
65757 00	Surgery	-	-	\$ 263.90	\$ 263.90
65760 00	Surgery	-	-	\$ 2,410.80	\$ 2,410.80
65765 00	Surgery	-	-	\$ 3,496.50	\$ 3,496.50
65767 00	Surgery	-	-	\$ 3,255.00	\$ 3,255.00
65770 00	Surgery	40.81	40.81	\$ 2,856.70	\$ 2,856.70
65771 00	Surgery	-	-	\$ 1,326.50	\$ 1,326.50
65772 00	Surgery	13.32	11.70	\$ 932.40	\$ 819.00
65775 00	Surgery	16.71	16.71	\$ 1,169.70	\$ 1,169.70
65778 00	Surgery	40.82	1.55	\$ 2,857.40	\$ 108.50
65779 00	Surgery	35.38	4.30	\$ 2,476.60	\$ 301.00
65780 00	Surgery	19.37	19.37	\$ 1,355.90	\$ 1,355.90
65781 00	Surgery	38.38	38.38	\$ 2,686.60	\$ 2,686.60
65782 00	Surgery	33.14	33.14	\$ 2,319.80	\$ 2,319.80
65785 00	Surgery	65.75	12.81	\$ 4,602.50	\$ 896.70
65800 00	Surgery	3.47	2.58	\$ 242.90	\$ 180.60
65810 00	Surgery	13.42	13.42	\$ 939.40	\$ 939.40
65815 00	Surgery	18.93	13.77	\$ 1,325.10	\$ 963.90
65820 00	Surgery	24.22	24.22	\$ 1,695.40	\$ 1,695.40
65850 00	Surgery	24.50	24.50	\$ 1,715.00	\$ 1,715.00
65855 00	Surgery	7.18	5.94	\$ 502.60	\$ 415.80
65860 00	Surgery	8.97	7.17	\$ 627.90	\$ 501.90
65865 00	Surgery	13.89	13.89	\$ 972.30	\$ 972.30
65870 00	Surgery	17.28	17.28	\$ 1,209.60	\$ 1,209.60
65875 00	Surgery	18.42	18.42	\$ 1,289.40	\$ 1,289.40
65880 00	Surgery	19.36	19.36	\$ 1,355.20	\$ 1,355.20
65900 00	Surgery	28.88	28.88	\$ 2,021.60	\$ 2,021.60
65920 00	Surgery	22.98	22.98	\$ 1,608.60	\$ 1,608.60
65930 00	Surgery	18.65	18.65	\$ 1,305.50	\$ 1,305.50
66020 00	Surgery	5.81	3.78	\$ 406.70	\$ 264.60
66030 00	Surgery	5.25	3.21	\$ 367.50	\$ 224.70
66130 00	Surgery	20.76	16.34	\$ 1,453.20	\$ 1,143.80
66150 00	Surgery	25.43	25.43	\$ 1,780.10	\$ 1,780.10
66155 00	Surgery	25.42	25.42	\$ 1,779.40	\$ 1,779.40
66160 00	Surgery	28.59	28.59	\$ 2,001.30	\$ 2,001.30
66170 00	Surgery	31.67	31.67	\$ 2,216.90	\$ 2,216.90
66172 00	Surgery	34.58	34.58	\$ 2,420.60	\$ 2,420.60
66174 00	Surgery	21.99	21.99	\$ 1,539.30	\$ 1,539.30
66175 00	Surgery	23.09	23.09	\$ 1,616.30	\$ 1,616.30
66179 00	Surgery	31.30	31.30	\$ 2,191.00	\$ 2,191.00
66180 00	Surgery	32.99	32.99	\$ 2,309.30	\$ 2,309.30
66183 00	Surgery	29.81	29.81	\$ 2,086.70	\$ 2,086.70
66184 00	Surgery	22.93	22.93	\$ 1,605.10	\$ 1,605.10
66185 00	Surgery	24.65	24.65	\$ 1,725.50	\$ 1,725.50
66225 00	Surgery	27.12	27.12	\$ 1,898.40	\$ 1,898.40

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
66250 00	Surgery	22.20	16.10	\$ 1,554.00	\$ 1,127.00
66500 00	Surgery	11.61	11.61	\$ 812.70	\$ 812.70
66505 00	Surgery	12.62	12.62	\$ 883.40	\$ 883.40
66600 00	Surgery	26.60	26.60	\$ 1,862.00	\$ 1,862.00
66605 00	Surgery	31.77	31.77	\$ 2,223.90	\$ 2,223.90
66625 00	Surgery	12.41	12.41	\$ 868.70	\$ 868.70
66630 00	Surgery	16.40	16.40	\$ 1,148.00	\$ 1,148.00
66635 00	Surgery	16.56	16.56	\$ 1,159.20	\$ 1,159.20
66680 00	Surgery	15.15	15.15	\$ 1,060.50	\$ 1,060.50
66682 00	Surgery	21.01	21.01	\$ 1,470.70	\$ 1,470.70
66700 00	Surgery	13.18	11.33	\$ 922.60	\$ 793.10
66710 00	Surgery	12.92	11.33	\$ 904.40	\$ 793.10
66711 00	Surgery	14.64	14.64	\$ 1,024.80	\$ 1,024.80
66720 00	Surgery	13.60	11.86	\$ 952.00	\$ 830.20
66740 00	Surgery	12.81	11.33	\$ 896.70	\$ 793.10
66761 00	Surgery	8.77	6.85	\$ 613.90	\$ 479.50
66762 00	Surgery	13.91	12.28	\$ 973.70	\$ 859.60
66770 00	Surgery	15.41	13.89	\$ 1,078.70	\$ 972.30
66820 00	Surgery	13.95	13.95	\$ 976.50	\$ 976.50
66821 00	Surgery	9.75	9.04	\$ 682.50	\$ 632.80
66825 00	Surgery	24.51	24.51	\$ 1,715.70	\$ 1,715.70
66830 00	Surgery	20.54	20.54	\$ 1,437.80	\$ 1,437.80
66840 00	Surgery	20.06	20.06	\$ 1,404.20	\$ 1,404.20
66850 00	Surgery	22.79	22.79	\$ 1,595.30	\$ 1,595.30
66852 00	Surgery	24.28	24.28	\$ 1,699.60	\$ 1,699.60
66920 00	Surgery	21.65	21.65	\$ 1,515.50	\$ 1,515.50
66930 00	Surgery	24.82	24.82	\$ 1,737.40	\$ 1,737.40
66940 00	Surgery	22.71	22.71	\$ 1,589.70	\$ 1,589.70
66982 00	Surgery	21.56	21.56	\$ 1,509.20	\$ 1,509.20
66983 00	Surgery	-	-	\$ 1,570.10	\$ 1,570.10
66984 00	Surgery	15.74	15.74	\$ 1,101.80	\$ 1,101.80
66985 00	Surgery	22.27	22.27	\$ 1,558.90	\$ 1,558.90
66986 00	Surgery	26.14	26.14	\$ 1,829.80	\$ 1,829.80
66987 00	Surgery	-	-	\$ 1,712.20	\$ 1,712.20
66988 00	Surgery	-	-	\$ 1,472.80	\$ 1,472.80
66989 00	Surgery	24.75	24.75	\$ 1,732.50	\$ 1,732.50
66990 00	Surgery	2.55	2.55	\$ 178.50	\$ 178.50
66991 00	Surgery	19.75	19.75	\$ 1,382.50	\$ 1,382.50
66999 00	Surgery	0.00	0.00	BR	BR
67005 00	Surgery	13.72	13.72	\$ 960.40	\$ 960.40
67010 00	Surgery	15.72	15.72	\$ 1,100.40	\$ 1,100.40
67015 00	Surgery	17.64	17.64	\$ 1,234.80	\$ 1,234.80
67025 00	Surgery	21.70	18.23	\$ 1,519.00	\$ 1,276.10
67027 00	Surgery	24.52	24.52	\$ 1,716.40	\$ 1,716.40
67028 00	Surgery	3.30	2.65	\$ 231.00	\$ 185.50
67030 00	Surgery	16.24	16.24	\$ 1,136.80	\$ 1,136.80
67031 00	Surgery	11.37	10.26	\$ 795.90	\$ 718.20
67036 00	Surgery	25.93	25.93	\$ 1,815.10	\$ 1,815.10
67039 00	Surgery	27.72	27.72	\$ 1,940.40	\$ 1,940.40
67040 00	Surgery	29.93	29.93	\$ 2,095.10	\$ 2,095.10
67041 00	Surgery	33.03	33.03	\$ 2,312.10	\$ 2,312.10
67042 00	Surgery	33.03	33.03	\$ 2,312.10	\$ 2,312.10
67043 00	Surgery	34.83	34.83	\$ 2,438.10	\$ 2,438.10
67101 00	Surgery	9.74	8.20	\$ 681.80	\$ 574.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
67105 00	Surgery	8.61	7.94	\$ 602.70	\$ 555.80
67107 00	Surgery	32.48	32.48	\$ 2,273.60	\$ 2,273.60
67108 00	Surgery	34.38	34.38	\$ 2,406.60	\$ 2,406.60
67110 00	Surgery	25.96	23.51	\$ 1,817.20	\$ 1,645.70
67113 00	Surgery	38.43	38.43	\$ 2,690.10	\$ 2,690.10
67115 00	Surgery	14.40	14.40	\$ 1,008.00	\$ 1,008.00
67120 00	Surgery	19.67	16.06	\$ 1,376.90	\$ 1,124.20
67121 00	Surgery	26.12	26.12	\$ 1,828.40	\$ 1,828.40
67141 00	Surgery	7.88	6.27	\$ 551.60	\$ 438.90
67145 00	Surgery	7.06	6.27	\$ 494.20	\$ 438.90
67208 00	Surgery	17.50	16.70	\$ 1,225.00	\$ 1,169.00
67210 00	Surgery	14.99	14.41	\$ 1,049.30	\$ 1,008.70
67218 00	Surgery	40.39	40.39	\$ 2,827.30	\$ 2,827.30
67220 00	Surgery	15.44	14.41	\$ 1,080.80	\$ 1,008.70
67221 00	Surgery	7.94	6.02	\$ 555.80	\$ 421.40
67225 00	Surgery	0.85	0.80	\$ 59.50	\$ 56.00
67227 00	Surgery	8.58	7.33	\$ 600.60	\$ 513.10
67228 00	Surgery	9.87	8.77	\$ 690.90	\$ 613.90
67229 00	Surgery	33.49	33.49	\$ 2,344.30	\$ 2,344.30
67250 00	Surgery	26.81	26.81	\$ 1,876.70	\$ 1,876.70
67255 00	Surgery	19.95	19.95	\$ 1,396.50	\$ 1,396.50
67299 00	Surgery	0.00	0.00	BR	BR
67311 00	Surgery	13.98	13.98	\$ 978.60	\$ 978.60
67312 00	Surgery	19.24	19.24	\$ 1,346.80	\$ 1,346.80
67314 00	Surgery	16.00	16.00	\$ 1,120.00	\$ 1,120.00
67316 00	Surgery	20.58	20.58	\$ 1,440.60	\$ 1,440.60
67318 00	Surgery	19.91	19.91	\$ 1,393.70	\$ 1,393.70
67320 00	Surgery	7.39	7.39	\$ 517.30	\$ 517.30
67331 00	Surgery	7.02	7.02	\$ 491.40	\$ 491.40
67332 00	Surgery	7.61	7.61	\$ 532.70	\$ 532.70
67334 00	Surgery	6.92	6.92	\$ 484.40	\$ 484.40
67335 00	Surgery	5.44	5.44	\$ 380.80	\$ 380.80
67340 00	Surgery	8.47	8.47	\$ 592.90	\$ 592.90
67343 00	Surgery	19.42	19.42	\$ 1,359.40	\$ 1,359.40
67345 00	Surgery	7.10	6.28	\$ 497.00	\$ 439.60
67346 00	Surgery	5.50	5.50	\$ 385.00	\$ 385.00
67399 00	Surgery	0.00	0.00	BR	BR
67400 00	Surgery	30.67	30.67	\$ 2,146.90	\$ 2,146.90
67405 00	Surgery	26.80	26.80	\$ 1,876.00	\$ 1,876.00
67412 00	Surgery	29.52	29.52	\$ 2,066.40	\$ 2,066.40
67413 00	Surgery	28.62	28.62	\$ 2,003.40	\$ 2,003.40
67414 00	Surgery	43.29	43.29	\$ 3,030.30	\$ 3,030.30
67415 00	Surgery	2.96	2.96	\$ 207.20	\$ 207.20
67420 00	Surgery	51.37	51.37	\$ 3,595.90	\$ 3,595.90
67430 00	Surgery	40.98	40.98	\$ 2,868.60	\$ 2,868.60
67440 00	Surgery	39.79	39.79	\$ 2,785.30	\$ 2,785.30
67445 00	Surgery	45.05	45.05	\$ 3,153.50	\$ 3,153.50
67450 00	Surgery	41.17	41.17	\$ 2,881.90	\$ 2,881.90
67500 00	Surgery	2.22	1.82	\$ 155.40	\$ 127.40
67505 00	Surgery	2.53	2.09	\$ 177.10	\$ 146.30
67515 00	Surgery	1.52	1.37	\$ 106.40	\$ 95.90
67550 00	Surgery	32.10	32.10	\$ 2,247.00	\$ 2,247.00
67560 00	Surgery	32.78	32.78	\$ 2,294.60	\$ 2,294.60
67570 00	Surgery	40.88	40.88	\$ 2,861.60	\$ 2,861.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
67599 00	Surgery	0.00	0.00	BR	BR
67700 00	Surgery	8.57	3.36	\$ 599.90	\$ 235.20
67710 00	Surgery	7.32	2.83	\$ 512.40	\$ 198.10
67715 00	Surgery	7.95	3.14	\$ 556.50	\$ 219.80
67800 00	Surgery	3.76	2.96	\$ 263.20	\$ 207.20
67801 00	Surgery	4.75	3.80	\$ 332.50	\$ 266.00
67805 00	Surgery	5.94	4.74	\$ 415.80	\$ 331.80
67808 00	Surgery	10.64	10.64	\$ 744.80	\$ 744.80
67810 00	Surgery	5.55	1.98	\$ 388.50	\$ 138.60
67820 00	Surgery	0.56	0.64	\$ 39.20	\$ 44.80
67825 00	Surgery	3.97	3.52	\$ 277.90	\$ 246.40
67830 00	Surgery	8.06	3.95	\$ 564.20	\$ 276.50
67835 00	Surgery	12.76	12.76	\$ 893.20	\$ 893.20
67840 00	Surgery	8.39	4.56	\$ 587.30	\$ 319.20
67850 00	Surgery	6.41	3.76	\$ 448.70	\$ 263.20
67875 00	Surgery	5.43	2.75	\$ 380.10	\$ 192.50
67880 00	Surgery	13.76	10.64	\$ 963.20	\$ 744.80
67882 00	Surgery	16.78	13.60	\$ 1,174.60	\$ 952.00
67900 00	Surgery	19.12	14.64	\$ 1,338.40	\$ 1,024.80
67901 00	Surgery	23.51	17.11	\$ 1,645.70	\$ 1,197.70
67902 00	Surgery	21.04	21.04	\$ 1,472.80	\$ 1,472.80
67903 00	Surgery	17.77	13.91	\$ 1,243.90	\$ 973.70
67904 00	Surgery	21.78	17.22	\$ 1,524.60	\$ 1,205.40
67906 00	Surgery	14.61	14.61	\$ 1,022.70	\$ 1,022.70
67908 00	Surgery	15.97	12.51	\$ 1,117.90	\$ 875.70
67909 00	Surgery	16.20	12.70	\$ 1,134.00	\$ 889.00
67911 00	Surgery	16.17	16.17	\$ 1,131.90	\$ 1,131.90
67912 00	Surgery	27.16	14.11	\$ 1,901.20	\$ 987.70
67914 00	Surgery	14.52	9.49	\$ 1,016.40	\$ 664.30
67915 00	Surgery	9.44	5.75	\$ 660.80	\$ 402.50
67916 00	Surgery	18.10	12.42	\$ 1,267.00	\$ 869.40
67917 00	Surgery	18.49	13.20	\$ 1,294.30	\$ 924.00
67921 00	Surgery	14.21	8.99	\$ 994.70	\$ 629.30
67922 00	Surgery	9.14	5.76	\$ 639.80	\$ 403.20
67923 00	Surgery	18.09	12.41	\$ 1,266.30	\$ 868.70
67924 00	Surgery	19.25	13.18	\$ 1,347.50	\$ 922.60
67930 00	Surgery	10.95	6.83	\$ 766.50	\$ 478.10
67935 00	Surgery	17.65	12.75	\$ 1,235.50	\$ 892.50
67938 00	Surgery	8.20	3.40	\$ 574.00	\$ 238.00
67950 00	Surgery	17.25	13.39	\$ 1,207.50	\$ 937.30
67961 00	Surgery	17.30	13.12	\$ 1,211.00	\$ 918.40
67966 00	Surgery	22.82	18.91	\$ 1,597.40	\$ 1,323.70
67971 00	Surgery	20.82	20.82	\$ 1,457.40	\$ 1,457.40
67973 00	Surgery	26.73	26.73	\$ 1,871.10	\$ 1,871.10
67974 00	Surgery	26.67	26.67	\$ 1,866.90	\$ 1,866.90
67975 00	Surgery	19.71	19.71	\$ 1,379.70	\$ 1,379.70
67999 00	Surgery	0.00	0.00	BR	BR
68020 00	Surgery	3.54	3.20	\$ 247.80	\$ 224.00
68040 00	Surgery	1.81	1.38	\$ 126.70	\$ 96.60
68100 00	Surgery	5.38	2.75	\$ 376.60	\$ 192.50
68110 00	Surgery	7.00	4.26	\$ 490.00	\$ 298.20
68115 00	Surgery	9.93	5.29	\$ 695.10	\$ 370.30
68130 00	Surgery	16.31	11.93	\$ 1,141.70	\$ 835.10
68135 00	Surgery	4.56	4.30	\$ 319.20	\$ 301.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
68200 00	Surgery	1.22	0.99	\$ 85.40	\$ 69.30
68320 00	Surgery	21.94	15.61	\$ 1,535.80	\$ 1,092.70
68325 00	Surgery	18.94	18.94	\$ 1,325.80	\$ 1,325.80
68326 00	Surgery	18.60	18.60	\$ 1,302.00	\$ 1,302.00
68328 00	Surgery	20.42	20.42	\$ 1,429.40	\$ 1,429.40
68330 00	Surgery	18.37	13.27	\$ 1,285.90	\$ 928.90
68335 00	Surgery	18.65	18.65	\$ 1,305.50	\$ 1,305.50
68340 00	Surgery	17.92	11.51	\$ 1,254.40	\$ 805.70
68360 00	Surgery	16.01	11.85	\$ 1,120.70	\$ 829.50
68362 00	Surgery	18.90	18.90	\$ 1,323.00	\$ 1,323.00
68371 00	Surgery	11.94	11.94	\$ 835.80	\$ 835.80
68399 00	Surgery	0.00	0.00	BR	BR
68400 00	Surgery	8.87	3.76	\$ 620.90	\$ 263.20
68420 00	Surgery	9.94	4.82	\$ 695.80	\$ 337.40
68440 00	Surgery	3.04	2.89	\$ 212.80	\$ 202.30
68500 00	Surgery	31.13	31.13	\$ 2,179.10	\$ 2,179.10
68505 00	Surgery	30.99	30.99	\$ 2,169.30	\$ 2,169.30
68510 00	Surgery	13.39	8.27	\$ 937.30	\$ 578.90
68520 00	Surgery	21.63	21.63	\$ 1,514.10	\$ 1,514.10
68525 00	Surgery	7.49	7.49	\$ 524.30	\$ 524.30
68530 00	Surgery	12.89	7.31	\$ 902.30	\$ 511.70
68540 00	Surgery	28.77	28.77	\$ 2,013.90	\$ 2,013.90
68550 00	Surgery	35.85	35.85	\$ 2,509.50	\$ 2,509.50
68700 00	Surgery	17.42	17.42	\$ 1,219.40	\$ 1,219.40
68705 00	Surgery	7.82	4.79	\$ 547.40	\$ 335.30
68720 00	Surgery	23.73	23.73	\$ 1,661.10	\$ 1,661.10
68745 00	Surgery	23.84	23.84	\$ 1,668.80	\$ 1,668.80
68750 00	Surgery	25.24	25.24	\$ 1,766.80	\$ 1,766.80
68760 00	Surgery	6.54	4.19	\$ 457.80	\$ 293.30
68761 00	Surgery	4.34	3.41	\$ 303.80	\$ 238.70
68770 00	Surgery	18.13	18.13	\$ 1,269.10	\$ 1,269.10
68801 00	Surgery	2.83	2.27	\$ 198.10	\$ 158.90
68810 00	Surgery	4.74	3.68	\$ 331.80	\$ 257.60
68811 00	Surgery	3.88	3.88	\$ 271.60	\$ 271.60
68815 00	Surgery	11.22	6.42	\$ 785.40	\$ 449.40
68816 00	Surgery	26.25	4.55	\$ 1,837.50	\$ 318.50
68840 00	Surgery	3.90	3.38	\$ 273.00	\$ 236.60
68841 00	Surgery	1.11	0.94	\$ 77.70	\$ 65.80
68850 00	Surgery	1.75	1.52	\$ 122.50	\$ 106.40
68899 00	Surgery	0.00	0.00	BR	BR
69000 00	Surgery	5.60	3.67	\$ 392.00	\$ 256.90
69005 00	Surgery	6.57	4.74	\$ 459.90	\$ 331.80
69020 00	Surgery	7.08	4.27	\$ 495.60	\$ 298.90
69090 00	Surgery	-	-	\$ 64.40	\$ 64.40
69100 00	Surgery	2.88	1.36	\$ 201.60	\$ 95.20
69105 00	Surgery	4.39	1.84	\$ 307.30	\$ 128.80
69110 00	Surgery	14.16	9.78	\$ 991.20	\$ 684.60
69120 00	Surgery	11.70	11.70	\$ 819.00	\$ 819.00
69140 00	Surgery	27.26	27.26	\$ 1,908.20	\$ 1,908.20
69145 00	Surgery	12.43	7.67	\$ 870.10	\$ 536.90
69150 00	Surgery	30.24	30.24	\$ 2,116.80	\$ 2,116.80
69155 00	Surgery	48.47	48.47	\$ 3,392.90	\$ 3,392.90
69200 00	Surgery	2.38	1.39	\$ 166.60	\$ 97.30
69205 00	Surgery	2.80	2.80	\$ 196.00	\$ 196.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
69209 00	Surgery	0.45	0.45	\$ 31.50	\$ 31.50
69210 00	Surgery	1.40	0.97	\$ 98.00	\$ 67.90
69220 00	Surgery	2.29	1.49	\$ 160.30	\$ 104.30
69222 00	Surgery	6.50	4.05	\$ 455.00	\$ 283.50
69300 00	Surgery	19.39	13.82	\$ 1,357.30	\$ 967.40
69310 00	Surgery	33.77	33.77	\$ 2,363.90	\$ 2,363.90
69320 00	Surgery	46.98	46.98	\$ 3,288.60	\$ 3,288.60
69399 00	Surgery	0.00	0.00	BR	BR
69420 00	Surgery	5.72	3.55	\$ 400.40	\$ 248.50
69421 00	Surgery	4.50	4.50	\$ 315.00	\$ 315.00
69424 00	Surgery	3.88	1.77	\$ 271.60	\$ 123.90
69433 00	Surgery	6.04	3.89	\$ 422.80	\$ 272.30
69436 00	Surgery	4.72	4.72	\$ 330.40	\$ 330.40
69440 00	Surgery	20.76	20.76	\$ 1,453.20	\$ 1,453.20
69450 00	Surgery	16.51	16.51	\$ 1,155.70	\$ 1,155.70
69501 00	Surgery	21.28	21.28	\$ 1,489.60	\$ 1,489.60
69502 00	Surgery	28.21	28.21	\$ 1,974.70	\$ 1,974.70
69505 00	Surgery	37.01	37.01	\$ 2,590.70	\$ 2,590.70
69511 00	Surgery	37.86	37.86	\$ 2,650.20	\$ 2,650.20
69530 00	Surgery	50.33	50.33	\$ 3,523.10	\$ 3,523.10
69535 00	Surgery	79.69	79.69	\$ 5,578.30	\$ 5,578.30
69540 00	Surgery	6.38	3.87	\$ 446.60	\$ 270.90
69550 00	Surgery	32.04	32.04	\$ 2,242.80	\$ 2,242.80
69552 00	Surgery	47.64	47.64	\$ 3,334.80	\$ 3,334.80
69554 00	Surgery	75.56	75.56	\$ 5,289.20	\$ 5,289.20
69601 00	Surgery	30.50	30.50	\$ 2,135.00	\$ 2,135.00
69602 00	Surgery	32.64	32.64	\$ 2,284.80	\$ 2,284.80
69603 00	Surgery	38.66	38.66	\$ 2,706.20	\$ 2,706.20
69604 00	Surgery	33.34	33.34	\$ 2,333.80	\$ 2,333.80
69610 00	Surgery	11.43	8.49	\$ 800.10	\$ 594.30
69620 00	Surgery	22.37	14.74	\$ 1,565.90	\$ 1,031.80
69631 00	Surgery	26.71	26.71	\$ 1,869.70	\$ 1,869.70
69632 00	Surgery	32.59	32.59	\$ 2,281.30	\$ 2,281.30
69633 00	Surgery	31.56	31.56	\$ 2,209.20	\$ 2,209.20
69635 00	Surgery	38.18	38.18	\$ 2,672.60	\$ 2,672.60
69636 00	Surgery	42.41	42.41	\$ 2,968.70	\$ 2,968.70
69637 00	Surgery	43.25	43.25	\$ 3,027.50	\$ 3,027.50
69641 00	Surgery	31.28	31.28	\$ 2,189.60	\$ 2,189.60
69642 00	Surgery	40.13	40.13	\$ 2,809.10	\$ 2,809.10
69643 00	Surgery	36.72	36.72	\$ 2,570.40	\$ 2,570.40
69644 00	Surgery	45.31	45.31	\$ 3,171.70	\$ 3,171.70
69645 00	Surgery	44.59	44.59	\$ 3,121.30	\$ 3,121.30
69646 00	Surgery	47.19	47.19	\$ 3,303.30	\$ 3,303.30
69650 00	Surgery	24.11	24.11	\$ 1,687.70	\$ 1,687.70
69660 00	Surgery	27.70	27.70	\$ 1,939.00	\$ 1,939.00
69661 00	Surgery	36.00	36.00	\$ 2,520.00	\$ 2,520.00
69662 00	Surgery	34.64	34.64	\$ 2,424.80	\$ 2,424.80
69666 00	Surgery	24.24	24.24	\$ 1,696.80	\$ 1,696.80
69667 00	Surgery	24.25	24.25	\$ 1,697.50	\$ 1,697.50
69670 00	Surgery	28.38	28.38	\$ 1,986.60	\$ 1,986.60
69676 00	Surgery	25.05	25.05	\$ 1,753.50	\$ 1,753.50
69700 00	Surgery	19.93	19.93	\$ 1,395.10	\$ 1,395.10
69705 00	Surgery	85.01	5.11	\$ 5,950.70	\$ 357.70
69706 00	Surgery	87.75	7.14	\$ 6,142.50	\$ 499.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
69710 00	Surgery	0.00	0.00	BR	BR
69711 00	Surgery	25.12	25.12	\$ 1,758.40	\$ 1,758.40
69714 00	Surgery	19.23	19.23	\$ 1,346.10	\$ 1,346.10
69716 00	Surgery	17.98	17.98	\$ 1,258.60	\$ 1,258.60
69717 00	Surgery	19.40	19.40	\$ 1,358.00	\$ 1,358.00
69719 00	Surgery	17.98	17.98	\$ 1,258.60	\$ 1,258.60
69720 00	Surgery	35.56	35.56	\$ 2,489.20	\$ 2,489.20
69725 00	Surgery	55.66	55.66	\$ 3,896.20	\$ 3,896.20
69726 00	Surgery	12.24	12.24	\$ 856.80	\$ 856.80
69727 00	Surgery	14.00	14.00	\$ 980.00	\$ 980.00
69740 00	Surgery	34.65	34.65	\$ 2,425.50	\$ 2,425.50
69745 00	Surgery	36.95	36.95	\$ 2,586.50	\$ 2,586.50
69799 00	Surgery	0.00	0.00	BR	BR
69801 00	Surgery	6.83	3.65	\$ 478.10	\$ 255.50
69805 00	Surgery	30.66	30.66	\$ 2,146.20	\$ 2,146.20
69806 00	Surgery	27.56	27.56	\$ 1,929.20	\$ 1,929.20
69905 00	Surgery	27.55	27.55	\$ 1,928.50	\$ 1,928.50
69910 00	Surgery	29.60	29.60	\$ 2,072.00	\$ 2,072.00
69915 00	Surgery	44.75	44.75	\$ 3,132.50	\$ 3,132.50
69930 00	Surgery	36.29	36.29	\$ 2,540.30	\$ 2,540.30
69949 00	Surgery	0.00	0.00	BR	BR
69950 00	Surgery	51.80	51.80	\$ 3,626.00	\$ 3,626.00
69955 00	Surgery	58.53	58.53	\$ 4,097.10	\$ 4,097.10
69960 00	Surgery	56.00	56.00	\$ 3,920.00	\$ 3,920.00
69970 00	Surgery	63.27	63.27	\$ 4,428.90	\$ 4,428.90
69979 00	Surgery	0.00	0.00	BR	BR
69990 00	Surgery	6.40	6.40	\$ 448.00	\$ 448.00

Historical Note

New Appendix A, Surgery Codes 2019-2020 made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Surgery Codes 2019-2020 will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Surgery Codes 2019-2020 repealed; new Appendix A, Surgery Codes 2020-2021 made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Surgery Codes 2020-2021 repealed; new Appendix A, Surgery Codes 2021-2022 made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Surgery Codes 2021-2022 repealed; new Surgery Codes 2022-2023 made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

RADIOLOGY GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2022 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT® are preceded by an AZ identifier and numbered in the following format: AZxxx. Additional information regarding publications (e.g., CMS Guidelines) adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to CMS and CPT® guidelines and represent additional guidance from the Commission relative to unit values for these services. To the extent that a conflict may exist between an adopted portion of the CPT® and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

A. GENERAL GUIDELINES

1. Values include usual contrast media, equipment, and materials. An additional charge may be warranted when special surgical trays and materials are provided by the healthcare provider.
2. Values include consultation and written reports to the referring healthcare provider.
3. X-ray findings and attending healthcare provider's written order for x-rays must be included with statement for x-ray services. Bills unsupported by findings will not be paid.
4. X-rays should be taken, reported, and be properly marked for identification and orientation in accordance with the accepted standard of radiologic practice in the State of Arizona.

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CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

B. MODIFIERS

Modifiers identify circumstances that alter or enhance the description of the service. For radiology codes, two modifiers affect the assigned unit value and are listed in *The Essential RBRVS*. However, other modifiers may be required for correct reporting of service. See CMS and the 2022 CPT® publication for additional information on modifiers. Listed radiology modifiers affect the unit values as follows:

1. Total: When no modifier is listed, the unit value represents the global value of the procedure. The five-digit code is used to represent a global service inclusive of professional and technical value of providing that service. The following sections provide additional definitions for each component.
2. Professional: Modifier 26 is used to designate professional services. The professional component includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the examination, and consultation with referring healthcare providers.
3. Technical: Modifier TC is used to designate the technical value of providing the service. The technical component includes personnel, materials, space, equipment, and other allocated facility overhead normally included in providing the service. Note that modifier TC is not CPT® compatible.

C. REFERENCE TO RELATIVE VALUES

Two patterns of billing currently prevail in radiology. A total charge for the radiology service, to include both professional fees and technical costs, is made by radiologists working in offices, clinics and, under some circumstances, in hospital or ambulatory surgery center x-ray departments.

In a majority of voluntary hospital or ambulatory surgery center radiology departments, the radiologist submits a separate statement to the patient for his professional services. The hospital or ambulatory surgery center charges for use of the department facilities and the services of its employees. This pattern is similar to the charges made by the hospital or ambulatory surgery center for the use of delivery rooms or surgical suites. Such charges are entirely separate from the fees charged by obstetricians and surgeons. In most separate radiology billing situations, the total will approximate the amount billed singly by the radiologist in their office or billed singly by the hospital or ambulatory surgery center.

The two separate scales in Radiology Relative Values have been devised for use in radiology and are not coordinated with scales for services in other branches of medicine such as surgery, medicine or pathology. The two scales are compatible only within themselves. Within each of the two separate headings, the total dollar value and the PC or professional components dollar value, where appropriate, can be used. Some procedures are noted as a "BR" value or "By Report". This usage is intended to indicate that circumstances involving a given patient procedure may require much more than the average amount of time and effort to perform and thus a value would be unique and could not be anticipated or established. When such added involvement is claimed, a written explanation will usually be required as an addendum to the bill.

The PC values do not include charges made by the hospital in which the procedure was accomplished. Such charges by the hospital or ambulatory surgery center cover the services of technologists and other helpers, the films, contrast media, radioactive agents, chemical and other materials, the use of the space and facilities of the x-ray department plus any other hospital or ambulatory surgery center costs. Most hospitals or ambulatory surgery centers have derived their own schedule of charges of these items. Establishment of hospital or ambulatory surgery center charges is not the subject of the Fee Schedule.

The separation of billing in no way implies a division of responsibility, but only a division of the charge. The radiologist is a physician performing a needed medical service for a patient, and he must retain full responsibility for his own activity and also full responsibility for the supervision of technologists, the selection and maintenance of equipment, the control of radiation hazards and the general administration of the radiology department.

D. REVIEW OF DIAGNOSTIC STUDIES

No separate charge is warranted for prior studies reviewed in conjunction with a visit, consultation, record review, or other evaluation by a healthcare provider; neither the professional component value modifier 26 nor the radiological consultation CPT® code 76140 is reimbursable. The review of diagnostic tests is included in the evaluation and management codes.

Historical Note

New Appendix A. Radiology Guidelines made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A. Radiology Guidelines will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Radiology Guidelines repealed; new Appendix A, Radiology Guidelines made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Radiology Guidelines repealed; new Appendix A, Radiology Guidelines made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Radiology Guidelines repealed; new Radiology Guidelines made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

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CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

ARIZONA PHYSICIANS' FEE SCHEDULE
Radiology Codes 2022
Radiology Conversion Factor \$70.00

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
70010 00	Radiology	1.72	1.72	\$ 120.40	\$ 120.40
70015 00	Radiology	5.12	5.12	\$ 358.40	\$ 358.40
70015 26	Radiology	1.69	1.69	\$ 118.30	\$ 118.30
70015 TC	Radiology	3.43	3.43	\$ 240.10	\$ 240.10
70030 00	Radiology	0.97	0.97	\$ 67.90	\$ 67.90
70030 26	Radiology	0.26	0.26	\$ 18.20	\$ 18.20
70030 TC	Radiology	0.71	0.71	\$ 49.70	\$ 49.70
70100 00	Radiology	1.15	1.15	\$ 80.50	\$ 80.50
70100 26	Radiology	0.26	0.26	\$ 18.20	\$ 18.20
70100 TC	Radiology	0.89	0.89	\$ 62.30	\$ 62.30
70110 00	Radiology	1.31	1.31	\$ 91.70	\$ 91.70
70110 26	Radiology	0.35	0.35	\$ 24.50	\$ 24.50
70110 TC	Radiology	0.96	0.96	\$ 67.20	\$ 67.20
70120 00	Radiology	1.16	1.16	\$ 81.20	\$ 81.20
70120 26	Radiology	0.26	0.26	\$ 18.20	\$ 18.20
70120 TC	Radiology	0.90	0.90	\$ 63.00	\$ 63.00
70130 00	Radiology	1.88	1.88	\$ 131.60	\$ 131.60
70130 26	Radiology	0.49	0.49	\$ 34.30	\$ 34.30
70130 TC	Radiology	1.39	1.39	\$ 97.30	\$ 97.30
70134 00	Radiology	1.84	1.84	\$ 128.80	\$ 128.80
70134 26	Radiology	0.51	0.51	\$ 35.70	\$ 35.70
70134 TC	Radiology	1.33	1.33	\$ 93.10	\$ 93.10
70140 00	Radiology	0.96	0.96	\$ 67.20	\$ 67.20
70140 26	Radiology	0.29	0.29	\$ 20.30	\$ 20.30
70140 TC	Radiology	0.67	0.67	\$ 46.90	\$ 46.90
70150 00	Radiology	1.42	1.42	\$ 99.40	\$ 99.40
70150 26	Radiology	0.37	0.37	\$ 25.90	\$ 25.90
70150 TC	Radiology	1.05	1.05	\$ 73.50	\$ 73.50
70160 00	Radiology	1.14	1.14	\$ 79.80	\$ 79.80
70160 26	Radiology	0.25	0.25	\$ 17.50	\$ 17.50
70160 TC	Radiology	0.89	0.89	\$ 62.30	\$ 62.30
70170 00	Radiology	-	-	\$ 101.50	\$ 101.50
70170 26	Radiology	0.42	0.42	\$ 29.40	\$ 29.40
70170 TC	Radiology	-	-	\$ 72.10	\$ 72.10
70190 00	Radiology	1.14	1.14	\$ 79.80	\$ 79.80
70190 26	Radiology	0.32	0.32	\$ 22.40	\$ 22.40
70190 TC	Radiology	0.82	0.82	\$ 57.40	\$ 57.40
70200 00	Radiology	1.45	1.45	\$ 101.50	\$ 101.50
70200 26	Radiology	0.40	0.40	\$ 28.00	\$ 28.00
70200 TC	Radiology	1.05	1.05	\$ 73.50	\$ 73.50
70210 00	Radiology	0.97	0.97	\$ 67.90	\$ 67.90
70210 26	Radiology	0.25	0.25	\$ 17.50	\$ 17.50
70210 TC	Radiology	0.72	0.72	\$ 50.40	\$ 50.40
70220 00	Radiology	1.13	1.13	\$ 79.10	\$ 79.10
70220 26	Radiology	0.31	0.31	\$ 21.70	\$ 21.70
70220 TC	Radiology	0.82	0.82	\$ 57.40	\$ 57.40
70240 00	Radiology	0.99	0.99	\$ 69.30	\$ 69.30
70240 26	Radiology	0.27	0.27	\$ 18.90	\$ 18.90
70240 TC	Radiology	0.72	0.72	\$ 50.40	\$ 50.40
70250 00	Radiology	1.07	1.07	\$ 74.90	\$ 74.90
70250 26	Radiology	0.26	0.26	\$ 18.20	\$ 18.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
70250 TC	Radiology	0.81	0.81	\$ 56.70	\$ 56.70
70260 00	Radiology	1.34	1.34	\$ 93.80	\$ 93.80
70260 26	Radiology	0.40	0.40	\$ 28.00	\$ 28.00
70260 TC	Radiology	0.94	0.94	\$ 65.80	\$ 65.80
70300 00	Radiology	0.38	0.38	\$ 26.60	\$ 26.60
70300 26	Radiology	0.15	0.15	\$ 10.50	\$ 10.50
70300 TC	Radiology	0.23	0.23	\$ 16.10	\$ 16.10
70310 00	Radiology	1.14	1.14	\$ 79.80	\$ 79.80
70310 26	Radiology	0.23	0.23	\$ 16.10	\$ 16.10
70310 TC	Radiology	0.91	0.91	\$ 63.70	\$ 63.70
70320 00	Radiology	1.63	1.63	\$ 114.10	\$ 114.10
70320 26	Radiology	0.32	0.32	\$ 22.40	\$ 22.40
70320 TC	Radiology	1.31	1.31	\$ 91.70	\$ 91.70
70328 00	Radiology	1.04	1.04	\$ 72.80	\$ 72.80
70328 26	Radiology	0.26	0.26	\$ 18.20	\$ 18.20
70328 TC	Radiology	0.78	0.78	\$ 54.60	\$ 54.60
70330 00	Radiology	1.60	1.60	\$ 112.00	\$ 112.00
70330 26	Radiology	0.34	0.34	\$ 23.80	\$ 23.80
70330 TC	Radiology	1.26	1.26	\$ 88.20	\$ 88.20
70332 00	Radiology	2.58	2.58	\$ 180.60	\$ 180.60
70332 26	Radiology	0.78	0.78	\$ 54.60	\$ 54.60
70332 TC	Radiology	1.80	1.80	\$ 126.00	\$ 126.00
70336 00	Radiology	8.42	8.42	\$ 589.40	\$ 589.40
70336 26	Radiology	2.08	2.08	\$ 145.60	\$ 145.60
70336 TC	Radiology	6.34	6.34	\$ 443.80	\$ 443.80
70350 00	Radiology	0.48	0.48	\$ 33.60	\$ 33.60
70350 26	Radiology	0.25	0.25	\$ 17.50	\$ 17.50
70350 TC	Radiology	0.23	0.23	\$ 16.10	\$ 16.10
70355 00	Radiology	0.53	0.53	\$ 37.10	\$ 37.10
70355 26	Radiology	0.29	0.29	\$ 20.30	\$ 20.30
70355 TC	Radiology	0.24	0.24	\$ 16.80	\$ 16.80
70360 00	Radiology	0.94	0.94	\$ 65.80	\$ 65.80
70360 26	Radiology	0.26	0.26	\$ 18.20	\$ 18.20
70360 TC	Radiology	0.68	0.68	\$ 47.60	\$ 47.60
70370 00	Radiology	3.09	3.09	\$ 216.30	\$ 216.30
70370 26	Radiology	0.44	0.44	\$ 30.80	\$ 30.80
70370 TC	Radiology	2.65	2.65	\$ 185.50	\$ 185.50
70371 00	Radiology	3.13	3.13	\$ 219.10	\$ 219.10
70371 26	Radiology	1.19	1.19	\$ 83.30	\$ 83.30
70371 TC	Radiology	1.94	1.94	\$ 135.80	\$ 135.80
70380 00	Radiology	1.13	1.13	\$ 79.10	\$ 79.10
70380 26	Radiology	0.24	0.24	\$ 16.80	\$ 16.80
70380 TC	Radiology	0.89	0.89	\$ 62.30	\$ 62.30
70390 00	Radiology	3.61	3.61	\$ 252.70	\$ 252.70
70390 26	Radiology	0.54	0.54	\$ 37.80	\$ 37.80
70390 TC	Radiology	3.07	3.07	\$ 214.90	\$ 214.90
70450 00	Radiology	3.27	3.27	\$ 228.90	\$ 228.90
70450 26	Radiology	1.19	1.19	\$ 83.30	\$ 83.30
70450 TC	Radiology	2.08	2.08	\$ 145.60	\$ 145.60
70460 00	Radiology	4.60	4.60	\$ 322.00	\$ 322.00
70460 26	Radiology	1.59	1.59	\$ 111.30	\$ 111.30
70460 TC	Radiology	3.01	3.01	\$ 210.70	\$ 210.70
70470 00	Radiology	5.41	5.41	\$ 378.70	\$ 378.70
70470 26	Radiology	1.80	1.80	\$ 126.00	\$ 126.00
70470 TC	Radiology	3.61	3.61	\$ 252.70	\$ 252.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
70480 00	Radiology	4.92	4.92	\$ 344.40	\$ 344.40
70480 26	Radiology	1.81	1.81	\$ 126.70	\$ 126.70
70480 TC	Radiology	3.11	3.11	\$ 217.70	\$ 217.70
70481 00	Radiology	5.62	5.62	\$ 393.40	\$ 393.40
70481 26	Radiology	1.58	1.58	\$ 110.60	\$ 110.60
70481 TC	Radiology	4.04	4.04	\$ 282.80	\$ 282.80
70482 00	Radiology	6.61	6.61	\$ 462.70	\$ 462.70
70482 26	Radiology	1.79	1.79	\$ 125.30	\$ 125.30
70482 TC	Radiology	4.82	4.82	\$ 337.40	\$ 337.40
70486 00	Radiology	3.96	3.96	\$ 277.20	\$ 277.20
70486 26	Radiology	1.20	1.20	\$ 84.00	\$ 84.00
70486 TC	Radiology	2.76	2.76	\$ 193.20	\$ 193.20
70487 00	Radiology	4.72	4.72	\$ 330.40	\$ 330.40
70487 26	Radiology	1.58	1.58	\$ 110.60	\$ 110.60
70487 TC	Radiology	3.14	3.14	\$ 219.80	\$ 219.80
70488 00	Radiology	5.77	5.77	\$ 403.90	\$ 403.90
70488 26	Radiology	1.79	1.79	\$ 125.30	\$ 125.30
70488 TC	Radiology	3.98	3.98	\$ 278.60	\$ 278.60
70490 00	Radiology	4.66	4.66	\$ 326.20	\$ 326.20
70490 26	Radiology	1.81	1.81	\$ 126.70	\$ 126.70
70490 TC	Radiology	2.85	2.85	\$ 199.50	\$ 199.50
70491 00	Radiology	5.75	5.75	\$ 402.50	\$ 402.50
70491 26	Radiology	1.95	1.95	\$ 136.50	\$ 136.50
70491 TC	Radiology	3.80	3.80	\$ 266.00	\$ 266.00
70492 00	Radiology	6.92	6.92	\$ 484.40	\$ 484.40
70492 26	Radiology	2.28	2.28	\$ 159.60	\$ 159.60
70492 TC	Radiology	4.64	4.64	\$ 324.80	\$ 324.80
70496 00	Radiology	8.58	8.58	\$ 600.60	\$ 600.60
70496 26	Radiology	2.46	2.46	\$ 172.20	\$ 172.20
70496 TC	Radiology	6.12	6.12	\$ 428.40	\$ 428.40
70498 00	Radiology	8.57	8.57	\$ 599.90	\$ 599.90
70498 26	Radiology	2.46	2.46	\$ 172.20	\$ 172.20
70498 TC	Radiology	6.11	6.11	\$ 427.70	\$ 427.70
70540 00	Radiology	7.14	7.14	\$ 499.80	\$ 499.80
70540 26	Radiology	1.90	1.90	\$ 133.00	\$ 133.00
70540 TC	Radiology	5.24	5.24	\$ 366.80	\$ 366.80
70542 00	Radiology	8.48	8.48	\$ 593.60	\$ 593.60
70542 26	Radiology	2.28	2.28	\$ 159.60	\$ 159.60
70542 TC	Radiology	6.20	6.20	\$ 434.00	\$ 434.00
70543 00	Radiology	10.70	10.70	\$ 749.00	\$ 749.00
70543 26	Radiology	3.01	3.01	\$ 210.70	\$ 210.70
70543 TC	Radiology	7.69	7.69	\$ 538.30	\$ 538.30
70544 00	Radiology	6.75	6.75	\$ 472.50	\$ 472.50
70544 26	Radiology	1.70	1.70	\$ 119.00	\$ 119.00
70544 TC	Radiology	5.05	5.05	\$ 353.50	\$ 353.50
70545 00	Radiology	7.12	7.12	\$ 498.40	\$ 498.40
70545 26	Radiology	1.69	1.69	\$ 118.30	\$ 118.30
70545 TC	Radiology	5.43	5.43	\$ 380.10	\$ 380.10
70546 00	Radiology	10.33	10.33	\$ 723.10	\$ 723.10
70546 26	Radiology	2.09	2.09	\$ 146.30	\$ 146.30
70546 TC	Radiology	8.24	8.24	\$ 576.80	\$ 576.80
70547 00	Radiology	6.77	6.77	\$ 473.90	\$ 473.90
70547 26	Radiology	1.70	1.70	\$ 119.00	\$ 119.00
70547 TC	Radiology	5.07	5.07	\$ 354.90	\$ 354.90
70548 00	Radiology	7.71	7.71	\$ 539.70	\$ 539.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
70548 26	Radiology	2.12	2.12	\$ 148.40	\$ 148.40
70548 TC	Radiology	5.59	5.59	\$ 391.30	\$ 391.30
70549 00	Radiology	10.83	10.83	\$ 758.10	\$ 758.10
70549 26	Radiology	2.54	2.54	\$ 177.80	\$ 177.80
70549 TC	Radiology	8.29	8.29	\$ 580.30	\$ 580.30
70551 00	Radiology	6.13	6.13	\$ 429.10	\$ 429.10
70551 26	Radiology	2.09	2.09	\$ 146.30	\$ 146.30
70551 TC	Radiology	4.04	4.04	\$ 282.80	\$ 282.80
70552 00	Radiology	8.48	8.48	\$ 593.60	\$ 593.60
70552 26	Radiology	2.51	2.51	\$ 175.70	\$ 175.70
70552 TC	Radiology	5.97	5.97	\$ 417.90	\$ 417.90
70553 00	Radiology	10.01	10.01	\$ 700.70	\$ 700.70
70553 26	Radiology	3.22	3.22	\$ 225.40	\$ 225.40
70553 TC	Radiology	6.79	6.79	\$ 475.30	\$ 475.30
70554 00	Radiology	11.96	11.96	\$ 837.20	\$ 837.20
70554 26	Radiology	2.98	2.98	\$ 208.60	\$ 208.60
70554 TC	Radiology	8.98	8.98	\$ 628.60	\$ 628.60
70555 00	Radiology	-	-	\$ 1,449.70	\$ 1,449.70
70555 26	Radiology	3.52	3.52	\$ 246.40	\$ 246.40
70555 TC	Radiology	-	-	\$ 1,203.30	\$ 1,203.30
70557 00	Radiology	-	-	\$ 2,971.50	\$ 2,971.50
70557 26	Radiology	4.67	4.67	\$ 326.90	\$ 326.90
70557 TC	Radiology	-	-	\$ 2,644.60	\$ 2,644.60
70558 00	Radiology	-	-	\$ 3,150.00	\$ 3,150.00
70558 26	Radiology	4.95	4.95	\$ 346.50	\$ 346.50
70558 TC	Radiology	-	-	\$ 2,803.50	\$ 2,803.50
70559 00	Radiology	-	-	\$ 2,971.50	\$ 2,971.50
70559 26	Radiology	4.67	4.67	\$ 326.90	\$ 326.90
70559 TC	Radiology	-	-	\$ 2,644.60	\$ 2,644.60
71045 00	Radiology	0.77	0.77	\$ 53.90	\$ 53.90
71045 26	Radiology	0.26	0.26	\$ 18.20	\$ 18.20
71045 TC	Radiology	0.51	0.51	\$ 35.70	\$ 35.70
71046 00	Radiology	1.00	1.00	\$ 70.00	\$ 70.00
71046 26	Radiology	0.31	0.31	\$ 21.70	\$ 21.70
71046 TC	Radiology	0.69	0.69	\$ 48.30	\$ 48.30
71047 00	Radiology	1.26	1.26	\$ 88.20	\$ 88.20
71047 26	Radiology	0.38	0.38	\$ 26.60	\$ 26.60
71047 TC	Radiology	0.88	0.88	\$ 61.60	\$ 61.60
71048 00	Radiology	1.38	1.38	\$ 96.60	\$ 96.60
71048 26	Radiology	0.44	0.44	\$ 30.80	\$ 30.80
71048 TC	Radiology	0.94	0.94	\$ 65.80	\$ 65.80
71100 00	Radiology	1.10	1.10	\$ 77.00	\$ 77.00
71100 26	Radiology	0.32	0.32	\$ 22.40	\$ 22.40
71100 TC	Radiology	0.78	0.78	\$ 54.60	\$ 54.60
71101 00	Radiology	1.26	1.26	\$ 88.20	\$ 88.20
71101 26	Radiology	0.38	0.38	\$ 26.60	\$ 26.60
71101 TC	Radiology	0.88	0.88	\$ 61.60	\$ 61.60
71110 00	Radiology	1.31	1.31	\$ 91.70	\$ 91.70
71110 26	Radiology	0.41	0.41	\$ 28.70	\$ 28.70
71110 TC	Radiology	0.90	0.90	\$ 63.00	\$ 63.00
71111 00	Radiology	1.57	1.57	\$ 109.90	\$ 109.90
71111 26	Radiology	0.45	0.45	\$ 31.50	\$ 31.50
71111 TC	Radiology	1.12	1.12	\$ 78.40	\$ 78.40
71120 00	Radiology	1.01	1.01	\$ 70.70	\$ 70.70
71120 26	Radiology	0.28	0.28	\$ 19.60	\$ 19.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
71120 TC	Radiology	0.73	0.73	\$ 51.10	\$ 51.10
71130 00	Radiology	1.24	1.24	\$ 86.80	\$ 86.80
71130 26	Radiology	0.31	0.31	\$ 21.70	\$ 21.70
71130 TC	Radiology	0.93	0.93	\$ 65.10	\$ 65.10
71250 00	Radiology	4.11	4.11	\$ 287.70	\$ 287.70
71250 26	Radiology	1.52	1.52	\$ 106.40	\$ 106.40
71250 TC	Radiology	2.59	2.59	\$ 181.30	\$ 181.30
71260 00	Radiology	5.17	5.17	\$ 361.90	\$ 361.90
71260 26	Radiology	1.63	1.63	\$ 114.10	\$ 114.10
71260 TC	Radiology	3.54	3.54	\$ 247.80	\$ 247.80
71270 00	Radiology	6.15	6.15	\$ 430.50	\$ 430.50
71270 26	Radiology	1.77	1.77	\$ 123.90	\$ 123.90
71270 TC	Radiology	4.38	4.38	\$ 306.60	\$ 306.60
71271 00	Radiology	4.25	4.25	\$ 297.50	\$ 297.50
71271 26	Radiology	1.52	1.52	\$ 106.40	\$ 106.40
71271 TC	Radiology	2.73	2.73	\$ 191.10	\$ 191.10
71275 00	Radiology	8.76	8.76	\$ 613.20	\$ 613.20
71275 26	Radiology	2.56	2.56	\$ 179.20	\$ 179.20
71275 TC	Radiology	6.20	6.20	\$ 434.00	\$ 434.00
71550 00	Radiology	10.78	10.78	\$ 754.60	\$ 754.60
71550 26	Radiology	2.06	2.06	\$ 144.20	\$ 144.20
71550 TC	Radiology	8.72	8.72	\$ 610.40	\$ 610.40
71551 00	Radiology	11.92	11.92	\$ 834.40	\$ 834.40
71551 26	Radiology	2.44	2.44	\$ 170.80	\$ 170.80
71551 TC	Radiology	9.48	9.48	\$ 663.60	\$ 663.60
71552 00	Radiology	15.05	15.05	\$ 1,053.50	\$ 1,053.50
71552 26	Radiology	3.17	3.17	\$ 221.90	\$ 221.90
71552 TC	Radiology	11.88	11.88	\$ 831.60	\$ 831.60
71555 00	Radiology	10.54	10.54	\$ 737.80	\$ 737.80
71555 26	Radiology	2.53	2.53	\$ 177.10	\$ 177.10
71555 TC	Radiology	8.01	8.01	\$ 560.70	\$ 560.70
72020 00	Radiology	0.73	0.73	\$ 51.10	\$ 51.10
72020 26	Radiology	0.23	0.23	\$ 16.10	\$ 16.10
72020 TC	Radiology	0.50	0.50	\$ 35.00	\$ 35.00
72040 00	Radiology	1.18	1.18	\$ 82.60	\$ 82.60
72040 26	Radiology	0.32	0.32	\$ 22.40	\$ 22.40
72040 TC	Radiology	0.86	0.86	\$ 60.20	\$ 60.20
72050 00	Radiology	1.59	1.59	\$ 111.30	\$ 111.30
72050 26	Radiology	0.39	0.39	\$ 27.30	\$ 27.30
72050 TC	Radiology	1.20	1.20	\$ 84.00	\$ 84.00
72052 00	Radiology	1.85	1.85	\$ 129.50	\$ 129.50
72052 26	Radiology	0.42	0.42	\$ 29.40	\$ 29.40
72052 TC	Radiology	1.43	1.43	\$ 100.10	\$ 100.10
72070 00	Radiology	0.98	0.98	\$ 68.60	\$ 68.60
72070 26	Radiology	0.29	0.29	\$ 20.30	\$ 20.30
72070 TC	Radiology	0.69	0.69	\$ 48.30	\$ 48.30
72072 00	Radiology	1.17	1.17	\$ 81.90	\$ 81.90
72072 26	Radiology	0.32	0.32	\$ 22.40	\$ 22.40
72072 TC	Radiology	0.85	0.85	\$ 59.50	\$ 59.50
72074 00	Radiology	1.33	1.33	\$ 93.10	\$ 93.10
72074 26	Radiology	0.35	0.35	\$ 24.50	\$ 24.50
72074 TC	Radiology	0.98	0.98	\$ 68.60	\$ 68.60
72080 00	Radiology	1.04	1.04	\$ 72.80	\$ 72.80
72080 26	Radiology	0.30	0.30	\$ 21.00	\$ 21.00
72080 TC	Radiology	0.74	0.74	\$ 51.80	\$ 51.80

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CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
72081 00	Radiology	1.27	1.27	\$ 88.90	\$ 88.90
72081 26	Radiology	0.37	0.37	\$ 25.90	\$ 25.90
72081 TC	Radiology	0.90	0.90	\$ 63.00	\$ 63.00
72082 00	Radiology	2.10	2.10	\$ 147.00	\$ 147.00
72082 26	Radiology	0.45	0.45	\$ 31.50	\$ 31.50
72082 TC	Radiology	1.65	1.65	\$ 115.50	\$ 115.50
72083 00	Radiology	2.35	2.35	\$ 164.50	\$ 164.50
72083 26	Radiology	0.51	0.51	\$ 35.70	\$ 35.70
72083 TC	Radiology	1.84	1.84	\$ 128.80	\$ 128.80
72084 00	Radiology	2.95	2.95	\$ 206.50	\$ 206.50
72084 26	Radiology	0.60	0.60	\$ 42.00	\$ 42.00
72084 TC	Radiology	2.35	2.35	\$ 164.50	\$ 164.50
72100 00	Radiology	1.19	1.19	\$ 83.30	\$ 83.30
72100 26	Radiology	0.32	0.32	\$ 22.40	\$ 22.40
72100 TC	Radiology	0.87	0.87	\$ 60.90	\$ 60.90
72110 00	Radiology	1.53	1.53	\$ 107.10	\$ 107.10
72110 26	Radiology	0.37	0.37	\$ 25.90	\$ 25.90
72110 TC	Radiology	1.16	1.16	\$ 81.20	\$ 81.20
72114 00	Radiology	1.85	1.85	\$ 129.50	\$ 129.50
72114 26	Radiology	0.43	0.43	\$ 30.10	\$ 30.10
72114 TC	Radiology	1.42	1.42	\$ 99.40	\$ 99.40
72120 00	Radiology	1.22	1.22	\$ 85.40	\$ 85.40
72120 26	Radiology	0.32	0.32	\$ 22.40	\$ 22.40
72120 TC	Radiology	0.90	0.90	\$ 63.00	\$ 63.00
72125 00	Radiology	4.03	4.03	\$ 282.10	\$ 282.10
72125 26	Radiology	1.41	1.41	\$ 98.70	\$ 98.70
72125 TC	Radiology	2.62	2.62	\$ 183.40	\$ 183.40
72126 00	Radiology	5.25	5.25	\$ 367.50	\$ 367.50
72126 26	Radiology	1.72	1.72	\$ 120.40	\$ 120.40
72126 TC	Radiology	3.53	3.53	\$ 247.10	\$ 247.10
72127 00	Radiology	6.18	6.18	\$ 432.60	\$ 432.60
72127 26	Radiology	1.80	1.80	\$ 126.00	\$ 126.00
72127 TC	Radiology	4.38	4.38	\$ 306.60	\$ 306.60
72128 00	Radiology	4.02	4.02	\$ 281.40	\$ 281.40
72128 26	Radiology	1.41	1.41	\$ 98.70	\$ 98.70
72128 TC	Radiology	2.61	2.61	\$ 182.70	\$ 182.70
72129 00	Radiology	5.29	5.29	\$ 370.30	\$ 370.30
72129 26	Radiology	1.73	1.73	\$ 121.10	\$ 121.10
72129 TC	Radiology	3.56	3.56	\$ 249.20	\$ 249.20
72130 00	Radiology	6.20	6.20	\$ 434.00	\$ 434.00
72130 26	Radiology	1.79	1.79	\$ 125.30	\$ 125.30
72130 TC	Radiology	4.41	4.41	\$ 308.70	\$ 308.70
72131 00	Radiology	4.01	4.01	\$ 280.70	\$ 280.70
72131 26	Radiology	1.41	1.41	\$ 98.70	\$ 98.70
72131 TC	Radiology	2.60	2.60	\$ 182.00	\$ 182.00
72132 00	Radiology	5.25	5.25	\$ 367.50	\$ 367.50
72132 26	Radiology	1.72	1.72	\$ 120.40	\$ 120.40
72132 TC	Radiology	3.53	3.53	\$ 247.10	\$ 247.10
72133 00	Radiology	6.17	6.17	\$ 431.90	\$ 431.90
72133 26	Radiology	1.80	1.80	\$ 126.00	\$ 126.00
72133 TC	Radiology	4.37	4.37	\$ 305.90	\$ 305.90
72141 00	Radiology	5.99	5.99	\$ 419.30	\$ 419.30
72141 26	Radiology	2.10	2.10	\$ 147.00	\$ 147.00
72141 TC	Radiology	3.89	3.89	\$ 272.30	\$ 272.30
72142 00	Radiology	8.68	8.68	\$ 607.60	\$ 607.60

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
72142 26	Radiology	2.52	2.52	\$ 176.40	\$ 176.40
72142 TC	Radiology	6.16	6.16	\$ 431.20	\$ 431.20
72146 00	Radiology	5.98	5.98	\$ 418.60	\$ 418.60
72146 26	Radiology	2.09	2.09	\$ 146.30	\$ 146.30
72146 TC	Radiology	3.89	3.89	\$ 272.30	\$ 272.30
72147 00	Radiology	8.59	8.59	\$ 601.30	\$ 601.30
72147 26	Radiology	2.51	2.51	\$ 175.70	\$ 175.70
72147 TC	Radiology	6.08	6.08	\$ 425.60	\$ 425.60
72148 00	Radiology	6.00	6.00	\$ 420.00	\$ 420.00
72148 26	Radiology	2.10	2.10	\$ 147.00	\$ 147.00
72148 TC	Radiology	3.90	3.90	\$ 273.00	\$ 273.00
72149 00	Radiology	8.52	8.52	\$ 596.40	\$ 596.40
72149 26	Radiology	2.51	2.51	\$ 175.70	\$ 175.70
72149 TC	Radiology	6.01	6.01	\$ 420.70	\$ 420.70
72156 00	Radiology	10.07	10.07	\$ 704.90	\$ 704.90
72156 26	Radiology	3.22	3.22	\$ 225.40	\$ 225.40
72156 TC	Radiology	6.85	6.85	\$ 479.50	\$ 479.50
72157 00	Radiology	10.08	10.08	\$ 705.60	\$ 705.60
72157 26	Radiology	3.22	3.22	\$ 225.40	\$ 225.40
72157 TC	Radiology	6.86	6.86	\$ 480.20	\$ 480.20
72158 00	Radiology	10.04	10.04	\$ 702.80	\$ 702.80
72158 26	Radiology	3.22	3.22	\$ 225.40	\$ 225.40
72158 TC	Radiology	6.82	6.82	\$ 477.40	\$ 477.40
72159 00	Radiology	10.89	10.89	\$ 762.30	\$ 762.30
72159 26	Radiology	2.54	2.54	\$ 177.80	\$ 177.80
72159 TC	Radiology	8.35	8.35	\$ 584.50	\$ 584.50
72170 00	Radiology	0.83	0.83	\$ 58.10	\$ 58.10
72170 26	Radiology	0.25	0.25	\$ 17.50	\$ 17.50
72170 TC	Radiology	0.58	0.58	\$ 40.60	\$ 40.60
72190 00	Radiology	1.26	1.26	\$ 88.20	\$ 88.20
72190 26	Radiology	0.36	0.36	\$ 25.20	\$ 25.20
72190 TC	Radiology	0.90	0.90	\$ 63.00	\$ 63.00
72191 00	Radiology	9.57	9.57	\$ 669.90	\$ 669.90
72191 26	Radiology	2.52	2.52	\$ 176.40	\$ 176.40
72191 TC	Radiology	7.05	7.05	\$ 493.50	\$ 493.50
72192 00	Radiology	4.12	4.12	\$ 288.40	\$ 288.40
72192 26	Radiology	1.53	1.53	\$ 107.10	\$ 107.10
72192 TC	Radiology	2.59	2.59	\$ 181.30	\$ 181.30
72193 00	Radiology	7.27	7.27	\$ 508.90	\$ 508.90
72193 26	Radiology	1.63	1.63	\$ 114.10	\$ 114.10
72193 TC	Radiology	5.64	5.64	\$ 394.80	\$ 394.80
72194 00	Radiology	8.02	8.02	\$ 561.40	\$ 561.40
72194 26	Radiology	1.72	1.72	\$ 120.40	\$ 120.40
72194 TC	Radiology	6.30	6.30	\$ 441.00	\$ 441.00
72195 00	Radiology	7.26	7.26	\$ 508.20	\$ 508.20
72195 26	Radiology	2.07	2.07	\$ 144.90	\$ 144.90
72195 TC	Radiology	5.19	5.19	\$ 363.30	\$ 363.30
72196 00	Radiology	8.50	8.50	\$ 595.00	\$ 595.00
72196 26	Radiology	2.44	2.44	\$ 170.80	\$ 170.80
72196 TC	Radiology	6.06	6.06	\$ 424.20	\$ 424.20
72197 00	Radiology	10.68	10.68	\$ 747.60	\$ 747.60
72197 26	Radiology	3.09	3.09	\$ 216.30	\$ 216.30
72197 TC	Radiology	7.59	7.59	\$ 531.30	\$ 531.30
72198 00	Radiology	10.59	10.59	\$ 741.30	\$ 741.30
72198 26	Radiology	2.51	2.51	\$ 175.70	\$ 175.70

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
72198 TC	Radiology	8.08	8.08	\$ 565.60	\$ 565.60
72200 00	Radiology	0.98	0.98	\$ 68.60	\$ 68.60
72200 26	Radiology	0.24	0.24	\$ 16.80	\$ 16.80
72200 TC	Radiology	0.74	0.74	\$ 51.80	\$ 51.80
72202 00	Radiology	1.17	1.17	\$ 81.90	\$ 81.90
72202 26	Radiology	0.32	0.32	\$ 22.40	\$ 22.40
72202 TC	Radiology	0.85	0.85	\$ 59.50	\$ 59.50
72220 00	Radiology	0.97	0.97	\$ 67.90	\$ 67.90
72220 26	Radiology	0.25	0.25	\$ 17.50	\$ 17.50
72220 TC	Radiology	0.72	0.72	\$ 50.40	\$ 50.40
72240 00	Radiology	3.46	3.46	\$ 242.20	\$ 242.20
72240 26	Radiology	1.30	1.30	\$ 91.00	\$ 91.00
72240 TC	Radiology	2.16	2.16	\$ 151.20	\$ 151.20
72255 00	Radiology	3.53	3.53	\$ 247.10	\$ 247.10
72255 26	Radiology	1.33	1.33	\$ 93.10	\$ 93.10
72255 TC	Radiology	2.20	2.20	\$ 154.00	\$ 154.00
72265 00	Radiology	3.28	3.28	\$ 229.60	\$ 229.60
72265 26	Radiology	1.17	1.17	\$ 81.90	\$ 81.90
72265 TC	Radiology	2.11	2.11	\$ 147.70	\$ 147.70
72270 00	Radiology	5.01	5.01	\$ 350.70	\$ 350.70
72270 26	Radiology	1.97	1.97	\$ 137.90	\$ 137.90
72270 TC	Radiology	3.04	3.04	\$ 212.80	\$ 212.80
72285 00	Radiology	3.79	3.79	\$ 265.30	\$ 265.30
72285 26	Radiology	1.65	1.65	\$ 115.50	\$ 115.50
72285 TC	Radiology	2.14	2.14	\$ 149.80	\$ 149.80
72295 00	Radiology	3.36	3.36	\$ 235.20	\$ 235.20
72295 26	Radiology	1.19	1.19	\$ 83.30	\$ 83.30
72295 TC	Radiology	2.17	2.17	\$ 151.90	\$ 151.90
73000 00	Radiology	0.96	0.96	\$ 67.20	\$ 67.20
73000 26	Radiology	0.24	0.24	\$ 16.80	\$ 16.80
73000 TC	Radiology	0.72	0.72	\$ 50.40	\$ 50.40
73010 00	Radiology	0.71	0.71	\$ 49.70	\$ 49.70
73010 26	Radiology	0.26	0.26	\$ 18.20	\$ 18.20
73010 TC	Radiology	0.45	0.45	\$ 31.50	\$ 31.50
73020 00	Radiology	0.64	0.64	\$ 44.80	\$ 44.80
73020 26	Radiology	0.22	0.22	\$ 15.40	\$ 15.40
73020 TC	Radiology	0.42	0.42	\$ 29.40	\$ 29.40
73030 00	Radiology	1.03	1.03	\$ 72.10	\$ 72.10
73030 26	Radiology	0.27	0.27	\$ 18.90	\$ 18.90
73030 TC	Radiology	0.76	0.76	\$ 53.20	\$ 53.20
73040 00	Radiology	3.98	3.98	\$ 278.60	\$ 278.60
73040 26	Radiology	0.80	0.80	\$ 56.00	\$ 56.00
73040 TC	Radiology	3.18	3.18	\$ 222.60	\$ 222.60
73050 00	Radiology	0.85	0.85	\$ 59.50	\$ 59.50
73050 26	Radiology	0.27	0.27	\$ 18.90	\$ 18.90
73050 TC	Radiology	0.58	0.58	\$ 40.60	\$ 40.60
73060 00	Radiology	0.95	0.95	\$ 66.50	\$ 66.50
73060 26	Radiology	0.23	0.23	\$ 16.10	\$ 16.10
73060 TC	Radiology	0.72	0.72	\$ 50.40	\$ 50.40
73070 00	Radiology	0.87	0.87	\$ 60.90	\$ 60.90
73070 26	Radiology	0.24	0.24	\$ 16.80	\$ 16.80
73070 TC	Radiology	0.63	0.63	\$ 44.10	\$ 44.10
73080 00	Radiology	0.97	0.97	\$ 67.90	\$ 67.90
73080 26	Radiology	0.25	0.25	\$ 17.50	\$ 17.50
73080 TC	Radiology	0.72	0.72	\$ 50.40	\$ 50.40

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
73085 00	Radiology	3.41	3.41	\$ 238.70	\$ 238.70
73085 26	Radiology	0.82	0.82	\$ 57.40	\$ 57.40
73085 TC	Radiology	2.59	2.59	\$ 181.30	\$ 181.30
73090 00	Radiology	0.87	0.87	\$ 60.90	\$ 60.90
73090 26	Radiology	0.23	0.23	\$ 16.10	\$ 16.10
73090 TC	Radiology	0.64	0.64	\$ 44.80	\$ 44.80
73092 00	Radiology	0.95	0.95	\$ 66.50	\$ 66.50
73092 26	Radiology	0.23	0.23	\$ 16.10	\$ 16.10
73092 TC	Radiology	0.72	0.72	\$ 50.40	\$ 50.40
73100 00	Radiology	1.01	1.01	\$ 70.70	\$ 70.70
73100 26	Radiology	0.24	0.24	\$ 16.80	\$ 16.80
73100 TC	Radiology	0.77	0.77	\$ 53.90	\$ 53.90
73110 00	Radiology	1.22	1.22	\$ 85.40	\$ 85.40
73110 26	Radiology	0.25	0.25	\$ 17.50	\$ 17.50
73110 TC	Radiology	0.97	0.97	\$ 67.90	\$ 67.90
73115 00	Radiology	4.13	4.13	\$ 289.10	\$ 289.10
73115 26	Radiology	0.81	0.81	\$ 56.70	\$ 56.70
73115 TC	Radiology	3.32	3.32	\$ 232.40	\$ 232.40
73120 00	Radiology	0.93	0.93	\$ 65.10	\$ 65.10
73120 26	Radiology	0.24	0.24	\$ 16.80	\$ 16.80
73120 TC	Radiology	0.69	0.69	\$ 48.30	\$ 48.30
73130 00	Radiology	1.09	1.09	\$ 76.30	\$ 76.30
73130 26	Radiology	0.25	0.25	\$ 17.50	\$ 17.50
73130 TC	Radiology	0.84	0.84	\$ 58.80	\$ 58.80
73140 00	Radiology	1.12	1.12	\$ 78.40	\$ 78.40
73140 26	Radiology	0.20	0.20	\$ 14.00	\$ 14.00
73140 TC	Radiology	0.92	0.92	\$ 64.40	\$ 64.40
73200 00	Radiology	5.08	5.08	\$ 355.60	\$ 355.60
73200 26	Radiology	1.41	1.41	\$ 98.70	\$ 98.70
73200 TC	Radiology	3.67	3.67	\$ 256.90	\$ 256.90
73201 00	Radiology	6.29	6.29	\$ 440.30	\$ 440.30
73201 26	Radiology	1.62	1.62	\$ 113.40	\$ 113.40
73201 TC	Radiology	4.67	4.67	\$ 326.90	\$ 326.90
73202 00	Radiology	7.89	7.89	\$ 552.30	\$ 552.30
73202 26	Radiology	1.72	1.72	\$ 120.40	\$ 120.40
73202 TC	Radiology	6.17	6.17	\$ 431.90	\$ 431.90
73206 00	Radiology	9.33	9.33	\$ 653.10	\$ 653.10
73206 26	Radiology	2.52	2.52	\$ 176.40	\$ 176.40
73206 TC	Radiology	6.81	6.81	\$ 476.70	\$ 476.70
73218 00	Radiology	9.65	9.65	\$ 675.50	\$ 675.50
73218 26	Radiology	1.92	1.92	\$ 134.40	\$ 134.40
73218 TC	Radiology	7.73	7.73	\$ 541.10	\$ 541.10
73219 00	Radiology	10.52	10.52	\$ 736.40	\$ 736.40
73219 26	Radiology	2.30	2.30	\$ 161.00	\$ 161.00
73219 TC	Radiology	8.22	8.22	\$ 575.40	\$ 575.40
73220 00	Radiology	13.06	13.06	\$ 914.20	\$ 914.20
73220 26	Radiology	3.03	3.03	\$ 212.10	\$ 212.10
73220 TC	Radiology	10.03	10.03	\$ 702.10	\$ 702.10
73221 00	Radiology	6.34	6.34	\$ 443.80	\$ 443.80
73221 26	Radiology	1.93	1.93	\$ 135.10	\$ 135.10
73221 TC	Radiology	4.41	4.41	\$ 308.70	\$ 308.70
73222 00	Radiology	9.97	9.97	\$ 697.90	\$ 697.90
73222 26	Radiology	2.31	2.31	\$ 161.70	\$ 161.70
73222 TC	Radiology	7.66	7.66	\$ 536.20	\$ 536.20
73223 00	Radiology	12.34	12.34	\$ 863.80	\$ 863.80

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73223 26	Radiology	3.03	3.03	\$ 212.10	\$ 212.10
73223 TC	Radiology	9.31	9.31	\$ 651.70	\$ 651.70
73225 00	Radiology	10.80	10.80	\$ 756.00	\$ 756.00
73225 26	Radiology	2.45	2.45	\$ 171.50	\$ 171.50
73225 TC	Radiology	8.35	8.35	\$ 584.50	\$ 584.50
73501 00	Radiology	0.97	0.97	\$ 67.90	\$ 67.90
73501 26	Radiology	0.27	0.27	\$ 18.90	\$ 18.90
73501 TC	Radiology	0.70	0.70	\$ 49.00	\$ 49.00
73502 00	Radiology	1.40	1.40	\$ 98.00	\$ 98.00
73502 26	Radiology	0.32	0.32	\$ 22.40	\$ 22.40
73502 TC	Radiology	1.08	1.08	\$ 75.60	\$ 75.60
73503 00	Radiology	1.76	1.76	\$ 123.20	\$ 123.20
73503 26	Radiology	0.39	0.39	\$ 27.30	\$ 27.30
73503 TC	Radiology	1.37	1.37	\$ 95.90	\$ 95.90
73521 00	Radiology	1.23	1.23	\$ 86.10	\$ 86.10
73521 26	Radiology	0.32	0.32	\$ 22.40	\$ 22.40
73521 TC	Radiology	0.91	0.91	\$ 63.70	\$ 63.70
73522 00	Radiology	1.60	1.60	\$ 112.00	\$ 112.00
73522 26	Radiology	0.42	0.42	\$ 29.40	\$ 29.40
73522 TC	Radiology	1.18	1.18	\$ 82.60	\$ 82.60
73523 00	Radiology	1.83	1.83	\$ 128.10	\$ 128.10
73523 26	Radiology	0.44	0.44	\$ 30.80	\$ 30.80
73523 TC	Radiology	1.39	1.39	\$ 97.30	\$ 97.30
73525 00	Radiology	4.05	4.05	\$ 283.50	\$ 283.50
73525 26	Radiology	0.84	0.84	\$ 58.80	\$ 58.80
73525 TC	Radiology	3.21	3.21	\$ 224.70	\$ 224.70
73551 00	Radiology	0.87	0.87	\$ 60.90	\$ 60.90
73551 26	Radiology	0.24	0.24	\$ 16.80	\$ 16.80
73551 TC	Radiology	0.63	0.63	\$ 44.10	\$ 44.10
73552 00	Radiology	1.05	1.05	\$ 73.50	\$ 73.50
73552 26	Radiology	0.26	0.26	\$ 18.20	\$ 18.20
73552 TC	Radiology	0.79	0.79	\$ 55.30	\$ 55.30
73560 00	Radiology	1.02	1.02	\$ 71.40	\$ 71.40
73560 26	Radiology	0.24	0.24	\$ 16.80	\$ 16.80
73560 TC	Radiology	0.78	0.78	\$ 54.60	\$ 54.60
73562 00	Radiology	1.22	1.22	\$ 85.40	\$ 85.40
73562 26	Radiology	0.27	0.27	\$ 18.90	\$ 18.90
73562 TC	Radiology	0.95	0.95	\$ 66.50	\$ 66.50
73564 00	Radiology	1.38	1.38	\$ 96.60	\$ 96.60
73564 26	Radiology	0.32	0.32	\$ 22.40	\$ 22.40
73564 TC	Radiology	1.06	1.06	\$ 74.20	\$ 74.20
73565 00	Radiology	1.21	1.21	\$ 84.70	\$ 84.70
73565 26	Radiology	0.25	0.25	\$ 17.50	\$ 17.50
73565 TC	Radiology	0.96	0.96	\$ 67.20	\$ 67.20
73580 00	Radiology	4.47	4.47	\$ 312.90	\$ 312.90
73580 26	Radiology	0.84	0.84	\$ 58.80	\$ 58.80
73580 TC	Radiology	3.63	3.63	\$ 254.10	\$ 254.10
73590 00	Radiology	0.94	0.94	\$ 65.80	\$ 65.80
73590 26	Radiology	0.23	0.23	\$ 16.10	\$ 16.10
73590 TC	Radiology	0.71	0.71	\$ 49.70	\$ 49.70
73592 00	Radiology	0.95	0.95	\$ 66.50	\$ 66.50
73592 26	Radiology	0.23	0.23	\$ 16.10	\$ 16.10
73592 TC	Radiology	0.72	0.72	\$ 50.40	\$ 50.40
73600 00	Radiology	0.96	0.96	\$ 67.20	\$ 67.20
73600 26	Radiology	0.23	0.23	\$ 16.10	\$ 16.10

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
73600 TC	Radiology	0.73	0.73	\$ 51.10	\$ 51.10
73610 00	Radiology	1.10	1.10	\$ 77.00	\$ 77.00
73610 26	Radiology	0.25	0.25	\$ 17.50	\$ 17.50
73610 TC	Radiology	0.85	0.85	\$ 59.50	\$ 59.50
73615 00	Radiology	4.02	4.02	\$ 281.40	\$ 281.40
73615 26	Radiology	0.82	0.82	\$ 57.40	\$ 57.40
73615 TC	Radiology	3.20	3.20	\$ 224.00	\$ 224.00
73620 00	Radiology	0.84	0.84	\$ 58.80	\$ 58.80
73620 26	Radiology	0.22	0.22	\$ 15.40	\$ 15.40
73620 TC	Radiology	0.62	0.62	\$ 43.40	\$ 43.40
73630 00	Radiology	1.03	1.03	\$ 72.10	\$ 72.10
73630 26	Radiology	0.24	0.24	\$ 16.80	\$ 16.80
73630 TC	Radiology	0.79	0.79	\$ 55.30	\$ 55.30
73650 00	Radiology	0.86	0.86	\$ 60.20	\$ 60.20
73650 26	Radiology	0.23	0.23	\$ 16.10	\$ 16.10
73650 TC	Radiology	0.63	0.63	\$ 44.10	\$ 44.10
73660 00	Radiology	0.87	0.87	\$ 60.90	\$ 60.90
73660 26	Radiology	0.19	0.19	\$ 13.30	\$ 13.30
73660 TC	Radiology	0.68	0.68	\$ 47.60	\$ 47.60
73700 00	Radiology	4.01	4.01	\$ 280.70	\$ 280.70
73700 26	Radiology	1.41	1.41	\$ 98.70	\$ 98.70
73700 TC	Radiology	2.60	2.60	\$ 182.00	\$ 182.00
73701 00	Radiology	5.18	5.18	\$ 362.60	\$ 362.60
73701 26	Radiology	1.63	1.63	\$ 114.10	\$ 114.10
73701 TC	Radiology	3.55	3.55	\$ 248.50	\$ 248.50
73702 00	Radiology	6.08	6.08	\$ 425.60	\$ 425.60
73702 26	Radiology	1.72	1.72	\$ 120.40	\$ 120.40
73702 TC	Radiology	4.36	4.36	\$ 305.20	\$ 305.20
73706 00	Radiology	10.12	10.12	\$ 708.40	\$ 708.40
73706 26	Radiology	2.64	2.64	\$ 184.80	\$ 184.80
73706 TC	Radiology	7.48	7.48	\$ 523.60	\$ 523.60
73718 00	Radiology	7.05	7.05	\$ 493.50	\$ 493.50
73718 26	Radiology	1.90	1.90	\$ 133.00	\$ 133.00
73718 TC	Radiology	5.15	5.15	\$ 360.50	\$ 360.50
73719 00	Radiology	8.30	8.30	\$ 581.00	\$ 581.00
73719 26	Radiology	2.29	2.29	\$ 160.30	\$ 160.30
73719 TC	Radiology	6.01	6.01	\$ 420.70	\$ 420.70
73720 00	Radiology	10.68	10.68	\$ 747.60	\$ 747.60
73720 26	Radiology	3.02	3.02	\$ 211.40	\$ 211.40
73720 TC	Radiology	7.66	7.66	\$ 536.20	\$ 536.20
73721 00	Radiology	6.33	6.33	\$ 443.10	\$ 443.10
73721 26	Radiology	1.93	1.93	\$ 135.10	\$ 135.10
73721 TC	Radiology	4.40	4.40	\$ 308.00	\$ 308.00
73722 00	Radiology	9.99	9.99	\$ 699.30	\$ 699.30
73722 26	Radiology	2.31	2.31	\$ 161.70	\$ 161.70
73722 TC	Radiology	7.68	7.68	\$ 537.60	\$ 537.60
73723 00	Radiology	12.30	12.30	\$ 861.00	\$ 861.00
73723 26	Radiology	3.02	3.02	\$ 211.40	\$ 211.40
73723 TC	Radiology	9.28	9.28	\$ 649.60	\$ 649.60
73725 00	Radiology	10.55	10.55	\$ 738.50	\$ 738.50
73725 26	Radiology	2.52	2.52	\$ 176.40	\$ 176.40
73725 TC	Radiology	8.03	8.03	\$ 562.10	\$ 562.10
74018 00	Radiology	0.90	0.90	\$ 63.00	\$ 63.00
74018 26	Radiology	0.26	0.26	\$ 18.20	\$ 18.20
74018 TC	Radiology	0.64	0.64	\$ 44.80	\$ 44.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
74019 00	Radiology	1.10	1.10	\$ 77.00	\$ 77.00
74019 26	Radiology	0.33	0.33	\$ 23.10	\$ 23.10
74019 TC	Radiology	0.77	0.77	\$ 53.90	\$ 53.90
74021 00	Radiology	1.29	1.29	\$ 90.30	\$ 90.30
74021 26	Radiology	0.38	0.38	\$ 26.60	\$ 26.60
74021 TC	Radiology	0.91	0.91	\$ 63.70	\$ 63.70
74022 00	Radiology	1.49	1.49	\$ 104.30	\$ 104.30
74022 26	Radiology	0.45	0.45	\$ 31.50	\$ 31.50
74022 TC	Radiology	1.04	1.04	\$ 72.80	\$ 72.80
74150 00	Radiology	4.25	4.25	\$ 297.50	\$ 297.50
74150 26	Radiology	1.69	1.69	\$ 118.30	\$ 118.30
74150 TC	Radiology	2.56	2.56	\$ 179.20	\$ 179.20
74160 00	Radiology	7.42	7.42	\$ 519.40	\$ 519.40
74160 26	Radiology	1.80	1.80	\$ 126.00	\$ 126.00
74160 TC	Radiology	5.62	5.62	\$ 393.40	\$ 393.40
74170 00	Radiology	8.31	8.31	\$ 581.70	\$ 581.70
74170 26	Radiology	1.98	1.98	\$ 138.60	\$ 138.60
74170 TC	Radiology	6.33	6.33	\$ 443.10	\$ 443.10
74174 00	Radiology	11.93	11.93	\$ 835.10	\$ 835.10
74174 26	Radiology	3.07	3.07	\$ 214.90	\$ 214.90
74174 TC	Radiology	8.86	8.86	\$ 620.20	\$ 620.20
74175 00	Radiology	9.58	9.58	\$ 670.60	\$ 670.60
74175 26	Radiology	2.54	2.54	\$ 177.80	\$ 177.80
74175 TC	Radiology	7.04	7.04	\$ 492.80	\$ 492.80
74176 00	Radiology	5.66	5.66	\$ 396.20	\$ 396.20
74176 26	Radiology	2.45	2.45	\$ 171.50	\$ 171.50
74176 TC	Radiology	3.21	3.21	\$ 224.70	\$ 224.70
74177 00	Radiology	9.63	9.63	\$ 674.10	\$ 674.10
74177 26	Radiology	2.57	2.57	\$ 179.90	\$ 179.90
74177 TC	Radiology	7.06	7.06	\$ 494.20	\$ 494.20
74178 00	Radiology	10.78	10.78	\$ 754.60	\$ 754.60
74178 26	Radiology	2.82	2.82	\$ 197.40	\$ 197.40
74178 TC	Radiology	7.96	7.96	\$ 557.20	\$ 557.20
74181 00	Radiology	6.15	6.15	\$ 430.50	\$ 430.50
74181 26	Radiology	2.06	2.06	\$ 144.20	\$ 144.20
74181 TC	Radiology	4.09	4.09	\$ 286.30	\$ 286.30
74182 00	Radiology	9.57	9.57	\$ 669.90	\$ 669.90
74182 26	Radiology	2.44	2.44	\$ 170.80	\$ 170.80
74182 TC	Radiology	7.13	7.13	\$ 499.10	\$ 499.10
74183 00	Radiology	10.70	10.70	\$ 749.00	\$ 749.00
74183 26	Radiology	3.08	3.08	\$ 215.60	\$ 215.60
74183 TC	Radiology	7.62	7.62	\$ 533.40	\$ 533.40
74185 00	Radiology	10.61	10.61	\$ 742.70	\$ 742.70
74185 26	Radiology	2.51	2.51	\$ 175.70	\$ 175.70
74185 TC	Radiology	8.10	8.10	\$ 567.00	\$ 567.00
74190 00	Radiology	-	-	\$ 115.50	\$ 115.50
74190 26	Radiology	0.66	0.66	\$ 46.20	\$ 46.20
74190 TC	Radiology	-	-	\$ 69.30	\$ 69.30
74210 00	Radiology	2.98	2.98	\$ 208.60	\$ 208.60
74210 26	Radiology	0.84	0.84	\$ 58.80	\$ 58.80
74210 TC	Radiology	2.14	2.14	\$ 149.80	\$ 149.80
74220 00	Radiology	3.01	3.01	\$ 210.70	\$ 210.70
74220 26	Radiology	0.85	0.85	\$ 59.50	\$ 59.50
74220 TC	Radiology	2.16	2.16	\$ 151.20	\$ 151.20
74221 00	Radiology	3.39	3.39	\$ 237.30	\$ 237.30

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
74221 26	Radiology	0.99	0.99	\$ 69.30	\$ 69.30
74221 TC	Radiology	2.40	2.40	\$ 168.00	\$ 168.00
74230 00	Radiology	3.90	3.90	\$ 273.00	\$ 273.00
74230 26	Radiology	0.76	0.76	\$ 53.20	\$ 53.20
74230 TC	Radiology	3.14	3.14	\$ 219.80	\$ 219.80
74235 00	Radiology	-	-	\$ 338.10	\$ 338.10
74235 26	Radiology	1.69	1.69	\$ 118.30	\$ 118.30
74235 TC	Radiology	-	-	\$ 219.80	\$ 219.80
74240 00	Radiology	3.77	3.77	\$ 263.90	\$ 263.90
74240 26	Radiology	1.13	1.13	\$ 79.10	\$ 79.10
74240 TC	Radiology	2.64	2.64	\$ 184.80	\$ 184.80
74246 00	Radiology	4.30	4.30	\$ 301.00	\$ 301.00
74246 26	Radiology	1.26	1.26	\$ 88.20	\$ 88.20
74246 TC	Radiology	3.04	3.04	\$ 212.80	\$ 212.80
74248 00	Radiology	2.54	2.54	\$ 177.80	\$ 177.80
74248 26	Radiology	0.99	0.99	\$ 69.30	\$ 69.30
74248 TC	Radiology	1.55	1.55	\$ 108.50	\$ 108.50
74250 00	Radiology	3.76	3.76	\$ 263.20	\$ 263.20
74250 26	Radiology	1.14	1.14	\$ 79.80	\$ 79.80
74250 TC	Radiology	2.62	2.62	\$ 183.40	\$ 183.40
74251 00	Radiology	11.53	11.53	\$ 807.10	\$ 807.10
74251 26	Radiology	1.66	1.66	\$ 116.20	\$ 116.20
74251 TC	Radiology	9.87	9.87	\$ 690.90	\$ 690.90
74261 00	Radiology	13.23	13.23	\$ 926.10	\$ 926.10
74261 26	Radiology	3.37	3.37	\$ 235.90	\$ 235.90
74261 TC	Radiology	9.86	9.86	\$ 690.20	\$ 690.20
74262 00	Radiology	14.96	14.96	\$ 1,047.20	\$ 1,047.20
74262 26	Radiology	3.51	3.51	\$ 245.70	\$ 245.70
74262 TC	Radiology	11.45	11.45	\$ 801.50	\$ 801.50
74263 00	Radiology	21.19	21.19	\$ 1,483.30	\$ 1,483.30
74263 26	Radiology	3.26	3.26	\$ 228.20	\$ 228.20
74263 TC	Radiology	17.93	17.93	\$ 1,255.10	\$ 1,255.10
74270 00	Radiology	4.73	4.73	\$ 331.10	\$ 331.10
74270 26	Radiology	1.46	1.46	\$ 102.20	\$ 102.20
74270 TC	Radiology	3.27	3.27	\$ 228.90	\$ 228.90
74280 00	Radiology	6.82	6.82	\$ 477.40	\$ 477.40
74280 26	Radiology	1.78	1.78	\$ 124.60	\$ 124.60
74280 TC	Radiology	5.04	5.04	\$ 352.80	\$ 352.80
74283 00	Radiology	7.81	7.81	\$ 546.70	\$ 546.70
74283 26	Radiology	2.96	2.96	\$ 207.20	\$ 207.20
74283 TC	Radiology	4.85	4.85	\$ 339.50	\$ 339.50
74290 00	Radiology	2.65	2.65	\$ 185.50	\$ 185.50
74290 26	Radiology	0.45	0.45	\$ 31.50	\$ 31.50
74290 TC	Radiology	2.20	2.20	\$ 154.00	\$ 154.00
74300 00	Radiology	-	-	\$ 77.70	\$ 77.70
74300 26	Radiology	0.39	0.39	\$ 27.30	\$ 27.30
74300 TC	Radiology	-	-	\$ 50.40	\$ 50.40
74301 00	Radiology	-	-	\$ 60.20	\$ 60.20
74301 26	Radiology	0.30	0.30	\$ 21.00	\$ 21.00
74301 TC	Radiology	-	-	\$ 39.20	\$ 39.20
74328 00	Radiology	-	-	\$ 158.90	\$ 158.90
74328 26	Radiology	0.68	0.68	\$ 47.60	\$ 47.60
74328 TC	Radiology	-	-	\$ 111.30	\$ 111.30
74329 00	Radiology	-	-	\$ 135.80	\$ 135.80
74329 26	Radiology	0.68	0.68	\$ 47.60	\$ 47.60

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
74329 TC	Radiology	-	-	\$ 88.20	\$ 88.20
74330 00	Radiology	-	-	\$ 221.20	\$ 221.20
74330 26	Radiology	0.85	0.85	\$ 59.50	\$ 59.50
74330 TC	Radiology	-	-	\$ 161.70	\$ 161.70
74340 00	Radiology	-	-	\$ 215.60	\$ 215.60
74340 26	Radiology	0.77	0.77	\$ 53.90	\$ 53.90
74340 TC	Radiology	-	-	\$ 161.70	\$ 161.70
74355 00	Radiology	-	-	\$ 280.00	\$ 280.00
74355 26	Radiology	1.08	1.08	\$ 75.60	\$ 75.60
74355 TC	Radiology	-	-	\$ 204.40	\$ 204.40
74360 00	Radiology	-	-	\$ 233.10	\$ 233.10
74360 26	Radiology	0.80	0.80	\$ 56.00	\$ 56.00
74360 TC	Radiology	-	-	\$ 177.10	\$ 177.10
74363 00	Radiology	-	-	\$ 245.70	\$ 245.70
74363 26	Radiology	1.23	1.23	\$ 86.10	\$ 86.10
74363 TC	Radiology	-	-	\$ 159.60	\$ 159.60
74400 00	Radiology	4.13	4.13	\$ 289.10	\$ 289.10
74400 26	Radiology	0.68	0.68	\$ 47.60	\$ 47.60
74400 TC	Radiology	3.45	3.45	\$ 241.50	\$ 241.50
74410 00	Radiology	4.27	4.27	\$ 298.90	\$ 298.90
74410 26	Radiology	0.68	0.68	\$ 47.60	\$ 47.60
74410 TC	Radiology	3.59	3.59	\$ 251.30	\$ 251.30
74415 00	Radiology	4.72	4.72	\$ 330.40	\$ 330.40
74415 26	Radiology	0.68	0.68	\$ 47.60	\$ 47.60
74415 TC	Radiology	4.04	4.04	\$ 282.80	\$ 282.80
74420 00	Radiology	2.29	2.29	\$ 160.30	\$ 160.30
74420 26	Radiology	0.72	0.72	\$ 50.40	\$ 50.40
74420 TC	Radiology	1.57	1.57	\$ 109.90	\$ 109.90
74425 00	Radiology	4.16	4.16	\$ 291.20	\$ 291.20
74425 26	Radiology	0.70	0.70	\$ 49.00	\$ 49.00
74425 TC	Radiology	3.46	3.46	\$ 242.20	\$ 242.20
74430 00	Radiology	1.21	1.21	\$ 84.70	\$ 84.70
74430 26	Radiology	0.44	0.44	\$ 30.80	\$ 30.80
74430 TC	Radiology	0.77	0.77	\$ 53.90	\$ 53.90
74440 00	Radiology	2.96	2.96	\$ 207.20	\$ 207.20
74440 26	Radiology	0.52	0.52	\$ 36.40	\$ 36.40
74440 TC	Radiology	2.44	2.44	\$ 170.80	\$ 170.80
74445 00	Radiology	-	-	\$ 192.50	\$ 192.50
74445 26	Radiology	1.57	1.57	\$ 109.90	\$ 109.90
74445 TC	Radiology	-	-	\$ 82.60	\$ 82.60
74450 00	Radiology	-	-	\$ 140.00	\$ 140.00
74450 26	Radiology	0.46	0.46	\$ 32.20	\$ 32.20
74450 TC	Radiology	-	-	\$ 107.80	\$ 107.80
74455 00	Radiology	3.18	3.18	\$ 222.60	\$ 222.60
74455 26	Radiology	0.45	0.45	\$ 31.50	\$ 31.50
74455 TC	Radiology	2.73	2.73	\$ 191.10	\$ 191.10
74470 00	Radiology	-	-	\$ 144.20	\$ 144.20
74470 26	Radiology	0.74	0.74	\$ 51.80	\$ 51.80
74470 TC	Radiology	-	-	\$ 92.40	\$ 92.40
74485 00	Radiology	3.58	3.58	\$ 250.60	\$ 250.60
74485 26	Radiology	1.13	1.13	\$ 79.10	\$ 79.10
74485 TC	Radiology	2.45	2.45	\$ 171.50	\$ 171.50
74710 00	Radiology	1.20	1.20	\$ 84.00	\$ 84.00
74710 26	Radiology	0.48	0.48	\$ 33.60	\$ 33.60
74710 TC	Radiology	0.72	0.72	\$ 50.40	\$ 50.40

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74712 00	Radiology	12.90	12.90	\$ 903.00	\$ 903.00
74712 26	Radiology	4.21	4.21	\$ 294.70	\$ 294.70
74712 TC	Radiology	8.69	8.69	\$ 608.30	\$ 608.30
74713 00	Radiology	6.27	6.27	\$ 438.90	\$ 438.90
74713 26	Radiology	2.61	2.61	\$ 182.70	\$ 182.70
74713 TC	Radiology	3.66	3.66	\$ 256.20	\$ 256.20
74740 00	Radiology	2.94	2.94	\$ 205.80	\$ 205.80
74740 26	Radiology	0.54	0.54	\$ 37.80	\$ 37.80
74740 TC	Radiology	2.40	2.40	\$ 168.00	\$ 168.00
74742 00	Radiology	-	-	\$ 174.30	\$ 174.30
74742 26	Radiology	0.87	0.87	\$ 60.90	\$ 60.90
74742 TC	Radiology	-	-	\$ 113.40	\$ 113.40
74775 00	Radiology	-	-	\$ 170.80	\$ 170.80
74775 26	Radiology	0.88	0.88	\$ 61.60	\$ 61.60
74775 TC	Radiology	-	-	\$ 109.20	\$ 109.20
75557 00	Radiology	8.83	8.83	\$ 618.10	\$ 618.10
75557 26	Radiology	3.27	3.27	\$ 228.90	\$ 228.90
75557 TC	Radiology	5.56	5.56	\$ 389.20	\$ 389.20
75559 00	Radiology	11.91	11.91	\$ 833.70	\$ 833.70
75559 26	Radiology	4.07	4.07	\$ 284.90	\$ 284.90
75559 TC	Radiology	7.84	7.84	\$ 548.80	\$ 548.80
75561 00	Radiology	11.59	11.59	\$ 811.30	\$ 811.30
75561 26	Radiology	3.62	3.62	\$ 253.40	\$ 253.40
75561 TC	Radiology	7.97	7.97	\$ 557.90	\$ 557.90
75563 00	Radiology	13.58	13.58	\$ 950.60	\$ 950.60
75563 26	Radiology	4.15	4.15	\$ 290.50	\$ 290.50
75563 TC	Radiology	9.43	9.43	\$ 660.10	\$ 660.10
75565 00	Radiology	1.46	1.46	\$ 102.20	\$ 102.20
75565 26	Radiology	0.35	0.35	\$ 24.50	\$ 24.50
75565 TC	Radiology	1.11	1.11	\$ 77.70	\$ 77.70
75571 00	Radiology	3.06	3.06	\$ 214.20	\$ 214.20
75571 26	Radiology	0.82	0.82	\$ 57.40	\$ 57.40
75571 TC	Radiology	2.24	2.24	\$ 156.80	\$ 156.80
75572 00	Radiology	7.04	7.04	\$ 492.80	\$ 492.80
75572 26	Radiology	2.45	2.45	\$ 171.50	\$ 171.50
75572 TC	Radiology	4.59	4.59	\$ 321.30	\$ 321.30
75573 00	Radiology	9.45	9.45	\$ 661.50	\$ 661.50
75573 26	Radiology	3.57	3.57	\$ 249.90	\$ 249.90
75573 TC	Radiology	5.88	5.88	\$ 411.60	\$ 411.60
75574 00	Radiology	10.05	10.05	\$ 703.50	\$ 703.50
75574 26	Radiology	3.34	3.34	\$ 233.80	\$ 233.80
75574 TC	Radiology	6.71	6.71	\$ 469.70	\$ 469.70
75600 00	Radiology	5.66	5.66	\$ 396.20	\$ 396.20
75600 26	Radiology	0.71	0.71	\$ 49.70	\$ 49.70
75600 TC	Radiology	4.95	4.95	\$ 346.50	\$ 346.50
75605 00	Radiology	3.62	3.62	\$ 253.40	\$ 253.40
75605 26	Radiology	1.58	1.58	\$ 110.60	\$ 110.60
75605 TC	Radiology	2.04	2.04	\$ 142.80	\$ 142.80
75625 00	Radiology	3.82	3.82	\$ 267.40	\$ 267.40
75625 26	Radiology	2.00	2.00	\$ 140.00	\$ 140.00
75625 TC	Radiology	1.82	1.82	\$ 127.40	\$ 127.40
75630 00	Radiology	4.73	4.73	\$ 331.10	\$ 331.10
75630 26	Radiology	2.78	2.78	\$ 194.60	\$ 194.60
75630 TC	Radiology	1.95	1.95	\$ 136.50	\$ 136.50
75635 00	Radiology	12.75	12.75	\$ 892.50	\$ 892.50

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
75635 26	Radiology	3.32	3.32	\$ 232.40	\$ 232.40
75635 TC	Radiology	9.43	9.43	\$ 660.10	\$ 660.10
75705 00	Radiology	7.26	7.26	\$ 508.20	\$ 508.20
75705 26	Radiology	3.39	3.39	\$ 237.30	\$ 237.30
75705 TC	Radiology	3.87	3.87	\$ 270.90	\$ 270.90
75710 00	Radiology	4.52	4.52	\$ 316.40	\$ 316.40
75710 26	Radiology	2.44	2.44	\$ 170.80	\$ 170.80
75710 TC	Radiology	2.08	2.08	\$ 145.60	\$ 145.60
75716 00	Radiology	4.88	4.88	\$ 341.60	\$ 341.60
75716 26	Radiology	2.73	2.73	\$ 191.10	\$ 191.10
75716 TC	Radiology	2.15	2.15	\$ 150.50	\$ 150.50
75726 00	Radiology	5.07	5.07	\$ 354.90	\$ 354.90
75726 26	Radiology	2.75	2.75	\$ 192.50	\$ 192.50
75726 TC	Radiology	2.32	2.32	\$ 162.40	\$ 162.40
75731 00	Radiology	4.50	4.50	\$ 315.00	\$ 315.00
75731 26	Radiology	1.60	1.60	\$ 112.00	\$ 112.00
75731 TC	Radiology	2.90	2.90	\$ 203.00	\$ 203.00
75733 00	Radiology	5.00	5.00	\$ 350.00	\$ 350.00
75733 26	Radiology	1.80	1.80	\$ 126.00	\$ 126.00
75733 TC	Radiology	3.20	3.20	\$ 224.00	\$ 224.00
75736 00	Radiology	4.20	4.20	\$ 294.00	\$ 294.00
75736 26	Radiology	1.54	1.54	\$ 107.80	\$ 107.80
75736 TC	Radiology	2.66	2.66	\$ 186.20	\$ 186.20
75741 00	Radiology	3.89	3.89	\$ 272.30	\$ 272.30
75741 26	Radiology	1.77	1.77	\$ 123.90	\$ 123.90
75741 TC	Radiology	2.12	2.12	\$ 148.40	\$ 148.40
75743 00	Radiology	4.42	4.42	\$ 309.40	\$ 309.40
75743 26	Radiology	2.26	2.26	\$ 158.20	\$ 158.20
75743 TC	Radiology	2.16	2.16	\$ 151.20	\$ 151.20
75746 00	Radiology	3.99	3.99	\$ 279.30	\$ 279.30
75746 26	Radiology	1.57	1.57	\$ 109.90	\$ 109.90
75746 TC	Radiology	2.42	2.42	\$ 169.40	\$ 169.40
75756 00	Radiology	4.71	4.71	\$ 329.70	\$ 329.70
75756 26	Radiology	1.61	1.61	\$ 112.70	\$ 112.70
75756 TC	Radiology	3.10	3.10	\$ 217.00	\$ 217.00
75774 00	Radiology	2.91	2.91	\$ 203.70	\$ 203.70
75774 26	Radiology	1.37	1.37	\$ 95.90	\$ 95.90
75774 TC	Radiology	1.54	1.54	\$ 107.80	\$ 107.80
75801 00	Radiology	-	-	\$ 510.30	\$ 510.30
75801 26	Radiology	1.24	1.24	\$ 86.80	\$ 86.80
75801 TC	Radiology	-	-	\$ 423.50	\$ 423.50
75803 00	Radiology	-	-	\$ 521.50	\$ 521.50
75803 26	Radiology	1.64	1.64	\$ 114.80	\$ 114.80
75803 TC	Radiology	-	-	\$ 406.70	\$ 406.70
75805 00	Radiology	-	-	\$ 532.00	\$ 532.00
75805 26	Radiology	1.14	1.14	\$ 79.80	\$ 79.80
75805 TC	Radiology	-	-	\$ 452.20	\$ 452.20
75807 00	Radiology	-	-	\$ 546.00	\$ 546.00
75807 26	Radiology	1.56	1.56	\$ 109.20	\$ 109.20
75807 TC	Radiology	-	-	\$ 436.80	\$ 436.80
75809 00	Radiology	2.46	2.46	\$ 172.20	\$ 172.20
75809 26	Radiology	0.68	0.68	\$ 47.60	\$ 47.60
75809 TC	Radiology	1.78	1.78	\$ 124.60	\$ 124.60
75810 00	Radiology	-	-	\$ 897.40	\$ 897.40
75810 26	Radiology	1.41	1.41	\$ 98.70	\$ 98.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
75810 TC	Radiology	-	-	\$ 798.70	\$ 798.70
75820 00	Radiology	3.30	3.30	\$ 231.00	\$ 231.00
75820 26	Radiology	1.47	1.47	\$ 102.90	\$ 102.90
75820 TC	Radiology	1.83	1.83	\$ 128.10	\$ 128.10
75822 00	Radiology	3.99	3.99	\$ 279.30	\$ 279.30
75822 26	Radiology	2.02	2.02	\$ 141.40	\$ 141.40
75822 TC	Radiology	1.97	1.97	\$ 137.90	\$ 137.90
75825 00	Radiology	3.40	3.40	\$ 238.00	\$ 238.00
75825 26	Radiology	1.55	1.55	\$ 108.50	\$ 108.50
75825 TC	Radiology	1.85	1.85	\$ 129.50	\$ 129.50
75827 00	Radiology	3.58	3.58	\$ 250.60	\$ 250.60
75827 26	Radiology	1.57	1.57	\$ 109.90	\$ 109.90
75827 TC	Radiology	2.01	2.01	\$ 140.70	\$ 140.70
75831 00	Radiology	3.56	3.56	\$ 249.20	\$ 249.20
75831 26	Radiology	1.52	1.52	\$ 106.40	\$ 106.40
75831 TC	Radiology	2.04	2.04	\$ 142.80	\$ 142.80
75833 00	Radiology	4.41	4.41	\$ 308.70	\$ 308.70
75833 26	Radiology	2.07	2.07	\$ 144.90	\$ 144.90
75833 TC	Radiology	2.34	2.34	\$ 163.80	\$ 163.80
75840 00	Radiology	3.84	3.84	\$ 268.80	\$ 268.80
75840 26	Radiology	1.60	1.60	\$ 112.00	\$ 112.00
75840 TC	Radiology	2.24	2.24	\$ 156.80	\$ 156.80
75842 00	Radiology	4.72	4.72	\$ 330.40	\$ 330.40
75842 26	Radiology	2.11	2.11	\$ 147.70	\$ 147.70
75842 TC	Radiology	2.61	2.61	\$ 182.70	\$ 182.70
75860 00	Radiology	3.76	3.76	\$ 263.20	\$ 263.20
75860 26	Radiology	1.58	1.58	\$ 110.60	\$ 110.60
75860 TC	Radiology	2.18	2.18	\$ 152.60	\$ 152.60
75870 00	Radiology	4.81	4.81	\$ 336.70	\$ 336.70
75870 26	Radiology	1.74	1.74	\$ 121.80	\$ 121.80
75870 TC	Radiology	3.07	3.07	\$ 214.90	\$ 214.90
75872 00	Radiology	3.84	3.84	\$ 268.80	\$ 268.80
75872 26	Radiology	1.60	1.60	\$ 112.00	\$ 112.00
75872 TC	Radiology	2.24	2.24	\$ 156.80	\$ 156.80
75880 00	Radiology	3.22	3.22	\$ 225.40	\$ 225.40
75880 26	Radiology	0.99	0.99	\$ 69.30	\$ 69.30
75880 TC	Radiology	2.23	2.23	\$ 156.10	\$ 156.10
75885 00	Radiology	4.04	4.04	\$ 282.80	\$ 282.80
75885 26	Radiology	1.90	1.90	\$ 133.00	\$ 133.00
75885 TC	Radiology	2.14	2.14	\$ 149.80	\$ 149.80
75887 00	Radiology	4.11	4.11	\$ 287.70	\$ 287.70
75887 26	Radiology	1.93	1.93	\$ 135.10	\$ 135.10
75887 TC	Radiology	2.18	2.18	\$ 152.60	\$ 152.60
75889 00	Radiology	3.68	3.68	\$ 257.60	\$ 257.60
75889 26	Radiology	1.52	1.52	\$ 106.40	\$ 106.40
75889 TC	Radiology	2.16	2.16	\$ 151.20	\$ 151.20
75891 00	Radiology	3.70	3.70	\$ 259.00	\$ 259.00
75891 26	Radiology	1.53	1.53	\$ 107.10	\$ 107.10
75891 TC	Radiology	2.17	2.17	\$ 151.90	\$ 151.90
75893 00	Radiology	3.08	3.08	\$ 215.60	\$ 215.60
75893 26	Radiology	0.74	0.74	\$ 51.80	\$ 51.80
75893 TC	Radiology	2.34	2.34	\$ 163.80	\$ 163.80
75894 00	Radiology	-	-	\$ 2,070.60	\$ 2,070.60
75894 26	Radiology	2.07	2.07	\$ 144.90	\$ 144.90
75894 TC	Radiology	-	-	\$ 1,925.70	\$ 1,925.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
75898 00	Radiology	-	-	\$ 273.70	\$ 273.70
75898 26	Radiology	2.62	2.62	\$ 183.40	\$ 183.40
75898 TC	Radiology	-	-	\$ 90.30	\$ 90.30
75901 00	Radiology	7.18	7.18	\$ 502.60	\$ 502.60
75901 26	Radiology	0.68	0.68	\$ 47.60	\$ 47.60
75901 TC	Radiology	6.50	6.50	\$ 455.00	\$ 455.00
75902 00	Radiology	2.81	2.81	\$ 196.70	\$ 196.70
75902 26	Radiology	0.55	0.55	\$ 38.50	\$ 38.50
75902 TC	Radiology	2.26	2.26	\$ 158.20	\$ 158.20
75956 00	Radiology	-	-	\$ 688.80	\$ 688.80
75956 26	Radiology	9.84	9.84	\$ 688.80	\$ 688.80
75956 TC	Radiology	0.00	0.00	BR	BR
75957 00	Radiology	-	-	\$ 588.70	\$ 588.70
75957 26	Radiology	8.41	8.41	\$ 588.70	\$ 588.70
75957 TC	Radiology	0.00	0.00	BR	BR
75958 00	Radiology	-	-	\$ 391.30	\$ 391.30
75958 26	Radiology	5.59	5.59	\$ 391.30	\$ 391.30
75958 TC	Radiology	0.00	0.00	BR	BR
75959 00	Radiology	-	-	\$ 344.40	\$ 344.40
75959 26	Radiology	4.92	4.92	\$ 344.40	\$ 344.40
75959 TC	Radiology	0.00	0.00	BR	BR
75970 00	Radiology	-	-	\$ 863.10	\$ 863.10
75970 26	Radiology	1.11	1.11	\$ 77.70	\$ 77.70
75970 TC	Radiology	-	-	\$ 785.40	\$ 785.40
75984 00	Radiology	2.91	2.91	\$ 203.70	\$ 203.70
75984 26	Radiology	1.11	1.11	\$ 77.70	\$ 77.70
75984 TC	Radiology	1.80	1.80	\$ 126.00	\$ 126.00
75989 00	Radiology	3.42	3.42	\$ 239.40	\$ 239.40
75989 26	Radiology	1.64	1.64	\$ 114.80	\$ 114.80
75989 TC	Radiology	1.78	1.78	\$ 124.60	\$ 124.60
76000 00	Radiology	1.28	1.28	\$ 89.60	\$ 89.60
76000 26	Radiology	0.45	0.45	\$ 31.50	\$ 31.50
76000 TC	Radiology	0.83	0.83	\$ 58.10	\$ 58.10
76010 00	Radiology	0.89	0.89	\$ 62.30	\$ 62.30
76010 26	Radiology	0.26	0.26	\$ 18.20	\$ 18.20
76010 TC	Radiology	0.63	0.63	\$ 44.10	\$ 44.10
76080 00	Radiology	1.81	1.81	\$ 126.70	\$ 126.70
76080 26	Radiology	0.74	0.74	\$ 51.80	\$ 51.80
76080 TC	Radiology	1.07	1.07	\$ 74.90	\$ 74.90
76098 00	Radiology	1.21	1.21	\$ 84.70	\$ 84.70
76098 26	Radiology	0.45	0.45	\$ 31.50	\$ 31.50
76098 TC	Radiology	0.76	0.76	\$ 53.20	\$ 53.20
76100 00	Radiology	2.69	2.69	\$ 188.30	\$ 188.30
76100 26	Radiology	0.83	0.83	\$ 58.10	\$ 58.10
76100 TC	Radiology	1.86	1.86	\$ 130.20	\$ 130.20
76120 00	Radiology	3.48	3.48	\$ 243.60	\$ 243.60
76120 26	Radiology	0.57	0.57	\$ 39.90	\$ 39.90
76120 TC	Radiology	2.91	2.91	\$ 203.70	\$ 203.70
76125 00	Radiology	-	-	\$ 86.10	\$ 86.10
76125 26	Radiology	0.38	0.38	\$ 26.60	\$ 26.60
76125 TC	Radiology	-	-	\$ 59.50	\$ 59.50
76140 00	Radiology	0.00	0.00	BR	BR
76145 00	Radiology	24.07	24.07	\$ 1,684.90	\$ 1,684.90
76376 00	Radiology	0.68	0.68	\$ 47.60	\$ 47.60
76376 26	Radiology	0.28	0.28	\$ 19.60	\$ 19.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
76376 TC	Radiology	0.40	0.40	\$ 28.00	\$ 28.00
76377 00	Radiology	2.14	2.14	\$ 149.80	\$ 149.80
76377 26	Radiology	1.12	1.12	\$ 78.40	\$ 78.40
76377 TC	Radiology	1.02	1.02	\$ 71.40	\$ 71.40
76380 00	Radiology	4.10	4.10	\$ 287.00	\$ 287.00
76380 26	Radiology	1.35	1.35	\$ 94.50	\$ 94.50
76380 TC	Radiology	2.75	2.75	\$ 192.50	\$ 192.50
76390 00	Radiology	-	-	\$ 812.00	\$ 812.00
76390 26	Radiology	-	-	\$ 140.70	\$ 140.70
76390 TC	Radiology	-	-	\$ 671.30	\$ 671.30
76391 00	Radiology	6.37	6.37	\$ 445.90	\$ 445.90
76391 26	Radiology	1.55	1.55	\$ 108.50	\$ 108.50
76391 TC	Radiology	4.82	4.82	\$ 337.40	\$ 337.40
76496 00	Radiology	-	-	\$ 119.00	\$ 119.00
76496 26	Radiology	-	-	\$ 42.00	\$ 42.00
76496 TC	Radiology	-	-	\$ 77.00	\$ 77.00
76497 00	Radiology	-	-	\$ 195.30	\$ 195.30
76497 26	Radiology	-	-	\$ 39.20	\$ 39.20
76497 TC	Radiology	-	-	\$ 156.10	\$ 156.10
76498 00	Radiology	-	-	\$ 170.10	\$ 170.10
76498 26	Radiology	-	-	\$ 34.30	\$ 34.30
76498 TC	Radiology	-	-	\$ 135.80	\$ 135.80
76499 00	Radiology	0.00	0.00	BR	BR
76499 26	Radiology	0.00	0.00	BR	BR
76499 TC	Radiology	0.00	0.00	BR	BR
76506 00	Radiology	3.47	3.47	\$ 242.90	\$ 242.90
76506 26	Radiology	0.91	0.91	\$ 63.70	\$ 63.70
76506 TC	Radiology	2.56	2.56	\$ 179.20	\$ 179.20
76510 00	Radiology	2.05	2.05	\$ 143.50	\$ 143.50
76510 26	Radiology	1.14	1.14	\$ 79.80	\$ 79.80
76510 TC	Radiology	0.91	0.91	\$ 63.70	\$ 63.70
76511 00	Radiology	1.67	1.67	\$ 116.90	\$ 116.90
76511 26	Radiology	1.03	1.03	\$ 72.10	\$ 72.10
76511 TC	Radiology	0.64	0.64	\$ 44.80	\$ 44.80
76512 00	Radiology	1.41	1.41	\$ 98.70	\$ 98.70
76512 26	Radiology	0.89	0.89	\$ 62.30	\$ 62.30
76512 TC	Radiology	0.52	0.52	\$ 36.40	\$ 36.40
76513 00	Radiology	2.24	2.24	\$ 156.80	\$ 156.80
76513 26	Radiology	0.94	0.94	\$ 65.80	\$ 65.80
76513 TC	Radiology	1.30	1.30	\$ 91.00	\$ 91.00
76514 00	Radiology	0.34	0.34	\$ 23.80	\$ 23.80
76514 26	Radiology	0.23	0.23	\$ 16.10	\$ 16.10
76514 TC	Radiology	0.11	0.11	\$ 7.70	\$ 7.70
76516 00	Radiology	1.37	1.37	\$ 95.90	\$ 95.90
76516 26	Radiology	0.65	0.65	\$ 45.50	\$ 45.50
76516 TC	Radiology	0.72	0.72	\$ 50.40	\$ 50.40
76519 00	Radiology	1.98	1.98	\$ 138.60	\$ 138.60
76519 26	Radiology	0.88	0.88	\$ 61.60	\$ 61.60
76519 TC	Radiology	1.10	1.10	\$ 77.00	\$ 77.00
76529 00	Radiology	2.54	2.54	\$ 177.80	\$ 177.80
76529 26	Radiology	0.93	0.93	\$ 65.10	\$ 65.10
76529 TC	Radiology	1.61	1.61	\$ 112.70	\$ 112.70
76536 00	Radiology	3.37	3.37	\$ 235.90	\$ 235.90
76536 26	Radiology	0.81	0.81	\$ 56.70	\$ 56.70
76536 TC	Radiology	2.56	2.56	\$ 179.20	\$ 179.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
76604 00	Radiology	1.74	1.74	\$ 121.80	\$ 121.80
76604 26	Radiology	0.82	0.82	\$ 57.40	\$ 57.40
76604 TC	Radiology	0.92	0.92	\$ 64.40	\$ 64.40
76641 00	Radiology	3.10	3.10	\$ 217.00	\$ 217.00
76641 26	Radiology	1.03	1.03	\$ 72.10	\$ 72.10
76641 TC	Radiology	2.07	2.07	\$ 144.90	\$ 144.90
76642 00	Radiology	2.54	2.54	\$ 177.80	\$ 177.80
76642 26	Radiology	0.96	0.96	\$ 67.20	\$ 67.20
76642 TC	Radiology	1.58	1.58	\$ 110.60	\$ 110.60
76700 00	Radiology	3.53	3.53	\$ 247.10	\$ 247.10
76700 26	Radiology	1.14	1.14	\$ 79.80	\$ 79.80
76700 TC	Radiology	2.39	2.39	\$ 167.30	\$ 167.30
76705 00	Radiology	2.64	2.64	\$ 184.80	\$ 184.80
76705 26	Radiology	0.84	0.84	\$ 58.80	\$ 58.80
76705 TC	Radiology	1.80	1.80	\$ 126.00	\$ 126.00
76706 00	Radiology	3.21	3.21	\$ 224.70	\$ 224.70
76706 26	Radiology	0.78	0.78	\$ 54.60	\$ 54.60
76706 TC	Radiology	2.43	2.43	\$ 170.10	\$ 170.10
76770 00	Radiology	3.27	3.27	\$ 228.90	\$ 228.90
76770 26	Radiology	1.04	1.04	\$ 72.80	\$ 72.80
76770 TC	Radiology	2.23	2.23	\$ 156.10	\$ 156.10
76775 00	Radiology	1.73	1.73	\$ 121.10	\$ 121.10
76775 26	Radiology	0.82	0.82	\$ 57.40	\$ 57.40
76775 TC	Radiology	0.91	0.91	\$ 63.70	\$ 63.70
76776 00	Radiology	4.49	4.49	\$ 314.30	\$ 314.30
76776 26	Radiology	1.07	1.07	\$ 74.90	\$ 74.90
76776 TC	Radiology	3.42	3.42	\$ 239.40	\$ 239.40
76800 00	Radiology	4.38	4.38	\$ 306.60	\$ 306.60
76800 26	Radiology	1.75	1.75	\$ 122.50	\$ 122.50
76800 TC	Radiology	2.63	2.63	\$ 184.10	\$ 184.10
76801 00	Radiology	3.52	3.52	\$ 246.40	\$ 246.40
76801 26	Radiology	1.39	1.39	\$ 97.30	\$ 97.30
76801 TC	Radiology	2.13	2.13	\$ 149.10	\$ 149.10
76802 00	Radiology	1.82	1.82	\$ 127.40	\$ 127.40
76802 26	Radiology	1.18	1.18	\$ 82.60	\$ 82.60
76802 TC	Radiology	0.64	0.64	\$ 44.80	\$ 44.80
76805 00	Radiology	4.05	4.05	\$ 283.50	\$ 283.50
76805 26	Radiology	1.40	1.40	\$ 98.00	\$ 98.00
76805 TC	Radiology	2.65	2.65	\$ 185.50	\$ 185.50
76810 00	Radiology	2.63	2.63	\$ 184.10	\$ 184.10
76810 26	Radiology	1.38	1.38	\$ 96.60	\$ 96.60
76810 TC	Radiology	1.25	1.25	\$ 87.50	\$ 87.50
76811 00	Radiology	5.19	5.19	\$ 363.30	\$ 363.30
76811 26	Radiology	2.69	2.69	\$ 188.30	\$ 188.30
76811 TC	Radiology	2.50	2.50	\$ 175.00	\$ 175.00
76812 00	Radiology	5.78	5.78	\$ 404.60	\$ 404.60
76812 26	Radiology	2.53	2.53	\$ 177.10	\$ 177.10
76812 TC	Radiology	3.25	3.25	\$ 227.50	\$ 227.50
76813 00	Radiology	3.53	3.53	\$ 247.10	\$ 247.10
76813 26	Radiology	1.67	1.67	\$ 116.90	\$ 116.90
76813 TC	Radiology	1.86	1.86	\$ 130.20	\$ 130.20
76814 00	Radiology	2.26	2.26	\$ 158.20	\$ 158.20
76814 26	Radiology	1.41	1.41	\$ 98.70	\$ 98.70
76814 TC	Radiology	0.85	0.85	\$ 59.50	\$ 59.50
76815 00	Radiology	2.44	2.44	\$ 170.80	\$ 170.80

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76815 26	Radiology	0.92	0.92	\$ 64.40	\$ 64.40
76815 TC	Radiology	1.52	1.52	\$ 106.40	\$ 106.40
76816 00	Radiology	3.29	3.29	\$ 230.30	\$ 230.30
76816 26	Radiology	1.21	1.21	\$ 84.70	\$ 84.70
76816 TC	Radiology	2.08	2.08	\$ 145.60	\$ 145.60
76817 00	Radiology	2.79	2.79	\$ 195.30	\$ 195.30
76817 26	Radiology	1.07	1.07	\$ 74.90	\$ 74.90
76817 TC	Radiology	1.72	1.72	\$ 120.40	\$ 120.40
76818 00	Radiology	3.42	3.42	\$ 239.40	\$ 239.40
76818 26	Radiology	1.49	1.49	\$ 104.30	\$ 104.30
76818 TC	Radiology	1.93	1.93	\$ 135.10	\$ 135.10
76819 00	Radiology	2.50	2.50	\$ 175.00	\$ 175.00
76819 26	Radiology	1.10	1.10	\$ 77.00	\$ 77.00
76819 TC	Radiology	1.40	1.40	\$ 98.00	\$ 98.00
76820 00	Radiology	1.35	1.35	\$ 94.50	\$ 94.50
76820 26	Radiology	0.71	0.71	\$ 49.70	\$ 49.70
76820 TC	Radiology	0.64	0.64	\$ 44.80	\$ 44.80
76821 00	Radiology	2.65	2.65	\$ 185.50	\$ 185.50
76821 26	Radiology	0.99	0.99	\$ 69.30	\$ 69.30
76821 TC	Radiology	1.66	1.66	\$ 116.20	\$ 116.20
76825 00	Radiology	7.92	7.92	\$ 554.40	\$ 554.40
76825 26	Radiology	2.34	2.34	\$ 163.80	\$ 163.80
76825 TC	Radiology	5.58	5.58	\$ 390.60	\$ 390.60
76826 00	Radiology	4.77	4.77	\$ 333.90	\$ 333.90
76826 26	Radiology	1.18	1.18	\$ 82.60	\$ 82.60
76826 TC	Radiology	3.59	3.59	\$ 251.30	\$ 251.30
76827 00	Radiology	2.11	2.11	\$ 147.70	\$ 147.70
76827 26	Radiology	0.81	0.81	\$ 56.70	\$ 56.70
76827 TC	Radiology	1.30	1.30	\$ 91.00	\$ 91.00
76828 00	Radiology	1.48	1.48	\$ 103.60	\$ 103.60
76828 26	Radiology	0.79	0.79	\$ 55.30	\$ 55.30
76828 TC	Radiology	0.69	0.69	\$ 48.30	\$ 48.30
76830 00	Radiology	3.61	3.61	\$ 252.70	\$ 252.70
76830 26	Radiology	0.98	0.98	\$ 68.60	\$ 68.60
76830 TC	Radiology	2.63	2.63	\$ 184.10	\$ 184.10
76831 00	Radiology	3.51	3.51	\$ 245.70	\$ 245.70
76831 26	Radiology	1.03	1.03	\$ 72.10	\$ 72.10
76831 TC	Radiology	2.48	2.48	\$ 173.60	\$ 173.60
76856 00	Radiology	3.19	3.19	\$ 223.30	\$ 223.30
76856 26	Radiology	0.98	0.98	\$ 68.60	\$ 68.60
76856 TC	Radiology	2.21	2.21	\$ 154.70	\$ 154.70
76857 00	Radiology	1.42	1.42	\$ 99.40	\$ 99.40
76857 26	Radiology	0.69	0.69	\$ 48.30	\$ 48.30
76857 TC	Radiology	0.73	0.73	\$ 51.10	\$ 51.10
76870 00	Radiology	3.04	3.04	\$ 212.80	\$ 212.80
76870 26	Radiology	0.91	0.91	\$ 63.70	\$ 63.70
76870 TC	Radiology	2.13	2.13	\$ 149.10	\$ 149.10
76872 00	Radiology	6.11	6.11	\$ 427.70	\$ 427.70
76872 26	Radiology	0.95	0.95	\$ 66.50	\$ 66.50
76872 TC	Radiology	5.16	5.16	\$ 361.20	\$ 361.20
76873 00	Radiology	5.18	5.18	\$ 362.60	\$ 362.60
76873 26	Radiology	2.23	2.23	\$ 156.10	\$ 156.10
76873 TC	Radiology	2.95	2.95	\$ 206.50	\$ 206.50
76881 00	Radiology	1.74	1.74	\$ 121.80	\$ 121.80
76881 26	Radiology	0.89	0.89	\$ 62.30	\$ 62.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
76881 TC	Radiology	0.85	0.85	\$ 59.50	\$ 59.50
76882 00	Radiology	1.67	1.67	\$ 116.90	\$ 116.90
76882 26	Radiology	0.68	0.68	\$ 47.60	\$ 47.60
76882 TC	Radiology	0.99	0.99	\$ 69.30	\$ 69.30
76885 00	Radiology	4.14	4.14	\$ 289.80	\$ 289.80
76885 26	Radiology	1.05	1.05	\$ 73.50	\$ 73.50
76885 TC	Radiology	3.09	3.09	\$ 216.30	\$ 216.30
76886 00	Radiology	3.03	3.03	\$ 212.10	\$ 212.10
76886 26	Radiology	0.88	0.88	\$ 61.60	\$ 61.60
76886 TC	Radiology	2.15	2.15	\$ 150.50	\$ 150.50
76932 00	Radiology	-	-	\$ 198.80	\$ 198.80
76932 26	Radiology	1.05	1.05	\$ 73.50	\$ 73.50
76932 TC	Radiology	-	-	\$ 125.30	\$ 125.30
76936 00	Radiology	7.84	7.84	\$ 548.80	\$ 548.80
76936 26	Radiology	2.78	2.78	\$ 194.60	\$ 194.60
76936 TC	Radiology	5.06	5.06	\$ 354.20	\$ 354.20
76937 00	Radiology	1.17	1.17	\$ 81.90	\$ 81.90
76937 26	Radiology	0.40	0.40	\$ 28.00	\$ 28.00
76937 TC	Radiology	0.77	0.77	\$ 53.90	\$ 53.90
76940 00	Radiology	-	-	\$ 331.10	\$ 331.10
76940 26	Radiology	2.93	2.93	\$ 205.10	\$ 205.10
76940 TC	Radiology	-	-	\$ 126.00	\$ 126.00
76941 00	Radiology	-	-	\$ 245.00	\$ 245.00
76941 26	Radiology	1.89	1.89	\$ 132.30	\$ 132.30
76941 TC	Radiology	-	-	\$ 112.70	\$ 112.70
76942 00	Radiology	1.72	1.72	\$ 120.40	\$ 120.40
76942 26	Radiology	0.90	0.90	\$ 63.00	\$ 63.00
76942 TC	Radiology	0.82	0.82	\$ 57.40	\$ 57.40
76945 00	Radiology	-	-	\$ 182.70	\$ 182.70
76945 26	Radiology	0.94	0.94	\$ 65.80	\$ 65.80
76945 TC	Radiology	-	-	\$ 116.90	\$ 116.90
76946 00	Radiology	0.95	0.95	\$ 66.50	\$ 66.50
76946 26	Radiology	0.53	0.53	\$ 37.10	\$ 37.10
76946 TC	Radiology	0.42	0.42	\$ 29.40	\$ 29.40
76948 00	Radiology	2.39	2.39	\$ 167.30	\$ 167.30
76948 26	Radiology	0.94	0.94	\$ 65.80	\$ 65.80
76948 TC	Radiology	1.45	1.45	\$ 101.50	\$ 101.50
76965 00	Radiology	2.73	2.73	\$ 191.10	\$ 191.10
76965 26	Radiology	1.95	1.95	\$ 136.50	\$ 136.50
76965 TC	Radiology	0.78	0.78	\$ 54.60	\$ 54.60
76975 00	Radiology	-	-	\$ 203.00	\$ 203.00
76975 26	Radiology	1.19	1.19	\$ 83.30	\$ 83.30
76975 TC	Radiology	-	-	\$ 119.70	\$ 119.70
76977 00	Radiology	0.21	0.21	\$ 14.70	\$ 14.70
76977 26	Radiology	0.08	0.08	\$ 5.60	\$ 5.60
76977 TC	Radiology	0.13	0.13	\$ 9.10	\$ 9.10
76978 00	Radiology	8.94	8.94	\$ 625.80	\$ 625.80
76978 26	Radiology	2.29	2.29	\$ 160.30	\$ 160.30
76978 TC	Radiology	6.65	6.65	\$ 465.50	\$ 465.50
76979 00	Radiology	5.92	5.92	\$ 414.40	\$ 414.40
76979 26	Radiology	1.20	1.20	\$ 84.00	\$ 84.00
76979 TC	Radiology	4.72	4.72	\$ 330.40	\$ 330.40
76981 00	Radiology	3.13	3.13	\$ 219.10	\$ 219.10
76981 26	Radiology	0.85	0.85	\$ 59.50	\$ 59.50
76981 TC	Radiology	2.28	2.28	\$ 159.60	\$ 159.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
76982 00	Radiology	2.82	2.82	\$ 197.40	\$ 197.40
76982 26	Radiology	0.85	0.85	\$ 59.50	\$ 59.50
76982 TC	Radiology	1.97	1.97	\$ 137.90	\$ 137.90
76983 00	Radiology	1.83	1.83	\$ 128.10	\$ 128.10
76983 26	Radiology	0.72	0.72	\$ 50.40	\$ 50.40
76983 TC	Radiology	1.11	1.11	\$ 77.70	\$ 77.70
76998 00	Radiology	-	-	\$ 126.70	\$ 126.70
76998 26	Radiology	1.81	1.81	\$ 126.70	\$ 126.70
76998 TC	Radiology	0.00	0.00	BR	BR
76999 00	Radiology	0.00	0.00	BR	BR
76999 26	Radiology	0.00	0.00	BR	BR
76999 TC	Radiology	0.00	0.00	BR	BR
77001 00	Radiology	3.08	3.08	\$ 215.60	\$ 215.60
77001 26	Radiology	0.54	0.54	\$ 37.80	\$ 37.80
77001 TC	Radiology	2.54	2.54	\$ 177.80	\$ 177.80
77002 00	Radiology	3.49	3.49	\$ 244.30	\$ 244.30
77002 26	Radiology	0.80	0.80	\$ 56.00	\$ 56.00
77002 TC	Radiology	2.69	2.69	\$ 188.30	\$ 188.30
77003 00	Radiology	3.16	3.16	\$ 221.20	\$ 221.20
77003 26	Radiology	0.85	0.85	\$ 59.50	\$ 59.50
77003 TC	Radiology	2.31	2.31	\$ 161.70	\$ 161.70
77011 00	Radiology	6.76	6.76	\$ 473.20	\$ 473.20
77011 26	Radiology	1.81	1.81	\$ 126.70	\$ 126.70
77011 TC	Radiology	4.95	4.95	\$ 346.50	\$ 346.50
77012 00	Radiology	4.25	4.25	\$ 297.50	\$ 297.50
77012 26	Radiology	2.07	2.07	\$ 144.90	\$ 144.90
77012 TC	Radiology	2.18	2.18	\$ 152.60	\$ 152.60
77013 00	Radiology	-	-	\$ 1,040.20	\$ 1,040.20
77013 26	Radiology	5.35	5.35	\$ 374.50	\$ 374.50
77013 TC	Radiology	-	-	\$ 665.70	\$ 665.70
77014 00	Radiology	3.58	3.58	\$ 250.60	\$ 250.60
77014 26	Radiology	1.31	1.31	\$ 91.70	\$ 91.70
77014 TC	Radiology	2.27	2.27	\$ 158.90	\$ 158.90
77021 00	Radiology	12.83	12.83	\$ 898.10	\$ 898.10
77021 26	Radiology	2.06	2.06	\$ 144.20	\$ 144.20
77021 TC	Radiology	10.77	10.77	\$ 753.90	\$ 753.90
77022 00	Radiology	-	-	\$ 1,343.30	\$ 1,343.30
77022 26	Radiology	5.95	5.95	\$ 416.50	\$ 416.50
77022 TC	Radiology	-	-	\$ 926.80	\$ 926.80
77046 00	Radiology	6.71	6.71	\$ 469.70	\$ 469.70
77046 26	Radiology	2.05	2.05	\$ 143.50	\$ 143.50
77046 TC	Radiology	4.66	4.66	\$ 326.20	\$ 326.20
77047 00	Radiology	6.89	6.89	\$ 482.30	\$ 482.30
77047 26	Radiology	2.25	2.25	\$ 157.50	\$ 157.50
77047 TC	Radiology	4.64	4.64	\$ 324.80	\$ 324.80
77048 00	Radiology	10.62	10.62	\$ 743.40	\$ 743.40
77048 26	Radiology	2.95	2.95	\$ 206.50	\$ 206.50
77048 TC	Radiology	7.67	7.67	\$ 536.90	\$ 536.90
77049 00	Radiology	10.84	10.84	\$ 758.80	\$ 758.80
77049 26	Radiology	3.23	3.23	\$ 226.10	\$ 226.10
77049 TC	Radiology	7.61	7.61	\$ 532.70	\$ 532.70
77053 00	Radiology	1.59	1.59	\$ 111.30	\$ 111.30
77053 26	Radiology	0.51	0.51	\$ 35.70	\$ 35.70
77053 TC	Radiology	1.08	1.08	\$ 75.60	\$ 75.60
77054 00	Radiology	2.05	2.05	\$ 143.50	\$ 143.50

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
77054 26	Radiology	0.63	0.63	\$ 44.10	\$ 44.10
77054 TC	Radiology	1.42	1.42	\$ 99.40	\$ 99.40
77061 00	Radiology	-	-	\$ 263.20	\$ 263.20
77061 26	Radiology	-	-	\$ 79.80	\$ 79.80
77061 TC	Radiology	-	-	\$ 183.40	\$ 183.40
77062 00	Radiology	-	-	\$ 332.50	\$ 332.50
77062 26	Radiology	-	-	\$ 98.70	\$ 98.70
77062 TC	Radiology	-	-	\$ 233.80	\$ 233.80
77063 00	Radiology	1.56	1.56	\$ 109.20	\$ 109.20
77063 26	Radiology	0.86	0.86	\$ 60.20	\$ 60.20
77063 TC	Radiology	0.70	0.70	\$ 49.00	\$ 49.00
77065 00	Radiology	3.76	3.76	\$ 263.20	\$ 263.20
77065 26	Radiology	1.14	1.14	\$ 79.80	\$ 79.80
77065 TC	Radiology	2.62	2.62	\$ 183.40	\$ 183.40
77066 00	Radiology	4.75	4.75	\$ 332.50	\$ 332.50
77066 26	Radiology	1.41	1.41	\$ 98.70	\$ 98.70
77066 TC	Radiology	3.34	3.34	\$ 233.80	\$ 233.80
77067 00	Radiology	3.83	3.83	\$ 268.10	\$ 268.10
77067 26	Radiology	1.07	1.07	\$ 74.90	\$ 74.90
77067 TC	Radiology	2.76	2.76	\$ 193.20	\$ 193.20
77071 00	Radiology	1.65	1.65	\$ 115.50	\$ 115.50
77072 00	Radiology	0.78	0.78	\$ 54.60	\$ 54.60
77072 26	Radiology	0.27	0.27	\$ 18.90	\$ 18.90
77072 TC	Radiology	0.51	0.51	\$ 35.70	\$ 35.70
77073 00	Radiology	1.35	1.35	\$ 94.50	\$ 94.50
77073 26	Radiology	0.39	0.39	\$ 27.30	\$ 27.30
77073 TC	Radiology	0.96	0.96	\$ 67.20	\$ 67.20
77074 00	Radiology	1.95	1.95	\$ 136.50	\$ 136.50
77074 26	Radiology	0.62	0.62	\$ 43.40	\$ 43.40
77074 TC	Radiology	1.33	1.33	\$ 93.10	\$ 93.10
77075 00	Radiology	2.98	2.98	\$ 208.60	\$ 208.60
77075 26	Radiology	0.79	0.79	\$ 55.30	\$ 55.30
77075 TC	Radiology	2.19	2.19	\$ 153.30	\$ 153.30
77076 00	Radiology	3.20	3.20	\$ 224.00	\$ 224.00
77076 26	Radiology	0.99	0.99	\$ 69.30	\$ 69.30
77076 TC	Radiology	2.21	2.21	\$ 154.70	\$ 154.70
77077 00	Radiology	1.40	1.40	\$ 98.00	\$ 98.00
77077 26	Radiology	0.49	0.49	\$ 34.30	\$ 34.30
77077 TC	Radiology	0.91	0.91	\$ 63.70	\$ 63.70
77078 00	Radiology	3.21	3.21	\$ 224.70	\$ 224.70
77078 26	Radiology	0.35	0.35	\$ 24.50	\$ 24.50
77078 TC	Radiology	2.86	2.86	\$ 200.20	\$ 200.20
77080 00	Radiology	1.10	1.10	\$ 77.00	\$ 77.00
77080 26	Radiology	0.28	0.28	\$ 19.60	\$ 19.60
77080 TC	Radiology	0.82	0.82	\$ 57.40	\$ 57.40
77081 00	Radiology	0.92	0.92	\$ 64.40	\$ 64.40
77081 26	Radiology	0.29	0.29	\$ 20.30	\$ 20.30
77081 TC	Radiology	0.63	0.63	\$ 44.10	\$ 44.10
77084 00	Radiology	10.07	10.07	\$ 704.90	\$ 704.90
77084 26	Radiology	2.26	2.26	\$ 158.20	\$ 158.20
77084 TC	Radiology	7.81	7.81	\$ 546.70	\$ 546.70
77085 00	Radiology	1.51	1.51	\$ 105.70	\$ 105.70
77085 26	Radiology	0.43	0.43	\$ 30.10	\$ 30.10
77085 TC	Radiology	1.08	1.08	\$ 75.60	\$ 75.60
77086 00	Radiology	0.97	0.97	\$ 67.90	\$ 67.90

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
77086 26	Radiology	0.24	0.24	\$ 16.80	\$ 16.80
77086 TC	Radiology	0.73	0.73	\$ 51.10	\$ 51.10
77089 00	Radiology	1.20	1.89	\$ 84.00	\$ 132.30
77090 00	Radiology	0.07	0.00	\$ 4.90	BR
77091 00	Radiology	0.83	4.69	\$ 58.10	\$ 328.30
77092 00	Radiology	0.30	2.66	\$ 21.00	\$ 186.20
77261 00	Radiology	2.08	2.08	\$ 145.60	\$ 145.60
77262 00	Radiology	3.15	3.15	\$ 220.50	\$ 220.50
77263 00	Radiology	4.92	4.92	\$ 344.40	\$ 344.40
77280 00	Radiology	7.96	7.96	\$ 557.20	\$ 557.20
77280 26	Radiology	1.11	1.11	\$ 77.70	\$ 77.70
77280 TC	Radiology	6.85	6.85	\$ 479.50	\$ 479.50
77285 00	Radiology	13.16	13.16	\$ 921.20	\$ 921.20
77285 26	Radiology	1.66	1.66	\$ 116.20	\$ 116.20
77285 TC	Radiology	11.50	11.50	\$ 805.00	\$ 805.00
77290 00	Radiology	13.56	13.56	\$ 949.20	\$ 949.20
77290 26	Radiology	2.41	2.41	\$ 168.70	\$ 168.70
77290 TC	Radiology	11.15	11.15	\$ 780.50	\$ 780.50
77293 00	Radiology	12.37	12.37	\$ 865.90	\$ 865.90
77293 26	Radiology	3.08	3.08	\$ 215.60	\$ 215.60
77293 TC	Radiology	9.29	9.29	\$ 650.30	\$ 650.30
77295 00	Radiology	13.95	13.95	\$ 976.50	\$ 976.50
77295 26	Radiology	6.58	6.58	\$ 460.60	\$ 460.60
77295 TC	Radiology	7.37	7.37	\$ 515.90	\$ 515.90
77299 00	Radiology	0.00	0.00	BR	BR
77299 26	Radiology	0.00	0.00	BR	BR
77299 TC	Radiology	0.00	0.00	BR	BR
77300 00	Radiology	1.91	1.91	\$ 133.70	\$ 133.70
77300 26	Radiology	0.95	0.95	\$ 66.50	\$ 66.50
77300 TC	Radiology	0.96	0.96	\$ 67.20	\$ 67.20
77301 00	Radiology	53.86	53.86	\$ 3,770.20	\$ 3,770.20
77301 26	Radiology	12.23	12.23	\$ 856.10	\$ 856.10
77301 TC	Radiology	41.63	41.63	\$ 2,914.10	\$ 2,914.10
77306 00	Radiology	4.28	4.28	\$ 299.60	\$ 299.60
77306 26	Radiology	2.14	2.14	\$ 149.80	\$ 149.80
77306 TC	Radiology	2.14	2.14	\$ 149.80	\$ 149.80
77307 00	Radiology	8.32	8.32	\$ 582.40	\$ 582.40
77307 26	Radiology	4.44	4.44	\$ 310.80	\$ 310.80
77307 TC	Radiology	3.88	3.88	\$ 271.60	\$ 271.60
77316 00	Radiology	7.11	7.11	\$ 497.70	\$ 497.70
77316 26	Radiology	2.14	2.14	\$ 149.80	\$ 149.80
77316 TC	Radiology	4.97	4.97	\$ 347.90	\$ 347.90
77317 00	Radiology	9.40	9.40	\$ 658.00	\$ 658.00
77317 26	Radiology	2.82	2.82	\$ 197.40	\$ 197.40
77317 TC	Radiology	6.58	6.58	\$ 460.60	\$ 460.60
77318 00	Radiology	13.33	13.33	\$ 933.10	\$ 933.10
77318 26	Radiology	4.44	4.44	\$ 310.80	\$ 310.80
77318 TC	Radiology	8.89	8.89	\$ 622.30	\$ 622.30
77321 00	Radiology	2.74	2.74	\$ 191.80	\$ 191.80
77321 26	Radiology	1.46	1.46	\$ 102.20	\$ 102.20
77321 TC	Radiology	1.28	1.28	\$ 89.60	\$ 89.60
77331 00	Radiology	1.89	1.89	\$ 132.30	\$ 132.30
77331 26	Radiology	1.34	1.34	\$ 93.80	\$ 93.80
77331 TC	Radiology	0.55	0.55	\$ 38.50	\$ 38.50
77332 00	Radiology	1.13	1.13	\$ 79.10	\$ 79.10

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
77332 26	Radiology	0.70	0.70	\$ 49.00	\$ 49.00
77332 TC	Radiology	0.43	0.43	\$ 30.10	\$ 30.10
77333 00	Radiology	4.11	4.11	\$ 287.70	\$ 287.70
77333 26	Radiology	1.16	1.16	\$ 81.20	\$ 81.20
77333 TC	Radiology	2.95	2.95	\$ 206.50	\$ 206.50
77334 00	Radiology	3.64	3.64	\$ 254.80	\$ 254.80
77334 26	Radiology	1.76	1.76	\$ 123.20	\$ 123.20
77334 TC	Radiology	1.88	1.88	\$ 131.60	\$ 131.60
77336 00	Radiology	2.43	2.43	\$ 170.10	\$ 170.10
77338 00	Radiology	13.47	13.47	\$ 942.90	\$ 942.90
77338 26	Radiology	6.58	6.58	\$ 460.60	\$ 460.60
77338 TC	Radiology	6.89	6.89	\$ 482.30	\$ 482.30
77370 00	Radiology	3.87	3.87	\$ 270.90	\$ 270.90
77371 00	Radiology	-	-	\$ 2,310.00	\$ 2,310.00
77372 00	Radiology	29.09	29.09	\$ 2,036.30	\$ 2,036.30
77373 00	Radiology	30.05	30.05	\$ 2,103.50	\$ 2,103.50
77385 00	Radiology	-	-	\$ 756.00	\$ 756.00
77386 00	Radiology	-	-	\$ 758.80	\$ 758.80
77387 00	Radiology	-	-	\$ 262.50	\$ 262.50
77399 00	Radiology	0.00	0.00	BR	BR
77399 26	Radiology	0.00	0.00	BR	BR
77399 TC	Radiology	0.00	0.00	BR	BR
77401 00	Radiology	1.22	1.22	\$ 85.40	\$ 85.40
77402 00	Radiology	-	-	\$ 273.70	\$ 273.70
77407 00	Radiology	-	-	\$ 375.20	\$ 375.20
77412 00	Radiology	-	-	\$ 498.40	\$ 498.40
77417 00	Radiology	0.37	0.37	\$ 25.90	\$ 25.90
77423 00	Radiology	-	-	\$ 182.70	\$ 182.70
77424 00	Radiology	0.00	0.00	BR	BR
77425 00	Radiology	0.00	0.00	BR	BR
77427 00	Radiology	5.57	5.57	\$ 389.90	\$ 389.90
77431 00	Radiology	3.12	3.12	\$ 218.40	\$ 218.40
77432 00	Radiology	12.43	12.43	\$ 870.10	\$ 870.10
77435 00	Radiology	18.75	18.75	\$ 1,312.50	\$ 1,312.50
77469 00	Radiology	9.30	9.30	\$ 651.00	\$ 651.00
77470 00	Radiology	3.98	3.98	\$ 278.60	\$ 278.60
77470 26	Radiology	3.13	3.13	\$ 219.10	\$ 219.10
77470 TC	Radiology	0.85	0.85	\$ 59.50	\$ 59.50
77499 00	Radiology	0.00	0.00	BR	BR
77499 26	Radiology	0.00	0.00	BR	BR
77499 TC	Radiology	0.00	0.00	BR	BR
77520 00	Radiology	-	-	\$ 1,814.40	\$ 1,814.40
77522 00	Radiology	-	-	\$ 1,819.30	\$ 1,819.30
77523 00	Radiology	-	-	\$ 2,113.30	\$ 2,113.30
77525 00	Radiology	-	-	\$ 2,338.00	\$ 2,338.00
77600 00	Radiology	15.09	15.09	\$ 1,056.30	\$ 1,056.30
77600 26	Radiology	2.06	2.06	\$ 144.20	\$ 144.20
77600 TC	Radiology	13.03	13.03	\$ 912.10	\$ 912.10
77605 00	Radiology	29.73	29.73	\$ 2,081.10	\$ 2,081.10
77605 26	Radiology	2.98	2.98	\$ 208.60	\$ 208.60
77605 TC	Radiology	26.75	26.75	\$ 1,872.50	\$ 1,872.50
77610 00	Radiology	20.66	20.66	\$ 1,446.20	\$ 1,446.20
77610 26	Radiology	2.01	2.01	\$ 140.70	\$ 140.70
77610 TC	Radiology	18.65	18.65	\$ 1,305.50	\$ 1,305.50
77615 00	Radiology	32.18	32.18	\$ 2,252.60	\$ 2,252.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
77615 26	Radiology	2.83	2.83	\$ 198.10	\$ 198.10
77615 TC	Radiology	29.35	29.35	\$ 2,054.50	\$ 2,054.50
77620 00	Radiology	19.43	19.43	\$ 1,360.10	\$ 1,360.10
77620 26	Radiology	2.48	2.48	\$ 173.60	\$ 173.60
77620 TC	Radiology	16.95	16.95	\$ 1,186.50	\$ 1,186.50
77750 00	Radiology	11.44	11.44	\$ 800.80	\$ 800.80
77750 26	Radiology	7.68	7.68	\$ 537.60	\$ 537.60
77750 TC	Radiology	3.76	3.76	\$ 263.20	\$ 263.20
77761 00	Radiology	12.12	12.12	\$ 848.40	\$ 848.40
77761 26	Radiology	5.89	5.89	\$ 412.30	\$ 412.30
77761 TC	Radiology	6.23	6.23	\$ 436.10	\$ 436.10
77762 00	Radiology	15.92	15.92	\$ 1,114.40	\$ 1,114.40
77762 26	Radiology	8.83	8.83	\$ 618.10	\$ 618.10
77762 TC	Radiology	7.09	7.09	\$ 496.30	\$ 496.30
77763 00	Radiology	22.41	22.41	\$ 1,568.70	\$ 1,568.70
77763 26	Radiology	13.27	13.27	\$ 928.90	\$ 928.90
77763 TC	Radiology	9.14	9.14	\$ 639.80	\$ 639.80
77767 00	Radiology	7.29	7.29	\$ 510.30	\$ 510.30
77767 26	Radiology	1.61	1.61	\$ 112.70	\$ 112.70
77767 TC	Radiology	5.68	5.68	\$ 397.60	\$ 397.60
77768 00	Radiology	10.63	10.63	\$ 744.10	\$ 744.10
77768 26	Radiology	2.15	2.15	\$ 150.50	\$ 150.50
77768 TC	Radiology	8.48	8.48	\$ 593.60	\$ 593.60
77770 00	Radiology	10.17	10.17	\$ 711.90	\$ 711.90
77770 26	Radiology	3.00	3.00	\$ 210.00	\$ 210.00
77770 TC	Radiology	7.17	7.17	\$ 501.90	\$ 501.90
77771 00	Radiology	17.49	17.49	\$ 1,224.30	\$ 1,224.30
77771 26	Radiology	5.80	5.80	\$ 406.00	\$ 406.00
77771 TC	Radiology	11.69	11.69	\$ 818.30	\$ 818.30
77772 00	Radiology	26.01	26.01	\$ 1,820.70	\$ 1,820.70
77772 26	Radiology	8.20	8.20	\$ 574.00	\$ 574.00
77772 TC	Radiology	17.81	17.81	\$ 1,246.70	\$ 1,246.70
77778 00	Radiology	26.43	26.43	\$ 1,850.10	\$ 1,850.10
77778 26	Radiology	13.42	13.42	\$ 939.40	\$ 939.40
77778 TC	Radiology	13.01	13.01	\$ 910.70	\$ 910.70
77789 00	Radiology	3.90	3.90	\$ 273.00	\$ 273.00
77789 26	Radiology	1.76	1.76	\$ 123.20	\$ 123.20
77789 TC	Radiology	2.14	2.14	\$ 149.80	\$ 149.80
77790 00	Radiology	0.47	0.47	\$ 32.90	\$ 32.90
77799 00	Radiology	0.00	0.00	BR	BR
77799 26	Radiology	0.00	0.00	BR	BR
77799 TC	Radiology	0.00	0.00	BR	BR
78012 00	Radiology	2.39	2.39	\$ 167.30	\$ 167.30
78012 26	Radiology	0.26	0.26	\$ 18.20	\$ 18.20
78012 TC	Radiology	2.13	2.13	\$ 149.10	\$ 149.10
78013 00	Radiology	5.50	5.50	\$ 385.00	\$ 385.00
78013 26	Radiology	0.51	0.51	\$ 35.70	\$ 35.70
78013 TC	Radiology	4.99	4.99	\$ 349.30	\$ 349.30
78014 00	Radiology	6.75	6.75	\$ 472.50	\$ 472.50
78014 26	Radiology	0.69	0.69	\$ 48.30	\$ 48.30
78014 TC	Radiology	6.06	6.06	\$ 424.20	\$ 424.20
78015 00	Radiology	6.51	6.51	\$ 455.70	\$ 455.70
78015 26	Radiology	0.95	0.95	\$ 66.50	\$ 66.50
78015 TC	Radiology	5.56	5.56	\$ 389.20	\$ 389.20
78016 00	Radiology	8.00	8.00	\$ 560.00	\$ 560.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
78016 26	Radiology	0.97	0.97	\$ 67.90	\$ 67.90
78016 TC	Radiology	7.03	7.03	\$ 492.10	\$ 492.10
78018 00	Radiology	8.88	8.88	\$ 621.60	\$ 621.60
78018 26	Radiology	1.17	1.17	\$ 81.90	\$ 81.90
78018 TC	Radiology	7.71	7.71	\$ 539.70	\$ 539.70
78020 00	Radiology	2.36	2.36	\$ 165.20	\$ 165.20
78020 26	Radiology	0.79	0.79	\$ 55.30	\$ 55.30
78020 TC	Radiology	1.57	1.57	\$ 109.90	\$ 109.90
78070 00	Radiology	8.29	8.29	\$ 580.30	\$ 580.30
78070 26	Radiology	1.10	1.10	\$ 77.00	\$ 77.00
78070 TC	Radiology	7.19	7.19	\$ 503.30	\$ 503.30
78071 00	Radiology	9.91	9.91	\$ 693.70	\$ 693.70
78071 26	Radiology	1.65	1.65	\$ 115.50	\$ 115.50
78071 TC	Radiology	8.26	8.26	\$ 578.20	\$ 578.20
78072 00	Radiology	12.46	12.46	\$ 872.20	\$ 872.20
78072 26	Radiology	2.17	2.17	\$ 151.90	\$ 151.90
78072 TC	Radiology	10.29	10.29	\$ 720.30	\$ 720.30
78075 00	Radiology	12.60	12.60	\$ 882.00	\$ 882.00
78075 26	Radiology	1.05	1.05	\$ 73.50	\$ 73.50
78075 TC	Radiology	11.55	11.55	\$ 808.50	\$ 808.50
78099 00	Radiology	0.00	0.00	BR	BR
78099 26	Radiology	0.00	0.00	BR	BR
78099 TC	Radiology	0.00	0.00	BR	BR
78102 00	Radiology	4.89	4.89	\$ 342.30	\$ 342.30
78102 26	Radiology	0.74	0.74	\$ 51.80	\$ 51.80
78102 TC	Radiology	4.15	4.15	\$ 290.50	\$ 290.50
78103 00	Radiology	5.38	5.38	\$ 376.60	\$ 376.60
78103 26	Radiology	0.89	0.89	\$ 62.30	\$ 62.30
78103 TC	Radiology	4.49	4.49	\$ 314.30	\$ 314.30
78104 00	Radiology	7.09	7.09	\$ 496.30	\$ 496.30
78104 26	Radiology	1.10	1.10	\$ 77.00	\$ 77.00
78104 TC	Radiology	5.99	5.99	\$ 419.30	\$ 419.30
78110 00	Radiology	2.07	2.07	\$ 144.90	\$ 144.90
78110 26	Radiology	0.23	0.23	\$ 16.10	\$ 16.10
78110 TC	Radiology	1.84	1.84	\$ 128.80	\$ 128.80
78111 00	Radiology	2.20	2.20	\$ 154.00	\$ 154.00
78111 26	Radiology	0.27	0.27	\$ 18.90	\$ 18.90
78111 TC	Radiology	1.93	1.93	\$ 135.10	\$ 135.10
78120 00	Radiology	2.12	2.12	\$ 148.40	\$ 148.40
78120 26	Radiology	0.28	0.28	\$ 19.60	\$ 19.60
78120 TC	Radiology	1.84	1.84	\$ 128.80	\$ 128.80
78121 00	Radiology	2.32	2.32	\$ 162.40	\$ 162.40
78121 26	Radiology	0.39	0.39	\$ 27.30	\$ 27.30
78121 TC	Radiology	1.93	1.93	\$ 135.10	\$ 135.10
78122 00	Radiology	2.89	2.89	\$ 202.30	\$ 202.30
78122 26	Radiology	0.60	0.60	\$ 42.00	\$ 42.00
78122 TC	Radiology	2.29	2.29	\$ 160.30	\$ 160.30
78130 00	Radiology	3.71	3.71	\$ 259.70	\$ 259.70
78130 26	Radiology	0.73	0.73	\$ 51.10	\$ 51.10
78130 TC	Radiology	2.98	2.98	\$ 208.60	\$ 208.60
78140 00	Radiology	3.29	3.29	\$ 230.30	\$ 230.30
78140 26	Radiology	0.73	0.73	\$ 51.10	\$ 51.10
78140 TC	Radiology	2.56	2.56	\$ 179.20	\$ 179.20
78185 00	Radiology	4.89	4.89	\$ 342.30	\$ 342.30
78185 26	Radiology	0.48	0.48	\$ 33.60	\$ 33.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
78185 TC	Radiology	4.41	4.41	\$ 308.70	\$ 308.70
78191 00	Radiology	3.71	3.71	\$ 259.70	\$ 259.70
78191 26	Radiology	0.73	0.73	\$ 51.10	\$ 51.10
78191 TC	Radiology	2.98	2.98	\$ 208.60	\$ 208.60
78195 00	Radiology	10.02	10.02	\$ 701.40	\$ 701.40
78195 26	Radiology	1.64	1.64	\$ 114.80	\$ 114.80
78195 TC	Radiology	8.38	8.38	\$ 586.60	\$ 586.60
78199 00	Radiology	0.00	0.00	BR	BR
78199 26	Radiology	0.00	0.00	BR	BR
78199 TC	Radiology	0.00	0.00	BR	BR
78201 00	Radiology	5.41	5.41	\$ 378.70	\$ 378.70
78201 26	Radiology	0.60	0.60	\$ 42.00	\$ 42.00
78201 TC	Radiology	4.81	4.81	\$ 336.70	\$ 336.70
78202 00	Radiology	5.99	5.99	\$ 419.30	\$ 419.30
78202 26	Radiology	0.69	0.69	\$ 48.30	\$ 48.30
78202 TC	Radiology	5.30	5.30	\$ 371.00	\$ 371.00
78215 00	Radiology	5.57	5.57	\$ 389.90	\$ 389.90
78215 26	Radiology	0.68	0.68	\$ 47.60	\$ 47.60
78215 TC	Radiology	4.89	4.89	\$ 342.30	\$ 342.30
78216 00	Radiology	3.80	3.80	\$ 266.00	\$ 266.00
78216 26	Radiology	0.77	0.77	\$ 53.90	\$ 53.90
78216 TC	Radiology	3.03	3.03	\$ 212.10	\$ 212.10
78226 00	Radiology	9.21	9.21	\$ 644.70	\$ 644.70
78226 26	Radiology	1.03	1.03	\$ 72.10	\$ 72.10
78226 TC	Radiology	8.18	8.18	\$ 572.60	\$ 572.60
78227 00	Radiology	12.39	12.39	\$ 867.30	\$ 867.30
78227 26	Radiology	1.25	1.25	\$ 87.50	\$ 87.50
78227 TC	Radiology	11.14	11.14	\$ 779.80	\$ 779.80
78230 00	Radiology	5.00	5.00	\$ 350.00	\$ 350.00
78230 26	Radiology	0.63	0.63	\$ 44.10	\$ 44.10
78230 TC	Radiology	4.37	4.37	\$ 305.90	\$ 305.90
78231 00	Radiology	3.12	3.12	\$ 218.40	\$ 218.40
78231 26	Radiology	0.62	0.62	\$ 43.40	\$ 43.40
78231 TC	Radiology	2.50	2.50	\$ 175.00	\$ 175.00
78232 00	Radiology	3.07	3.07	\$ 214.90	\$ 214.90
78232 26	Radiology	0.56	0.56	\$ 39.20	\$ 39.20
78232 TC	Radiology	2.51	2.51	\$ 175.70	\$ 175.70
78258 00	Radiology	6.06	6.06	\$ 424.20	\$ 424.20
78258 26	Radiology	0.98	0.98	\$ 68.60	\$ 68.60
78258 TC	Radiology	5.08	5.08	\$ 355.60	\$ 355.60
78261 00	Radiology	5.82	5.82	\$ 407.40	\$ 407.40
78261 26	Radiology	0.82	0.82	\$ 57.40	\$ 57.40
78261 TC	Radiology	5.00	5.00	\$ 350.00	\$ 350.00
78262 00	Radiology	6.96	6.96	\$ 487.20	\$ 487.20
78262 26	Radiology	0.97	0.97	\$ 67.90	\$ 67.90
78262 TC	Radiology	5.99	5.99	\$ 419.30	\$ 419.30
78264 00	Radiology	9.36	9.36	\$ 655.20	\$ 655.20
78264 26	Radiology	1.10	1.10	\$ 77.00	\$ 77.00
78264 TC	Radiology	8.26	8.26	\$ 578.20	\$ 578.20
78265 00	Radiology	11.08	11.08	\$ 775.60	\$ 775.60
78265 26	Radiology	1.35	1.35	\$ 94.50	\$ 94.50
78265 TC	Radiology	9.73	9.73	\$ 681.10	\$ 681.10
78266 00	Radiology	12.43	12.43	\$ 870.10	\$ 870.10
78266 26	Radiology	1.43	1.43	\$ 100.10	\$ 100.10
78266 TC	Radiology	11.00	11.00	\$ 770.00	\$ 770.00

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78267 00	Radiology	0.32	0.32	\$ 22.37	\$ 22.37
78268 00	Radiology	2.73	2.73	\$ 190.97	\$ 190.97
78278 00	Radiology	9.86	9.86	\$ 690.20	\$ 690.20
78278 26	Radiology	1.37	1.37	\$ 95.90	\$ 95.90
78278 TC	Radiology	8.49	8.49	\$ 594.30	\$ 594.30
78282 00	Radiology	-	-	\$ 128.80	\$ 128.80
78282 26	Radiology	0.46	0.46	\$ 32.20	\$ 32.20
78282 TC	Radiology	-	-	\$ 96.60	\$ 96.60
78290 00	Radiology	9.33	9.33	\$ 653.10	\$ 653.10
78290 26	Radiology	0.94	0.94	\$ 65.80	\$ 65.80
78290 TC	Radiology	8.39	8.39	\$ 587.30	\$ 587.30
78291 00	Radiology	7.43	7.43	\$ 520.10	\$ 520.10
78291 26	Radiology	1.24	1.24	\$ 86.80	\$ 86.80
78291 TC	Radiology	6.19	6.19	\$ 433.30	\$ 433.30
78299 00	Radiology	0.00	0.00	BR	BR
78299 26	Radiology	0.00	0.00	BR	BR
78299 TC	Radiology	0.00	0.00	BR	BR
78300 00	Radiology	6.47	6.47	\$ 452.90	\$ 452.90
78300 26	Radiology	0.88	0.88	\$ 61.60	\$ 61.60
78300 TC	Radiology	5.59	5.59	\$ 391.30	\$ 391.30
78305 00	Radiology	7.80	7.80	\$ 546.00	\$ 546.00
78305 26	Radiology	1.15	1.15	\$ 80.50	\$ 80.50
78305 TC	Radiology	6.65	6.65	\$ 465.50	\$ 465.50
78306 00	Radiology	8.39	8.39	\$ 587.30	\$ 587.30
78306 26	Radiology	1.18	1.18	\$ 82.60	\$ 82.60
78306 TC	Radiology	7.21	7.21	\$ 504.70	\$ 504.70
78315 00	Radiology	9.79	9.79	\$ 685.30	\$ 685.30
78315 26	Radiology	1.40	1.40	\$ 98.00	\$ 98.00
78315 TC	Radiology	8.39	8.39	\$ 587.30	\$ 587.30
78350 00	Radiology	0.93	0.93	\$ 65.10	\$ 65.10
78350 26	Radiology	0.32	0.32	\$ 22.40	\$ 22.40
78350 TC	Radiology	0.61	0.61	\$ 42.70	\$ 42.70
78351 00	Radiology	0.44	0.44	\$ 30.80	\$ 30.80
78399 00	Radiology	0.00	0.00	BR	BR
78399 26	Radiology	0.00	0.00	BR	BR
78399 TC	Radiology	0.00	0.00	BR	BR
78414 00	Radiology	-	-	\$ 147.00	\$ 147.00
78414 26	Radiology	0.63	0.63	\$ 44.10	\$ 44.10
78414 TC	Radiology	-	-	\$ 102.90	\$ 102.90
78428 00	Radiology	5.35	5.35	\$ 374.50	\$ 374.50
78428 26	Radiology	1.08	1.08	\$ 75.60	\$ 75.60
78428 TC	Radiology	4.27	4.27	\$ 298.90	\$ 298.90
78429 00	Radiology	-	-	\$ 963.20	\$ 963.20
78429 26	Radiology	2.34	2.34	\$ 163.80	\$ 163.80
78429 TC	Radiology	-	-	\$ 799.40	\$ 799.40
78430 00	Radiology	-	-	\$ 1,115.10	\$ 1,115.10
78430 26	Radiology	2.23	2.23	\$ 156.10	\$ 156.10
78430 TC	Radiology	-	-	\$ 959.00	\$ 959.00
78431 00	Radiology	-	-	\$ 1,299.90	\$ 1,299.90
78431 26	Radiology	2.60	2.60	\$ 182.00	\$ 182.00
78431 TC	Radiology	-	-	\$ 1,117.90	\$ 1,117.90
78432 00	Radiology	-	-	\$ 1,374.80	\$ 1,374.80
78432 26	Radiology	2.75	2.75	\$ 192.50	\$ 192.50
78432 TC	Radiology	-	-	\$ 1,182.30	\$ 1,182.30
78433 00	Radiology	-	-	\$ 1,514.80	\$ 1,514.80

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78433 26	Radiology	3.03	3.03	\$ 212.10	\$ 212.10
78433 TC	Radiology	-	-	\$ 1,302.70	\$ 1,302.70
78434 00	Radiology	-	-	\$ 429.80	\$ 429.80
78434 26	Radiology	0.86	0.86	\$ 60.20	\$ 60.20
78434 TC	Radiology	-	-	\$ 369.60	\$ 369.60
78445 00	Radiology	5.97	5.97	\$ 417.90	\$ 417.90
78445 26	Radiology	0.73	0.73	\$ 51.10	\$ 51.10
78445 TC	Radiology	5.24	5.24	\$ 366.80	\$ 366.80
78451 00	Radiology	9.63	9.63	\$ 674.10	\$ 674.10
78451 26	Radiology	1.90	1.90	\$ 133.00	\$ 133.00
78451 TC	Radiology	7.73	7.73	\$ 541.10	\$ 541.10
78452 00	Radiology	13.42	13.42	\$ 939.40	\$ 939.40
78452 26	Radiology	2.25	2.25	\$ 157.50	\$ 157.50
78452 TC	Radiology	11.17	11.17	\$ 781.90	\$ 781.90
78453 00	Radiology	8.36	8.36	\$ 585.20	\$ 585.20
78453 26	Radiology	1.38	1.38	\$ 96.60	\$ 96.60
78453 TC	Radiology	6.98	6.98	\$ 488.60	\$ 488.60
78454 00	Radiology	12.29	12.29	\$ 860.30	\$ 860.30
78454 26	Radiology	1.88	1.88	\$ 131.60	\$ 131.60
78454 TC	Radiology	10.41	10.41	\$ 728.70	\$ 728.70
78456 00	Radiology	8.89	8.89	\$ 622.30	\$ 622.30
78456 26	Radiology	1.39	1.39	\$ 97.30	\$ 97.30
78456 TC	Radiology	7.50	7.50	\$ 525.00	\$ 525.00
78457 00	Radiology	5.14	5.14	\$ 359.80	\$ 359.80
78457 26	Radiology	1.08	1.08	\$ 75.60	\$ 75.60
78457 TC	Radiology	4.06	4.06	\$ 284.20	\$ 284.20
78458 00	Radiology	5.87	5.87	\$ 410.90	\$ 410.90
78458 26	Radiology	1.27	1.27	\$ 88.90	\$ 88.90
78458 TC	Radiology	4.60	4.60	\$ 322.00	\$ 322.00
78459 00	Radiology	-	-	\$ 886.20	\$ 886.20
78459 26	Radiology	2.15	2.15	\$ 150.50	\$ 150.50
78459 TC	Radiology	-	-	\$ 735.70	\$ 735.70
78466 00	Radiology	5.53	5.53	\$ 387.10	\$ 387.10
78466 26	Radiology	1.00	1.00	\$ 70.00	\$ 70.00
78466 TC	Radiology	4.53	4.53	\$ 317.10	\$ 317.10
78468 00	Radiology	5.59	5.59	\$ 391.30	\$ 391.30
78468 26	Radiology	1.11	1.11	\$ 77.70	\$ 77.70
78468 TC	Radiology	4.48	4.48	\$ 313.60	\$ 313.60
78469 00	Radiology	6.29	6.29	\$ 440.30	\$ 440.30
78469 26	Radiology	1.28	1.28	\$ 89.60	\$ 89.60
78469 TC	Radiology	5.01	5.01	\$ 350.70	\$ 350.70
78472 00	Radiology	6.48	6.48	\$ 453.60	\$ 453.60
78472 26	Radiology	1.36	1.36	\$ 95.20	\$ 95.20
78472 TC	Radiology	5.12	5.12	\$ 358.40	\$ 358.40
78473 00	Radiology	8.21	8.21	\$ 574.70	\$ 574.70
78473 26	Radiology	2.01	2.01	\$ 140.70	\$ 140.70
78473 TC	Radiology	6.20	6.20	\$ 434.00	\$ 434.00
78481 00	Radiology	5.07	5.07	\$ 354.90	\$ 354.90
78481 26	Radiology	1.36	1.36	\$ 95.20	\$ 95.20
78481 TC	Radiology	3.71	3.71	\$ 259.70	\$ 259.70
78483 00	Radiology	6.91	6.91	\$ 483.70	\$ 483.70
78483 26	Radiology	2.04	2.04	\$ 142.80	\$ 142.80
78483 TC	Radiology	4.87	4.87	\$ 340.90	\$ 340.90
78491 00	Radiology	-	-	\$ 910.00	\$ 910.00
78491 26	Radiology	2.08	2.08	\$ 145.60	\$ 145.60

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
78491 TC	Radiology	-	-	\$ 764.40	\$ 764.40
78492 00	Radiology	-	-	\$ 1,085.00	\$ 1,085.00
78492 26	Radiology	2.48	2.48	\$ 173.60	\$ 173.60
78492 TC	Radiology	-	-	\$ 911.40	\$ 911.40
78494 00	Radiology	6.52	6.52	\$ 456.40	\$ 456.40
78494 26	Radiology	1.65	1.65	\$ 115.50	\$ 115.50
78494 TC	Radiology	4.87	4.87	\$ 340.90	\$ 340.90
78496 00	Radiology	1.26	1.26	\$ 88.20	\$ 88.20
78496 26	Radiology	0.70	0.70	\$ 49.00	\$ 49.00
78496 TC	Radiology	0.56	0.56	\$ 39.20	\$ 39.20
78499 00	Radiology	0.00	0.00	BR	BR
78499 26	Radiology	0.00	0.00	BR	BR
78499 TC	Radiology	0.00	0.00	BR	BR
78579 00	Radiology	5.30	5.30	\$ 371.00	\$ 371.00
78579 26	Radiology	0.67	0.67	\$ 46.90	\$ 46.90
78579 TC	Radiology	4.63	4.63	\$ 324.10	\$ 324.10
78580 00	Radiology	6.70	6.70	\$ 469.00	\$ 469.00
78580 26	Radiology	1.03	1.03	\$ 72.10	\$ 72.10
78580 TC	Radiology	5.67	5.67	\$ 396.90	\$ 396.90
78582 00	Radiology	9.41	9.41	\$ 658.70	\$ 658.70
78582 26	Radiology	1.47	1.47	\$ 102.90	\$ 102.90
78582 TC	Radiology	7.94	7.94	\$ 555.80	\$ 555.80
78597 00	Radiology	5.71	5.71	\$ 399.70	\$ 399.70
78597 26	Radiology	0.99	0.99	\$ 69.30	\$ 69.30
78597 TC	Radiology	4.72	4.72	\$ 330.40	\$ 330.40
78598 00	Radiology	8.60	8.60	\$ 602.00	\$ 602.00
78598 26	Radiology	1.16	1.16	\$ 81.20	\$ 81.20
78598 TC	Radiology	7.44	7.44	\$ 520.80	\$ 520.80
78599 00	Radiology	0.00	0.00	BR	BR
78599 26	Radiology	0.00	0.00	BR	BR
78599 TC	Radiology	0.00	0.00	BR	BR
78600 00	Radiology	5.22	5.22	\$ 365.40	\$ 365.40
78600 26	Radiology	0.62	0.62	\$ 43.40	\$ 43.40
78600 TC	Radiology	4.60	4.60	\$ 322.00	\$ 322.00
78601 00	Radiology	6.11	6.11	\$ 427.70	\$ 427.70
78601 26	Radiology	0.70	0.70	\$ 49.00	\$ 49.00
78601 TC	Radiology	5.41	5.41	\$ 378.70	\$ 378.70
78605 00	Radiology	5.68	5.68	\$ 397.60	\$ 397.60
78605 26	Radiology	0.74	0.74	\$ 51.80	\$ 51.80
78605 TC	Radiology	4.94	4.94	\$ 345.80	\$ 345.80
78606 00	Radiology	9.28	9.28	\$ 649.60	\$ 649.60
78606 26	Radiology	0.89	0.89	\$ 62.30	\$ 62.30
78606 TC	Radiology	8.39	8.39	\$ 587.30	\$ 587.30
78608 00	Radiology	-	-	\$ 1,178.10	\$ 1,178.10
78608 26	Radiology	2.02	2.02	\$ 141.40	\$ 141.40
78608 TC	Radiology	-	-	\$ 1,036.70	\$ 1,036.70
78609 00	Radiology	2.16	2.16	\$ 151.20	\$ 151.20
78609 26	Radiology	2.16	2.16	\$ 151.20	\$ 151.20
78609 TC	Radiology	0.00	0.00	BR	BR
78610 00	Radiology	4.96	4.96	\$ 347.20	\$ 347.20
78610 26	Radiology	0.41	0.41	\$ 28.70	\$ 28.70
78610 TC	Radiology	4.55	4.55	\$ 318.50	\$ 318.50
78630 00	Radiology	9.57	9.57	\$ 669.90	\$ 669.90
78630 26	Radiology	0.95	0.95	\$ 66.50	\$ 66.50
78630 TC	Radiology	8.62	8.62	\$ 603.40	\$ 603.40

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
78635 00	Radiology	9.55	9.55	\$ 668.50	\$ 668.50
78635 26	Radiology	0.87	0.87	\$ 60.90	\$ 60.90
78635 TC	Radiology	8.68	8.68	\$ 607.60	\$ 607.60
78645 00	Radiology	9.14	9.14	\$ 639.80	\$ 639.80
78645 26	Radiology	0.77	0.77	\$ 53.90	\$ 53.90
78645 TC	Radiology	8.37	8.37	\$ 585.90	\$ 585.90
78650 00	Radiology	7.86	7.86	\$ 550.20	\$ 550.20
78650 26	Radiology	0.73	0.73	\$ 51.10	\$ 51.10
78650 TC	Radiology	7.13	7.13	\$ 499.10	\$ 499.10
78660 00	Radiology	5.28	5.28	\$ 369.60	\$ 369.60
78660 26	Radiology	0.74	0.74	\$ 51.80	\$ 51.80
78660 TC	Radiology	4.54	4.54	\$ 317.80	\$ 317.80
78699 00	Radiology	0.00	0.00	BR	BR
78699 26	Radiology	0.00	0.00	BR	BR
78699 TC	Radiology	0.00	0.00	BR	BR
78700 00	Radiology	4.85	4.85	\$ 339.50	\$ 339.50
78700 26	Radiology	0.62	0.62	\$ 43.40	\$ 43.40
78700 TC	Radiology	4.23	4.23	\$ 296.10	\$ 296.10
78701 00	Radiology	6.27	6.27	\$ 438.90	\$ 438.90
78701 26	Radiology	0.68	0.68	\$ 47.60	\$ 47.60
78701 TC	Radiology	5.59	5.59	\$ 391.30	\$ 391.30
78707 00	Radiology	6.58	6.58	\$ 460.60	\$ 460.60
78707 26	Radiology	1.30	1.30	\$ 91.00	\$ 91.00
78707 TC	Radiology	5.28	5.28	\$ 369.60	\$ 369.60
78708 00	Radiology	5.18	5.18	\$ 362.60	\$ 362.60
78708 26	Radiology	1.66	1.66	\$ 116.20	\$ 116.20
78708 TC	Radiology	3.52	3.52	\$ 246.40	\$ 246.40
78709 00	Radiology	10.47	10.47	\$ 732.90	\$ 732.90
78709 26	Radiology	1.94	1.94	\$ 135.80	\$ 135.80
78709 TC	Radiology	8.53	8.53	\$ 597.10	\$ 597.10
78725 00	Radiology	3.33	3.33	\$ 233.10	\$ 233.10
78725 26	Radiology	0.52	0.52	\$ 36.40	\$ 36.40
78725 TC	Radiology	2.81	2.81	\$ 196.70	\$ 196.70
78730 00	Radiology	2.14	2.14	\$ 149.80	\$ 149.80
78730 26	Radiology	0.22	0.22	\$ 15.40	\$ 15.40
78730 TC	Radiology	1.92	1.92	\$ 134.40	\$ 134.40
78740 00	Radiology	6.17	6.17	\$ 431.90	\$ 431.90
78740 26	Radiology	0.76	0.76	\$ 53.20	\$ 53.20
78740 TC	Radiology	5.41	5.41	\$ 378.70	\$ 378.70
78761 00	Radiology	6.03	6.03	\$ 422.10	\$ 422.10
78761 26	Radiology	1.01	1.01	\$ 70.70	\$ 70.70
78761 TC	Radiology	5.02	5.02	\$ 351.40	\$ 351.40
78799 00	Radiology	0.00	0.00	BR	BR
78799 26	Radiology	0.00	0.00	BR	BR
78799 TC	Radiology	0.00	0.00	BR	BR
78800 00	Radiology	7.19	7.19	\$ 503.30	\$ 503.30
78800 26	Radiology	0.91	0.91	\$ 63.70	\$ 63.70
78800 TC	Radiology	6.28	6.28	\$ 439.60	\$ 439.60
78801 00	Radiology	7.80	7.80	\$ 546.00	\$ 546.00
78801 26	Radiology	1.00	1.00	\$ 70.00	\$ 70.00
78801 TC	Radiology	6.80	6.80	\$ 476.00	\$ 476.00
78802 00	Radiology	8.79	8.79	\$ 615.30	\$ 615.30
78802 26	Radiology	1.10	1.10	\$ 77.00	\$ 77.00
78802 TC	Radiology	7.69	7.69	\$ 538.30	\$ 538.30
78803 00	Radiology	10.86	10.86	\$ 760.20	\$ 760.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
78803 26	Radiology	1.47	1.47	\$ 102.90	\$ 102.90
78803 TC	Radiology	9.39	9.39	\$ 657.30	\$ 657.30
78804 00	Radiology	18.50	18.50	\$ 1,295.00	\$ 1,295.00
78804 26	Radiology	1.39	1.39	\$ 97.30	\$ 97.30
78804 TC	Radiology	17.11	17.11	\$ 1,197.70	\$ 1,197.70
78808 00	Radiology	1.19	1.19	\$ 83.30	\$ 83.30
78811 00	Radiology	-	-	\$ 1,219.40	\$ 1,219.40
78811 26	Radiology	2.09	2.09	\$ 146.30	\$ 146.30
78811 TC	Radiology	-	-	\$ 1,073.10	\$ 1,073.10
78812 00	Radiology	-	-	\$ 1,540.00	\$ 1,540.00
78812 26	Radiology	2.64	2.64	\$ 184.80	\$ 184.80
78812 TC	Radiology	-	-	\$ 1,355.20	\$ 1,355.20
78813 00	Radiology	-	-	\$ 1,545.60	\$ 1,545.60
78813 26	Radiology	2.65	2.65	\$ 185.50	\$ 185.50
78813 TC	Radiology	-	-	\$ 1,360.10	\$ 1,360.10
78814 00	Radiology	-	-	\$ 1,755.60	\$ 1,755.60
78814 26	Radiology	3.01	3.01	\$ 210.70	\$ 210.70
78814 TC	Radiology	-	-	\$ 1,544.90	\$ 1,544.90
78815 00	Radiology	-	-	\$ 1,948.10	\$ 1,948.10
78815 26	Radiology	3.34	3.34	\$ 233.80	\$ 233.80
78815 TC	Radiology	-	-	\$ 1,714.30	\$ 1,714.30
78816 00	Radiology	-	-	\$ 1,965.60	\$ 1,965.60
78816 26	Radiology	3.37	3.37	\$ 235.90	\$ 235.90
78816 TC	Radiology	-	-	\$ 1,729.70	\$ 1,729.70
78830 00	Radiology	13.71	13.71	\$ 959.70	\$ 959.70
78830 26	Radiology	2.00	2.00	\$ 140.00	\$ 140.00
78830 TC	Radiology	11.71	11.71	\$ 819.70	\$ 819.70
78831 00	Radiology	19.99	19.99	\$ 1,399.30	\$ 1,399.30
78831 26	Radiology	2.47	2.47	\$ 172.90	\$ 172.90
78831 TC	Radiology	17.52	17.52	\$ 1,226.40	\$ 1,226.40
78832 00	Radiology	26.02	26.02	\$ 1,821.40	\$ 1,821.40
78832 26	Radiology	2.87	2.87	\$ 200.90	\$ 200.90
78832 TC	Radiology	23.15	23.15	\$ 1,620.50	\$ 1,620.50
78835 00	Radiology	2.83	2.83	\$ 198.10	\$ 198.10
78835 26	Radiology	0.63	0.63	\$ 44.10	\$ 44.10
78835 TC	Radiology	2.20	2.20	\$ 154.00	\$ 154.00
78999 00	Radiology	0.00	0.00	BR	BR
78999 26	Radiology	0.00	0.00	BR	BR
78999 TC	Radiology	0.00	0.00	BR	BR
79005 00	Radiology	4.00	4.00	\$ 280.00	\$ 280.00
79005 26	Radiology	2.49	2.49	\$ 174.30	\$ 174.30
79005 TC	Radiology	1.51	1.51	\$ 105.70	\$ 105.70
79101 00	Radiology	4.33	4.33	\$ 303.10	\$ 303.10
79101 26	Radiology	2.76	2.76	\$ 193.20	\$ 193.20
79101 TC	Radiology	1.57	1.57	\$ 109.90	\$ 109.90
79200 00	Radiology	3.96	3.96	\$ 277.20	\$ 277.20
79200 26	Radiology	2.36	2.36	\$ 165.20	\$ 165.20
79200 TC	Radiology	1.60	1.60	\$ 112.00	\$ 112.00
79300 00	Radiology	-	-	\$ 220.50	\$ 220.50
79300 26	Radiology	1.89	1.89	\$ 132.30	\$ 132.30
79300 TC	Radiology	-	-	\$ 88.20	\$ 88.20
79403 00	Radiology	4.69	4.69	\$ 328.30	\$ 328.30
79403 26	Radiology	2.66	2.66	\$ 186.20	\$ 186.20
79403 TC	Radiology	2.03	2.03	\$ 142.10	\$ 142.10
79440 00	Radiology	3.57	3.57	\$ 249.90	\$ 249.90

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
79440 26	Radiology	2.36	2.36	\$ 165.20	\$ 165.20
79440 TC	Radiology	1.21	1.21	\$ 84.70	\$ 84.70
79445 00	Radiology	-	-	\$ 407.40	\$ 407.40
79445 26	Radiology	3.20	3.20	\$ 224.00	\$ 224.00
79445 TC	Radiology	-	-	\$ 183.40	\$ 183.40
79999 00	Radiology	0.00	0.00	BR	BR
79999 26	Radiology	0.00	0.00	BR	BR
79999 TC	Radiology	0.00	0.00	BR	BR

Historical Note

New Appendix A, Radiology Codes 2019-2020 made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A Radiology Codes 2019-2020 will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Radiology Codes 2019-2020 repealed; new Appendix A, Radiology Codes 2020-2021 made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Radiology Codes 2020-2021 repealed; new Appendix A, Radiology Codes 2021-2022 made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Radiology Codes 2021-2022 repealed; new Appendix A, Radiology Codes 2022-2023 made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

PATHOLOGY AND LABORATORY GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2022 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT® are preceded by an AZ identifier and numbered in the following format: AZxxx. The Industrial Commission has adopted the Clinical Laboratory Fee Schedule (CLAB) used by Medicare to reimburse the majority of pathology and laboratory services (see additional information regarding publications adopted by reference in the Introduction Section of the Fee Schedule).

The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to unit values for these services. To the extent that a conflict may exist between an adopted portion of the CPT® and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

- A. A healthcare provider seeking reimbursement for presumptive or "point of care" drug testing must submit to the payer written documentation establishing:
1. That the testing is medically necessary and reasonably required;
 2. The type of drug testing utilized; and
 3. The healthcare provider's interpretation of the "point of care" testing.

For purposes of this section, presumptive or "point of care" testing is testing that is performed at or near the site of patient care (*i.e.*, the healthcare provider's office).

CPT® codes 80305-80307 are used for reporting presumptive drug class screening. Each code represents all drugs and drug classes performed by the respective methodology per date of service.

Healthcare providers performing validity testing on urine specimens utilized for drug testing shall not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed.

Definitive drug testing may be reported with HCPCS codes G0480 - G0483. These codes differ based on the number of drug classes including metabolites tested. Only one code from this group of codes may be reported per date of service. Any request for quantitative or definitive testing requires documentation that qualifies necessity.

G0480 – Definitive drug testing 1 – 7 drug class(es) including metabolites(s) if performed

G0481 – Definitive drug testing 8 – 14 drug class(es) including metabolite(s) if performed

G0482 – Definitive drug testing 15 – 21 drug class(es) including metabolites(s) if performed

G0483 – Definitive drug testing 22 or more drug class(es), including metabolite(s) if performed.

U0001 – Laboratory testing for infection of SARS-CoV-2/2019-nCoV (COVID-19). Tests developed by the CDC.

U0002 – Laboratory testing for infection of SARS-CoV2/2019-nCoV (COVID-19). Non-CDC developed tests.

Historical Note

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

New Appendix A, Pathology and Laboratory Guidelines made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Pathology and Laboratory Guidelines will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Pathology and Laboratory Guidelines repealed; new Appendix A, Pathology and Laboratory Guidelines made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Pathology and Laboratory Guidelines repealed; new Appendix A, Pathology and Laboratory Guidelines made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Pathology and Laboratory Guidelines repealed; new Appendix A, Pathology and Laboratory Guidelines made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

ARIZONA PHYSICIANS' FEE SCHEDULE
Pathology Codes 2022
Pathology Conversion Factor \$65.00

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
80047 00	Pathology	0.40	0.40	\$ 25.79	\$ 25.79
80048 00	Pathology	0.24	0.24	\$ 15.89	\$ 15.89
80050 00	Pathology	-	-	\$ 77.35	\$ 77.35
80051 00	Pathology	0.20	0.20	\$ 13.17	\$ 13.17
80053 00	Pathology	0.31	0.31	\$ 19.83	\$ 19.83
80055 00	Pathology	1.38	1.38	\$ 89.80	\$ 89.80
80061 00	Pathology	0.39	0.39	\$ 25.15	\$ 25.15
80069 00	Pathology	0.25	0.25	\$ 16.30	\$ 16.30
80074 00	Pathology	1.38	1.38	\$ 89.46	\$ 89.46
80076 00	Pathology	0.24	0.24	\$ 15.35	\$ 15.35
80081 00	Pathology	2.16	2.16	\$ 140.61	\$ 140.61
80143 00	Pathology	0.54	0.54	\$ 35.01	\$ 35.01
80145 00	Pathology	1.11	1.11	\$ 72.45	\$ 72.45
80150 00	Pathology	0.44	0.44	\$ 28.32	\$ 28.32
80151 00	Pathology	0.54	0.54	\$ 35.01	\$ 35.01
80155 00	Pathology	1.11	1.11	\$ 72.45	\$ 72.45
80156 00	Pathology	0.42	0.42	\$ 27.37	\$ 27.37
80157 00	Pathology	0.38	0.38	\$ 24.89	\$ 24.89
80158 00	Pathology	0.52	0.52	\$ 33.90	\$ 33.90
80159 00	Pathology	0.58	0.58	\$ 37.85	\$ 37.85
80161 00	Pathology	0.54	0.54	\$ 35.01	\$ 35.01
80162 00	Pathology	0.38	0.38	\$ 24.94	\$ 24.94
80163 00	Pathology	0.38	0.38	\$ 24.94	\$ 24.94
80164 00	Pathology	0.39	0.39	\$ 25.43	\$ 25.43
80165 00	Pathology	0.39	0.39	\$ 25.43	\$ 25.43
80167 00	Pathology	0.54	0.54	\$ 35.01	\$ 35.01
80168 00	Pathology	0.47	0.47	\$ 30.69	\$ 30.69
80169 00	Pathology	0.40	0.40	\$ 25.79	\$ 25.79
80170 00	Pathology	0.47	0.47	\$ 30.77	\$ 30.77
80171 00	Pathology	0.63	0.63	\$ 40.70	\$ 40.70
80173 00	Pathology	0.46	0.46	\$ 29.64	\$ 29.64
80175 00	Pathology	0.38	0.38	\$ 24.89	\$ 24.89
80176 00	Pathology	0.42	0.42	\$ 27.59	\$ 27.59
80177 00	Pathology	0.38	0.38	\$ 24.89	\$ 24.89
80178 00	Pathology	0.19	0.19	\$ 12.42	\$ 12.42
80179 00	Pathology	0.54	0.54	\$ 35.01	\$ 35.01
80180 00	Pathology	0.52	0.52	\$ 33.90	\$ 33.90
80181 00	Pathology	0.54	0.54	\$ 35.01	\$ 35.01
80183 00	Pathology	0.38	0.38	\$ 24.89	\$ 24.89
80184 00	Pathology	0.44	0.44	\$ 28.74	\$ 28.74
80185 00	Pathology	0.38	0.38	\$ 24.89	\$ 24.89
80186 00	Pathology	0.40	0.40	\$ 25.85	\$ 25.85
80187 00	Pathology	0.78	0.78	\$ 50.92	\$ 50.92

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CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
80188 00	Pathology	0.48	0.48	\$ 31.16	\$ 31.16
80189 00	Pathology	0.78	0.78	\$ 50.92	\$ 50.92
80190 00	Pathology	1.73	1.73	\$ 112.70	\$ 112.70
80192 00	Pathology	0.48	0.48	\$ 31.46	\$ 31.46
80193 00	Pathology	1.11	1.11	\$ 72.45	\$ 72.45
80194 00	Pathology	0.42	0.42	\$ 27.42	\$ 27.42
80195 00	Pathology	0.40	0.40	\$ 25.79	\$ 25.79
80197 00	Pathology	0.40	0.40	\$ 25.79	\$ 25.79
80198 00	Pathology	0.41	0.41	\$ 26.56	\$ 26.56
80199 00	Pathology	0.78	0.78	\$ 50.92	\$ 50.92
80200 00	Pathology	0.47	0.47	\$ 30.30	\$ 30.30
80201 00	Pathology	0.34	0.34	\$ 22.39	\$ 22.39
80202 00	Pathology	0.39	0.39	\$ 25.43	\$ 25.43
80203 00	Pathology	0.38	0.38	\$ 24.89	\$ 24.89
80204 00	Pathology	1.11	1.11	\$ 72.45	\$ 72.45
80210 00	Pathology	0.78	0.78	\$ 50.92	\$ 50.92
80220 00	Pathology	0.54	0.54	\$ 35.01	\$ 35.01
80230 00	Pathology	1.11	1.11	\$ 72.45	\$ 72.45
80235 00	Pathology	0.78	0.78	\$ 50.92	\$ 50.92
80280 00	Pathology	1.11	1.11	\$ 72.45	\$ 72.45
80285 00	Pathology	0.78	0.78	\$ 50.92	\$ 50.92
80299 00	Pathology	0.54	0.54	\$ 35.01	\$ 35.01
80305 00	Pathology	0.36	0.36	\$ 23.67	\$ 23.67
80306 00	Pathology	0.50	0.50	\$ 32.19	\$ 32.19
80307 00	Pathology	1.80	1.80	\$ 116.72	\$ 116.72
80320 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80321 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80322 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80323 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80324 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80325 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80326 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80327 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80328 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80329 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80330 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80331 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80332 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80333 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80334 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80335 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80336 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80337 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80338 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80339 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80340 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80341 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80342 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80343 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80344 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80345 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80346 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80347 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80348 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80349 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
80350 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80351 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80352 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80353 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80354 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80355 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80356 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80357 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80358 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80359 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80360 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80361 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80362 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80363 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80364 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80365 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80366 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80367 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80368 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80369 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80370 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80371 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80372 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80373 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80374 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80375 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80376 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80377 00	Pathology	0.00	0.00	See G0480-G0483	See G0480-G0483
80400 00	Pathology	0.94	0.94	\$ 61.27	\$ 61.27
80402 00	Pathology	2.51	2.51	\$ 163.33	\$ 163.33
80406 00	Pathology	2.26	2.26	\$ 146.99	\$ 146.99
80408 00	Pathology	3.63	3.63	\$ 235.72	\$ 235.72
80410 00	Pathology	2.32	2.32	\$ 150.96	\$ 150.96
80412 00	Pathology	23.16	23.16	\$ 1,505.66	\$ 1,505.66
80414 00	Pathology	1.49	1.49	\$ 96.99	\$ 96.99
80415 00	Pathology	1.62	1.62	\$ 104.98	\$ 104.98
80416 00	Pathology	6.05	6.05	\$ 393.16	\$ 393.16
80417 00	Pathology	1.27	1.27	\$ 82.63	\$ 82.63
80418 00	Pathology	16.74	16.74	\$ 1,088.42	\$ 1,088.42
80420 00	Pathology	4.68	4.68	\$ 304.06	\$ 304.06
80422 00	Pathology	1.33	1.33	\$ 86.53	\$ 86.53
80424 00	Pathology	1.46	1.46	\$ 94.85	\$ 94.85
80426 00	Pathology	4.29	4.29	\$ 278.75	\$ 278.75
80428 00	Pathology	1.93	1.93	\$ 125.28	\$ 125.28
80430 00	Pathology	3.74	3.74	\$ 242.92	\$ 242.92
80432 00	Pathology	4.79	4.79	\$ 311.06	\$ 311.06
80434 00	Pathology	8.24	8.24	\$ 535.37	\$ 535.37
80435 00	Pathology	2.98	2.98	\$ 193.46	\$ 193.46
80436 00	Pathology	2.63	2.63	\$ 171.22	\$ 171.22
80438 00	Pathology	1.46	1.46	\$ 94.68	\$ 94.68
80439 00	Pathology	1.94	1.94	\$ 126.24	\$ 126.24
80503 00	Pathology	0.77	0.65	\$ 50.05	\$ 42.25
80504 00	Pathology	1.54	1.39	\$ 100.10	\$ 90.35
80505 00	Pathology	2.79	2.62	\$ 181.35	\$ 170.30
80506 00	Pathology	1.25	1.25	\$ 81.25	\$ 81.25

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
81000 00	Pathology	0.12	0.12	\$ 7.55	\$ 7.55
81001 00	Pathology	0.09	0.09	\$ 5.95	\$ 5.95
81002 00	Pathology	0.10	0.10	\$ 6.54	\$ 6.54
81003 00	Pathology	0.07	0.07	\$ 4.23	\$ 4.23
81005 00	Pathology	0.06	0.06	\$ 4.08	\$ 4.08
81007 00	Pathology	0.87	0.87	\$ 56.31	\$ 56.31
81015 00	Pathology	0.09	0.09	\$ 5.73	\$ 5.73
81020 00	Pathology	0.14	0.14	\$ 8.83	\$ 8.83
81025 00	Pathology	0.25	0.25	\$ 16.17	\$ 16.17
81050 00	Pathology	0.11	0.11	\$ 6.84	\$ 6.84
81099 00	Pathology	0.00	0.00	BR	BR
81105 00	Pathology	3.53	3.53	\$ 229.56	\$ 229.56
81106 00	Pathology	3.53	3.53	\$ 229.56	\$ 229.56
81107 00	Pathology	3.53	3.53	\$ 229.56	\$ 229.56
81108 00	Pathology	3.53	3.53	\$ 229.56	\$ 229.56
81109 00	Pathology	3.53	3.53	\$ 229.56	\$ 229.56
81110 00	Pathology	3.53	3.53	\$ 229.56	\$ 229.56
81111 00	Pathology	3.53	3.53	\$ 229.56	\$ 229.56
81112 00	Pathology	3.53	3.53	\$ 229.56	\$ 229.56
81120 00	Pathology	5.58	5.58	\$ 362.98	\$ 362.98
81121 00	Pathology	8.55	8.55	\$ 555.58	\$ 555.58
81161 00	Pathology	8.06	8.06	\$ 524.04	\$ 524.04
81162 00	Pathology	52.73	52.73	\$ 3,427.63	\$ 3,427.63
81163 00	Pathology	13.52	13.52	\$ 879.03	\$ 879.03
81164 00	Pathology	16.88	16.88	\$ 1,097.35	\$ 1,097.35
81165 00	Pathology	8.17	8.17	\$ 531.33	\$ 531.33
81166 00	Pathology	8.71	8.71	\$ 566.02	\$ 566.02
81167 00	Pathology	8.17	8.17	\$ 531.33	\$ 531.33
81168 00	Pathology	5.99	5.99	\$ 389.39	\$ 389.39
81170 00	Pathology	8.67	8.67	\$ 563.48	\$ 563.48
81171 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81172 00	Pathology	7.94	7.94	\$ 516.21	\$ 516.21
81173 00	Pathology	8.71	8.71	\$ 566.02	\$ 566.02
81174 00	Pathology	5.35	5.35	\$ 347.86	\$ 347.86
81175 00	Pathology	19.55	19.55	\$ 1,270.65	\$ 1,270.65
81176 00	Pathology	6.99	6.99	\$ 454.35	\$ 454.35
81177 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81178 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81179 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81180 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81181 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81182 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81183 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81184 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81185 00	Pathology	24.45	24.45	\$ 1,589.53	\$ 1,589.53
81186 00	Pathology	5.35	5.35	\$ 347.86	\$ 347.86
81187 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81188 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81189 00	Pathology	7.94	7.94	\$ 516.21	\$ 516.21
81190 00	Pathology	5.35	5.35	\$ 347.86	\$ 347.86
81191 00	Pathology	5.99	5.99	\$ 389.39	\$ 389.39
81192 00	Pathology	5.99	5.99	\$ 389.39	\$ 389.39
81193 00	Pathology	5.99	5.99	\$ 389.39	\$ 389.39
81194 00	Pathology	14.98	14.98	\$ 973.47	\$ 973.47
81200 00	Pathology	1.37	1.37	\$ 88.75	\$ 88.75

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
81201 00	Pathology	22.54	22.54	\$ 1,465.06	\$ 1,465.06
81202 00	Pathology	8.09	8.09	\$ 525.92	\$ 525.92
81203 00	Pathology	5.78	5.78	\$ 375.66	\$ 375.66
81204 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81205 00	Pathology	2.74	2.74	\$ 178.42	\$ 178.42
81206 00	Pathology	4.74	4.74	\$ 307.96	\$ 307.96
81207 00	Pathology	4.19	4.19	\$ 272.05	\$ 272.05
81208 00	Pathology	6.20	6.20	\$ 403.12	\$ 403.12
81209 00	Pathology	1.14	1.14	\$ 73.84	\$ 73.84
81210 00	Pathology	5.07	5.07	\$ 329.45	\$ 329.45
81212 00	Pathology	12.71	12.71	\$ 826.44	\$ 826.44
81215 00	Pathology	10.84	10.84	\$ 704.82	\$ 704.82
81216 00	Pathology	5.35	5.35	\$ 347.71	\$ 347.71
81217 00	Pathology	10.84	10.84	\$ 704.82	\$ 704.82
81218 00	Pathology	6.99	6.99	\$ 454.35	\$ 454.35
81219 00	Pathology	3.51	3.51	\$ 228.45	\$ 228.45
81220 00	Pathology	16.08	16.08	\$ 1,045.45	\$ 1,045.45
81221 00	Pathology	2.81	2.81	\$ 182.61	\$ 182.61
81222 00	Pathology	12.57	12.57	\$ 817.18	\$ 817.18
81223 00	Pathology	14.42	14.42	\$ 937.26	\$ 937.26
81224 00	Pathology	4.88	4.88	\$ 316.96	\$ 316.96
81225 00	Pathology	8.42	8.42	\$ 547.25	\$ 547.25
81226 00	Pathology	13.03	13.03	\$ 846.93	\$ 846.93
81227 00	Pathology	5.05	5.05	\$ 328.34	\$ 328.34
81228 00	Pathology	26.01	26.01	\$ 1,690.45	\$ 1,690.45
81229 00	Pathology	33.52	33.52	\$ 2,178.80	\$ 2,178.80
81230 00	Pathology	5.05	5.05	\$ 328.34	\$ 328.34
81231 00	Pathology	5.05	5.05	\$ 328.34	\$ 328.34
81232 00	Pathology	5.05	5.05	\$ 328.34	\$ 328.34
81233 00	Pathology	5.07	5.07	\$ 329.45	\$ 329.45
81234 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81235 00	Pathology	9.38	9.38	\$ 609.65	\$ 609.65
81236 00	Pathology	8.17	8.17	\$ 531.33	\$ 531.33
81237 00	Pathology	5.07	5.07	\$ 329.45	\$ 329.45
81238 00	Pathology	17.34	17.34	\$ 1,126.97	\$ 1,126.97
81239 00	Pathology	7.94	7.94	\$ 516.21	\$ 516.21
81240 00	Pathology	1.90	1.90	\$ 123.38	\$ 123.38
81241 00	Pathology	2.12	2.12	\$ 137.81	\$ 137.81
81242 00	Pathology	1.06	1.06	\$ 68.78	\$ 68.78
81243 00	Pathology	1.65	1.65	\$ 107.14	\$ 107.14
81244 00	Pathology	1.30	1.30	\$ 84.32	\$ 84.32
81245 00	Pathology	4.78	4.78	\$ 310.87	\$ 310.87
81246 00	Pathology	2.40	2.40	\$ 155.90	\$ 155.90
81247 00	Pathology	5.05	5.05	\$ 328.34	\$ 328.34
81248 00	Pathology	10.84	10.84	\$ 704.82	\$ 704.82
81249 00	Pathology	17.34	17.34	\$ 1,126.97	\$ 1,126.97
81250 00	Pathology	1.69	1.69	\$ 109.86	\$ 109.86
81251 00	Pathology	1.37	1.37	\$ 88.75	\$ 88.75
81252 00	Pathology	2.92	2.92	\$ 189.93	\$ 189.93
81253 00	Pathology	1.78	1.78	\$ 115.55	\$ 115.55
81254 00	Pathology	1.01	1.01	\$ 65.74	\$ 65.74
81255 00	Pathology	1.49	1.49	\$ 96.64	\$ 96.64
81256 00	Pathology	1.89	1.89	\$ 122.76	\$ 122.76
81257 00	Pathology	2.95	2.95	\$ 192.07	\$ 192.07
81258 00	Pathology	10.84	10.84	\$ 704.82	\$ 704.82

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
81259 00	Pathology	17.34	17.34	\$ 1,126.97	\$ 1,126.97
81260 00	Pathology	1.14	1.14	\$ 73.84	\$ 73.84
81261 00	Pathology	5.72	5.72	\$ 371.88	\$ 371.88
81262 00	Pathology	1.98	1.98	\$ 128.76	\$ 128.76
81263 00	Pathology	8.51	8.51	\$ 553.19	\$ 553.19
81264 00	Pathology	4.99	4.99	\$ 324.43	\$ 324.43
81265 00	Pathology	6.73	6.73	\$ 437.77	\$ 437.77
81266 00	Pathology	8.81	8.81	\$ 572.52	\$ 572.52
81267 00	Pathology	5.99	5.99	\$ 389.67	\$ 389.67
81268 00	Pathology	7.54	7.54	\$ 489.84	\$ 489.84
81269 00	Pathology	5.85	5.85	\$ 380.16	\$ 380.16
81270 00	Pathology	2.65	2.65	\$ 172.16	\$ 172.16
81271 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81272 00	Pathology	9.52	9.52	\$ 618.91	\$ 618.91
81273 00	Pathology	3.61	3.61	\$ 234.54	\$ 234.54
81274 00	Pathology	7.94	7.94	\$ 516.21	\$ 516.21
81275 00	Pathology	5.58	5.58	\$ 362.98	\$ 362.98
81276 00	Pathology	5.58	5.58	\$ 362.98	\$ 362.98
81277 00	Pathology	33.52	33.52	\$ 2,178.80	\$ 2,178.80
81278 00	Pathology	5.99	5.99	\$ 389.39	\$ 389.39
81279 00	Pathology	5.35	5.35	\$ 347.86	\$ 347.86
81283 00	Pathology	2.12	2.12	\$ 137.81	\$ 137.81
81284 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81285 00	Pathology	7.94	7.94	\$ 516.21	\$ 516.21
81286 00	Pathology	7.94	7.94	\$ 516.21	\$ 516.21
81287 00	Pathology	3.60	3.60	\$ 234.11	\$ 234.11
81288 00	Pathology	5.56	5.56	\$ 361.23	\$ 361.23
81289 00	Pathology	5.35	5.35	\$ 347.86	\$ 347.86
81290 00	Pathology	1.14	1.14	\$ 73.84	\$ 73.84
81291 00	Pathology	1.89	1.89	\$ 122.73	\$ 122.73
81292 00	Pathology	19.52	19.52	\$ 1,268.59	\$ 1,268.59
81293 00	Pathology	9.56	9.56	\$ 621.71	\$ 621.71
81294 00	Pathology	5.85	5.85	\$ 380.16	\$ 380.16
81295 00	Pathology	11.03	11.03	\$ 716.94	\$ 716.94
81296 00	Pathology	9.76	9.76	\$ 634.35	\$ 634.35
81297 00	Pathology	6.16	6.16	\$ 400.64	\$ 400.64
81298 00	Pathology	18.55	18.55	\$ 1,205.57	\$ 1,205.57
81299 00	Pathology	8.90	8.90	\$ 578.51	\$ 578.51
81300 00	Pathology	6.88	6.88	\$ 447.03	\$ 447.03
81301 00	Pathology	10.07	10.07	\$ 654.69	\$ 654.69
81302 00	Pathology	15.25	15.25	\$ 991.49	\$ 991.49
81303 00	Pathology	3.47	3.47	\$ 225.39	\$ 225.39
81304 00	Pathology	4.33	4.33	\$ 281.74	\$ 281.74
81305 00	Pathology	5.07	5.07	\$ 329.45	\$ 329.45
81306 00	Pathology	8.42	8.42	\$ 547.25	\$ 547.25
81307 00	Pathology	19.55	19.55	\$ 1,270.65	\$ 1,270.65
81308 00	Pathology	8.71	8.71	\$ 566.02	\$ 566.02
81309 00	Pathology	7.94	7.94	\$ 516.21	\$ 516.21
81310 00	Pathology	7.12	7.12	\$ 463.03	\$ 463.03
81311 00	Pathology	8.55	8.55	\$ 555.58	\$ 555.58
81312 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81313 00	Pathology	7.37	7.37	\$ 479.05	\$ 479.05
81314 00	Pathology	9.52	9.52	\$ 618.91	\$ 618.91
81315 00	Pathology	5.99	5.99	\$ 389.39	\$ 389.39
81316 00	Pathology	5.99	5.99	\$ 389.39	\$ 389.39

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
81317 00	Pathology	19.55	19.55	\$ 1,270.65	\$ 1,270.65
81318 00	Pathology	9.56	9.56	\$ 621.71	\$ 621.71
81319 00	Pathology	5.88	5.88	\$ 382.23	\$ 382.23
81320 00	Pathology	8.42	8.42	\$ 547.25	\$ 547.25
81321 00	Pathology	17.34	17.34	\$ 1,126.97	\$ 1,126.97
81322 00	Pathology	1.35	1.35	\$ 87.53	\$ 87.53
81323 00	Pathology	8.67	8.67	\$ 563.48	\$ 563.48
81324 00	Pathology	21.91	21.91	\$ 1,424.41	\$ 1,424.41
81325 00	Pathology	22.24	22.24	\$ 1,445.48	\$ 1,445.48
81326 00	Pathology	1.35	1.35	\$ 87.53	\$ 87.53
81327 00	Pathology	5.55	5.55	\$ 360.63	\$ 360.63
81328 00	Pathology	5.05	5.05	\$ 328.34	\$ 328.34
81329 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81330 00	Pathology	1.36	1.36	\$ 88.28	\$ 88.28
81331 00	Pathology	1.48	1.48	\$ 95.92	\$ 95.92
81332 00	Pathology	1.26	1.26	\$ 81.99	\$ 81.99
81333 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81334 00	Pathology	9.52	9.52	\$ 618.91	\$ 618.91
81335 00	Pathology	5.05	5.05	\$ 328.34	\$ 328.34
81336 00	Pathology	8.71	8.71	\$ 566.02	\$ 566.02
81337 00	Pathology	5.35	5.35	\$ 347.86	\$ 347.86
81338 00	Pathology	4.34	4.34	\$ 282.36	\$ 282.36
81339 00	Pathology	5.35	5.35	\$ 347.86	\$ 347.86
81340 00	Pathology	6.04	6.04	\$ 392.41	\$ 392.41
81341 00	Pathology	1.43	1.43	\$ 93.14	\$ 93.14
81342 00	Pathology	5.82	5.82	\$ 378.47	\$ 378.47
81343 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81344 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81345 00	Pathology	5.35	5.35	\$ 347.86	\$ 347.86
81346 00	Pathology	5.05	5.05	\$ 328.34	\$ 328.34
81347 00	Pathology	5.58	5.58	\$ 362.98	\$ 362.98
81348 00	Pathology	5.07	5.07	\$ 329.45	\$ 329.45
81349 00	Pathology	0.00	0.00	BR	BR
81350 00	Pathology	6.76	6.76	\$ 439.52	\$ 439.52
81351 00	Pathology	18.55	18.55	\$ 1,205.57	\$ 1,205.57
81352 00	Pathology	9.52	9.52	\$ 618.91	\$ 618.91
81353 00	Pathology	8.90	8.90	\$ 578.51	\$ 578.51
81355 00	Pathology	2.55	2.55	\$ 165.66	\$ 165.66
81357 00	Pathology	5.58	5.58	\$ 362.98	\$ 362.98
81360 00	Pathology	5.58	5.58	\$ 362.98	\$ 362.98
81361 00	Pathology	5.05	5.05	\$ 328.34	\$ 328.34
81362 00	Pathology	10.84	10.84	\$ 704.82	\$ 704.82
81363 00	Pathology	5.85	5.85	\$ 380.16	\$ 380.16
81364 00	Pathology	9.38	9.38	\$ 609.65	\$ 609.65
81370 00	Pathology	11.62	11.62	\$ 755.29	\$ 755.29
81371 00	Pathology	11.69	11.69	\$ 759.80	\$ 759.80
81372 00	Pathology	11.66	11.66	\$ 758.05	\$ 758.05
81373 00	Pathology	3.68	3.68	\$ 239.35	\$ 239.35
81374 00	Pathology	2.15	2.15	\$ 139.61	\$ 139.61
81375 00	Pathology	6.38	6.38	\$ 414.61	\$ 414.61
81376 00	Pathology	3.53	3.53	\$ 229.56	\$ 229.56
81377 00	Pathology	2.74	2.74	\$ 177.95	\$ 177.95
81378 00	Pathology	9.99	9.99	\$ 649.08	\$ 649.08
81379 00	Pathology	9.69	9.69	\$ 629.94	\$ 629.94
81380 00	Pathology	5.12	5.12	\$ 332.92	\$ 332.92

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
81381 00	Pathology	4.91	4.91	\$ 319.12	\$ 319.12
81382 00	Pathology	3.57	3.57	\$ 232.31	\$ 232.31
81383 00	Pathology	3.15	3.15	\$ 204.98	\$ 204.98
81400 00	Pathology	1.85	1.85	\$ 120.13	\$ 120.13
81401 00	Pathology	3.96	3.96	\$ 257.32	\$ 257.32
81402 00	Pathology	4.34	4.34	\$ 282.36	\$ 282.36
81403 00	Pathology	5.35	5.35	\$ 347.86	\$ 347.86
81404 00	Pathology	7.94	7.94	\$ 516.21	\$ 516.21
81405 00	Pathology	8.71	8.71	\$ 566.02	\$ 566.02
81406 00	Pathology	8.17	8.17	\$ 531.33	\$ 531.33
81407 00	Pathology	24.45	24.45	\$ 1,589.53	\$ 1,589.53
81408 00	Pathology	57.79	57.79	\$ 3,756.55	\$ 3,756.55
81410 00	Pathology	14.56	14.56	\$ 946.65	\$ 946.65
81411 00	Pathology	39.02	39.02	\$ 2,536.03	\$ 2,536.03
81412 00	Pathology	70.75	70.75	\$ 4,599.07	\$ 4,599.07
81413 00	Pathology	16.90	16.90	\$ 1,098.60	\$ 1,098.60
81414 00	Pathology	16.90	16.90	\$ 1,098.60	\$ 1,098.60
81415 00	Pathology	138.13	138.13	\$ 8,978.16	\$ 8,978.16
81416 00	Pathology	346.76	346.76	\$ 22,539.31	\$ 22,539.31
81417 00	Pathology	9.25	9.25	\$ 601.05	\$ 601.05
81419 00	Pathology	70.75	70.75	\$ 4,599.07	\$ 4,599.07
81420 00	Pathology	21.93	21.93	\$ 1,425.71	\$ 1,425.71
81422 00	Pathology	21.93	21.93	\$ 1,425.71	\$ 1,425.71
81425 00	Pathology	145.38	145.38	\$ 9,449.98	\$ 9,449.98
81426 00	Pathology	78.31	78.31	\$ 5,090.03	\$ 5,090.03
81427 00	Pathology	67.55	67.55	\$ 4,390.75	\$ 4,390.75
81430 00	Pathology	46.96	46.96	\$ 3,052.20	\$ 3,052.20
81431 00	Pathology	19.64	19.64	\$ 1,276.42	\$ 1,276.42
81432 00	Pathology	19.62	19.62	\$ 1,275.44	\$ 1,275.44
81433 00	Pathology	12.68	12.68	\$ 824.43	\$ 824.43
81434 00	Pathology	17.28	17.28	\$ 1,123.04	\$ 1,123.04
81435 00	Pathology	16.90	16.90	\$ 1,098.60	\$ 1,098.60
81436 00	Pathology	16.90	16.90	\$ 1,098.60	\$ 1,098.60
81437 00	Pathology	12.68	12.68	\$ 824.43	\$ 824.43
81438 00	Pathology	12.68	12.68	\$ 824.43	\$ 824.43
81439 00	Pathology	16.90	16.90	\$ 1,098.60	\$ 1,098.60
81440 00	Pathology	96.05	96.05	\$ 6,243.39	\$ 6,243.39
81442 00	Pathology	61.94	61.94	\$ 4,026.27	\$ 4,026.27
81443 00	Pathology	70.75	70.75	\$ 4,599.07	\$ 4,599.07
81445 00	Pathology	17.28	17.28	\$ 1,123.04	\$ 1,123.04
81448 00	Pathology	16.90	16.90	\$ 1,098.60	\$ 1,098.60
81450 00	Pathology	21.95	21.95	\$ 1,426.61	\$ 1,426.61
81455 00	Pathology	84.37	84.37	\$ 5,483.82	\$ 5,483.82
81460 00	Pathology	37.19	37.19	\$ 2,417.34	\$ 2,417.34
81465 00	Pathology	27.05	27.05	\$ 1,758.07	\$ 1,758.07
81470 00	Pathology	26.41	26.41	\$ 1,716.74	\$ 1,716.74
81471 00	Pathology	26.41	26.41	\$ 1,716.74	\$ 1,716.74
81479 00	Pathology	0.00	0.00	BR	BR
81490 00	Pathology	24.29	24.29	\$ 1,578.97	\$ 1,578.97
81493 00	Pathology	30.34	30.34	\$ 1,972.19	\$ 1,972.19
81500 00	Pathology	7.53	7.53	\$ 489.29	\$ 489.29
81503 00	Pathology	25.92	25.92	\$ 1,684.81	\$ 1,684.81
81504 00	Pathology	15.03	15.03	\$ 976.70	\$ 976.70
81506 00	Pathology	1.99	1.99	\$ 129.45	\$ 129.45
81507 00	Pathology	22.97	22.97	\$ 1,493.23	\$ 1,493.23

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
81508 00	Pathology	1.57	1.57	\$ 101.99	\$ 101.99
81509 00	Pathology	42.98	42.98	\$ 2,793.69	\$ 2,793.69
81510 00	Pathology	1.60	1.60	\$ 104.32	\$ 104.32
81511 00	Pathology	4.44	4.44	\$ 288.32	\$ 288.32
81512 00	Pathology	2.01	2.01	\$ 130.58	\$ 130.58
81513 00	Pathology	4.12	4.12	\$ 267.90	\$ 267.90
81514 00	Pathology	7.60	7.60	\$ 493.97	\$ 493.97
81518 00	Pathology	111.92	111.92	\$ 7,274.56	\$ 7,274.56
81519 00	Pathology	111.92	111.92	\$ 7,274.56	\$ 7,274.56
81520 00	Pathology	72.54	72.54	\$ 4,714.87	\$ 4,714.87
81521 00	Pathology	111.92	111.92	\$ 7,274.56	\$ 7,274.56
81522 00	Pathology	111.92	111.92	\$ 7,274.56	\$ 7,274.56
81523 00	Pathology	111.92	111.92	\$ 7,274.56	\$ 7,274.56
81525 00	Pathology	90.04	90.04	\$ 5,852.71	\$ 5,852.71
81528 00	Pathology	14.70	14.70	\$ 955.80	\$ 955.80
81529 00	Pathology	207.85	207.85	\$ 13,510.44	\$ 13,510.44
81535 00	Pathology	16.74	16.74	\$ 1,088.39	\$ 1,088.39
81536 00	Pathology	5.13	5.13	\$ 333.51	\$ 333.51
81538 00	Pathology	82.96	82.96	\$ 5,392.53	\$ 5,392.53
81539 00	Pathology	21.96	21.96	\$ 1,427.49	\$ 1,427.49
81540 00	Pathology	108.36	108.36	\$ 7,043.54	\$ 7,043.54
81541 00	Pathology	111.92	111.92	\$ 7,274.56	\$ 7,274.56
81542 00	Pathology	111.92	111.92	\$ 7,274.56	\$ 7,274.56
81546 00	Pathology	104.03	104.03	\$ 6,761.79	\$ 6,761.79
81551 00	Pathology	58.66	58.66	\$ 3,812.90	\$ 3,812.90
81552 00	Pathology	224.70	224.70	\$ 14,605.48	\$ 14,605.48
81554 00	Pathology	158.93	158.93	\$ 10,330.52	\$ 10,330.52
81560 00	Pathology	0.00	0.00	BR	BR
81595 00	Pathology	93.62	93.62	\$ 6,085.61	\$ 6,085.61
81596 00	Pathology	2.09	2.09	\$ 135.59	\$ 135.59
81599 00	Pathology	0.00	0.00	BR	BR
82009 00	Pathology	0.13	0.13	\$ 8.49	\$ 8.49
82010 00	Pathology	0.24	0.24	\$ 15.35	\$ 15.35
82013 00	Pathology	0.36	0.36	\$ 23.08	\$ 23.08
82016 00	Pathology	0.48	0.48	\$ 30.97	\$ 30.97
82017 00	Pathology	0.49	0.49	\$ 31.69	\$ 31.69
82024 00	Pathology	1.12	1.12	\$ 72.54	\$ 72.54
82030 00	Pathology	0.75	0.75	\$ 48.46	\$ 48.46
82040 00	Pathology	0.14	0.14	\$ 9.30	\$ 9.30
82042 00	Pathology	0.22	0.22	\$ 14.61	\$ 14.61
82043 00	Pathology	0.17	0.17	\$ 10.86	\$ 10.86
82044 00	Pathology	0.18	0.18	\$ 11.70	\$ 11.70
82045 00	Pathology	0.98	0.98	\$ 63.75	\$ 63.75
82075 00	Pathology	0.87	0.87	\$ 56.35	\$ 56.35
82077 00	Pathology	0.50	0.50	\$ 32.44	\$ 32.44
82085 00	Pathology	0.28	0.28	\$ 18.24	\$ 18.24
82088 00	Pathology	1.18	1.18	\$ 76.54	\$ 76.54
82103 00	Pathology	0.39	0.39	\$ 25.24	\$ 25.24
82104 00	Pathology	0.42	0.42	\$ 27.16	\$ 27.16
82105 00	Pathology	0.48	0.48	\$ 31.50	\$ 31.50
82106 00	Pathology	0.49	0.49	\$ 31.93	\$ 31.93
82107 00	Pathology	1.86	1.86	\$ 120.98	\$ 120.98
82108 00	Pathology	0.74	0.74	\$ 47.86	\$ 47.86
82120 00	Pathology	0.17	0.17	\$ 11.25	\$ 11.25
82127 00	Pathology	0.41	0.41	\$ 26.63	\$ 26.63

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
82128 00	Pathology	0.40	0.40	\$ 26.05	\$ 26.05
82131 00	Pathology	0.66	0.66	\$ 43.16	\$ 43.16
82135 00	Pathology	0.48	0.48	\$ 30.90	\$ 30.90
82136 00	Pathology	0.57	0.57	\$ 36.83	\$ 36.83
82139 00	Pathology	0.49	0.49	\$ 31.69	\$ 31.69
82140 00	Pathology	0.42	0.42	\$ 27.37	\$ 27.37
82143 00	Pathology	0.27	0.27	\$ 17.56	\$ 17.56
82150 00	Pathology	0.19	0.19	\$ 12.17	\$ 12.17
82154 00	Pathology	0.83	0.83	\$ 54.15	\$ 54.15
82157 00	Pathology	0.85	0.85	\$ 55.00	\$ 55.00
82160 00	Pathology	0.74	0.74	\$ 47.99	\$ 47.99
82163 00	Pathology	0.59	0.59	\$ 38.54	\$ 38.54
82164 00	Pathology	0.42	0.42	\$ 27.42	\$ 27.42
82172 00	Pathology	0.61	0.61	\$ 39.61	\$ 39.61
82175 00	Pathology	0.55	0.55	\$ 35.63	\$ 35.63
82180 00	Pathology	0.29	0.29	\$ 18.58	\$ 18.58
82190 00	Pathology	0.46	0.46	\$ 29.86	\$ 29.86
82232 00	Pathology	0.47	0.47	\$ 30.39	\$ 30.39
82239 00	Pathology	0.49	0.49	\$ 32.16	\$ 32.16
82240 00	Pathology	0.77	0.77	\$ 49.92	\$ 49.92
82247 00	Pathology	0.15	0.15	\$ 9.43	\$ 9.43
82248 00	Pathology	0.15	0.15	\$ 9.43	\$ 9.43
82252 00	Pathology	0.13	0.13	\$ 8.56	\$ 8.56
82261 00	Pathology	0.49	0.49	\$ 31.69	\$ 31.69
82270 00	Pathology	0.13	0.13	\$ 8.23	\$ 8.23
82271 00	Pathology	0.15	0.15	\$ 9.99	\$ 9.99
82272 00	Pathology	0.12	0.12	\$ 7.95	\$ 7.95
82274 00	Pathology	0.46	0.46	\$ 29.90	\$ 29.90
82286 00	Pathology	0.15	0.15	\$ 9.69	\$ 9.69
82300 00	Pathology	0.68	0.68	\$ 44.40	\$ 44.40
82306 00	Pathology	0.86	0.86	\$ 55.60	\$ 55.60
82308 00	Pathology	0.77	0.77	\$ 50.32	\$ 50.32
82310 00	Pathology	0.15	0.15	\$ 9.69	\$ 9.69
82330 00	Pathology	0.40	0.40	\$ 25.69	\$ 25.69
82331 00	Pathology	0.39	0.39	\$ 25.06	\$ 25.06
82340 00	Pathology	0.17	0.17	\$ 11.33	\$ 11.33
82355 00	Pathology	0.33	0.33	\$ 21.75	\$ 21.75
82360 00	Pathology	0.37	0.37	\$ 24.17	\$ 24.17
82365 00	Pathology	0.37	0.37	\$ 24.23	\$ 24.23
82370 00	Pathology	0.36	0.36	\$ 23.52	\$ 23.52
82373 00	Pathology	0.52	0.52	\$ 33.92	\$ 33.92
82374 00	Pathology	0.14	0.14	\$ 9.17	\$ 9.17
82375 00	Pathology	0.36	0.36	\$ 23.14	\$ 23.14
82376 00	Pathology	0.41	0.41	\$ 26.43	\$ 26.43
82378 00	Pathology	0.55	0.55	\$ 35.61	\$ 35.61
82379 00	Pathology	0.49	0.49	\$ 31.69	\$ 31.69
82380 00	Pathology	0.27	0.27	\$ 17.32	\$ 17.32
82382 00	Pathology	0.79	0.79	\$ 51.28	\$ 51.28
82383 00	Pathology	0.84	0.84	\$ 54.62	\$ 54.62
82384 00	Pathology	0.73	0.73	\$ 47.43	\$ 47.43
82387 00	Pathology	0.52	0.52	\$ 33.92	\$ 33.92
82390 00	Pathology	0.31	0.31	\$ 20.17	\$ 20.17
82397 00	Pathology	0.41	0.41	\$ 26.52	\$ 26.52
82415 00	Pathology	0.37	0.37	\$ 23.80	\$ 23.80
82435 00	Pathology	0.13	0.13	\$ 8.64	\$ 8.64

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
82436 00	Pathology	0.17	0.17	\$ 10.80	\$ 10.80
82438 00	Pathology	0.14	0.14	\$ 9.39	\$ 9.39
82441 00	Pathology	0.17	0.17	\$ 11.29	\$ 11.29
82465 00	Pathology	0.13	0.13	\$ 8.17	\$ 8.17
82480 00	Pathology	0.23	0.23	\$ 14.78	\$ 14.78
82482 00	Pathology	0.28	0.28	\$ 18.43	\$ 18.43
82485 00	Pathology	0.60	0.60	\$ 38.79	\$ 38.79
82495 00	Pathology	0.59	0.59	\$ 38.09	\$ 38.09
82507 00	Pathology	0.80	0.80	\$ 52.22	\$ 52.22
82523 00	Pathology	0.54	0.54	\$ 35.09	\$ 35.09
82525 00	Pathology	0.36	0.36	\$ 23.31	\$ 23.31
82528 00	Pathology	0.65	0.65	\$ 42.30	\$ 42.30
82530 00	Pathology	0.48	0.48	\$ 31.39	\$ 31.39
82533 00	Pathology	0.47	0.47	\$ 30.62	\$ 30.62
82540 00	Pathology	0.13	0.13	\$ 8.72	\$ 8.72
82542 00	Pathology	0.70	0.70	\$ 45.25	\$ 45.25
82550 00	Pathology	0.19	0.19	\$ 12.23	\$ 12.23
82552 00	Pathology	0.39	0.39	\$ 25.15	\$ 25.15
82553 00	Pathology	0.33	0.33	\$ 21.69	\$ 21.69
82554 00	Pathology	0.34	0.34	\$ 22.30	\$ 22.30
82565 00	Pathology	0.15	0.15	\$ 9.62	\$ 9.62
82570 00	Pathology	0.15	0.15	\$ 9.73	\$ 9.73
82575 00	Pathology	0.27	0.27	\$ 17.77	\$ 17.77
82585 00	Pathology	0.41	0.41	\$ 26.56	\$ 26.56
82595 00	Pathology	0.19	0.19	\$ 12.15	\$ 12.15
82600 00	Pathology	0.56	0.56	\$ 36.44	\$ 36.44
82607 00	Pathology	0.44	0.44	\$ 28.32	\$ 28.32
82608 00	Pathology	0.41	0.41	\$ 26.90	\$ 26.90
82610 00	Pathology	0.54	0.54	\$ 34.79	\$ 34.79
82615 00	Pathology	0.28	0.28	\$ 17.94	\$ 17.94
82626 00	Pathology	0.73	0.73	\$ 47.46	\$ 47.46
82627 00	Pathology	0.64	0.64	\$ 41.75	\$ 41.75
82633 00	Pathology	0.90	0.90	\$ 58.19	\$ 58.19
82634 00	Pathology	0.85	0.85	\$ 55.00	\$ 55.00
82638 00	Pathology	0.35	0.35	\$ 23.01	\$ 23.01
82642 00	Pathology	0.85	0.85	\$ 55.00	\$ 55.00
82652 00	Pathology	1.11	1.11	\$ 72.31	\$ 72.31
82653 00	Pathology	0.66	0.66	\$ 43.14	\$ 43.14
82656 00	Pathology	0.33	0.33	\$ 21.66	\$ 21.66
82657 00	Pathology	0.64	0.64	\$ 41.64	\$ 41.64
82658 00	Pathology	1.27	1.27	\$ 82.70	\$ 82.70
82664 00	Pathology	1.78	1.78	\$ 115.51	\$ 115.51
82668 00	Pathology	0.54	0.54	\$ 35.29	\$ 35.29
82670 00	Pathology	0.81	0.81	\$ 52.48	\$ 52.48
82671 00	Pathology	0.93	0.93	\$ 60.67	\$ 60.67
82672 00	Pathology	0.63	0.63	\$ 40.76	\$ 40.76
82677 00	Pathology	0.70	0.70	\$ 45.42	\$ 45.42
82679 00	Pathology	0.72	0.72	\$ 46.86	\$ 46.86
82681 00	Pathology	0.81	0.81	\$ 52.48	\$ 52.48
82693 00	Pathology	0.43	0.43	\$ 27.99	\$ 27.99
82696 00	Pathology	0.76	0.76	\$ 49.29	\$ 49.29
82705 00	Pathology	0.15	0.15	\$ 9.58	\$ 9.58
82710 00	Pathology	0.49	0.49	\$ 31.56	\$ 31.56
82715 00	Pathology	0.66	0.66	\$ 43.14	\$ 43.14
82725 00	Pathology	0.54	0.54	\$ 35.26	\$ 35.26

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
82726 00	Pathology	0.57	0.57	\$ 37.10	\$ 37.10
82728 00	Pathology	0.39	0.39	\$ 25.60	\$ 25.60
82731 00	Pathology	1.86	1.86	\$ 120.98	\$ 120.98
82735 00	Pathology	0.54	0.54	\$ 34.82	\$ 34.82
82746 00	Pathology	0.42	0.42	\$ 27.61	\$ 27.61
82747 00	Pathology	0.51	0.51	\$ 33.15	\$ 33.15
82757 00	Pathology	0.50	0.50	\$ 32.57	\$ 32.57
82759 00	Pathology	0.62	0.62	\$ 40.35	\$ 40.35
82760 00	Pathology	0.32	0.32	\$ 21.04	\$ 21.04
82775 00	Pathology	0.61	0.61	\$ 39.58	\$ 39.58
82776 00	Pathology	0.34	0.34	\$ 22.05	\$ 22.05
82777 00	Pathology	1.28	1.28	\$ 83.11	\$ 83.11
82784 00	Pathology	0.27	0.27	\$ 17.47	\$ 17.47
82785 00	Pathology	0.48	0.48	\$ 30.92	\$ 30.92
82787 00	Pathology	0.23	0.23	\$ 15.06	\$ 15.06
82800 00	Pathology	0.32	0.32	\$ 20.66	\$ 20.66
82803 00	Pathology	0.75	0.75	\$ 48.97	\$ 48.97
82805 00	Pathology	2.28	2.28	\$ 147.95	\$ 147.95
82810 00	Pathology	0.28	0.28	\$ 18.35	\$ 18.35
82820 00	Pathology	0.39	0.39	\$ 25.06	\$ 25.06
82930 00	Pathology	0.19	0.19	\$ 12.60	\$ 12.60
82938 00	Pathology	0.51	0.51	\$ 33.23	\$ 33.23
82941 00	Pathology	0.51	0.51	\$ 33.11	\$ 33.11
82943 00	Pathology	0.41	0.41	\$ 26.84	\$ 26.84
82945 00	Pathology	0.11	0.11	\$ 7.38	\$ 7.38
82946 00	Pathology	0.51	0.51	\$ 33.38	\$ 33.38
82947 00	Pathology	0.11	0.11	\$ 7.38	\$ 7.38
82948 00	Pathology	0.15	0.15	\$ 9.47	\$ 9.47
82950 00	Pathology	0.14	0.14	\$ 8.92	\$ 8.92
82951 00	Pathology	0.37	0.37	\$ 24.17	\$ 24.17
82952 00	Pathology	0.11	0.11	\$ 7.36	\$ 7.36
82955 00	Pathology	0.28	0.28	\$ 18.22	\$ 18.22
82960 00	Pathology	0.17	0.17	\$ 11.36	\$ 11.36
82962 00	Pathology	0.09	0.09	\$ 6.16	\$ 6.16
82963 00	Pathology	0.62	0.62	\$ 40.35	\$ 40.35
82965 00	Pathology	0.38	0.38	\$ 24.70	\$ 24.70
82977 00	Pathology	0.21	0.21	\$ 13.52	\$ 13.52
82978 00	Pathology	0.45	0.45	\$ 29.02	\$ 29.02
82979 00	Pathology	0.27	0.27	\$ 17.73	\$ 17.73
82985 00	Pathology	0.48	0.48	\$ 31.48	\$ 31.48
83001 00	Pathology	0.54	0.54	\$ 34.90	\$ 34.90
83002 00	Pathology	0.54	0.54	\$ 34.79	\$ 34.79
83003 00	Pathology	0.48	0.48	\$ 31.31	\$ 31.31
83006 00	Pathology	2.18	2.18	\$ 142.00	\$ 142.00
83009 00	Pathology	1.95	1.95	\$ 126.52	\$ 126.52
83010 00	Pathology	0.36	0.36	\$ 23.63	\$ 23.63
83012 00	Pathology	0.78	0.78	\$ 50.51	\$ 50.51
83013 00	Pathology	1.95	1.95	\$ 126.52	\$ 126.52
83014 00	Pathology	0.23	0.23	\$ 14.76	\$ 14.76
83015 00	Pathology	0.61	0.61	\$ 39.33	\$ 39.33
83018 00	Pathology	0.63	0.63	\$ 41.25	\$ 41.25
83020 00	Pathology	0.37	0.37	\$ 24.17	\$ 24.17
83020 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45
83021 00	Pathology	0.52	0.52	\$ 33.92	\$ 33.92
83026 00	Pathology	0.12	0.12	\$ 7.53	\$ 7.53

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
83030 00	Pathology	0.31	0.31	\$ 20.17	\$ 20.17
83033 00	Pathology	0.23	0.23	\$ 15.03	\$ 15.03
83036 00	Pathology	0.28	0.28	\$ 18.24	\$ 18.24
83037 00	Pathology	0.28	0.28	\$ 18.24	\$ 18.24
83045 00	Pathology	0.19	0.19	\$ 12.19	\$ 12.19
83050 00	Pathology	0.24	0.24	\$ 15.40	\$ 15.40
83051 00	Pathology	0.21	0.21	\$ 13.73	\$ 13.73
83060 00	Pathology	0.25	0.25	\$ 16.53	\$ 16.53
83065 00	Pathology	0.26	0.26	\$ 16.90	\$ 16.90
83068 00	Pathology	0.27	0.27	\$ 17.79	\$ 17.79
83069 00	Pathology	0.11	0.11	\$ 7.42	\$ 7.42
83070 00	Pathology	0.14	0.14	\$ 8.92	\$ 8.92
83080 00	Pathology	0.49	0.49	\$ 31.69	\$ 31.69
83088 00	Pathology	0.85	0.85	\$ 55.47	\$ 55.47
83090 00	Pathology	0.52	0.52	\$ 33.66	\$ 33.66
83150 00	Pathology	0.65	0.65	\$ 42.09	\$ 42.09
83491 00	Pathology	0.52	0.52	\$ 33.62	\$ 33.62
83497 00	Pathology	0.37	0.37	\$ 24.23	\$ 24.23
83498 00	Pathology	0.79	0.79	\$ 51.03	\$ 51.03
83500 00	Pathology	0.65	0.65	\$ 42.54	\$ 42.54
83505 00	Pathology	0.70	0.70	\$ 45.64	\$ 45.64
83516 00	Pathology	0.33	0.33	\$ 21.66	\$ 21.66
83518 00	Pathology	0.28	0.28	\$ 18.11	\$ 18.11
83519 00	Pathology	0.53	0.53	\$ 34.56	\$ 34.56
83520 00	Pathology	0.50	0.50	\$ 32.44	\$ 32.44
83521 00	Pathology	0.50	0.50	\$ 32.44	\$ 32.44
83525 00	Pathology	0.33	0.33	\$ 21.47	\$ 21.47
83527 00	Pathology	0.37	0.37	\$ 24.32	\$ 24.32
83528 00	Pathology	0.57	0.57	\$ 37.23	\$ 37.23
83529 00	Pathology	0.50	0.50	\$ 32.44	\$ 32.44
83540 00	Pathology	0.19	0.19	\$ 12.15	\$ 12.15
83550 00	Pathology	0.25	0.25	\$ 16.42	\$ 16.42
83570 00	Pathology	0.26	0.26	\$ 16.62	\$ 16.62
83582 00	Pathology	0.45	0.45	\$ 29.06	\$ 29.06
83586 00	Pathology	0.37	0.37	\$ 24.04	\$ 24.04
83593 00	Pathology	0.82	0.82	\$ 53.53	\$ 53.53
83605 00	Pathology	0.33	0.33	\$ 21.73	\$ 21.73
83615 00	Pathology	0.17	0.17	\$ 11.34	\$ 11.34
83625 00	Pathology	0.37	0.37	\$ 24.02	\$ 24.02
83630 00	Pathology	0.57	0.57	\$ 37.00	\$ 37.00
83631 00	Pathology	0.57	0.57	\$ 36.87	\$ 36.87
83632 00	Pathology	0.58	0.58	\$ 37.98	\$ 37.98
83633 00	Pathology	0.33	0.33	\$ 21.13	\$ 21.13
83655 00	Pathology	0.35	0.35	\$ 22.75	\$ 22.75
83661 00	Pathology	0.64	0.64	\$ 41.30	\$ 41.30
83662 00	Pathology	0.55	0.55	\$ 35.52	\$ 35.52
83663 00	Pathology	0.55	0.55	\$ 35.52	\$ 35.52
83664 00	Pathology	0.56	0.56	\$ 36.29	\$ 36.29
83670 00	Pathology	0.28	0.28	\$ 18.43	\$ 18.43
83690 00	Pathology	0.20	0.20	\$ 12.94	\$ 12.94
83695 00	Pathology	0.41	0.41	\$ 26.90	\$ 26.90
83698 00	Pathology	1.34	1.34	\$ 86.98	\$ 86.98
83700 00	Pathology	0.33	0.33	\$ 21.15	\$ 21.15
83701 00	Pathology	0.98	0.98	\$ 63.60	\$ 63.60
83704 00	Pathology	0.99	0.99	\$ 64.22	\$ 64.22

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
83718 00	Pathology	0.24	0.24	\$ 15.38	\$ 15.38
83719 00	Pathology	0.37	0.37	\$ 23.95	\$ 23.95
83721 00	Pathology	0.30	0.30	\$ 19.72	\$ 19.72
83722 00	Pathology	0.99	0.99	\$ 64.22	\$ 64.22
83727 00	Pathology	0.50	0.50	\$ 32.29	\$ 32.29
83735 00	Pathology	0.19	0.19	\$ 12.58	\$ 12.58
83775 00	Pathology	0.21	0.21	\$ 13.84	\$ 13.84
83785 00	Pathology	0.77	0.77	\$ 50.06	\$ 50.06
83789 00	Pathology	0.70	0.70	\$ 45.29	\$ 45.29
83825 00	Pathology	0.47	0.47	\$ 30.54	\$ 30.54
83835 00	Pathology	0.49	0.49	\$ 31.82	\$ 31.82
83857 00	Pathology	0.31	0.31	\$ 20.17	\$ 20.17
83861 00	Pathology	0.65	0.65	\$ 42.22	\$ 42.22
83864 00	Pathology	0.82	0.82	\$ 53.53	\$ 53.53
83872 00	Pathology	0.17	0.17	\$ 11.01	\$ 11.01
83873 00	Pathology	0.50	0.50	\$ 32.31	\$ 32.31
83874 00	Pathology	0.37	0.37	\$ 24.27	\$ 24.27
83876 00	Pathology	1.47	1.47	\$ 95.53	\$ 95.53
83880 00	Pathology	1.13	1.13	\$ 73.74	\$ 73.74
83883 00	Pathology	0.39	0.39	\$ 25.54	\$ 25.54
83885 00	Pathology	0.71	0.71	\$ 46.04	\$ 46.04
83915 00	Pathology	0.32	0.32	\$ 20.94	\$ 20.94
83916 00	Pathology	0.79	0.79	\$ 51.45	\$ 51.45
83918 00	Pathology	0.68	0.68	\$ 44.33	\$ 44.33
83919 00	Pathology	0.48	0.48	\$ 30.90	\$ 30.90
83921 00	Pathology	0.61	0.61	\$ 39.84	\$ 39.84
83930 00	Pathology	0.19	0.19	\$ 12.42	\$ 12.42
83935 00	Pathology	0.20	0.20	\$ 12.81	\$ 12.81
83937 00	Pathology	0.86	0.86	\$ 56.07	\$ 56.07
83945 00	Pathology	0.42	0.42	\$ 27.14	\$ 27.14
83950 00	Pathology	1.86	1.86	\$ 120.98	\$ 120.98
83951 00	Pathology	1.86	1.86	\$ 120.98	\$ 120.98
83970 00	Pathology	1.19	1.19	\$ 77.54	\$ 77.54
83986 00	Pathology	0.10	0.10	\$ 6.72	\$ 6.72
83987 00	Pathology	0.10	0.10	\$ 6.72	\$ 6.72
83992 00	Pathology	-	-	\$ 70.20	\$ 70.20
83993 00	Pathology	0.57	0.57	\$ 36.87	\$ 36.87
84030 00	Pathology	0.16	0.16	\$ 10.33	\$ 10.33
84035 00	Pathology	0.12	0.12	\$ 7.48	\$ 7.48
84060 00	Pathology	0.22	0.22	\$ 14.35	\$ 14.35
84066 00	Pathology	0.28	0.28	\$ 18.14	\$ 18.14
84075 00	Pathology	0.15	0.15	\$ 9.73	\$ 9.73
84078 00	Pathology	0.24	0.24	\$ 15.51	\$ 15.51
84080 00	Pathology	0.43	0.43	\$ 27.76	\$ 27.76
84081 00	Pathology	0.48	0.48	\$ 31.03	\$ 31.03
84085 00	Pathology	0.27	0.27	\$ 17.73	\$ 17.73
84087 00	Pathology	0.31	0.31	\$ 20.15	\$ 20.15
84100 00	Pathology	0.14	0.14	\$ 8.90	\$ 8.90
84105 00	Pathology	0.17	0.17	\$ 10.86	\$ 10.86
84106 00	Pathology	0.17	0.17	\$ 10.93	\$ 10.93
84110 00	Pathology	0.24	0.24	\$ 15.85	\$ 15.85
84112 00	Pathology	2.84	2.84	\$ 184.28	\$ 184.28
84119 00	Pathology	0.39	0.39	\$ 25.09	\$ 25.09
84120 00	Pathology	0.43	0.43	\$ 27.63	\$ 27.63
84126 00	Pathology	1.13	1.13	\$ 73.46	\$ 73.46

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
84132 00	Pathology	0.14	0.14	\$ 8.94	\$ 8.94
84133 00	Pathology	0.14	0.14	\$ 8.88	\$ 8.88
84134 00	Pathology	0.42	0.42	\$ 27.40	\$ 27.40
84135 00	Pathology	0.61	0.61	\$ 39.95	\$ 39.95
84138 00	Pathology	0.61	0.61	\$ 39.54	\$ 39.54
84140 00	Pathology	0.60	0.60	\$ 38.82	\$ 38.82
84143 00	Pathology	0.66	0.66	\$ 42.84	\$ 42.84
84144 00	Pathology	0.60	0.60	\$ 39.18	\$ 39.18
84145 00	Pathology	0.79	0.79	\$ 51.13	\$ 51.13
84146 00	Pathology	0.56	0.56	\$ 36.40	\$ 36.40
84150 00	Pathology	1.21	1.21	\$ 78.46	\$ 78.46
84152 00	Pathology	0.53	0.53	\$ 34.54	\$ 34.54
84153 00	Pathology	0.53	0.53	\$ 34.54	\$ 34.54
84154 00	Pathology	0.53	0.53	\$ 34.54	\$ 34.54
84155 00	Pathology	0.11	0.11	\$ 6.89	\$ 6.89
84156 00	Pathology	0.11	0.11	\$ 6.89	\$ 6.89
84157 00	Pathology	0.12	0.12	\$ 7.51	\$ 7.51
84160 00	Pathology	0.16	0.16	\$ 10.54	\$ 10.54
84163 00	Pathology	0.43	0.43	\$ 28.27	\$ 28.27
84165 00	Pathology	0.31	0.31	\$ 20.17	\$ 20.17
84165 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45
84166 00	Pathology	0.52	0.52	\$ 33.49	\$ 33.49
84166 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45
84181 00	Pathology	0.49	0.49	\$ 31.99	\$ 31.99
84181 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45
84182 00	Pathology	0.84	0.84	\$ 54.86	\$ 54.86
84182 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45
84202 00	Pathology	0.41	0.41	\$ 26.95	\$ 26.95
84203 00	Pathology	0.28	0.28	\$ 18.29	\$ 18.29
84206 00	Pathology	0.77	0.77	\$ 50.13	\$ 50.13
84207 00	Pathology	0.81	0.81	\$ 52.78	\$ 52.78
84210 00	Pathology	0.42	0.42	\$ 27.20	\$ 27.20
84220 00	Pathology	0.27	0.27	\$ 17.73	\$ 17.73
84228 00	Pathology	0.34	0.34	\$ 21.84	\$ 21.84
84233 00	Pathology	2.54	2.54	\$ 165.06	\$ 165.06
84234 00	Pathology	1.87	1.87	\$ 121.86	\$ 121.86
84235 00	Pathology	2.06	2.06	\$ 133.79	\$ 133.79
84238 00	Pathology	1.06	1.06	\$ 68.69	\$ 68.69
84244 00	Pathology	0.64	0.64	\$ 41.30	\$ 41.30
84252 00	Pathology	0.58	0.58	\$ 38.02	\$ 38.02
84255 00	Pathology	0.74	0.74	\$ 47.95	\$ 47.95
84260 00	Pathology	0.90	0.90	\$ 58.19	\$ 58.19
84270 00	Pathology	0.63	0.63	\$ 40.81	\$ 40.81
84275 00	Pathology	0.39	0.39	\$ 25.24	\$ 25.24
84285 00	Pathology	0.73	0.73	\$ 47.35	\$ 47.35
84295 00	Pathology	0.14	0.14	\$ 9.03	\$ 9.03
84300 00	Pathology	0.15	0.15	\$ 9.50	\$ 9.50
84302 00	Pathology	0.14	0.14	\$ 9.13	\$ 9.13
84305 00	Pathology	0.61	0.61	\$ 39.93	\$ 39.93
84307 00	Pathology	0.53	0.53	\$ 34.33	\$ 34.33
84311 00	Pathology	0.23	0.23	\$ 15.21	\$ 15.21
84315 00	Pathology	0.09	0.09	\$ 6.16	\$ 6.16
84375 00	Pathology	1.13	1.13	\$ 73.25	\$ 73.25
84376 00	Pathology	0.16	0.16	\$ 10.33	\$ 10.33
84377 00	Pathology	0.16	0.16	\$ 10.33	\$ 10.33

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
84378 00	Pathology	0.33	0.33	\$ 21.66	\$ 21.66
84379 00	Pathology	0.33	0.33	\$ 21.66	\$ 21.66
84392 00	Pathology	0.16	0.16	\$ 10.31	\$ 10.31
84402 00	Pathology	0.74	0.74	\$ 47.84	\$ 47.84
84403 00	Pathology	0.75	0.75	\$ 48.48	\$ 48.48
84410 00	Pathology	1.48	1.48	\$ 96.32	\$ 96.32
84425 00	Pathology	0.61	0.61	\$ 39.88	\$ 39.88
84430 00	Pathology	0.34	0.34	\$ 21.84	\$ 21.84
84431 00	Pathology	1.01	1.01	\$ 65.95	\$ 65.95
84432 00	Pathology	0.46	0.46	\$ 30.17	\$ 30.17
84436 00	Pathology	0.20	0.20	\$ 12.90	\$ 12.90
84437 00	Pathology	0.19	0.19	\$ 12.15	\$ 12.15
84439 00	Pathology	0.26	0.26	\$ 16.94	\$ 16.94
84442 00	Pathology	0.43	0.43	\$ 27.76	\$ 27.76
84443 00	Pathology	0.49	0.49	\$ 31.56	\$ 31.56
84445 00	Pathology	1.47	1.47	\$ 95.53	\$ 95.53
84446 00	Pathology	0.41	0.41	\$ 26.63	\$ 26.63
84449 00	Pathology	0.52	0.52	\$ 33.81	\$ 33.81
84450 00	Pathology	0.15	0.15	\$ 9.73	\$ 9.73
84460 00	Pathology	0.15	0.15	\$ 9.95	\$ 9.95
84466 00	Pathology	0.37	0.37	\$ 23.97	\$ 23.97
84478 00	Pathology	0.17	0.17	\$ 10.78	\$ 10.78
84479 00	Pathology	0.19	0.19	\$ 12.15	\$ 12.15
84480 00	Pathology	0.41	0.41	\$ 26.63	\$ 26.63
84481 00	Pathology	0.49	0.49	\$ 31.82	\$ 31.82
84482 00	Pathology	0.46	0.46	\$ 29.60	\$ 29.60
84484 00	Pathology	0.36	0.36	\$ 23.42	\$ 23.42
84485 00	Pathology	0.21	0.21	\$ 13.52	\$ 13.52
84488 00	Pathology	0.21	0.21	\$ 13.71	\$ 13.71
84490 00	Pathology	0.29	0.29	\$ 18.65	\$ 18.65
84510 00	Pathology	0.31	0.31	\$ 19.97	\$ 19.97
84512 00	Pathology	0.29	0.29	\$ 18.95	\$ 18.95
84520 00	Pathology	0.11	0.11	\$ 7.42	\$ 7.42
84525 00	Pathology	0.15	0.15	\$ 9.64	\$ 9.64
84540 00	Pathology	0.16	0.16	\$ 10.44	\$ 10.44
84545 00	Pathology	0.21	0.21	\$ 13.52	\$ 13.52
84550 00	Pathology	0.13	0.13	\$ 8.49	\$ 8.49
84560 00	Pathology	0.15	0.15	\$ 9.54	\$ 9.54
84577 00	Pathology	0.49	0.49	\$ 31.56	\$ 31.56
84578 00	Pathology	0.13	0.13	\$ 8.40	\$ 8.40
84580 00	Pathology	0.28	0.28	\$ 17.94	\$ 17.94
84583 00	Pathology	0.17	0.17	\$ 11.36	\$ 11.36
84585 00	Pathology	0.45	0.45	\$ 29.11	\$ 29.11
84586 00	Pathology	1.02	1.02	\$ 66.36	\$ 66.36
84588 00	Pathology	0.98	0.98	\$ 63.75	\$ 63.75
84590 00	Pathology	0.34	0.34	\$ 21.81	\$ 21.81
84591 00	Pathology	0.49	0.49	\$ 32.04	\$ 32.04
84597 00	Pathology	0.40	0.40	\$ 25.77	\$ 25.77
84600 00	Pathology	0.49	0.49	\$ 32.14	\$ 32.14
84620 00	Pathology	0.37	0.37	\$ 24.25	\$ 24.25
84630 00	Pathology	0.33	0.33	\$ 21.39	\$ 21.39
84681 00	Pathology	0.60	0.60	\$ 39.09	\$ 39.09
84702 00	Pathology	0.43	0.43	\$ 28.27	\$ 28.27
84703 00	Pathology	0.22	0.22	\$ 14.12	\$ 14.12
84704 00	Pathology	0.44	0.44	\$ 28.72	\$ 28.72

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
84830 00	Pathology	0.37	0.37	\$ 23.85	\$ 23.85
84999 00	Pathology	0.00	0.00	BR	BR
85002 00	Pathology	0.14	0.14	\$ 9.05	\$ 9.05
85004 00	Pathology	0.19	0.19	\$ 12.15	\$ 12.15
85007 00	Pathology	0.11	0.11	\$ 7.14	\$ 7.14
85008 00	Pathology	0.10	0.10	\$ 6.44	\$ 6.44
85009 00	Pathology	0.15	0.15	\$ 9.52	\$ 9.52
85013 00	Pathology	0.20	0.20	\$ 13.15	\$ 13.15
85014 00	Pathology	0.07	0.07	\$ 4.45	\$ 4.45
85018 00	Pathology	0.07	0.07	\$ 4.45	\$ 4.45
85025 00	Pathology	0.22	0.22	\$ 14.59	\$ 14.59
85027 00	Pathology	0.19	0.19	\$ 12.15	\$ 12.15
85032 00	Pathology	0.12	0.12	\$ 8.10	\$ 8.10
85041 00	Pathology	0.09	0.09	\$ 5.67	\$ 5.67
85044 00	Pathology	0.12	0.12	\$ 8.10	\$ 8.10
85045 00	Pathology	0.12	0.12	\$ 7.49	\$ 7.49
85046 00	Pathology	0.16	0.16	\$ 10.46	\$ 10.46
85048 00	Pathology	0.07	0.07	\$ 4.77	\$ 4.77
85049 00	Pathology	0.13	0.13	\$ 8.41	\$ 8.41
85055 00	Pathology	1.03	1.03	\$ 67.13	\$ 67.13
85060 00	Pathology	0.71	0.71	\$ 46.15	\$ 46.15
85097 00	Pathology	2.01	1.40	\$ 130.65	\$ 91.00
85130 00	Pathology	0.34	0.34	\$ 22.33	\$ 22.33
85170 00	Pathology	0.47	0.47	\$ 30.62	\$ 30.62
85175 00	Pathology	0.59	0.59	\$ 38.26	\$ 38.26
85210 00	Pathology	0.38	0.38	\$ 24.38	\$ 24.38
85220 00	Pathology	0.51	0.51	\$ 33.15	\$ 33.15
85230 00	Pathology	0.52	0.52	\$ 33.62	\$ 33.62
85240 00	Pathology	0.52	0.52	\$ 33.62	\$ 33.62
85244 00	Pathology	0.59	0.59	\$ 38.35	\$ 38.35
85245 00	Pathology	0.66	0.66	\$ 43.09	\$ 43.09
85246 00	Pathology	0.66	0.66	\$ 43.09	\$ 43.09
85247 00	Pathology	0.66	0.66	\$ 43.09	\$ 43.09
85250 00	Pathology	0.55	0.55	\$ 35.76	\$ 35.76
85260 00	Pathology	0.52	0.52	\$ 33.62	\$ 33.62
85270 00	Pathology	0.52	0.52	\$ 33.62	\$ 33.62
85280 00	Pathology	0.56	0.56	\$ 36.34	\$ 36.34
85290 00	Pathology	0.47	0.47	\$ 30.69	\$ 30.69
85291 00	Pathology	0.26	0.26	\$ 17.11	\$ 17.11
85292 00	Pathology	0.55	0.55	\$ 35.56	\$ 35.56
85293 00	Pathology	0.55	0.55	\$ 35.56	\$ 35.56
85300 00	Pathology	0.34	0.34	\$ 22.26	\$ 22.26
85301 00	Pathology	0.31	0.31	\$ 20.30	\$ 20.30
85302 00	Pathology	0.35	0.35	\$ 22.56	\$ 22.56
85303 00	Pathology	0.40	0.40	\$ 26.00	\$ 26.00
85305 00	Pathology	0.34	0.34	\$ 21.81	\$ 21.81
85306 00	Pathology	0.44	0.44	\$ 28.78	\$ 28.78
85307 00	Pathology	0.44	0.44	\$ 28.78	\$ 28.78
85335 00	Pathology	0.37	0.37	\$ 24.17	\$ 24.17
85337 00	Pathology	0.50	0.50	\$ 32.44	\$ 32.44
85345 00	Pathology	0.14	0.14	\$ 8.81	\$ 8.81
85347 00	Pathology	0.12	0.12	\$ 8.04	\$ 8.04
85348 00	Pathology	0.13	0.13	\$ 8.43	\$ 8.43
85360 00	Pathology	0.24	0.24	\$ 15.80	\$ 15.80
85362 00	Pathology	0.20	0.20	\$ 12.94	\$ 12.94

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
85366 00	Pathology	2.33	2.33	\$ 151.13	\$ 151.13
85370 00	Pathology	0.36	0.36	\$ 23.35	\$ 23.35
85378 00	Pathology	0.28	0.28	\$ 18.26	\$ 18.26
85379 00	Pathology	0.29	0.29	\$ 19.12	\$ 19.12
85380 00	Pathology	0.29	0.29	\$ 19.12	\$ 19.12
85384 00	Pathology	0.28	0.28	\$ 18.26	\$ 18.26
85385 00	Pathology	0.42	0.42	\$ 27.16	\$ 27.16
85390 00	Pathology	0.45	0.45	\$ 29.08	\$ 29.08
85390 26	Pathology	1.08	1.08	\$ 70.20	\$ 70.20
85396 00	Pathology	0.57	0.57	\$ 37.05	\$ 37.05
85397 00	Pathology	0.89	0.89	\$ 57.96	\$ 57.96
85400 00	Pathology	0.22	0.22	\$ 14.48	\$ 14.48
85410 00	Pathology	0.22	0.22	\$ 14.48	\$ 14.48
85415 00	Pathology	0.50	0.50	\$ 32.29	\$ 32.29
85420 00	Pathology	0.19	0.19	\$ 12.27	\$ 12.27
85421 00	Pathology	0.29	0.29	\$ 19.12	\$ 19.12
85441 00	Pathology	0.12	0.12	\$ 7.89	\$ 7.89
85445 00	Pathology	0.20	0.20	\$ 12.81	\$ 12.81
85460 00	Pathology	0.22	0.22	\$ 14.52	\$ 14.52
85461 00	Pathology	0.27	0.27	\$ 17.58	\$ 17.58
85475 00	Pathology	0.26	0.26	\$ 16.66	\$ 16.66
85520 00	Pathology	0.38	0.38	\$ 24.59	\$ 24.59
85525 00	Pathology	0.34	0.34	\$ 22.24	\$ 22.24
85530 00	Pathology	0.38	0.38	\$ 24.59	\$ 24.59
85536 00	Pathology	0.20	0.20	\$ 12.92	\$ 12.92
85540 00	Pathology	0.25	0.25	\$ 16.15	\$ 16.15
85547 00	Pathology	0.25	0.25	\$ 16.15	\$ 16.15
85549 00	Pathology	0.54	0.54	\$ 35.22	\$ 35.22
85555 00	Pathology	0.22	0.22	\$ 14.03	\$ 14.03
85557 00	Pathology	0.39	0.39	\$ 25.09	\$ 25.09
85576 00	Pathology	0.72	0.72	\$ 46.79	\$ 46.79
85576 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45
85597 00	Pathology	0.52	0.52	\$ 33.77	\$ 33.77
85598 00	Pathology	0.52	0.52	\$ 33.77	\$ 33.77
85610 00	Pathology	0.12	0.12	\$ 8.06	\$ 8.06
85611 00	Pathology	0.11	0.11	\$ 7.40	\$ 7.40
85612 00	Pathology	0.51	0.51	\$ 32.85	\$ 32.85
85613 00	Pathology	0.28	0.28	\$ 17.99	\$ 17.99
85635 00	Pathology	0.28	0.28	\$ 18.50	\$ 18.50
85651 00	Pathology	0.12	0.12	\$ 8.02	\$ 8.02
85652 00	Pathology	0.08	0.08	\$ 5.07	\$ 5.07
85660 00	Pathology	0.16	0.16	\$ 10.35	\$ 10.35
85670 00	Pathology	0.17	0.17	\$ 10.84	\$ 10.84
85675 00	Pathology	0.20	0.20	\$ 12.87	\$ 12.87
85705 00	Pathology	0.28	0.28	\$ 18.09	\$ 18.09
85730 00	Pathology	0.17	0.17	\$ 11.29	\$ 11.29
85732 00	Pathology	0.19	0.19	\$ 12.15	\$ 12.15
85810 00	Pathology	0.34	0.34	\$ 21.92	\$ 21.92
85999 00	Pathology	0.00	0.00	BR	BR
86000 00	Pathology	0.20	0.20	\$ 13.11	\$ 13.11
86001 00	Pathology	0.23	0.23	\$ 14.69	\$ 14.69
86003 00	Pathology	0.15	0.15	\$ 9.80	\$ 9.80
86005 00	Pathology	0.23	0.23	\$ 14.97	\$ 14.97
86008 00	Pathology	0.52	0.52	\$ 33.68	\$ 33.68
86015 00	Pathology	0.33	0.33	\$ 21.66	\$ 21.66

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
86021 00	Pathology	0.43	0.43	\$ 28.27	\$ 28.27
86022 00	Pathology	0.53	0.53	\$ 34.50	\$ 34.50
86023 00	Pathology	0.36	0.36	\$ 23.40	\$ 23.40
86036 00	Pathology	0.35	0.35	\$ 22.63	\$ 22.63
86037 00	Pathology	0.35	0.35	\$ 22.63	\$ 22.63
86038 00	Pathology	0.35	0.35	\$ 22.71	\$ 22.71
86039 00	Pathology	0.32	0.32	\$ 20.96	\$ 20.96
86051 00	Pathology	0.33	0.33	\$ 21.66	\$ 21.66
86052 00	Pathology	0.35	0.35	\$ 22.63	\$ 22.63
86053 00	Pathology	0.35	0.35	\$ 22.63	\$ 22.63
86060 00	Pathology	0.21	0.21	\$ 13.71	\$ 13.71
86063 00	Pathology	0.17	0.17	\$ 10.84	\$ 10.84
86077 00	Pathology	1.55	1.44	\$ 100.75	\$ 93.60
86078 00	Pathology	1.55	1.44	\$ 100.75	\$ 93.60
86079 00	Pathology	1.55	1.44	\$ 100.75	\$ 93.60
86140 00	Pathology	0.15	0.15	\$ 9.73	\$ 9.73
86141 00	Pathology	0.37	0.37	\$ 24.32	\$ 24.32
86146 00	Pathology	0.74	0.74	\$ 47.80	\$ 47.80
86147 00	Pathology	0.74	0.74	\$ 47.80	\$ 47.80
86148 00	Pathology	0.46	0.46	\$ 30.18	\$ 30.18
86152 00	Pathology	7.25	7.25	\$ 471.03	\$ 471.03
86153 26	Pathology	1.00	1.00	\$ 65.00	\$ 65.00
86155 00	Pathology	0.46	0.46	\$ 30.03	\$ 30.03
86156 00	Pathology	0.23	0.23	\$ 15.16	\$ 15.16
86157 00	Pathology	0.23	0.23	\$ 15.14	\$ 15.14
86160 00	Pathology	0.35	0.35	\$ 22.54	\$ 22.54
86161 00	Pathology	0.35	0.35	\$ 22.54	\$ 22.54
86162 00	Pathology	0.59	0.59	\$ 38.17	\$ 38.17
86171 00	Pathology	0.29	0.29	\$ 18.80	\$ 18.80
86200 00	Pathology	0.37	0.37	\$ 24.32	\$ 24.32
86215 00	Pathology	0.38	0.38	\$ 24.89	\$ 24.89
86225 00	Pathology	0.40	0.40	\$ 25.81	\$ 25.81
86226 00	Pathology	0.35	0.35	\$ 22.75	\$ 22.75
86231 00	Pathology	0.35	0.35	\$ 22.71	\$ 22.71
86235 00	Pathology	0.52	0.52	\$ 33.68	\$ 33.68
86255 00	Pathology	0.35	0.35	\$ 22.63	\$ 22.63
86255 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45
86256 00	Pathology	0.35	0.35	\$ 22.63	\$ 22.63
86256 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45
86258 00	Pathology	0.33	0.33	\$ 21.66	\$ 21.66
86277 00	Pathology	0.45	0.45	\$ 29.56	\$ 29.56
86280 00	Pathology	0.24	0.24	\$ 15.38	\$ 15.38
86294 00	Pathology	0.74	0.74	\$ 48.03	\$ 48.03
86300 00	Pathology	0.60	0.60	\$ 39.09	\$ 39.09
86301 00	Pathology	0.60	0.60	\$ 39.09	\$ 39.09
86304 00	Pathology	0.60	0.60	\$ 39.09	\$ 39.09
86305 00	Pathology	0.60	0.60	\$ 39.09	\$ 39.09
86308 00	Pathology	0.15	0.15	\$ 9.73	\$ 9.73
86309 00	Pathology	0.19	0.19	\$ 12.15	\$ 12.15
86310 00	Pathology	0.21	0.21	\$ 13.84	\$ 13.84
86316 00	Pathology	0.60	0.60	\$ 39.09	\$ 39.09
86317 00	Pathology	0.43	0.43	\$ 28.16	\$ 28.16
86318 00	Pathology	0.52	0.52	\$ 33.98	\$ 33.98
86320 00	Pathology	0.86	0.86	\$ 56.20	\$ 56.20
86320 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
86325 00	Pathology	0.67	0.67	\$ 43.44	\$ 43.44
86325 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45
86327 00	Pathology	0.86	0.86	\$ 56.20	\$ 56.20
86327 26	Pathology	0.63	0.63	\$ 40.95	\$ 40.95
86328 00	Pathology	1.31	1.31	\$ 85.05	\$ 85.05
86329 00	Pathology	0.41	0.41	\$ 26.39	\$ 26.39
86331 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
86332 00	Pathology	0.70	0.70	\$ 45.77	\$ 45.77
86334 00	Pathology	0.65	0.65	\$ 41.96	\$ 41.96
86334 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45
86335 00	Pathology	0.85	0.85	\$ 55.13	\$ 55.13
86335 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45
86336 00	Pathology	0.45	0.45	\$ 29.28	\$ 29.28
86337 00	Pathology	0.62	0.62	\$ 40.21	\$ 40.21
86340 00	Pathology	0.44	0.44	\$ 28.32	\$ 28.32
86341 00	Pathology	0.68	0.68	\$ 44.27	\$ 44.27
86343 00	Pathology	0.36	0.36	\$ 23.40	\$ 23.40
86344 00	Pathology	0.30	0.30	\$ 19.52	\$ 19.52
86352 00	Pathology	3.93	3.93	\$ 255.18	\$ 255.18
86353 00	Pathology	1.42	1.42	\$ 92.09	\$ 92.09
86355 00	Pathology	1.09	1.09	\$ 70.87	\$ 70.87
86356 00	Pathology	0.77	0.77	\$ 50.30	\$ 50.30
86357 00	Pathology	1.09	1.09	\$ 70.87	\$ 70.87
86359 00	Pathology	1.09	1.09	\$ 70.87	\$ 70.87
86360 00	Pathology	1.36	1.36	\$ 88.24	\$ 88.24
86361 00	Pathology	0.77	0.77	\$ 50.30	\$ 50.30
86362 00	Pathology	0.35	0.35	\$ 22.63	\$ 22.63
86363 00	Pathology	0.35	0.35	\$ 22.63	\$ 22.63
86364 00	Pathology	0.33	0.33	\$ 21.66	\$ 21.66
86367 00	Pathology	2.25	2.25	\$ 146.09	\$ 146.09
86376 00	Pathology	0.42	0.42	\$ 27.33	\$ 27.33
86381 00	Pathology	0.74	0.74	\$ 47.80	\$ 47.80
86382 00	Pathology	0.49	0.49	\$ 31.76	\$ 31.76
86384 00	Pathology	0.39	0.39	\$ 25.56	\$ 25.56
86386 00	Pathology	0.63	0.63	\$ 40.91	\$ 40.91
86403 00	Pathology	0.33	0.33	\$ 21.68	\$ 21.68
86406 00	Pathology	0.31	0.31	\$ 19.98	\$ 19.98
86408 00	Pathology	-	-	\$ 79.30	\$ 79.30
86409 00	Pathology	-	-	\$ 149.50	\$ 149.50
86413 00	Pathology	-	-	\$ 79.30	\$ 79.30
86430 00	Pathology	0.18	0.18	\$ 11.53	\$ 11.53
86431 00	Pathology	0.16	0.16	\$ 10.65	\$ 10.65
86480 00	Pathology	1.79	1.79	\$ 116.42	\$ 116.42
86481 00	Pathology	2.89	2.89	\$ 187.83	\$ 187.83
86485 00	Pathology	-	-	\$ 37.70	\$ 37.70
86486 00	Pathology	0.18	0.18	\$ 11.70	\$ 11.70
86490 00	Pathology	2.48	2.48	\$ 161.20	\$ 161.20
86510 00	Pathology	0.22	0.22	\$ 14.30	\$ 14.30
86580 00	Pathology	0.31	0.31	\$ 20.15	\$ 20.15
86590 00	Pathology	0.37	0.37	\$ 23.78	\$ 23.78
86592 00	Pathology	0.12	0.12	\$ 8.02	\$ 8.02
86593 00	Pathology	0.13	0.13	\$ 8.26	\$ 8.26
86596 00	Pathology	0.53	0.53	\$ 34.56	\$ 34.56
86602 00	Pathology	0.29	0.29	\$ 19.12	\$ 19.12
86603 00	Pathology	0.37	0.37	\$ 24.17	\$ 24.17

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
86606 00	Pathology	0.43	0.43	\$ 28.27	\$ 28.27
86609 00	Pathology	0.37	0.37	\$ 24.19	\$ 24.19
86611 00	Pathology	0.29	0.29	\$ 19.12	\$ 19.12
86612 00	Pathology	0.37	0.37	\$ 24.23	\$ 24.23
86615 00	Pathology	0.38	0.38	\$ 24.77	\$ 24.77
86617 00	Pathology	0.45	0.45	\$ 29.09	\$ 29.09
86618 00	Pathology	0.49	0.49	\$ 31.99	\$ 31.99
86619 00	Pathology	0.39	0.39	\$ 25.13	\$ 25.13
86622 00	Pathology	0.26	0.26	\$ 16.77	\$ 16.77
86625 00	Pathology	0.38	0.38	\$ 24.64	\$ 24.64
86628 00	Pathology	0.35	0.35	\$ 22.56	\$ 22.56
86631 00	Pathology	0.34	0.34	\$ 22.20	\$ 22.20
86632 00	Pathology	0.37	0.37	\$ 23.82	\$ 23.82
86635 00	Pathology	0.33	0.33	\$ 21.54	\$ 21.54
86638 00	Pathology	0.35	0.35	\$ 22.76	\$ 22.76
86641 00	Pathology	0.42	0.42	\$ 27.07	\$ 27.07
86644 00	Pathology	0.42	0.42	\$ 27.03	\$ 27.03
86645 00	Pathology	0.49	0.49	\$ 31.65	\$ 31.65
86648 00	Pathology	0.44	0.44	\$ 28.57	\$ 28.57
86651 00	Pathology	0.38	0.38	\$ 24.77	\$ 24.77
86652 00	Pathology	0.38	0.38	\$ 24.77	\$ 24.77
86653 00	Pathology	0.38	0.38	\$ 24.77	\$ 24.77
86654 00	Pathology	0.38	0.38	\$ 24.77	\$ 24.77
86658 00	Pathology	0.38	0.38	\$ 24.47	\$ 24.47
86663 00	Pathology	0.38	0.38	\$ 24.64	\$ 24.64
86664 00	Pathology	0.44	0.44	\$ 28.72	\$ 28.72
86665 00	Pathology	0.52	0.52	\$ 34.07	\$ 34.07
86666 00	Pathology	0.29	0.29	\$ 19.12	\$ 19.12
86668 00	Pathology	0.41	0.41	\$ 26.60	\$ 26.60
86671 00	Pathology	0.35	0.35	\$ 23.01	\$ 23.01
86674 00	Pathology	0.43	0.43	\$ 27.65	\$ 27.65
86677 00	Pathology	0.49	0.49	\$ 31.65	\$ 31.65
86682 00	Pathology	0.38	0.38	\$ 24.44	\$ 24.44
86684 00	Pathology	0.46	0.46	\$ 29.75	\$ 29.75
86687 00	Pathology	0.26	0.26	\$ 17.07	\$ 17.07
86688 00	Pathology	0.40	0.40	\$ 26.30	\$ 26.30
86689 00	Pathology	0.56	0.56	\$ 36.34	\$ 36.34
86692 00	Pathology	0.50	0.50	\$ 32.23	\$ 32.23
86694 00	Pathology	0.42	0.42	\$ 27.03	\$ 27.03
86695 00	Pathology	0.38	0.38	\$ 24.77	\$ 24.77
86696 00	Pathology	0.56	0.56	\$ 36.34	\$ 36.34
86698 00	Pathology	0.40	0.40	\$ 25.90	\$ 25.90
86701 00	Pathology	0.26	0.26	\$ 16.70	\$ 16.70
86702 00	Pathology	0.39	0.39	\$ 25.39	\$ 25.39
86703 00	Pathology	0.40	0.40	\$ 25.75	\$ 25.75
86704 00	Pathology	0.35	0.35	\$ 22.63	\$ 22.63
86705 00	Pathology	0.34	0.34	\$ 22.11	\$ 22.11
86706 00	Pathology	0.31	0.31	\$ 20.17	\$ 20.17
86707 00	Pathology	0.33	0.33	\$ 21.73	\$ 21.73
86708 00	Pathology	0.36	0.36	\$ 23.27	\$ 23.27
86709 00	Pathology	0.33	0.33	\$ 21.15	\$ 21.15
86710 00	Pathology	0.39	0.39	\$ 25.45	\$ 25.45
86711 00	Pathology	0.49	0.49	\$ 31.72	\$ 31.72
86713 00	Pathology	0.44	0.44	\$ 28.74	\$ 28.74
86717 00	Pathology	0.35	0.35	\$ 23.01	\$ 23.01

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
86720 00	Pathology	0.47	0.47	\$ 30.43	\$ 30.43
86723 00	Pathology	0.38	0.38	\$ 24.77	\$ 24.77
86727 00	Pathology	0.37	0.37	\$ 24.17	\$ 24.17
86732 00	Pathology	0.43	0.43	\$ 28.17	\$ 28.17
86735 00	Pathology	0.38	0.38	\$ 24.51	\$ 24.51
86738 00	Pathology	0.38	0.38	\$ 24.87	\$ 24.87
86741 00	Pathology	0.38	0.38	\$ 24.77	\$ 24.77
86744 00	Pathology	0.46	0.46	\$ 30.03	\$ 30.03
86747 00	Pathology	0.43	0.43	\$ 28.23	\$ 28.23
86750 00	Pathology	0.38	0.38	\$ 24.77	\$ 24.77
86753 00	Pathology	0.36	0.36	\$ 23.27	\$ 23.27
86756 00	Pathology	0.46	0.46	\$ 29.85	\$ 29.85
86757 00	Pathology	0.56	0.56	\$ 36.34	\$ 36.34
86759 00	Pathology	0.53	0.53	\$ 34.24	\$ 34.24
86762 00	Pathology	0.42	0.42	\$ 27.03	\$ 27.03
86765 00	Pathology	0.37	0.37	\$ 24.19	\$ 24.19
86768 00	Pathology	0.38	0.38	\$ 24.77	\$ 24.77
86769 00	Pathology	1.22	1.22	\$ 79.13	\$ 79.13
86771 00	Pathology	0.71	0.71	\$ 45.98	\$ 45.98
86774 00	Pathology	0.43	0.43	\$ 27.80	\$ 27.80
86777 00	Pathology	0.42	0.42	\$ 27.03	\$ 27.03
86778 00	Pathology	0.42	0.42	\$ 27.07	\$ 27.07
86780 00	Pathology	0.38	0.38	\$ 24.87	\$ 24.87
86784 00	Pathology	0.36	0.36	\$ 23.59	\$ 23.59
86787 00	Pathology	0.37	0.37	\$ 24.19	\$ 24.19
86788 00	Pathology	0.49	0.49	\$ 31.65	\$ 31.65
86789 00	Pathology	0.42	0.42	\$ 27.03	\$ 27.03
86790 00	Pathology	0.37	0.37	\$ 24.19	\$ 24.19
86793 00	Pathology	0.38	0.38	\$ 24.77	\$ 24.77
86794 00	Pathology	0.49	0.49	\$ 31.65	\$ 31.65
86800 00	Pathology	0.46	0.46	\$ 29.88	\$ 29.88
86803 00	Pathology	0.41	0.41	\$ 26.80	\$ 26.80
86804 00	Pathology	0.45	0.45	\$ 29.09	\$ 29.09
86805 00	Pathology	5.48	5.48	\$ 355.95	\$ 355.95
86806 00	Pathology	1.38	1.38	\$ 89.39	\$ 89.39
86807 00	Pathology	2.27	2.27	\$ 147.73	\$ 147.73
86808 00	Pathology	0.86	0.86	\$ 55.75	\$ 55.75
86812 00	Pathology	0.75	0.75	\$ 48.48	\$ 48.48
86813 00	Pathology	1.68	1.68	\$ 108.94	\$ 108.94
86816 00	Pathology	0.87	0.87	\$ 56.67	\$ 56.67
86817 00	Pathology	3.07	3.07	\$ 199.36	\$ 199.36
86821 00	Pathology	1.06	1.06	\$ 68.67	\$ 68.67
86825 00	Pathology	3.16	3.16	\$ 205.65	\$ 205.65
86826 00	Pathology	1.06	1.06	\$ 68.61	\$ 68.61
86828 00	Pathology	1.85	1.85	\$ 120.57	\$ 120.57
86829 00	Pathology	1.85	1.85	\$ 120.57	\$ 120.57
86830 00	Pathology	2.76	2.76	\$ 179.41	\$ 179.41
86831 00	Pathology	2.37	2.37	\$ 153.79	\$ 153.79
86832 00	Pathology	9.36	9.36	\$ 608.09	\$ 608.09
86833 00	Pathology	9.41	9.41	\$ 611.94	\$ 611.94
86834 00	Pathology	10.33	10.33	\$ 671.60	\$ 671.60
86835 00	Pathology	9.33	9.33	\$ 606.61	\$ 606.61
86849 00	Pathology	0.00	0.00	BR	BR
86850 00	Pathology	0.28	0.28	\$ 18.35	\$ 18.35
86860 00	Pathology	-	-	\$ 59.80	\$ 59.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
86870 00	Pathology	-	-	\$ 81.90	\$ 81.90
86880 00	Pathology	0.16	0.16	\$ 10.12	\$ 10.12
86885 00	Pathology	0.17	0.17	\$ 10.74	\$ 10.74
86886 00	Pathology	0.15	0.15	\$ 9.73	\$ 9.73
86890 00	Pathology	-	-	\$ 188.50	\$ 188.50
86891 00	Pathology	-	-	\$ 265.85	\$ 265.85
86900 00	Pathology	0.09	0.09	\$ 5.62	\$ 5.62
86901 00	Pathology	0.09	0.09	\$ 5.62	\$ 5.62
86902 00	Pathology	0.18	0.18	\$ 11.93	\$ 11.93
86904 00	Pathology	0.47	0.47	\$ 30.69	\$ 30.69
86905 00	Pathology	0.11	0.11	\$ 7.19	\$ 7.19
86906 00	Pathology	0.22	0.22	\$ 14.56	\$ 14.56
86910 00	Pathology	-	-	\$ 48.75	\$ 48.75
86911 00	Pathology	-	-	\$ 42.25	\$ 42.25
86920 00	Pathology	-	-	\$ 66.30	\$ 66.30
86921 00	Pathology	-	-	\$ 59.80	\$ 59.80
86922 00	Pathology	-	-	\$ 70.85	\$ 70.85
86923 00	Pathology	-	-	\$ 53.30	\$ 53.30
86927 00	Pathology	-	-	\$ 37.70	\$ 37.70
86930 00	Pathology	-	-	\$ 221.65	\$ 221.65
86931 00	Pathology	-	-	\$ 166.40	\$ 166.40
86932 00	Pathology	-	-	\$ 188.50	\$ 188.50
86940 00	Pathology	0.25	0.25	\$ 16.47	\$ 16.47
86941 00	Pathology	0.35	0.35	\$ 22.75	\$ 22.75
86945 00	Pathology	-	-	\$ 55.25	\$ 55.25
86950 00	Pathology	-	-	\$ 144.30	\$ 144.30
86960 00	Pathology	-	-	\$ 61.75	\$ 61.75
86965 00	Pathology	-	-	\$ 61.75	\$ 61.75
86970 00	Pathology	-	-	\$ 55.25	\$ 55.25
86971 00	Pathology	-	-	\$ 44.20	\$ 44.20
86972 00	Pathology	-	-	\$ 77.35	\$ 77.35
86975 00	Pathology	-	-	\$ 59.80	\$ 59.80
86976 00	Pathology	-	-	\$ 66.30	\$ 66.30
86977 00	Pathology	-	-	\$ 66.30	\$ 66.30
86978 00	Pathology	-	-	\$ 66.30	\$ 66.30
86985 00	Pathology	-	-	\$ 48.75	\$ 48.75
86999 00	Pathology	0.00	0.00	BR	BR
87003 00	Pathology	0.49	0.49	\$ 31.63	\$ 31.63
87015 00	Pathology	0.19	0.19	\$ 12.55	\$ 12.55
87040 00	Pathology	0.30	0.30	\$ 19.38	\$ 19.38
87045 00	Pathology	0.27	0.27	\$ 17.73	\$ 17.73
87046 00	Pathology	0.27	0.27	\$ 17.73	\$ 17.73
87070 00	Pathology	0.25	0.25	\$ 16.19	\$ 16.19
87071 00	Pathology	0.29	0.29	\$ 18.58	\$ 18.58
87073 00	Pathology	0.28	0.28	\$ 18.14	\$ 18.14
87075 00	Pathology	0.27	0.27	\$ 17.79	\$ 17.79
87076 00	Pathology	0.23	0.23	\$ 15.18	\$ 15.18
87077 00	Pathology	0.23	0.23	\$ 15.18	\$ 15.18
87081 00	Pathology	0.19	0.19	\$ 12.45	\$ 12.45
87084 00	Pathology	0.78	0.78	\$ 50.84	\$ 50.84
87086 00	Pathology	0.23	0.23	\$ 15.16	\$ 15.16
87088 00	Pathology	0.23	0.23	\$ 15.20	\$ 15.20
87101 00	Pathology	0.22	0.22	\$ 14.48	\$ 14.48
87102 00	Pathology	0.24	0.24	\$ 15.80	\$ 15.80
87103 00	Pathology	0.59	0.59	\$ 38.43	\$ 38.43

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
87106 00	Pathology	0.30	0.30	\$ 19.38	\$ 19.38
87107 00	Pathology	0.30	0.30	\$ 19.38	\$ 19.38
87109 00	Pathology	0.44	0.44	\$ 28.91	\$ 28.91
87110 00	Pathology	0.57	0.57	\$ 36.81	\$ 36.81
87116 00	Pathology	0.31	0.31	\$ 20.29	\$ 20.29
87118 00	Pathology	0.42	0.42	\$ 27.44	\$ 27.44
87140 00	Pathology	0.16	0.16	\$ 10.46	\$ 10.46
87143 00	Pathology	0.36	0.36	\$ 23.52	\$ 23.52
87147 00	Pathology	0.15	0.15	\$ 9.73	\$ 9.73
87149 00	Pathology	0.58	0.58	\$ 37.66	\$ 37.66
87150 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87152 00	Pathology	0.22	0.22	\$ 14.54	\$ 14.54
87153 00	Pathology	3.33	3.33	\$ 216.68	\$ 216.68
87154 00	Pathology	6.30	6.30	\$ 409.58	\$ 409.58
87158 00	Pathology	0.22	0.22	\$ 14.54	\$ 14.54
87164 00	Pathology	0.31	0.31	\$ 20.17	\$ 20.17
87164 26	Pathology	0.56	0.56	\$ 36.40	\$ 36.40
87166 00	Pathology	0.33	0.33	\$ 21.22	\$ 21.22
87168 00	Pathology	0.12	0.12	\$ 8.02	\$ 8.02
87169 00	Pathology	0.12	0.12	\$ 8.10	\$ 8.10
87172 00	Pathology	0.12	0.12	\$ 8.02	\$ 8.02
87176 00	Pathology	0.17	0.17	\$ 11.04	\$ 11.04
87177 00	Pathology	0.26	0.26	\$ 16.72	\$ 16.72
87181 00	Pathology	0.14	0.14	\$ 8.92	\$ 8.92
87184 00	Pathology	0.22	0.22	\$ 14.05	\$ 14.05
87185 00	Pathology	0.14	0.14	\$ 8.92	\$ 8.92
87186 00	Pathology	0.25	0.25	\$ 16.25	\$ 16.25
87187 00	Pathology	1.16	1.16	\$ 75.45	\$ 75.45
87188 00	Pathology	0.19	0.19	\$ 12.47	\$ 12.47
87190 00	Pathology	0.21	0.21	\$ 13.73	\$ 13.73
87197 00	Pathology	0.43	0.43	\$ 28.21	\$ 28.21
87205 00	Pathology	0.12	0.12	\$ 8.02	\$ 8.02
87206 00	Pathology	0.16	0.16	\$ 10.12	\$ 10.12
87207 00	Pathology	0.17	0.17	\$ 11.25	\$ 11.25
87207 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45
87209 00	Pathology	0.52	0.52	\$ 33.77	\$ 33.77
87210 00	Pathology	0.17	0.17	\$ 10.93	\$ 10.93
87220 00	Pathology	0.12	0.12	\$ 8.02	\$ 8.02
87230 00	Pathology	0.57	0.57	\$ 37.08	\$ 37.08
87250 00	Pathology	0.57	0.57	\$ 36.74	\$ 36.74
87252 00	Pathology	0.75	0.75	\$ 48.97	\$ 48.97
87253 00	Pathology	0.58	0.58	\$ 37.94	\$ 37.94
87254 00	Pathology	0.57	0.57	\$ 36.74	\$ 36.74
87255 00	Pathology	0.98	0.98	\$ 63.60	\$ 63.60
87260 00	Pathology	0.42	0.42	\$ 27.10	\$ 27.10
87265 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87267 00	Pathology	0.39	0.39	\$ 25.21	\$ 25.21
87269 00	Pathology	0.39	0.39	\$ 25.56	\$ 25.56
87270 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87271 00	Pathology	0.39	0.39	\$ 25.21	\$ 25.21
87272 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87273 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87274 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87275 00	Pathology	0.35	0.35	\$ 23.01	\$ 23.01
87276 00	Pathology	0.46	0.46	\$ 30.18	\$ 30.18

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
87278 00	Pathology	0.45	0.45	\$ 29.30	\$ 29.30
87279 00	Pathology	0.47	0.47	\$ 30.86	\$ 30.86
87280 00	Pathology	0.39	0.39	\$ 25.21	\$ 25.21
87281 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87283 00	Pathology	1.76	1.76	\$ 114.20	\$ 114.20
87285 00	Pathology	0.35	0.35	\$ 22.88	\$ 22.88
87290 00	Pathology	0.39	0.39	\$ 25.21	\$ 25.21
87299 00	Pathology	0.47	0.47	\$ 30.24	\$ 30.24
87300 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87301 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87305 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87320 00	Pathology	0.43	0.43	\$ 28.17	\$ 28.17
87324 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87327 00	Pathology	0.39	0.39	\$ 25.21	\$ 25.21
87328 00	Pathology	0.40	0.40	\$ 25.96	\$ 25.96
87329 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87332 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87335 00	Pathology	0.37	0.37	\$ 23.78	\$ 23.78
87336 00	Pathology	0.46	0.46	\$ 30.05	\$ 30.05
87337 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87338 00	Pathology	0.42	0.42	\$ 27.01	\$ 27.01
87339 00	Pathology	0.46	0.46	\$ 30.05	\$ 30.05
87340 00	Pathology	0.30	0.30	\$ 19.40	\$ 19.40
87341 00	Pathology	0.30	0.30	\$ 19.40	\$ 19.40
87350 00	Pathology	0.33	0.33	\$ 21.66	\$ 21.66
87380 00	Pathology	0.53	0.53	\$ 34.49	\$ 34.49
87385 00	Pathology	0.38	0.38	\$ 24.89	\$ 24.89
87389 00	Pathology	0.70	0.70	\$ 45.23	\$ 45.23
87390 00	Pathology	0.70	0.70	\$ 45.19	\$ 45.19
87391 00	Pathology	0.63	0.63	\$ 41.13	\$ 41.13
87400 00	Pathology	0.41	0.41	\$ 26.54	\$ 26.54
87420 00	Pathology	0.40	0.40	\$ 26.13	\$ 26.13
87425 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87426 00	Pathology	-	-	\$ 66.95	\$ 66.95
87427 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87428 00	Pathology	0.89	0.89	\$ 58.11	\$ 58.11
87430 00	Pathology	0.49	0.49	\$ 31.57	\$ 31.57
87449 00	Pathology	0.35	0.35	\$ 22.50	\$ 22.50
87451 00	Pathology	0.30	0.30	\$ 19.74	\$ 19.74
87471 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87472 00	Pathology	1.24	1.24	\$ 80.47	\$ 80.47
87475 00	Pathology	0.58	0.58	\$ 37.66	\$ 37.66
87476 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87480 00	Pathology	0.58	0.58	\$ 37.66	\$ 37.66
87481 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87482 00	Pathology	1.61	1.61	\$ 104.70	\$ 104.70
87483 00	Pathology	12.04	12.04	\$ 782.83	\$ 782.83
87485 00	Pathology	0.58	0.58	\$ 37.66	\$ 37.66
87486 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87487 00	Pathology	1.24	1.24	\$ 80.47	\$ 80.47
87490 00	Pathology	0.66	0.66	\$ 42.73	\$ 42.73
87491 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87492 00	Pathology	1.55	1.55	\$ 100.43	\$ 100.43
87493 00	Pathology	1.08	1.08	\$ 70.00	\$ 70.00
87495 00	Pathology	0.87	0.87	\$ 56.40	\$ 56.40

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
87496 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87497 00	Pathology	1.24	1.24	\$ 80.47	\$ 80.47
87498 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87500 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87501 00	Pathology	1.48	1.48	\$ 96.37	\$ 96.37
87502 00	Pathology	2.77	2.77	\$ 179.94	\$ 179.94
87503 00	Pathology	0.84	0.84	\$ 54.88	\$ 54.88
87505 00	Pathology	3.71	3.71	\$ 240.96	\$ 240.96
87506 00	Pathology	7.60	7.60	\$ 493.97	\$ 493.97
87507 00	Pathology	12.04	12.04	\$ 782.83	\$ 782.83
87510 00	Pathology	0.58	0.58	\$ 37.66	\$ 37.66
87511 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87512 00	Pathology	1.21	1.21	\$ 78.44	\$ 78.44
87516 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87517 00	Pathology	1.24	1.24	\$ 80.47	\$ 80.47
87520 00	Pathology	0.90	0.90	\$ 58.64	\$ 58.64
87521 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87522 00	Pathology	1.24	1.24	\$ 80.47	\$ 80.47
87525 00	Pathology	0.86	0.86	\$ 55.97	\$ 55.97
87526 00	Pathology	1.13	1.13	\$ 73.74	\$ 73.74
87527 00	Pathology	1.21	1.21	\$ 78.44	\$ 78.44
87528 00	Pathology	0.58	0.58	\$ 37.66	\$ 37.66
87529 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87530 00	Pathology	1.24	1.24	\$ 80.47	\$ 80.47
87531 00	Pathology	1.68	1.68	\$ 108.94	\$ 108.94
87532 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87533 00	Pathology	1.21	1.21	\$ 78.44	\$ 78.44
87534 00	Pathology	0.63	0.63	\$ 41.17	\$ 41.17
87535 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87536 00	Pathology	2.46	2.46	\$ 159.84	\$ 159.84
87537 00	Pathology	0.63	0.63	\$ 41.17	\$ 41.17
87538 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87539 00	Pathology	1.69	1.69	\$ 110.10	\$ 110.10
87540 00	Pathology	0.58	0.58	\$ 37.66	\$ 37.66
87541 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87542 00	Pathology	1.21	1.21	\$ 78.44	\$ 78.44
87550 00	Pathology	0.58	0.58	\$ 37.66	\$ 37.66
87551 00	Pathology	1.39	1.39	\$ 90.61	\$ 90.61
87552 00	Pathology	1.24	1.24	\$ 80.47	\$ 80.47
87555 00	Pathology	0.78	0.78	\$ 50.49	\$ 50.49
87556 00	Pathology	1.20	1.20	\$ 78.29	\$ 78.29
87557 00	Pathology	1.24	1.24	\$ 80.47	\$ 80.47
87560 00	Pathology	0.79	0.79	\$ 51.26	\$ 51.26
87561 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87562 00	Pathology	1.24	1.24	\$ 80.47	\$ 80.47
87563 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87580 00	Pathology	0.58	0.58	\$ 37.66	\$ 37.66
87581 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87582 00	Pathology	8.74	8.74	\$ 568.40	\$ 568.40
87590 00	Pathology	0.78	0.78	\$ 50.49	\$ 50.49
87591 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87592 00	Pathology	1.24	1.24	\$ 80.47	\$ 80.47
87623 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87624 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87625 00	Pathology	1.17	1.17	\$ 76.16	\$ 76.16

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
87631 00	Pathology	4.12	4.12	\$ 267.90	\$ 267.90
87632 00	Pathology	6.30	6.30	\$ 409.58	\$ 409.58
87633 00	Pathology	12.04	12.04	\$ 782.83	\$ 782.83
87634 00	Pathology	2.03	2.03	\$ 131.85	\$ 131.85
87635 00	Pathology	1.48	1.48	\$ 96.37	\$ 96.37
87636 00	Pathology	4.12	4.12	\$ 267.90	\$ 267.90
87637 00	Pathology	4.12	4.12	\$ 267.90	\$ 267.90
87640 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87641 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87650 00	Pathology	0.58	0.58	\$ 37.66	\$ 37.66
87651 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87652 00	Pathology	1.21	1.21	\$ 78.44	\$ 78.44
87653 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87660 00	Pathology	0.58	0.58	\$ 37.66	\$ 37.66
87661 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87662 00	Pathology	1.48	1.48	\$ 96.37	\$ 96.37
87797 00	Pathology	0.87	0.87	\$ 56.40	\$ 56.40
87798 00	Pathology	1.01	1.01	\$ 65.91	\$ 65.91
87799 00	Pathology	1.24	1.24	\$ 80.47	\$ 80.47
87800 00	Pathology	1.26	1.26	\$ 82.02	\$ 82.02
87801 00	Pathology	2.03	2.03	\$ 131.85	\$ 131.85
87802 00	Pathology	0.37	0.37	\$ 23.91	\$ 23.91
87803 00	Pathology	0.46	0.46	\$ 30.05	\$ 30.05
87804 00	Pathology	0.48	0.48	\$ 31.09	\$ 31.09
87806 00	Pathology	0.95	0.95	\$ 61.55	\$ 61.55
87807 00	Pathology	0.38	0.38	\$ 24.61	\$ 24.61
87808 00	Pathology	0.44	0.44	\$ 28.72	\$ 28.72
87809 00	Pathology	0.63	0.63	\$ 40.87	\$ 40.87
87810 00	Pathology	1.02	1.02	\$ 66.28	\$ 66.28
87811 00	Pathology	-	-	\$ 78.00	\$ 78.00
87850 00	Pathology	0.71	0.71	\$ 46.13	\$ 46.13
87880 00	Pathology	0.48	0.48	\$ 31.05	\$ 31.05
87899 00	Pathology	0.46	0.46	\$ 30.18	\$ 30.18
87900 00	Pathology	3.77	3.77	\$ 244.83	\$ 244.83
87901 00	Pathology	7.44	7.44	\$ 483.56	\$ 483.56
87902 00	Pathology	7.44	7.44	\$ 483.56	\$ 483.56
87903 00	Pathology	14.12	14.12	\$ 917.84	\$ 917.84
87904 00	Pathology	0.75	0.75	\$ 48.97	\$ 48.97
87905 00	Pathology	0.35	0.35	\$ 22.95	\$ 22.95
87906 00	Pathology	3.72	3.72	\$ 241.79	\$ 241.79
87910 00	Pathology	7.44	7.44	\$ 483.56	\$ 483.56
87912 00	Pathology	7.44	7.44	\$ 483.56	\$ 483.56
87999 00	Pathology	0.00	0.00	BR	BR
88000 00	Pathology	-	-	\$ 397.80	\$ 397.80
88005 00	Pathology	-	-	\$ 464.10	\$ 464.10
88007 00	Pathology	-	-	\$ 486.20	\$ 486.20
88012 00	Pathology	-	-	\$ 397.80	\$ 397.80
88014 00	Pathology	-	-	\$ 364.65	\$ 364.65
88016 00	Pathology	-	-	\$ 508.30	\$ 508.30
88020 00	Pathology	-	-	\$ 685.10	\$ 685.10
88025 00	Pathology	-	-	\$ 663.00	\$ 663.00
88027 00	Pathology	-	-	\$ 707.20	\$ 707.20
88028 00	Pathology	-	-	\$ 397.80	\$ 397.80
88029 00	Pathology	-	-	\$ 397.80	\$ 397.80
88036 00	Pathology	-	-	\$ 198.90	\$ 198.90

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
88037 00	Pathology	-	-	\$ 176.80	\$ 176.80
88040 00	Pathology	-	-	\$ 1,105.00	\$ 1,105.00
88045 00	Pathology	-	-	\$ 110.50	\$ 110.50
88099 00	Pathology	0.00	0.00	BR	BR
88104 00	Pathology	1.97	1.97	\$ 128.05	\$ 128.05
88104 26	Pathology	0.79	0.79	\$ 51.35	\$ 51.35
88104 TC	Pathology	1.18	1.18	\$ 76.70	\$ 76.70
88106 00	Pathology	1.97	1.97	\$ 128.05	\$ 128.05
88106 26	Pathology	0.55	0.55	\$ 35.75	\$ 35.75
88106 TC	Pathology	1.42	1.42	\$ 92.30	\$ 92.30
88108 00	Pathology	1.89	1.89	\$ 122.85	\$ 122.85
88108 26	Pathology	0.65	0.65	\$ 42.25	\$ 42.25
88108 TC	Pathology	1.24	1.24	\$ 80.60	\$ 80.60
88112 00	Pathology	1.95	1.95	\$ 126.75	\$ 126.75
88112 26	Pathology	0.80	0.80	\$ 52.00	\$ 52.00
88112 TC	Pathology	1.15	1.15	\$ 74.75	\$ 74.75
88120 00	Pathology	18.22	18.22	\$ 1,184.30	\$ 1,184.30
88120 26	Pathology	1.68	1.68	\$ 109.20	\$ 109.20
88120 TC	Pathology	16.54	16.54	\$ 1,075.10	\$ 1,075.10
88121 00	Pathology	12.83	12.83	\$ 833.95	\$ 833.95
88121 26	Pathology	1.39	1.39	\$ 90.35	\$ 90.35
88121 TC	Pathology	11.44	11.44	\$ 743.60	\$ 743.60
88125 00	Pathology	0.79	0.79	\$ 51.35	\$ 51.35
88125 26	Pathology	0.40	0.40	\$ 26.00	\$ 26.00
88125 TC	Pathology	0.39	0.39	\$ 25.35	\$ 25.35
88130 00	Pathology	0.52	0.52	\$ 33.77	\$ 33.77
88140 00	Pathology	0.23	0.23	\$ 15.01	\$ 15.01
88141 00	Pathology	0.65	0.65	\$ 42.25	\$ 42.25
88142 00	Pathology	0.59	0.59	\$ 38.05	\$ 38.05
88143 00	Pathology	0.67	0.67	\$ 43.28	\$ 43.28
88147 00	Pathology	1.46	1.46	\$ 94.97	\$ 94.97
88148 00	Pathology	0.46	0.46	\$ 30.05	\$ 30.05
88150 00	Pathology	0.46	0.46	\$ 29.90	\$ 29.90
88152 00	Pathology	0.80	0.80	\$ 51.92	\$ 51.92
88153 00	Pathology	0.69	0.69	\$ 45.13	\$ 45.13
88155 00	Pathology	0.42	0.42	\$ 27.52	\$ 27.52
88160 00	Pathology	2.10	2.10	\$ 136.50	\$ 136.50
88160 26	Pathology	0.74	0.74	\$ 48.10	\$ 48.10
88160 TC	Pathology	1.36	1.36	\$ 88.40	\$ 88.40
88161 00	Pathology	2.16	2.16	\$ 140.40	\$ 140.40
88161 26	Pathology	0.73	0.73	\$ 47.45	\$ 47.45
88161 TC	Pathology	1.43	1.43	\$ 92.95	\$ 92.95
88162 00	Pathology	3.33	3.33	\$ 216.45	\$ 216.45
88162 26	Pathology	1.13	1.13	\$ 73.45	\$ 73.45
88162 TC	Pathology	2.20	2.20	\$ 143.00	\$ 143.00
88164 00	Pathology	0.46	0.46	\$ 29.90	\$ 29.90
88165 00	Pathology	1.22	1.22	\$ 79.30	\$ 79.30
88166 00	Pathology	0.46	0.46	\$ 29.90	\$ 29.90
88167 00	Pathology	0.46	0.46	\$ 29.90	\$ 29.90
88172 00	Pathology	1.59	1.59	\$ 103.35	\$ 103.35
88172 26	Pathology	1.02	1.02	\$ 66.30	\$ 66.30
88172 TC	Pathology	0.57	0.57	\$ 37.05	\$ 37.05
88173 00	Pathology	4.61	4.61	\$ 299.65	\$ 299.65
88173 26	Pathology	2.03	2.03	\$ 131.95	\$ 131.95
88173 TC	Pathology	2.58	2.58	\$ 167.70	\$ 167.70

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
88174 00	Pathology	0.73	0.73	\$ 47.65	\$ 47.65
88175 00	Pathology	0.77	0.77	\$ 49.98	\$ 49.98
88177 00	Pathology	0.84	0.84	\$ 54.60	\$ 54.60
88177 26	Pathology	0.63	0.63	\$ 40.95	\$ 40.95
88177 TC	Pathology	0.21	0.21	\$ 13.65	\$ 13.65
88182 00	Pathology	4.31	4.31	\$ 280.15	\$ 280.15
88182 26	Pathology	1.11	1.11	\$ 72.15	\$ 72.15
88182 TC	Pathology	3.20	3.20	\$ 208.00	\$ 208.00
88184 00	Pathology	2.00	2.00	\$ 130.00	\$ 130.00
88185 00	Pathology	0.64	0.64	\$ 41.60	\$ 41.60
88187 00	Pathology	1.04	1.04	\$ 67.60	\$ 67.60
88188 00	Pathology	1.82	1.82	\$ 118.30	\$ 118.30
88189 00	Pathology	2.44	2.44	\$ 158.60	\$ 158.60
88199 00	Pathology	0.00	0.00	BR	BR
88199 26	Pathology	0.00	0.00	BR	BR
88199 TC	Pathology	0.00	0.00	BR	BR
88230 00	Pathology	3.37	3.37	\$ 218.80	\$ 218.80
88233 00	Pathology	4.07	4.07	\$ 264.33	\$ 264.33
88235 00	Pathology	4.34	4.34	\$ 282.30	\$ 282.30
88237 00	Pathology	4.15	4.15	\$ 270.00	\$ 270.00
88239 00	Pathology	4.26	4.26	\$ 277.08	\$ 277.08
88240 00	Pathology	0.38	0.38	\$ 24.55	\$ 24.55
88241 00	Pathology	0.35	0.35	\$ 22.71	\$ 22.71
88245 00	Pathology	5.00	5.00	\$ 325.26	\$ 325.26
88248 00	Pathology	5.00	5.00	\$ 325.26	\$ 325.26
88249 00	Pathology	5.00	5.00	\$ 325.26	\$ 325.26
88261 00	Pathology	7.64	7.64	\$ 496.50	\$ 496.50
88262 00	Pathology	3.63	3.63	\$ 235.70	\$ 235.70
88263 00	Pathology	4.34	4.34	\$ 282.29	\$ 282.29
88264 00	Pathology	4.18	4.18	\$ 271.62	\$ 271.62
88267 00	Pathology	5.45	5.45	\$ 354.19	\$ 354.19
88269 00	Pathology	5.02	5.02	\$ 326.18	\$ 326.18
88271 00	Pathology	0.62	0.62	\$ 40.23	\$ 40.23
88272 00	Pathology	1.18	1.18	\$ 76.45	\$ 76.45
88273 00	Pathology	1.01	1.01	\$ 65.38	\$ 65.38
88274 00	Pathology	1.22	1.22	\$ 79.60	\$ 79.60
88275 00	Pathology	1.48	1.48	\$ 96.15	\$ 96.15
88280 00	Pathology	0.97	0.97	\$ 62.87	\$ 62.87
88283 00	Pathology	1.98	1.98	\$ 128.85	\$ 128.85
88285 00	Pathology	0.78	0.78	\$ 50.54	\$ 50.54
88289 00	Pathology	0.99	0.99	\$ 64.67	\$ 64.67
88291 00	Pathology	0.97	0.97	\$ 63.05	\$ 63.05
88299 00	Pathology	0.00	0.00	BR	BR
88300 00	Pathology	0.45	0.45	\$ 29.25	\$ 29.25
88300 26	Pathology	0.13	0.13	\$ 8.45	\$ 8.45
88300 TC	Pathology	0.32	0.32	\$ 20.80	\$ 20.80
88302 00	Pathology	0.93	0.93	\$ 60.45	\$ 60.45
88302 26	Pathology	0.20	0.20	\$ 13.00	\$ 13.00
88302 TC	Pathology	0.73	0.73	\$ 47.45	\$ 47.45
88304 00	Pathology	1.22	1.22	\$ 79.30	\$ 79.30
88304 26	Pathology	0.33	0.33	\$ 21.45	\$ 21.45
88304 TC	Pathology	0.89	0.89	\$ 57.85	\$ 57.85
88305 00	Pathology	2.08	2.08	\$ 135.20	\$ 135.20
88305 26	Pathology	1.08	1.08	\$ 70.20	\$ 70.20
88305 TC	Pathology	1.00	1.00	\$ 65.00	\$ 65.00

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
88307 00	Pathology	8.40	8.40	\$ 546.00	\$ 546.00
88307 26	Pathology	2.38	2.38	\$ 154.70	\$ 154.70
88307 TC	Pathology	6.02	6.02	\$ 391.30	\$ 391.30
88309 00	Pathology	12.76	12.76	\$ 829.40	\$ 829.40
88309 26	Pathology	4.18	4.18	\$ 271.70	\$ 271.70
88309 TC	Pathology	8.58	8.58	\$ 557.70	\$ 557.70
88311 00	Pathology	0.61	0.61	\$ 39.65	\$ 39.65
88311 26	Pathology	0.36	0.36	\$ 23.40	\$ 23.40
88311 TC	Pathology	0.25	0.25	\$ 16.25	\$ 16.25
88312 00	Pathology	3.31	3.31	\$ 215.15	\$ 215.15
88312 26	Pathology	0.76	0.76	\$ 49.40	\$ 49.40
88312 TC	Pathology	2.55	2.55	\$ 165.75	\$ 165.75
88313 00	Pathology	2.38	2.38	\$ 154.70	\$ 154.70
88313 26	Pathology	0.35	0.35	\$ 22.75	\$ 22.75
88313 TC	Pathology	2.03	2.03	\$ 131.95	\$ 131.95
88314 00	Pathology	2.90	2.90	\$ 188.50	\$ 188.50
88314 26	Pathology	0.61	0.61	\$ 39.65	\$ 39.65
88314 TC	Pathology	2.29	2.29	\$ 148.85	\$ 148.85
88319 00	Pathology	4.11	4.11	\$ 267.15	\$ 267.15
88319 26	Pathology	0.78	0.78	\$ 50.70	\$ 50.70
88319 TC	Pathology	3.33	3.33	\$ 216.45	\$ 216.45
88321 00	Pathology	2.83	2.43	\$ 183.95	\$ 157.95
88323 00	Pathology	3.30	3.30	\$ 214.50	\$ 214.50
88323 26	Pathology	2.51	2.51	\$ 163.15	\$ 163.15
88323 TC	Pathology	0.79	0.79	\$ 51.35	\$ 51.35
88325 00	Pathology	4.59	3.92	\$ 298.35	\$ 254.80
88329 00	Pathology	1.68	1.03	\$ 109.20	\$ 66.95
88331 00	Pathology	2.99	2.99	\$ 194.35	\$ 194.35
88331 26	Pathology	1.79	1.79	\$ 116.35	\$ 116.35
88331 TC	Pathology	1.20	1.20	\$ 78.00	\$ 78.00
88332 00	Pathology	1.59	1.59	\$ 103.35	\$ 103.35
88332 26	Pathology	0.88	0.88	\$ 57.20	\$ 57.20
88332 TC	Pathology	0.71	0.71	\$ 46.15	\$ 46.15
88333 00	Pathology	2.73	2.73	\$ 177.45	\$ 177.45
88333 26	Pathology	1.78	1.78	\$ 115.70	\$ 115.70
88333 TC	Pathology	0.95	0.95	\$ 61.75	\$ 61.75
88334 00	Pathology	1.64	1.64	\$ 106.60	\$ 106.60
88334 26	Pathology	1.08	1.08	\$ 70.20	\$ 70.20
88334 TC	Pathology	0.56	0.56	\$ 36.40	\$ 36.40
88341 00	Pathology	2.59	2.59	\$ 168.35	\$ 168.35
88341 26	Pathology	0.81	0.81	\$ 52.65	\$ 52.65
88341 TC	Pathology	1.78	1.78	\$ 115.70	\$ 115.70
88342 00	Pathology	2.96	2.96	\$ 192.40	\$ 192.40
88342 26	Pathology	1.00	1.00	\$ 65.00	\$ 65.00
88342 TC	Pathology	1.96	1.96	\$ 127.40	\$ 127.40
88344 00	Pathology	5.00	5.00	\$ 325.00	\$ 325.00
88344 26	Pathology	1.10	1.10	\$ 71.50	\$ 71.50
88344 TC	Pathology	3.90	3.90	\$ 253.50	\$ 253.50
88346 00	Pathology	4.50	4.50	\$ 292.50	\$ 292.50
88346 26	Pathology	1.04	1.04	\$ 67.60	\$ 67.60
88346 TC	Pathology	3.46	3.46	\$ 224.90	\$ 224.90
88348 00	Pathology	13.39	13.39	\$ 870.35	\$ 870.35
88348 26	Pathology	2.24	2.24	\$ 145.60	\$ 145.60
88348 TC	Pathology	11.15	11.15	\$ 724.75	\$ 724.75
88350 00	Pathology	3.47	3.47	\$ 225.55	\$ 225.55

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CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
88350 26	Pathology	0.84	0.84	\$ 54.60	\$ 54.60
88350 TC	Pathology	2.63	2.63	\$ 170.95	\$ 170.95
88355 00	Pathology	4.13	4.13	\$ 268.45	\$ 268.45
88355 26	Pathology	2.37	2.37	\$ 154.05	\$ 154.05
88355 TC	Pathology	1.76	1.76	\$ 114.40	\$ 114.40
88356 00	Pathology	7.20	7.20	\$ 468.00	\$ 468.00
88356 26	Pathology	3.73	3.73	\$ 242.45	\$ 242.45
88356 TC	Pathology	3.47	3.47	\$ 225.55	\$ 225.55
88358 00	Pathology	4.09	4.09	\$ 265.85	\$ 265.85
88358 26	Pathology	1.43	1.43	\$ 92.95	\$ 92.95
88358 TC	Pathology	2.66	2.66	\$ 172.90	\$ 172.90
88360 00	Pathology	3.54	3.54	\$ 230.10	\$ 230.10
88360 26	Pathology	1.20	1.20	\$ 78.00	\$ 78.00
88360 TC	Pathology	2.34	2.34	\$ 152.10	\$ 152.10
88361 00	Pathology	3.53	3.53	\$ 229.45	\$ 229.45
88361 26	Pathology	1.26	1.26	\$ 81.90	\$ 81.90
88361 TC	Pathology	2.27	2.27	\$ 147.55	\$ 147.55
88362 00	Pathology	6.49	6.49	\$ 421.85	\$ 421.85
88362 26	Pathology	3.22	3.22	\$ 209.30	\$ 209.30
88362 TC	Pathology	3.27	3.27	\$ 212.55	\$ 212.55
88363 00	Pathology	0.67	0.56	\$ 43.55	\$ 36.40
88364 00	Pathology	4.05	4.05	\$ 263.25	\$ 263.25
88364 26	Pathology	0.99	0.99	\$ 64.35	\$ 64.35
88364 TC	Pathology	3.06	3.06	\$ 198.90	\$ 198.90
88365 00	Pathology	5.28	5.28	\$ 343.20	\$ 343.20
88365 26	Pathology	1.26	1.26	\$ 81.90	\$ 81.90
88365 TC	Pathology	4.02	4.02	\$ 261.30	\$ 261.30
88366 00	Pathology	8.37	8.37	\$ 544.05	\$ 544.05
88366 26	Pathology	1.79	1.79	\$ 116.35	\$ 116.35
88366 TC	Pathology	6.58	6.58	\$ 427.70	\$ 427.70
88367 00	Pathology	3.32	3.32	\$ 215.80	\$ 215.80
88367 26	Pathology	0.97	0.97	\$ 63.05	\$ 63.05
88367 TC	Pathology	2.35	2.35	\$ 152.75	\$ 152.75
88368 00	Pathology	3.99	3.99	\$ 259.35	\$ 259.35
88368 26	Pathology	1.19	1.19	\$ 77.35	\$ 77.35
88368 TC	Pathology	2.80	2.80	\$ 182.00	\$ 182.00
88369 00	Pathology	3.38	3.38	\$ 219.70	\$ 219.70
88369 26	Pathology	0.93	0.93	\$ 60.45	\$ 60.45
88369 TC	Pathology	2.45	2.45	\$ 159.25	\$ 159.25
88371 00	Pathology	0.64	0.64	\$ 41.75	\$ 41.75
88371 26	Pathology	0.56	0.56	\$ 36.40	\$ 36.40
88372 00	Pathology	0.76	0.76	\$ 49.25	\$ 49.25
88372 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45
88373 00	Pathology	2.03	2.03	\$ 131.95	\$ 131.95
88373 26	Pathology	0.74	0.74	\$ 48.10	\$ 48.10
88373 TC	Pathology	1.29	1.29	\$ 83.85	\$ 83.85
88374 00	Pathology	9.59	9.59	\$ 623.35	\$ 623.35
88374 26	Pathology	1.25	1.25	\$ 81.25	\$ 81.25
88374 TC	Pathology	8.34	8.34	\$ 542.10	\$ 542.10
88375 00	Pathology	1.40	1.40	\$ 91.00	\$ 91.00
88377 00	Pathology	11.90	11.90	\$ 773.50	\$ 773.50
88377 26	Pathology	1.84	1.84	\$ 119.60	\$ 119.60
88377 TC	Pathology	10.06	10.06	\$ 653.90	\$ 653.90
88380 00	Pathology	3.73	3.73	\$ 242.45	\$ 242.45
88380 26	Pathology	1.57	1.57	\$ 102.05	\$ 102.05

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CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
88380 TC	Pathology	2.16	2.16	\$ 140.40	\$ 140.40
88381 00	Pathology	6.18	6.18	\$ 401.70	\$ 401.70
88381 26	Pathology	0.69	0.69	\$ 44.85	\$ 44.85
88381 TC	Pathology	5.49	5.49	\$ 356.85	\$ 356.85
88387 00	Pathology	1.00	1.00	\$ 65.00	\$ 65.00
88387 26	Pathology	0.77	0.77	\$ 50.05	\$ 50.05
88387 TC	Pathology	0.23	0.23	\$ 14.95	\$ 14.95
88388 00	Pathology	1.10	1.10	\$ 71.50	\$ 71.50
88388 26	Pathology	0.68	0.68	\$ 44.20	\$ 44.20
88388 TC	Pathology	0.42	0.42	\$ 27.30	\$ 27.30
88399 00	Pathology	0.00	0.00	BR	BR
88399 26	Pathology	0.00	0.00	BR	BR
88399 TC	Pathology	0.00	0.00	BR	BR
88720 00	Pathology	0.15	0.15	\$ 9.43	\$ 9.43
88738 00	Pathology	0.15	0.15	\$ 9.43	\$ 9.43
88740 00	Pathology	0.27	0.27	\$ 17.60	\$ 17.60
88741 00	Pathology	0.27	0.27	\$ 17.60	\$ 17.60
88749 00	Pathology	0.00	0.00	BR	BR
89049 00	Pathology	7.93	1.77	\$ 515.45	\$ 115.05
89050 00	Pathology	0.14	0.14	\$ 8.87	\$ 8.87
89051 00	Pathology	0.16	0.16	\$ 10.52	\$ 10.52
89055 00	Pathology	0.12	0.12	\$ 8.02	\$ 8.02
89060 00	Pathology	0.21	0.21	\$ 13.77	\$ 13.77
89060 26	Pathology	0.53	0.53	\$ 34.45	\$ 34.45
89125 00	Pathology	0.17	0.17	\$ 11.04	\$ 11.04
89160 00	Pathology	0.14	0.14	\$ 9.11	\$ 9.11
89190 00	Pathology	0.17	0.17	\$ 10.88	\$ 10.88
89220 00	Pathology	0.55	0.55	\$ 35.75	\$ 35.75
89230 00	Pathology	0.07	0.07	\$ 4.55	\$ 4.55
89240 00	Pathology	0.00	0.00	BR	BR
89250 00	Pathology	-	-	\$ 1,990.30	\$ 1,990.30
89251 00	Pathology	-	-	\$ 2,070.25	\$ 2,070.25
89253 00	Pathology	0.00	0.00	BR	BR
89254 00	Pathology	0.00	0.00	BR	BR
89255 00	Pathology	0.00	0.00	BR	BR
89257 00	Pathology	0.00	0.00	BR	BR
89258 00	Pathology	0.00	0.00	BR	BR
89259 00	Pathology	0.00	0.00	BR	BR
89260 00	Pathology	0.00	0.00	BR	BR
89261 00	Pathology	0.00	0.00	BR	BR
89264 00	Pathology	0.00	0.00	BR	BR
89268 00	Pathology	0.00	0.00	BR	BR
89272 00	Pathology	0.00	0.00	BR	BR
89280 00	Pathology	0.00	0.00	BR	BR
89281 00	Pathology	0.00	0.00	BR	BR
89290 00	Pathology	0.00	0.00	BR	BR
89291 00	Pathology	0.00	0.00	BR	BR
89300 00	Pathology	0.28	0.28	\$ 18.48	\$ 18.48
89310 00	Pathology	0.25	0.25	\$ 16.17	\$ 16.17
89320 00	Pathology	0.36	0.36	\$ 23.12	\$ 23.12
89321 00	Pathology	0.35	0.35	\$ 22.63	\$ 22.63
89322 00	Pathology	0.45	0.45	\$ 29.11	\$ 29.11
89325 00	Pathology	0.31	0.31	\$ 20.04	\$ 20.04
89329 00	Pathology	0.57	0.57	\$ 36.80	\$ 36.80
89330 00	Pathology	0.30	0.30	\$ 19.50	\$ 19.50

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
89331 00	Pathology	0.57	0.57	\$ 36.80	\$ 36.80
89335 00	Pathology	0.00	0.00	BR	BR
89337 00	Pathology	0.00	0.00	BR	BR
89342 00	Pathology	0.00	0.00	BR	BR
89343 00	Pathology	0.00	0.00	BR	BR
89344 00	Pathology	0.00	0.00	BR	BR
89346 00	Pathology	0.00	0.00	BR	BR
89352 00	Pathology	0.00	0.00	BR	BR
89353 00	Pathology	0.00	0.00	BR	BR
89354 00	Pathology	0.00	0.00	BR	BR
89356 00	Pathology	0.00	0.00	BR	BR
89398 00	Pathology	0.00	0.00	BR	BR
G0480 00	Pathology	3.31	3.31	\$ 214.93	\$ 214.93
G0481 00	Pathology	4.52	4.52	\$ 294.12	\$ 294.12
G0482 00	Pathology	5.74	5.74	\$ 373.29	\$ 373.29
G0483 00	Pathology	7.14	7.14	\$ 463.78	\$ 463.78
G2023 00	Pathology	0.49	0.07	\$ 31.85	\$ 4.55
G2024 00	Pathology	0.74	0.74	\$ 47.82	\$ 47.82
U0001 00	Pathology	1.04	1.04	\$ 67.47	\$ 67.47
U0002 00	Pathology	1.48	1.48	\$ 96.37	\$ 96.37

Historical Note

New Appendix A, Pathology and Laboratory Codes 2019-2020 made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Pathology and Laboratory Codes 2019-2020 will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Pathology and Laboratory Codes 2019-2020 repealed; new Appendix A, Pathology and Laboratory Codes 2020-2021 made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Pathology Codes 2020-2021 repealed; new Appendix A, Pathology Codes 2021-2022 made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Pathology Codes 2021-2022 repealed; new Appendix A, Pathology Codes 2022- 2023 made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

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MEDICINE GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2022 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT® are preceded by an AZ identifier and numbered in the following format: AZxxx. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to unit values for these services. To the extent that a conflict may exist between an adopted portion of the CPT® and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

- A. **MATERIALS SUPPLIED BY A HEALTHCARE PROVIDER:** A healthcare provider may charge for materials and supplies as described in subsection (J)(4) of the Introduction Section of the Physician's Fee Schedule.
- B. **COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT:** Code 99199 can be used to bill for the services of an interpreter when they are used to comply with the provisions of "The Americans With Disabilities Act", *i.e.*, interpreters for the hearing impaired.
- C. **ADD-ON CODES:** Some of the listed procedures are commonly carried out in addition to the primary procedure performed. All add-on codes found in the CPT® codebook are exempt from the multiple procedure concept. They are exempt from the use of modifier 51.
- D. **SEPARATE PROCEDURES:** Some of the procedures or services listed in the CPT® codebook that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term "separate procedure". The codes designated as a "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

When a procedure or service is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending modifier 59 to the specific "separate procedure" code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure.

- E. **BUNDLED CODES:** Indicates that the service is always bundled in a payment for another service. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (*e.g.*, a telephone call from a hospital nurse regarding the care of a patient).

Historical Note

New Appendix A, Medicine Guidelines made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Medicine Guidelines will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Medicine Guidelines repealed; new Appendix A, Medicine Guidelines made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Medicine Guidelines repealed; new Appendix A, Medicine Guidelines made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Medicine Guidelines repealed; new Appendix A, Medicine Guidelines made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

ARIZONA PHYSICIANS' FEE SCHEDULE					
Medicine Codes 2022					
Medicine Conversion Factor \$65.00					
Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
90281 00	Medicine	0.00	0.00	BR	BR
90283 00	Medicine	0.00	0.00	BR	BR
90284 00	Medicine	0.00	0.00	BR	BR
90287 00	Medicine	0.00	0.00	BR	BR
90288 00	Medicine	0.00	0.00	BR	BR
90291 00	Medicine	0.00	0.00	BR	BR
90296 00	Medicine	0.00	0.00	BR	BR
90371 00	Medicine	-	-	\$ 254.80	\$ 254.80
90375 00	Medicine	-	-	\$ 579.80	\$ 579.80
90376 00	Medicine	-	-	\$ 669.50	\$ 669.50
90377 00	Medicine	-	-	\$ 450.45	\$ 450.45
90378 00	Medicine	0.00	0.00	BR	BR
90384 00	Medicine	-	-	\$ 175.50	\$ 175.50
90385 00	Medicine	-	-	\$ 79.95	\$ 79.95
90386 00	Medicine	-	-	\$ 187.85	\$ 187.85
90389 00	Medicine	-	-	\$ 162.50	\$ 162.50
90393 00	Medicine	0.00	0.00	BR	BR

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
90396 00	Medicine	-	-	\$ 180.05	\$ 180.05
90399 00	Medicine	0.00	0.00	BR	BR
90460 00	Medicine	0.49	0.49	\$ 31.85	\$ 31.85
90461 00	Medicine	0.37	0.37	\$ 24.05	\$ 24.05
90471 00	Medicine	0.49	0.49	\$ 31.85	\$ 31.85
90472 00	Medicine	0.37	0.37	\$ 24.05	\$ 24.05
90473 00	Medicine	0.49	0.49	\$ 31.85	\$ 31.85
90474 00	Medicine	0.37	0.37	\$ 24.05	\$ 24.05
90476 00	Medicine	0.00	0.00	BR	BR
90477 00	Medicine	0.00	0.00	BR	BR
90581 00	Medicine	-	-	\$ 208.65	\$ 208.65
90585 00	Medicine	-	-	\$ 187.85	\$ 187.85
90586 00	Medicine	-	-	\$ 265.85	\$ 265.85
90587 00	Medicine	0.00	0.00	BR	BR
90619 00	Medicine	0.00	0.00	BR	BR
90620 00	Medicine	0.00	0.00	BR	BR
90621 00	Medicine	0.00	0.00	BR	BR
90625 00	Medicine	0.00	0.00	BR	BR
90626 00	Medicine	0.00	0.00	BR	BR
90627 00	Medicine	0.00	0.00	BR	BR
90630 00	Medicine	0.00	0.00	BR	BR
90632 00	Medicine	-	-	\$ 121.55	\$ 121.55
90633 00	Medicine	-	-	\$ 50.05	\$ 50.05
90634 00	Medicine	-	-	\$ 52.65	\$ 52.65
90636 00	Medicine	-	-	\$ 137.80	\$ 137.80
90644 00	Medicine	-	-	\$ 40.30	\$ 40.30
90647 00	Medicine	-	-	\$ 42.25	\$ 42.25
90648 00	Medicine	-	-	\$ 40.30	\$ 40.30
90649 00	Medicine	-	-	\$ 190.45	\$ 190.45
90650 00	Medicine	0.00	0.00	BR	BR
90651 00	Medicine	0.00	0.00	BR	BR
90653 00	Medicine	0.00	0.00	BR	BR
90654 00	Medicine	0.00	0.00	BR	BR
90655 00	Medicine	-	-	\$ 22.75	\$ 22.75
90656 00	Medicine	-	-	\$ 22.75	\$ 22.75
90657 00	Medicine	-	-	\$ 23.40	\$ 23.40
90658 00	Medicine	-	-	\$ 23.40	\$ 23.40
90660 00	Medicine	-	-	\$ 29.90	\$ 29.90
90661 00	Medicine	0.00	0.00	BR	BR
90662 00	Medicine	-	-	\$ 122.85	\$ 122.85
90664 00	Medicine	0.00	0.00	BR	BR
90666 00	Medicine	0.00	0.00	BR	BR
90667 00	Medicine	0.00	0.00	BR	BR
90668 00	Medicine	0.00	0.00	BR	BR
90670 00	Medicine	-	-	\$ 453.70	\$ 453.70
90671 00	Medicine	-	-	\$ 462.15	\$ 462.15
90672 00	Medicine	-	-	\$ 50.70	\$ 50.70
90673 00	Medicine	0.00	0.00	BR	BR
90674 00	Medicine	-	-	\$ 56.55	\$ 56.55
90675 00	Medicine	-	-	\$ 642.20	\$ 642.20
90676 00	Medicine	0.00	0.00	BR	BR
90677 00	Medicine	-	-	\$ 497.25	\$ 497.25
90680 00	Medicine	-	-	\$ 112.45	\$ 112.45
90681 00	Medicine	-	-	\$ 112.45	\$ 112.45
90682 00	Medicine	-	-	\$ 122.85	\$ 122.85
90685 00	Medicine	-	-	\$ 40.95	\$ 40.95
90686 00	Medicine	-	-	\$ 38.35	\$ 38.35
90687 00	Medicine	-	-	\$ 18.85	\$ 18.85
90688 00	Medicine	-	-	\$ 37.70	\$ 37.70
90689 00	Medicine	0.00	0.00	BR	BR
90690 00	Medicine	-	-	\$ 57.85	\$ 57.85
90691 00	Medicine	-	-	\$ 81.90	\$ 81.90

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
90694 00	Medicine	-	-	\$ 124.80	\$ 124.80
90696 00	Medicine	0.00	0.00	BR	BR
90697 00	Medicine	0.00	0.00	BR	BR
90698 00	Medicine	-	-	\$ 112.45	\$ 112.45
90700 00	Medicine	-	-	\$ 37.70	\$ 37.70
90702 00	Medicine	-	-	\$ 30.55	\$ 30.55
90707 00	Medicine	-	-	\$ 75.40	\$ 75.40
90710 00	Medicine	-	-	\$ 499.85	\$ 499.85
90713 00	Medicine	-	-	\$ 42.25	\$ 42.25
90714 00	Medicine	-	-	\$ 52.00	\$ 52.00
90715 00	Medicine	-	-	\$ 67.60	\$ 67.60
90716 00	Medicine	-	-	\$ 109.85	\$ 109.85
90717 00	Medicine	-	-	\$ 127.40	\$ 127.40
90723 00	Medicine	-	-	\$ 109.85	\$ 109.85
90732 00	Medicine	-	-	\$ 250.90	\$ 250.90
90733 00	Medicine	-	-	\$ 150.15	\$ 150.15
90734 00	Medicine	-	-	\$ 473.20	\$ 473.20
90736 00	Medicine	-	-	\$ 240.50	\$ 240.50
90738 00	Medicine	-	-	\$ 99.45	\$ 99.45
90739 00	Medicine	-	-	\$ 271.05	\$ 271.05
90740 00	Medicine	-	-	\$ 264.55	\$ 264.55
90743 00	Medicine	-	-	\$ 75.40	\$ 75.40
90744 00	Medicine	-	-	\$ 53.95	\$ 53.95
90746 00	Medicine	-	-	\$ 131.95	\$ 131.95
90747 00	Medicine	-	-	\$ 264.55	\$ 264.55
90748 00	Medicine	-	-	\$ 83.85	\$ 83.85
90749 00	Medicine	0.00	0.00	BR	BR
90750 00	Medicine	0.00	0.00	BR	BR
90756 00	Medicine	-	-	\$ 53.30	\$ 53.30
90758 00	Medicine	0.00	0.00	BR	BR
90759 00	Medicine	0.00	0.00	BR	BR
90785 00	Medicine	0.43	0.38	\$ 27.95	\$ 24.70
90791 00	Medicine	5.17	4.45	\$ 336.05	\$ 289.25
90792 00	Medicine	5.79	5.08	\$ 376.35	\$ 330.20
90832 00	Medicine	2.25	1.99	\$ 146.25	\$ 129.35
90833 00	Medicine	2.06	1.84	\$ 133.90	\$ 119.60
90834 00	Medicine	2.97	2.62	\$ 193.05	\$ 170.30
90836 00	Medicine	2.60	2.32	\$ 169.00	\$ 150.80
90837 00	Medicine	4.36	3.84	\$ 283.40	\$ 249.60
90838 00	Medicine	3.42	3.07	\$ 222.30	\$ 199.55
90839 00	Medicine	4.17	3.69	\$ 271.05	\$ 239.85
90840 00	Medicine	2.08	1.86	\$ 135.20	\$ 120.90
90845 00	Medicine	2.81	2.50	\$ 182.65	\$ 162.50
90846 00	Medicine	2.84	2.82	\$ 184.60	\$ 183.30
90847 00	Medicine	2.94	2.93	\$ 191.10	\$ 190.45
90849 00	Medicine	1.02	0.82	\$ 66.30	\$ 53.30
90853 00	Medicine	0.79	0.69	\$ 51.35	\$ 44.85
90863 00	Medicine	0.75	0.71	\$ 48.75	\$ 46.15
90865 00	Medicine	4.87	3.65	\$ 316.55	\$ 237.25
90867 00	Medicine	-	-	\$ 469.95	\$ 469.95
90868 00	Medicine	-	-	\$ 302.25	\$ 302.25
90869 00	Medicine	-	-	\$ 429.00	\$ 429.00
90870 00	Medicine	5.11	3.10	\$ 332.15	\$ 201.50
90875 00	Medicine	1.78	1.76	\$ 115.70	\$ 114.40
90876 00	Medicine	3.10	2.80	\$ 201.50	\$ 182.00
90880 00	Medicine	3.10	2.62	\$ 201.50	\$ 170.30
90882 00	Medicine	-	-	\$ 159.25	\$ 159.25
90885 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
90887 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
90889 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
90899 00	Medicine	0.00	0.00	BR	BR
90901 00	Medicine	1.20	0.56	\$ 78.00	\$ 36.40

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
90912 00	Medicine	2.39	1.26	\$ 155.35	\$ 81.90
90913 00	Medicine	0.94	0.71	\$ 61.10	\$ 46.15
90935 00	Medicine	2.11	2.11	\$ 137.15	\$ 137.15
90937 00	Medicine	3.02	3.02	\$ 196.30	\$ 196.30
90940 00	Medicine	-	-	\$ 130.00	\$ 130.00
90945 00	Medicine	2.51	2.51	\$ 163.15	\$ 163.15
90947 00	Medicine	3.63	3.63	\$ 235.95	\$ 235.95
90951 00	Medicine	34.73	34.73	\$ 2,257.45	\$ 2,257.45
90952 00	Medicine	-	-	\$ 1,626.30	\$ 1,626.30
90953 00	Medicine	-	-	\$ 1,084.20	\$ 1,084.20
90954 00	Medicine	29.84	29.84	\$ 1,939.60	\$ 1,939.60
90955 00	Medicine	15.42	15.42	\$ 1,002.30	\$ 1,002.30
90956 00	Medicine	10.21	10.21	\$ 663.65	\$ 663.65
90957 00	Medicine	22.81	22.81	\$ 1,482.65	\$ 1,482.65
90958 00	Medicine	14.84	14.84	\$ 964.60	\$ 964.60
90959 00	Medicine	9.59	9.59	\$ 623.35	\$ 623.35
90960 00	Medicine	10.44	10.44	\$ 678.60	\$ 678.60
90961 00	Medicine	8.66	8.66	\$ 562.90	\$ 562.90
90962 00	Medicine	5.95	5.95	\$ 386.75	\$ 386.75
90963 00	Medicine	17.92	17.92	\$ 1,164.80	\$ 1,164.80
90964 00	Medicine	15.37	15.37	\$ 999.05	\$ 999.05
90965 00	Medicine	14.77	14.77	\$ 960.05	\$ 960.05
90966 00	Medicine	8.66	8.66	\$ 562.90	\$ 562.90
90967 00	Medicine	0.52	0.52	\$ 33.80	\$ 33.80
90968 00	Medicine	0.51	0.51	\$ 33.15	\$ 33.15
90969 00	Medicine	0.50	0.50	\$ 32.50	\$ 32.50
90970 00	Medicine	0.28	0.28	\$ 18.20	\$ 18.20
90989 00	Medicine	-	-	\$ 813.15	\$ 813.15
90993 00	Medicine	-	-	\$ 176.15	\$ 176.15
90997 00	Medicine	2.60	2.60	\$ 169.00	\$ 169.00
90999 00	Medicine	0.00	0.00	BR	BR
91010 00	Medicine	6.77	6.77	\$ 440.05	\$ 440.05
91010 26	Medicine	1.91	1.91	\$ 124.15	\$ 124.15
91010 TC	Medicine	4.86	4.86	\$ 315.90	\$ 315.90
91013 00	Medicine	0.78	0.78	\$ 50.70	\$ 50.70
91013 26	Medicine	0.27	0.27	\$ 17.55	\$ 17.55
91013 TC	Medicine	0.51	0.51	\$ 33.15	\$ 33.15
91020 00	Medicine	8.45	8.45	\$ 549.25	\$ 549.25
91020 26	Medicine	2.14	2.14	\$ 139.10	\$ 139.10
91020 TC	Medicine	6.31	6.31	\$ 410.15	\$ 410.15
91022 00	Medicine	5.16	5.16	\$ 335.40	\$ 335.40
91022 26	Medicine	2.13	2.13	\$ 138.45	\$ 138.45
91022 TC	Medicine	3.03	3.03	\$ 196.95	\$ 196.95
91030 00	Medicine	4.37	4.37	\$ 284.05	\$ 284.05
91030 26	Medicine	1.36	1.36	\$ 88.40	\$ 88.40
91030 TC	Medicine	3.01	3.01	\$ 195.65	\$ 195.65
91034 00	Medicine	5.82	5.82	\$ 378.30	\$ 378.30
91034 26	Medicine	1.46	1.46	\$ 94.90	\$ 94.90
91034 TC	Medicine	4.36	4.36	\$ 283.40	\$ 283.40
91035 00	Medicine	14.36	14.36	\$ 933.40	\$ 933.40
91035 26	Medicine	2.38	2.38	\$ 154.70	\$ 154.70
91035 TC	Medicine	11.98	11.98	\$ 778.70	\$ 778.70
91037 00	Medicine	5.14	5.14	\$ 334.10	\$ 334.10
91037 26	Medicine	1.44	1.44	\$ 93.60	\$ 93.60
91037 TC	Medicine	3.70	3.70	\$ 240.50	\$ 240.50
91038 00	Medicine	12.71	12.71	\$ 826.15	\$ 826.15
91038 26	Medicine	1.63	1.63	\$ 105.95	\$ 105.95
91038 TC	Medicine	11.08	11.08	\$ 720.20	\$ 720.20
91040 00	Medicine	16.41	16.41	\$ 1,066.65	\$ 1,066.65
91040 26	Medicine	1.45	1.45	\$ 94.25	\$ 94.25
91040 TC	Medicine	14.96	14.96	\$ 972.40	\$ 972.40
91065 00	Medicine	2.72	2.72	\$ 176.80	\$ 176.80

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CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
91065 26	Medicine	0.30	0.30	\$ 19.50	\$ 19.50
91065 TC	Medicine	2.42	2.42	\$ 157.30	\$ 157.30
91110 00	Medicine	23.32	23.32	\$ 1,515.80	\$ 1,515.80
91110 26	Medicine	3.32	3.32	\$ 215.80	\$ 215.80
91110 TC	Medicine	20.00	20.00	\$ 1,300.00	\$ 1,300.00
91111 00	Medicine	28.08	28.08	\$ 1,825.20	\$ 1,825.20
91111 26	Medicine	1.34	1.34	\$ 87.10	\$ 87.10
91111 TC	Medicine	26.74	26.74	\$ 1,738.10	\$ 1,738.10
91112 00	Medicine	51.86	51.86	\$ 3,370.90	\$ 3,370.90
91112 26	Medicine	3.12	3.12	\$ 202.80	\$ 202.80
91112 TC	Medicine	48.74	48.74	\$ 3,168.10	\$ 3,168.10
91113 00	Medicine	28.08	28.08	\$ 1,825.20	\$ 1,825.20
91113 26	Medicine	3.55	3.55	\$ 230.75	\$ 230.75
91113 TC	Medicine	24.53	24.53	\$ 1,594.45	\$ 1,594.45
91117 00	Medicine	3.99	3.99	\$ 259.35	\$ 259.35
91120 00	Medicine	15.88	15.88	\$ 1,032.20	\$ 1,032.20
91120 26	Medicine	1.42	1.42	\$ 92.30	\$ 92.30
91120 TC	Medicine	14.46	14.46	\$ 939.90	\$ 939.90
91122 00	Medicine	8.23	8.23	\$ 534.95	\$ 534.95
91122 26	Medicine	2.56	2.56	\$ 166.40	\$ 166.40
91122 TC	Medicine	5.67	5.67	\$ 368.55	\$ 368.55
91132 00	Medicine	14.04	14.04	\$ 912.60	\$ 912.60
91132 26	Medicine	0.77	0.77	\$ 50.05	\$ 50.05
91132 TC	Medicine	13.27	13.27	\$ 862.55	\$ 862.55
91133 00	Medicine	14.68	14.68	\$ 954.20	\$ 954.20
91133 26	Medicine	0.98	0.98	\$ 63.70	\$ 63.70
91133 TC	Medicine	13.70	13.70	\$ 890.50	\$ 890.50
91200 00	Medicine	0.91	0.91	\$ 59.15	\$ 59.15
91200 26	Medicine	0.31	0.31	\$ 20.15	\$ 20.15
91200 TC	Medicine	0.60	0.60	\$ 39.00	\$ 39.00
91299 00	Medicine	0.00	0.00	BR	BR
91299 26	Medicine	0.00	0.00	BR	BR
91299 TC	Medicine	0.00	0.00	BR	BR
91300 00	Medicine	0.00	0.00	BR	BR
91301 00	Medicine	0.00	0.00	BR	BR
91303 00	Medicine	0.00	0.00	BR	BR
91307 00	Medicine	0.00	0.00	BR	BR
92002 00	Medicine	2.53	1.36	\$ 164.45	\$ 88.40
92004 00	Medicine	4.39	2.77	\$ 285.35	\$ 180.05
92012 00	Medicine	2.62	1.48	\$ 170.30	\$ 96.20
92014 00	Medicine	3.71	2.23	\$ 241.15	\$ 144.95
92015 00	Medicine	0.58	0.57	\$ 37.70	\$ 37.05
92018 00	Medicine	4.02	4.02	\$ 261.30	\$ 261.30
92019 00	Medicine	2.08	2.08	\$ 135.20	\$ 135.20
92020 00	Medicine	0.82	0.59	\$ 53.30	\$ 38.35
92025 00	Medicine	1.06	1.06	\$ 68.90	\$ 68.90
92025 26	Medicine	0.56	0.56	\$ 36.40	\$ 36.40
92025 TC	Medicine	0.50	0.50	\$ 32.50	\$ 32.50
92060 00	Medicine	1.84	1.84	\$ 119.60	\$ 119.60
92060 26	Medicine	1.07	1.07	\$ 69.55	\$ 69.55
92060 TC	Medicine	0.77	0.77	\$ 50.05	\$ 50.05
92065 00	Medicine	1.55	1.55	\$ 100.75	\$ 100.75
92065 26	Medicine	0.51	0.51	\$ 33.15	\$ 33.15
92065 TC	Medicine	1.04	1.04	\$ 67.60	\$ 67.60
92071 00	Medicine	1.07	0.94	\$ 69.55	\$ 61.10
92072 00	Medicine	3.73	2.78	\$ 242.45	\$ 180.70
92081 00	Medicine	0.97	0.97	\$ 63.05	\$ 63.05
92081 26	Medicine	0.46	0.46	\$ 29.90	\$ 29.90
92081 TC	Medicine	0.51	0.51	\$ 33.15	\$ 33.15
92082 00	Medicine	1.36	1.36	\$ 88.40	\$ 88.40
92082 26	Medicine	0.60	0.60	\$ 39.00	\$ 39.00
92082 TC	Medicine	0.76	0.76	\$ 49.40	\$ 49.40

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CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
92083 00	Medicine	1.84	1.84	\$ 119.60	\$ 119.60
92083 26	Medicine	0.78	0.78	\$ 50.70	\$ 50.70
92083 TC	Medicine	1.06	1.06	\$ 68.90	\$ 68.90
92100 00	Medicine	2.50	0.94	\$ 162.50	\$ 61.10
92132 00	Medicine	0.92	0.92	\$ 59.80	\$ 59.80
92132 26	Medicine	0.47	0.47	\$ 30.55	\$ 30.55
92132 TC	Medicine	0.45	0.45	\$ 29.25	\$ 29.25
92133 00	Medicine	1.08	1.08	\$ 70.20	\$ 70.20
92133 26	Medicine	0.63	0.63	\$ 40.95	\$ 40.95
92133 TC	Medicine	0.45	0.45	\$ 29.25	\$ 29.25
92134 00	Medicine	1.19	1.19	\$ 77.35	\$ 77.35
92134 26	Medicine	0.73	0.73	\$ 47.45	\$ 47.45
92134 TC	Medicine	0.46	0.46	\$ 29.90	\$ 29.90
92136 00	Medicine	1.46	1.46	\$ 94.90	\$ 94.90
92136 26	Medicine	0.88	0.88	\$ 57.20	\$ 57.20
92136 TC	Medicine	0.58	0.58	\$ 37.70	\$ 37.70
92145 00	Medicine	0.37	0.37	\$ 24.05	\$ 24.05
92145 26	Medicine	0.16	0.16	\$ 10.40	\$ 10.40
92145 TC	Medicine	0.21	0.21	\$ 13.65	\$ 13.65
92201 00	Medicine	0.72	0.66	\$ 46.80	\$ 42.90
92202 00	Medicine	0.46	0.42	\$ 29.90	\$ 27.30
92227 00	Medicine	0.47	0.47	\$ 30.55	\$ 30.55
92228 00	Medicine	0.90	0.90	\$ 58.50	\$ 58.50
92228 26	Medicine	0.52	0.52	\$ 33.80	\$ 33.80
92228 TC	Medicine	0.38	0.38	\$ 24.70	\$ 24.70
92229 00	Medicine	1.36	1.36	\$ 88.40	\$ 88.40
92230 00	Medicine	2.88	0.95	\$ 187.20	\$ 61.75
92235 00	Medicine	3.69	3.69	\$ 239.85	\$ 239.85
92235 26	Medicine	1.22	1.22	\$ 79.30	\$ 79.30
92235 TC	Medicine	2.47	2.47	\$ 160.55	\$ 160.55
92240 00	Medicine	5.72	5.72	\$ 371.80	\$ 371.80
92240 26	Medicine	1.38	1.38	\$ 89.70	\$ 89.70
92240 TC	Medicine	4.34	4.34	\$ 282.10	\$ 282.10
92242 00	Medicine	7.38	7.38	\$ 479.70	\$ 479.70
92242 26	Medicine	1.58	1.58	\$ 102.70	\$ 102.70
92242 TC	Medicine	5.80	5.80	\$ 377.00	\$ 377.00
92250 00	Medicine	1.09	1.09	\$ 70.85	\$ 70.85
92250 26	Medicine	0.61	0.61	\$ 39.65	\$ 39.65
92250 TC	Medicine	0.48	0.48	\$ 31.20	\$ 31.20
92260 00	Medicine	0.58	0.31	\$ 37.70	\$ 20.15
92265 00	Medicine	2.53	2.53	\$ 164.45	\$ 164.45
92265 26	Medicine	1.32	1.32	\$ 85.80	\$ 85.80
92265 TC	Medicine	1.21	1.21	\$ 78.65	\$ 78.65
92270 00	Medicine	3.20	3.20	\$ 208.00	\$ 208.00
92270 26	Medicine	1.23	1.23	\$ 79.95	\$ 79.95
92270 TC	Medicine	1.97	1.97	\$ 128.05	\$ 128.05
92273 00	Medicine	3.73	3.73	\$ 242.45	\$ 242.45
92273 26	Medicine	1.06	1.06	\$ 68.90	\$ 68.90
92273 TC	Medicine	2.67	2.67	\$ 173.55	\$ 173.55
92274 00	Medicine	2.55	2.55	\$ 165.75	\$ 165.75
92274 26	Medicine	0.94	0.94	\$ 61.10	\$ 61.10
92274 TC	Medicine	1.61	1.61	\$ 104.65	\$ 104.65
92283 00	Medicine	1.59	1.59	\$ 103.35	\$ 103.35
92283 26	Medicine	0.26	0.26	\$ 16.90	\$ 16.90
92283 TC	Medicine	1.33	1.33	\$ 86.45	\$ 86.45
92284 00	Medicine	1.70	1.70	\$ 110.50	\$ 110.50
92284 26	Medicine	0.35	0.35	\$ 22.75	\$ 22.75
92284 TC	Medicine	1.35	1.35	\$ 87.75	\$ 87.75
92285 00	Medicine	0.68	0.68	\$ 44.20	\$ 44.20
92285 26	Medicine	0.09	0.09	\$ 5.85	\$ 5.85
92285 TC	Medicine	0.59	0.59	\$ 38.35	\$ 38.35
92286 00	Medicine	1.15	1.15	\$ 74.75	\$ 74.75

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
92286 26	Medicine	0.63	0.63	\$ 40.95	\$ 40.95
92286 TC	Medicine	0.52	0.52	\$ 33.80	\$ 33.80
92287 00	Medicine	5.32	5.32	\$ 345.80	\$ 345.80
92287 26	Medicine	1.32	1.32	\$ 85.80	\$ 85.80
92287 TC	Medicine	4.00	4.00	\$ 260.00	\$ 260.00
92310 00	Medicine	3.01	1.72	\$ 195.65	\$ 111.80
92311 00	Medicine	3.13	1.53	\$ 203.45	\$ 99.45
92312 00	Medicine	3.63	1.77	\$ 235.95	\$ 115.05
92313 00	Medicine	2.96	1.26	\$ 192.40	\$ 81.90
92314 00	Medicine	2.63	1.03	\$ 170.95	\$ 66.95
92315 00	Medicine	2.44	0.61	\$ 158.60	\$ 39.65
92316 00	Medicine	3.01	0.92	\$ 195.65	\$ 59.80
92317 00	Medicine	2.56	0.61	\$ 166.40	\$ 39.65
92325 00	Medicine	1.36	1.36	\$ 88.40	\$ 88.40
92326 00	Medicine	1.16	1.16	\$ 75.40	\$ 75.40
92340 00	Medicine	1.02	0.55	\$ 66.30	\$ 35.75
92341 00	Medicine	1.16	0.69	\$ 75.40	\$ 44.85
92342 00	Medicine	1.24	0.77	\$ 80.60	\$ 50.05
92352 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92353 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92354 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92355 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92358 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92370 00	Medicine	0.92	0.48	\$ 59.80	\$ 31.20
92371 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92499 00	Medicine	0.00	0.00	BR	BR
92499 26	Medicine	0.00	0.00	BR	BR
92499 TC	Medicine	0.00	0.00	BR	BR
92502 00	Medicine	2.78	2.78	\$ 180.70	\$ 180.70
92504 00	Medicine	0.86	0.27	\$ 55.90	\$ 17.55
92507 00	Medicine	2.26	2.26	\$ 146.90	\$ 146.90
92508 00	Medicine	0.70	0.70	\$ 45.50	\$ 45.50
92511 00	Medicine	3.53	1.10	\$ 229.45	\$ 71.50
92512 00	Medicine	1.84	0.81	\$ 119.60	\$ 52.65
92516 00	Medicine	2.05	0.67	\$ 133.25	\$ 43.55
92517 00	Medicine	2.02	1.22	\$ 131.30	\$ 79.30
92518 00	Medicine	1.90	1.22	\$ 123.50	\$ 79.30
92519 00	Medicine	3.14	1.83	\$ 204.10	\$ 118.95
92520 00	Medicine	2.43	1.16	\$ 157.95	\$ 75.40
92521 00	Medicine	3.92	3.92	\$ 254.80	\$ 254.80
92522 00	Medicine	3.29	3.29	\$ 213.85	\$ 213.85
92523 00	Medicine	6.69	6.69	\$ 434.85	\$ 434.85
92524 00	Medicine	3.24	3.24	\$ 210.60	\$ 210.60
92526 00	Medicine	2.51	2.51	\$ 163.15	\$ 163.15
92531 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92532 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92533 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92534 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92537 00	Medicine	1.21	1.21	\$ 78.65	\$ 78.65
92537 26	Medicine	0.91	0.91	\$ 59.15	\$ 59.15
92537 TC	Medicine	0.30	0.30	\$ 19.50	\$ 19.50
92538 00	Medicine	0.67	0.67	\$ 43.55	\$ 43.55
92538 26	Medicine	0.47	0.47	\$ 30.55	\$ 30.55
92538 TC	Medicine	0.20	0.20	\$ 13.00	\$ 13.00
92540 00	Medicine	3.27	3.27	\$ 212.55	\$ 212.55
92540 26	Medicine	2.28	2.28	\$ 148.20	\$ 148.20
92540 TC	Medicine	0.99	0.99	\$ 64.35	\$ 64.35
92541 00	Medicine	0.75	0.75	\$ 48.75	\$ 48.75
92541 26	Medicine	0.61	0.61	\$ 39.65	\$ 39.65
92541 TC	Medicine	0.14	0.14	\$ 9.10	\$ 9.10
92542 00	Medicine	0.86	0.86	\$ 55.90	\$ 55.90
92542 26	Medicine	0.73	0.73	\$ 47.45	\$ 47.45

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
92542 TC	Medicine	0.13	0.13	\$ 8.45	\$ 8.45
92544 00	Medicine	0.53	0.53	\$ 34.45	\$ 34.45
92544 26	Medicine	0.42	0.42	\$ 27.30	\$ 27.30
92544 TC	Medicine	0.11	0.11	\$ 7.15	\$ 7.15
92545 00	Medicine	0.50	0.50	\$ 32.50	\$ 32.50
92545 26	Medicine	0.39	0.39	\$ 25.35	\$ 25.35
92545 TC	Medicine	0.11	0.11	\$ 7.15	\$ 7.15
92546 00	Medicine	3.70	3.70	\$ 240.50	\$ 240.50
92546 26	Medicine	0.44	0.44	\$ 28.60	\$ 28.60
92546 TC	Medicine	3.26	3.26	\$ 211.90	\$ 211.90
92547 00	Medicine	0.31	0.31	\$ 20.15	\$ 20.15
92548 00	Medicine	1.44	1.44	\$ 93.60	\$ 93.60
92548 26	Medicine	1.00	1.00	\$ 65.00	\$ 65.00
92548 TC	Medicine	0.44	0.44	\$ 28.60	\$ 28.60
92549 00	Medicine	1.88	1.88	\$ 122.20	\$ 122.20
92549 26	Medicine	1.30	1.30	\$ 84.50	\$ 84.50
92549 TC	Medicine	0.58	0.58	\$ 37.70	\$ 37.70
92550 00	Medicine	0.66	0.66	\$ 42.90	\$ 42.90
92551 00	Medicine	0.34	0.34	\$ 22.10	\$ 22.10
92552 00	Medicine	0.99	0.99	\$ 64.35	\$ 64.35
92553 00	Medicine	1.20	1.20	\$ 78.00	\$ 78.00
92555 00	Medicine	0.75	0.75	\$ 48.75	\$ 48.75
92556 00	Medicine	1.18	1.18	\$ 76.70	\$ 76.70
92557 00	Medicine	1.11	0.95	\$ 72.15	\$ 61.75
92558 00	Medicine	0.28	0.25	\$ 18.20	\$ 16.25
92562 00	Medicine	1.36	1.36	\$ 88.40	\$ 88.40
92563 00	Medicine	0.94	0.94	\$ 61.10	\$ 61.10
92565 00	Medicine	0.56	0.56	\$ 36.40	\$ 36.40
92567 00	Medicine	0.49	0.31	\$ 31.85	\$ 20.15
92568 00	Medicine	0.46	0.45	\$ 29.90	\$ 29.25
92570 00	Medicine	0.97	0.87	\$ 63.05	\$ 56.55
92571 00	Medicine	0.84	0.84	\$ 54.60	\$ 54.60
92572 00	Medicine	1.21	1.21	\$ 78.65	\$ 78.65
92575 00	Medicine	2.07	2.07	\$ 134.55	\$ 134.55
92576 00	Medicine	1.12	1.12	\$ 72.80	\$ 72.80
92577 00	Medicine	0.55	0.55	\$ 35.75	\$ 35.75
92579 00	Medicine	1.36	1.11	\$ 88.40	\$ 72.15
92582 00	Medicine	2.28	2.28	\$ 148.20	\$ 148.20
92583 00	Medicine	1.49	1.49	\$ 96.85	\$ 96.85
92584 00	Medicine	3.40	3.40	\$ 221.00	\$ 221.00
92587 00	Medicine	0.65	0.65	\$ 42.25	\$ 42.25
92587 26	Medicine	0.53	0.53	\$ 34.45	\$ 34.45
92587 TC	Medicine	0.12	0.12	\$ 7.80	\$ 7.80
92588 00	Medicine	1.00	1.00	\$ 65.00	\$ 65.00
92588 26	Medicine	0.84	0.84	\$ 54.60	\$ 54.60
92588 TC	Medicine	0.16	0.16	\$ 10.40	\$ 10.40
92590 00	Medicine	-	-	\$ 106.60	\$ 106.60
92591 00	Medicine	-	-	\$ 135.85	\$ 135.85
92592 00	Medicine	-	-	\$ 42.25	\$ 42.25
92593 00	Medicine	-	-	\$ 70.20	\$ 70.20
92594 00	Medicine	-	-	\$ 40.30	\$ 40.30
92595 00	Medicine	-	-	\$ 87.75	\$ 87.75
92596 00	Medicine	2.02	2.02	\$ 131.30	\$ 131.30
92597 00	Medicine	2.13	2.13	\$ 138.45	\$ 138.45
92601 00	Medicine	4.82	3.63	\$ 313.30	\$ 235.95
92602 00	Medicine	3.05	2.05	\$ 198.25	\$ 133.25
92603 00	Medicine	4.51	3.53	\$ 293.15	\$ 229.45
92604 00	Medicine	2.72	1.96	\$ 176.80	\$ 127.40
92605 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92606 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92607 00	Medicine	3.66	3.66	\$ 237.90	\$ 237.90
92608 00	Medicine	1.45	1.45	\$ 94.25	\$ 94.25

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
92609 00	Medicine	3.07	3.07	\$ 199.55	\$ 199.55
92610 00	Medicine	2.52	2.06	\$ 163.80	\$ 133.90
92611 00	Medicine	2.71	2.71	\$ 176.15	\$ 176.15
92612 00	Medicine	5.74	1.96	\$ 373.10	\$ 127.40
92613 00	Medicine	1.07	1.07	\$ 69.55	\$ 69.55
92614 00	Medicine	4.32	1.94	\$ 280.80	\$ 126.10
92615 00	Medicine	0.96	0.96	\$ 62.40	\$ 62.40
92616 00	Medicine	6.39	2.89	\$ 415.35	\$ 187.85
92617 00	Medicine	1.20	1.20	\$ 78.00	\$ 78.00
92618 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92620 00	Medicine	2.69	2.36	\$ 174.85	\$ 153.40
92621 00	Medicine	0.65	0.55	\$ 42.25	\$ 35.75
92625 00	Medicine	2.02	1.80	\$ 131.30	\$ 117.00
92626 00	Medicine	2.60	2.19	\$ 169.00	\$ 142.35
92627 00	Medicine	0.61	0.52	\$ 39.65	\$ 33.80
92630 00	Medicine	0.00	0.00	BR	BR
92633 00	Medicine	0.00	0.00	BR	BR
92640 00	Medicine	3.28	2.78	\$ 213.20	\$ 180.70
92650 00	Medicine	0.85	0.85	\$ 55.25	\$ 55.25
92651 00	Medicine	2.61	2.61	\$ 169.65	\$ 169.65
92652 00	Medicine	3.42	3.42	\$ 222.30	\$ 222.30
92653 00	Medicine	2.54	2.54	\$ 165.10	\$ 165.10
92700 00	Medicine	0.00	0.00	BR	BR
92920 00	Medicine	15.53	15.53	\$ 1,009.45	\$ 1,009.45
92921 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92924 00	Medicine	18.51	18.51	\$ 1,203.15	\$ 1,203.15
92925 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92928 00	Medicine	17.28	17.28	\$ 1,123.20	\$ 1,123.20
92929 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92933 00	Medicine	19.38	19.38	\$ 1,259.70	\$ 1,259.70
92934 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92937 00	Medicine	17.26	17.26	\$ 1,121.90	\$ 1,121.90
92938 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92941 00	Medicine	19.42	19.42	\$ 1,262.30	\$ 1,262.30
92943 00	Medicine	19.42	19.42	\$ 1,262.30	\$ 1,262.30
92944 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
92950 00	Medicine	9.84	5.39	\$ 639.60	\$ 350.35
92953 00	Medicine	0.03	0.03	\$ 1.95	\$ 1.95
92960 00	Medicine	4.60	3.16	\$ 299.00	\$ 205.40
92961 00	Medicine	7.21	7.21	\$ 468.65	\$ 468.65
92970 00	Medicine	5.56	5.56	\$ 361.40	\$ 361.40
92971 00	Medicine	2.93	2.93	\$ 190.45	\$ 190.45
92973 00	Medicine	5.18	5.18	\$ 336.70	\$ 336.70
92974 00	Medicine	4.73	4.73	\$ 307.45	\$ 307.45
92975 00	Medicine	11.04	11.04	\$ 717.60	\$ 717.60
92977 00	Medicine	1.53	1.53	\$ 99.45	\$ 99.45
92978 00	Medicine	-	-	\$ 514.15	\$ 514.15
92978 26	Medicine	2.77	2.77	\$ 180.05	\$ 180.05
92978 TC	Medicine	-	-	\$ 334.10	\$ 334.10
92979 00	Medicine	-	-	\$ 312.00	\$ 312.00
92979 26	Medicine	2.21	2.21	\$ 143.65	\$ 143.65
92979 TC	Medicine	-	-	\$ 168.35	\$ 168.35
92986 00	Medicine	38.83	38.83	\$ 2,523.95	\$ 2,523.95
92987 00	Medicine	40.17	40.17	\$ 2,611.05	\$ 2,611.05
92990 00	Medicine	32.00	32.00	\$ 2,080.00	\$ 2,080.00
92997 00	Medicine	18.66	18.66	\$ 1,212.90	\$ 1,212.90
92998 00	Medicine	9.30	9.30	\$ 604.50	\$ 604.50
93000 00	Medicine	0.42	0.42	\$ 27.30	\$ 27.30
93005 00	Medicine	0.18	0.18	\$ 11.70	\$ 11.70
93010 00	Medicine	0.24	0.24	\$ 15.60	\$ 15.60
93015 00	Medicine	2.09	2.09	\$ 135.85	\$ 135.85
93016 00	Medicine	0.63	0.63	\$ 40.95	\$ 40.95

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
93017 00	Medicine	1.04	1.04	\$ 67.60	\$ 67.60
93018 00	Medicine	0.42	0.42	\$ 27.30	\$ 27.30
93024 00	Medicine	3.22	3.22	\$ 209.30	\$ 209.30
93024 26	Medicine	1.62	1.62	\$ 105.30	\$ 105.30
93024 TC	Medicine	1.60	1.60	\$ 104.00	\$ 104.00
93025 00	Medicine	3.56	3.56	\$ 231.40	\$ 231.40
93025 26	Medicine	1.08	1.08	\$ 70.20	\$ 70.20
93025 TC	Medicine	2.48	2.48	\$ 161.20	\$ 161.20
93040 00	Medicine	0.37	0.37	\$ 24.05	\$ 24.05
93041 00	Medicine	0.17	0.17	\$ 11.05	\$ 11.05
93042 00	Medicine	0.20	0.20	\$ 13.00	\$ 13.00
93050 00	Medicine	0.47	0.47	\$ 30.55	\$ 30.55
93050 26	Medicine	0.24	0.24	\$ 15.60	\$ 15.60
93050 TC	Medicine	0.23	0.23	\$ 14.95	\$ 14.95
93224 00	Medicine	2.23	2.23	\$ 144.95	\$ 144.95
93225 00	Medicine	0.57	0.57	\$ 37.05	\$ 37.05
93226 00	Medicine	1.12	1.12	\$ 72.80	\$ 72.80
93227 00	Medicine	0.54	0.54	\$ 35.10	\$ 35.10
93228 00	Medicine	0.75	0.75	\$ 48.75	\$ 48.75
93229 00	Medicine	26.35	26.35	\$ 1,712.75	\$ 1,712.75
93241 00	Medicine	-	-	\$ 217.75	\$ 217.75
93242 00	Medicine	0.42	0.42	\$ 27.30	\$ 27.30
93243 00	Medicine	-	-	\$ 109.85	\$ 109.85
93244 00	Medicine	0.71	0.71	\$ 46.15	\$ 46.15
93245 00	Medicine	-	-	\$ 184.60	\$ 184.60
93246 00	Medicine	0.42	0.42	\$ 27.30	\$ 27.30
93247 00	Medicine	-	-	\$ 113.75	\$ 113.75
93248 00	Medicine	0.78	0.78	\$ 50.70	\$ 50.70
93260 00	Medicine	2.30	2.30	\$ 149.50	\$ 149.50
93260 26	Medicine	1.24	1.24	\$ 80.60	\$ 80.60
93260 TC	Medicine	1.06	1.06	\$ 68.90	\$ 68.90
93261 00	Medicine	2.13	2.13	\$ 138.45	\$ 138.45
93261 26	Medicine	1.08	1.08	\$ 70.20	\$ 70.20
93261 TC	Medicine	1.05	1.05	\$ 68.25	\$ 68.25
93264 00	Medicine	1.46	1.03	\$ 94.90	\$ 66.95
93268 00	Medicine	5.47	5.47	\$ 355.55	\$ 355.55
93270 00	Medicine	0.25	0.25	\$ 16.25	\$ 16.25
93271 00	Medicine	4.50	4.50	\$ 292.50	\$ 292.50
93272 00	Medicine	0.72	0.72	\$ 46.80	\$ 46.80
93278 00	Medicine	0.85	0.85	\$ 55.25	\$ 55.25
93278 26	Medicine	0.36	0.36	\$ 23.40	\$ 23.40
93278 TC	Medicine	0.49	0.49	\$ 31.85	\$ 31.85
93279 00	Medicine	2.05	2.05	\$ 133.25	\$ 133.25
93279 26	Medicine	0.92	0.92	\$ 59.80	\$ 59.80
93279 TC	Medicine	1.13	1.13	\$ 73.45	\$ 73.45
93280 00	Medicine	2.43	2.43	\$ 157.95	\$ 157.95
93280 26	Medicine	1.11	1.11	\$ 72.15	\$ 72.15
93280 TC	Medicine	1.32	1.32	\$ 85.80	\$ 85.80
93281 00	Medicine	2.57	2.57	\$ 167.05	\$ 167.05
93281 26	Medicine	1.23	1.23	\$ 79.95	\$ 79.95
93281 TC	Medicine	1.34	1.34	\$ 87.10	\$ 87.10
93282 00	Medicine	2.45	2.45	\$ 159.25	\$ 159.25
93282 26	Medicine	1.23	1.23	\$ 79.95	\$ 79.95
93282 TC	Medicine	1.22	1.22	\$ 79.30	\$ 79.30
93283 00	Medicine	2.98	2.98	\$ 193.70	\$ 193.70
93283 26	Medicine	1.65	1.65	\$ 107.25	\$ 107.25
93283 TC	Medicine	1.33	1.33	\$ 86.45	\$ 86.45
93284 00	Medicine	3.21	3.21	\$ 208.65	\$ 208.65
93284 26	Medicine	1.79	1.79	\$ 116.35	\$ 116.35
93284 TC	Medicine	1.42	1.42	\$ 92.30	\$ 92.30
93285 00	Medicine	1.85	1.85	\$ 120.25	\$ 120.25
93285 26	Medicine	0.75	0.75	\$ 48.75	\$ 48.75

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CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
93285 TC	Medicine	1.10	1.10	\$ 71.50	\$ 71.50
93286 00	Medicine	1.42	1.42	\$ 92.30	\$ 92.30
93286 26	Medicine	0.44	0.44	\$ 28.60	\$ 28.60
93286 TC	Medicine	0.98	0.98	\$ 63.70	\$ 63.70
93287 00	Medicine	1.64	1.64	\$ 106.60	\$ 106.60
93287 26	Medicine	0.66	0.66	\$ 42.90	\$ 42.90
93287 TC	Medicine	0.98	0.98	\$ 63.70	\$ 63.70
93288 00	Medicine	1.73	1.73	\$ 112.45	\$ 112.45
93288 26	Medicine	0.61	0.61	\$ 39.65	\$ 39.65
93288 TC	Medicine	1.12	1.12	\$ 72.80	\$ 72.80
93289 00	Medicine	2.21	2.21	\$ 143.65	\$ 143.65
93289 26	Medicine	1.08	1.08	\$ 70.20	\$ 70.20
93289 TC	Medicine	1.13	1.13	\$ 73.45	\$ 73.45
93290 00	Medicine	1.65	1.65	\$ 107.25	\$ 107.25
93290 26	Medicine	0.62	0.62	\$ 40.30	\$ 40.30
93290 TC	Medicine	1.03	1.03	\$ 66.95	\$ 66.95
93291 00	Medicine	1.52	1.52	\$ 98.80	\$ 98.80
93291 26	Medicine	0.53	0.53	\$ 34.45	\$ 34.45
93291 TC	Medicine	0.99	0.99	\$ 64.35	\$ 64.35
93292 00	Medicine	1.54	1.54	\$ 100.10	\$ 100.10
93292 26	Medicine	0.61	0.61	\$ 39.65	\$ 39.65
93292 TC	Medicine	0.93	0.93	\$ 60.45	\$ 60.45
93293 00	Medicine	1.41	1.41	\$ 91.65	\$ 91.65
93293 26	Medicine	0.43	0.43	\$ 27.95	\$ 27.95
93293 TC	Medicine	0.98	0.98	\$ 63.70	\$ 63.70
93294 00	Medicine	0.88	0.88	\$ 57.20	\$ 57.20
93295 00	Medicine	1.09	1.09	\$ 70.85	\$ 70.85
93296 00	Medicine	0.69	0.69	\$ 44.85	\$ 44.85
93297 00	Medicine	0.77	0.77	\$ 50.05	\$ 50.05
93298 00	Medicine	0.77	0.77	\$ 50.05	\$ 50.05
93303 00	Medicine	6.68	6.68	\$ 434.20	\$ 434.20
93303 26	Medicine	1.81	1.81	\$ 117.65	\$ 117.65
93303 TC	Medicine	4.87	4.87	\$ 316.55	\$ 316.55
93304 00	Medicine	4.71	4.71	\$ 306.15	\$ 306.15
93304 26	Medicine	1.06	1.06	\$ 68.90	\$ 68.90
93304 TC	Medicine	3.65	3.65	\$ 237.25	\$ 237.25
93306 00	Medicine	5.92	5.92	\$ 384.80	\$ 384.80
93306 26	Medicine	2.03	2.03	\$ 131.95	\$ 131.95
93306 TC	Medicine	3.89	3.89	\$ 252.85	\$ 252.85
93307 00	Medicine	4.15	4.15	\$ 269.75	\$ 269.75
93307 26	Medicine	1.29	1.29	\$ 83.85	\$ 83.85
93307 TC	Medicine	2.86	2.86	\$ 185.90	\$ 185.90
93308 00	Medicine	2.94	2.94	\$ 191.10	\$ 191.10
93308 26	Medicine	0.73	0.73	\$ 47.45	\$ 47.45
93308 TC	Medicine	2.21	2.21	\$ 143.65	\$ 143.65
93312 00	Medicine	7.14	7.14	\$ 464.10	\$ 464.10
93312 26	Medicine	3.14	3.14	\$ 204.10	\$ 204.10
93312 TC	Medicine	4.00	4.00	\$ 260.00	\$ 260.00
93313 00	Medicine	0.33	0.33	\$ 21.45	\$ 21.45
93314 00	Medicine	6.86	6.86	\$ 445.90	\$ 445.90
93314 26	Medicine	2.63	2.63	\$ 170.95	\$ 170.95
93314 TC	Medicine	4.23	4.23	\$ 274.95	\$ 274.95
93315 00	Medicine	-	-	\$ 479.70	\$ 479.70
93315 26	Medicine	3.69	3.69	\$ 239.85	\$ 239.85
93315 TC	Medicine	-	-	\$ 239.85	\$ 239.85
93316 00	Medicine	0.76	0.76	\$ 49.40	\$ 49.40
93317 00	Medicine	-	-	\$ 338.00	\$ 338.00
93317 26	Medicine	2.60	2.60	\$ 169.00	\$ 169.00
93317 TC	Medicine	-	-	\$ 169.00	\$ 169.00
93318 00	Medicine	-	-	\$ 390.00	\$ 390.00
93318 26	Medicine	3.00	3.00	\$ 195.00	\$ 195.00
93318 TC	Medicine	-	-	\$ 195.00	\$ 195.00

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
93319 00	Medicine	1.79	0.73	\$ 116.35	\$ 47.45
93320 00	Medicine	1.53	1.53	\$ 99.45	\$ 99.45
93320 26	Medicine	0.52	0.52	\$ 33.80	\$ 33.80
93320 TC	Medicine	1.01	1.01	\$ 65.65	\$ 65.65
93321 00	Medicine	0.76	0.76	\$ 49.40	\$ 49.40
93321 26	Medicine	0.21	0.21	\$ 13.65	\$ 13.65
93321 TC	Medicine	0.55	0.55	\$ 35.75	\$ 35.75
93325 00	Medicine	0.71	0.71	\$ 46.15	\$ 46.15
93325 26	Medicine	0.09	0.09	\$ 5.85	\$ 5.85
93325 TC	Medicine	0.62	0.62	\$ 40.30	\$ 40.30
93350 00	Medicine	5.62	5.62	\$ 365.30	\$ 365.30
93350 26	Medicine	2.03	2.03	\$ 131.95	\$ 131.95
93350 TC	Medicine	3.59	3.59	\$ 233.35	\$ 233.35
93351 00	Medicine	6.98	6.98	\$ 453.70	\$ 453.70
93351 26	Medicine	2.44	2.44	\$ 158.60	\$ 158.60
93351 TC	Medicine	4.54	4.54	\$ 295.10	\$ 295.10
93352 00	Medicine	0.99	0.99	\$ 64.35	\$ 64.35
93355 00	Medicine	6.62	6.62	\$ 430.30	\$ 430.30
93356 00	Medicine	1.13	0.35	\$ 73.45	\$ 22.75
93451 00	Medicine	27.00	27.00	\$ 1,755.00	\$ 1,755.00
93451 26	Medicine	3.82	3.82	\$ 248.30	\$ 248.30
93451 TC	Medicine	23.18	23.18	\$ 1,506.70	\$ 1,506.70
93452 00	Medicine	27.96	27.96	\$ 1,817.40	\$ 1,817.40
93452 26	Medicine	6.93	6.93	\$ 450.45	\$ 450.45
93452 TC	Medicine	21.03	21.03	\$ 1,366.95	\$ 1,366.95
93453 00	Medicine	35.44	35.44	\$ 2,303.60	\$ 2,303.60
93453 26	Medicine	9.22	9.22	\$ 599.30	\$ 599.30
93453 TC	Medicine	26.22	26.22	\$ 1,704.30	\$ 1,704.30
93454 00	Medicine	28.02	28.02	\$ 1,821.30	\$ 1,821.30
93454 26	Medicine	7.01	7.01	\$ 455.65	\$ 455.65
93454 TC	Medicine	21.01	21.01	\$ 1,365.65	\$ 1,365.65
93455 00	Medicine	31.15	31.15	\$ 2,024.75	\$ 2,024.75
93455 26	Medicine	8.14	8.14	\$ 529.10	\$ 529.10
93455 TC	Medicine	23.01	23.01	\$ 1,495.65	\$ 1,495.65
93456 00	Medicine	34.81	34.81	\$ 2,262.65	\$ 2,262.65
93456 26	Medicine	9.08	9.08	\$ 590.20	\$ 590.20
93456 TC	Medicine	25.73	25.73	\$ 1,672.45	\$ 1,672.45
93457 00	Medicine	37.97	37.97	\$ 2,468.05	\$ 2,468.05
93457 26	Medicine	10.24	10.24	\$ 665.60	\$ 665.60
93457 TC	Medicine	27.73	27.73	\$ 1,802.45	\$ 1,802.45
93458 00	Medicine	32.12	32.12	\$ 2,087.80	\$ 2,087.80
93458 26	Medicine	8.62	8.62	\$ 560.30	\$ 560.30
93458 TC	Medicine	23.50	23.50	\$ 1,527.50	\$ 1,527.50
93459 00	Medicine	34.54	34.54	\$ 2,245.10	\$ 2,245.10
93459 26	Medicine	9.78	9.78	\$ 635.70	\$ 635.70
93459 TC	Medicine	24.76	24.76	\$ 1,609.40	\$ 1,609.40
93460 00	Medicine	38.38	38.38	\$ 2,494.70	\$ 2,494.70
93460 26	Medicine	10.95	10.95	\$ 711.75	\$ 711.75
93460 TC	Medicine	27.43	27.43	\$ 1,782.95	\$ 1,782.95
93461 00	Medicine	42.31	42.31	\$ 2,750.15	\$ 2,750.15
93461 26	Medicine	12.10	12.10	\$ 786.50	\$ 786.50
93461 TC	Medicine	30.21	30.21	\$ 1,963.65	\$ 1,963.65
93462 00	Medicine	6.17	6.17	\$ 401.05	\$ 401.05
93463 00	Medicine	2.88	2.88	\$ 187.20	\$ 187.20
93464 00	Medicine	6.67	6.67	\$ 433.55	\$ 433.55
93464 26	Medicine	2.59	2.59	\$ 168.35	\$ 168.35
93464 TC	Medicine	4.08	4.08	\$ 265.20	\$ 265.20
93503 00	Medicine	2.58	2.58	\$ 167.70	\$ 167.70
93505 00	Medicine	19.91	19.91	\$ 1,294.15	\$ 1,294.15
93505 26	Medicine	6.64	6.64	\$ 431.60	\$ 431.60
93505 TC	Medicine	13.27	13.27	\$ 862.55	\$ 862.55
93563 00	Medicine	1.70	1.70	\$ 110.50	\$ 110.50

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
93564 00	Medicine	1.77	1.77	\$ 115.05	\$ 115.05
93565 00	Medicine	1.36	1.36	\$ 88.40	\$ 88.40
93566 00	Medicine	3.89	1.35	\$ 252.85	\$ 87.75
93567 00	Medicine	3.29	1.53	\$ 213.85	\$ 99.45
93568 00	Medicine	3.68	1.40	\$ 239.20	\$ 91.00
93571 00	Medicine	-	-	\$ 391.95	\$ 391.95
93571 26	Medicine	2.11	2.11	\$ 137.15	\$ 137.15
93571 TC	Medicine	-	-	\$ 254.80	\$ 254.80
93572 00	Medicine	-	-	\$ 214.50	\$ 214.50
93572 26	Medicine	1.55	1.55	\$ 100.75	\$ 100.75
93572 TC	Medicine	-	-	\$ 113.75	\$ 113.75
93580 00	Medicine	28.54	28.54	\$ 1,855.10	\$ 1,855.10
93581 00	Medicine	38.87	38.87	\$ 2,526.55	\$ 2,526.55
93582 00	Medicine	19.45	19.45	\$ 1,264.25	\$ 1,264.25
93583 00	Medicine	21.72	21.72	\$ 1,411.80	\$ 1,411.80
93590 00	Medicine	31.33	31.33	\$ 2,036.45	\$ 2,036.45
93591 00	Medicine	25.88	25.88	\$ 1,682.20	\$ 1,682.20
93592 00	Medicine	11.42	11.42	\$ 742.30	\$ 742.30
93593 00	Medicine	-	-	\$ 359.45	\$ 359.45
93593 26	Medicine	5.53	5.53	\$ 359.45	\$ 359.45
93593 TC	Medicine	0.00	0.00	BR	BR
93594 00	Medicine	-	-	\$ 566.80	\$ 566.80
93594 26	Medicine	8.72	8.72	\$ 566.80	\$ 566.80
93594 TC	Medicine	0.00	0.00	BR	BR
93595 00	Medicine	-	-	\$ 511.55	\$ 511.55
93595 26	Medicine	7.87	7.87	\$ 511.55	\$ 511.55
93595 TC	Medicine	0.00	0.00	BR	BR
93596 00	Medicine	-	-	\$ 618.15	\$ 618.15
93596 26	Medicine	9.51	9.51	\$ 618.15	\$ 618.15
93596 TC	Medicine	0.00	0.00	BR	BR
93597 00	Medicine	-	-	\$ 825.50	\$ 825.50
93597 26	Medicine	12.70	12.70	\$ 825.50	\$ 825.50
93597 TC	Medicine	0.00	0.00	BR	BR
93598 00	Medicine	-	-	\$ 135.20	\$ 135.20
93598 26	Medicine	2.08	2.08	\$ 135.20	\$ 135.20
93598 TC	Medicine	0.00	0.00	BR	BR
93600 00	Medicine	-	-	\$ 374.40	\$ 374.40
93600 26	Medicine	3.45	3.45	\$ 224.25	\$ 224.25
93600 TC	Medicine	-	-	\$ 150.15	\$ 150.15
93602 00	Medicine	-	-	\$ 306.80	\$ 306.80
93602 26	Medicine	3.40	3.40	\$ 221.00	\$ 221.00
93602 TC	Medicine	-	-	\$ 85.80	\$ 85.80
93603 00	Medicine	-	-	\$ 351.00	\$ 351.00
93603 26	Medicine	3.40	3.40	\$ 221.00	\$ 221.00
93603 TC	Medicine	-	-	\$ 130.00	\$ 130.00
93609 00	Medicine	-	-	\$ 731.25	\$ 731.25
93609 26	Medicine	8.10	8.10	\$ 526.50	\$ 526.50
93609 TC	Medicine	-	-	\$ 204.75	\$ 204.75
93610 00	Medicine	-	-	\$ 416.00	\$ 416.00
93610 26	Medicine	4.80	4.80	\$ 312.00	\$ 312.00
93610 TC	Medicine	-	-	\$ 104.00	\$ 104.00
93612 00	Medicine	-	-	\$ 429.65	\$ 429.65
93612 26	Medicine	4.76	4.76	\$ 309.40	\$ 309.40
93612 TC	Medicine	-	-	\$ 120.25	\$ 120.25
93613 00	Medicine	8.68	8.68	\$ 564.20	\$ 564.20
93615 00	Medicine	-	-	\$ 89.70	\$ 89.70
93615 26	Medicine	1.09	1.09	\$ 70.85	\$ 70.85
93615 TC	Medicine	-	-	\$ 18.85	\$ 18.85
93616 00	Medicine	-	-	\$ 148.20	\$ 148.20
93616 26	Medicine	1.71	1.71	\$ 111.15	\$ 111.15
93616 TC	Medicine	-	-	\$ 37.05	\$ 37.05
93618 00	Medicine	-	-	\$ 694.20	\$ 694.20

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
93618 26	Medicine	6.41	6.41	\$ 416.65	\$ 416.65
93618 TC	Medicine	-	-	\$ 277.55	\$ 277.55
93619 00	Medicine	-	-	\$ 1,298.70	\$ 1,298.70
93619 26	Medicine	11.39	11.39	\$ 740.35	\$ 740.35
93619 TC	Medicine	-	-	\$ 558.35	\$ 558.35
93620 00	Medicine	-	-	\$ 1,587.30	\$ 1,587.30
93620 26	Medicine	18.31	18.31	\$ 1,190.15	\$ 1,190.15
93620 TC	Medicine	-	-	\$ 397.15	\$ 397.15
93621 00	Medicine	-	-	\$ 239.85	\$ 239.85
93621 26	Medicine	2.77	2.77	\$ 180.05	\$ 180.05
93621 TC	Medicine	-	-	\$ 59.80	\$ 59.80
93622 00	Medicine	-	-	\$ 434.85	\$ 434.85
93622 26	Medicine	5.02	5.02	\$ 326.30	\$ 326.30
93622 TC	Medicine	-	-	\$ 108.55	\$ 108.55
93623 00	Medicine	-	-	\$ 260.65	\$ 260.65
93623 26	Medicine	3.01	3.01	\$ 195.65	\$ 195.65
93623 TC	Medicine	-	-	\$ 65.00	\$ 65.00
93624 00	Medicine	-	-	\$ 585.00	\$ 585.00
93624 26	Medicine	7.02	7.02	\$ 456.30	\$ 456.30
93624 TC	Medicine	-	-	\$ 128.70	\$ 128.70
93631 00	Medicine	-	-	\$ 1,003.60	\$ 1,003.60
93631 26	Medicine	11.58	11.58	\$ 752.70	\$ 752.70
93631 TC	Medicine	-	-	\$ 250.90	\$ 250.90
93640 00	Medicine	-	-	\$ 848.25	\$ 848.25
93640 26	Medicine	5.22	5.22	\$ 339.30	\$ 339.30
93640 TC	Medicine	-	-	\$ 508.95	\$ 508.95
93641 00	Medicine	-	-	\$ 1,116.05	\$ 1,116.05
93641 26	Medicine	9.10	9.10	\$ 591.50	\$ 591.50
93641 TC	Medicine	-	-	\$ 524.55	\$ 524.55
93642 00	Medicine	9.87	9.87	\$ 641.55	\$ 641.55
93642 26	Medicine	7.44	7.44	\$ 483.60	\$ 483.60
93642 TC	Medicine	2.43	2.43	\$ 157.95	\$ 157.95
93644 00	Medicine	5.72	5.72	\$ 371.80	\$ 371.80
93644 26	Medicine	4.19	4.19	\$ 272.35	\$ 272.35
93644 TC	Medicine	1.53	1.53	\$ 99.45	\$ 99.45
93650 00	Medicine	17.32	17.32	\$ 1,125.80	\$ 1,125.80
93653 00	Medicine	24.49	24.49	\$ 1,591.85	\$ 1,591.85
93654 00	Medicine	32.76	32.76	\$ 2,129.40	\$ 2,129.40
93655 00	Medicine	9.15	9.15	\$ 594.75	\$ 594.75
93656 00	Medicine	32.86	32.86	\$ 2,135.90	\$ 2,135.90
93657 00	Medicine	9.14	9.14	\$ 594.10	\$ 594.10
93660 00	Medicine	4.69	4.69	\$ 304.85	\$ 304.85
93660 26	Medicine	2.69	2.69	\$ 174.85	\$ 174.85
93660 TC	Medicine	2.00	2.00	\$ 130.00	\$ 130.00
93662 00	Medicine	-	-	\$ 231.40	\$ 231.40
93662 26	Medicine	2.67	2.67	\$ 173.55	\$ 173.55
93662 TC	Medicine	-	-	\$ 57.85	\$ 57.85
93668 00	Medicine	0.41	0.41	\$ 26.65	\$ 26.65
93701 00	Medicine	0.81	0.81	\$ 52.65	\$ 52.65
93702 00	Medicine	4.17	4.17	\$ 271.05	\$ 271.05
93724 00	Medicine	8.39	8.39	\$ 545.35	\$ 545.35
93724 26	Medicine	7.01	7.01	\$ 455.65	\$ 455.65
93724 TC	Medicine	1.38	1.38	\$ 89.70	\$ 89.70
93740 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
93745 00	Medicine	-	-	\$ 190.45	\$ 190.45
93745 26	Medicine	-	-	\$ 124.15	\$ 124.15
93745 TC	Medicine	-	-	\$ 66.30	\$ 66.30
93750 00	Medicine	1.48	1.17	\$ 96.20	\$ 76.05
93770 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
93784 00	Medicine	1.35	1.35	\$ 87.75	\$ 87.75
93786 00	Medicine	0.67	0.67	\$ 43.55	\$ 43.55
93788 00	Medicine	0.15	0.15	\$ 9.75	\$ 9.75

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
93790 00	Medicine	0.53	0.53	\$ 34.45	\$ 34.45
93792 00	Medicine	1.88	1.88	\$ 122.20	\$ 122.20
93793 00	Medicine	0.33	0.33	\$ 21.45	\$ 21.45
93797 00	Medicine	0.49	0.27	\$ 31.85	\$ 17.55
93798 00	Medicine	0.76	0.40	\$ 49.40	\$ 26.00
93799 00	Medicine	0.00	0.00	BR	BR
93799 26	Medicine	0.00	0.00	BR	BR
93799 TC	Medicine	0.00	0.00	BR	BR
93880 00	Medicine	5.76	5.76	\$ 374.40	\$ 374.40
93880 26	Medicine	1.14	1.14	\$ 74.10	\$ 74.10
93880 TC	Medicine	4.62	4.62	\$ 300.30	\$ 300.30
93882 00	Medicine	3.77	3.77	\$ 245.05	\$ 245.05
93882 26	Medicine	0.72	0.72	\$ 46.80	\$ 46.80
93882 TC	Medicine	3.05	3.05	\$ 198.25	\$ 198.25
93886 00	Medicine	8.09	8.09	\$ 525.85	\$ 525.85
93886 26	Medicine	1.35	1.35	\$ 87.75	\$ 87.75
93886 TC	Medicine	6.74	6.74	\$ 438.10	\$ 438.10
93888 00	Medicine	4.82	4.82	\$ 313.30	\$ 313.30
93888 26	Medicine	0.74	0.74	\$ 48.10	\$ 48.10
93888 TC	Medicine	4.08	4.08	\$ 265.20	\$ 265.20
93890 00	Medicine	8.25	8.25	\$ 536.25	\$ 536.25
93890 26	Medicine	1.47	1.47	\$ 95.55	\$ 95.55
93890 TC	Medicine	6.78	6.78	\$ 440.70	\$ 440.70
93892 00	Medicine	9.43	9.43	\$ 612.95	\$ 612.95
93892 26	Medicine	1.73	1.73	\$ 112.45	\$ 112.45
93892 TC	Medicine	7.70	7.70	\$ 500.50	\$ 500.50
93893 00	Medicine	11.70	11.70	\$ 760.50	\$ 760.50
93893 26	Medicine	1.76	1.76	\$ 114.40	\$ 114.40
93893 TC	Medicine	9.94	9.94	\$ 646.10	\$ 646.10
93895 00	Medicine	0.00	0.00	BR	BR
93895 26	Medicine	0.00	0.00	BR	BR
93895 TC	Medicine	0.00	0.00	BR	BR
93922 00	Medicine	2.45	2.45	\$ 159.25	\$ 159.25
93922 26	Medicine	0.36	0.36	\$ 23.40	\$ 23.40
93922 TC	Medicine	2.09	2.09	\$ 135.85	\$ 135.85
93923 00	Medicine	3.84	3.84	\$ 249.60	\$ 249.60
93923 26	Medicine	0.65	0.65	\$ 42.25	\$ 42.25
93923 TC	Medicine	3.19	3.19	\$ 207.35	\$ 207.35
93924 00	Medicine	4.74	4.74	\$ 308.10	\$ 308.10
93924 26	Medicine	0.72	0.72	\$ 46.80	\$ 46.80
93924 TC	Medicine	4.02	4.02	\$ 261.30	\$ 261.30
93925 00	Medicine	7.29	7.29	\$ 473.85	\$ 473.85
93925 26	Medicine	1.12	1.12	\$ 72.80	\$ 72.80
93925 TC	Medicine	6.17	6.17	\$ 401.05	\$ 401.05
93926 00	Medicine	4.31	4.31	\$ 280.15	\$ 280.15
93926 26	Medicine	0.68	0.68	\$ 44.20	\$ 44.20
93926 TC	Medicine	3.63	3.63	\$ 235.95	\$ 235.95
93930 00	Medicine	5.91	5.91	\$ 384.15	\$ 384.15
93930 26	Medicine	1.13	1.13	\$ 73.45	\$ 73.45
93930 TC	Medicine	4.78	4.78	\$ 310.70	\$ 310.70
93931 00	Medicine	3.74	3.74	\$ 243.10	\$ 243.10
93931 26	Medicine	0.70	0.70	\$ 45.50	\$ 45.50
93931 TC	Medicine	3.04	3.04	\$ 197.60	\$ 197.60
93970 00	Medicine	5.66	5.66	\$ 367.90	\$ 367.90
93970 26	Medicine	0.99	0.99	\$ 64.35	\$ 64.35
93970 TC	Medicine	4.67	4.67	\$ 303.55	\$ 303.55
93971 00	Medicine	3.59	3.59	\$ 233.35	\$ 233.35
93971 26	Medicine	0.63	0.63	\$ 40.95	\$ 40.95
93971 TC	Medicine	2.96	2.96	\$ 192.40	\$ 192.40
93975 00	Medicine	8.00	8.00	\$ 520.00	\$ 520.00
93975 26	Medicine	1.63	1.63	\$ 105.95	\$ 105.95
93975 TC	Medicine	6.37	6.37	\$ 414.05	\$ 414.05

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
93976 00	Medicine	4.75	4.75	\$ 308.75	\$ 308.75
93976 26	Medicine	1.12	1.12	\$ 72.80	\$ 72.80
93976 TC	Medicine	3.63	3.63	\$ 235.95	\$ 235.95
93978 00	Medicine	5.45	5.45	\$ 354.25	\$ 354.25
93978 26	Medicine	1.13	1.13	\$ 73.45	\$ 73.45
93978 TC	Medicine	4.32	4.32	\$ 280.80	\$ 280.80
93979 00	Medicine	3.53	3.53	\$ 229.45	\$ 229.45
93979 26	Medicine	0.69	0.69	\$ 44.85	\$ 44.85
93979 TC	Medicine	2.84	2.84	\$ 184.60	\$ 184.60
93980 00	Medicine	3.43	3.43	\$ 222.95	\$ 222.95
93980 26	Medicine	1.73	1.73	\$ 112.45	\$ 112.45
93980 TC	Medicine	1.70	1.70	\$ 110.50	\$ 110.50
93981 00	Medicine	2.07	2.07	\$ 134.55	\$ 134.55
93981 26	Medicine	0.61	0.61	\$ 39.65	\$ 39.65
93981 TC	Medicine	1.46	1.46	\$ 94.90	\$ 94.90
93985 00	Medicine	7.55	7.55	\$ 490.75	\$ 490.75
93985 26	Medicine	1.12	1.12	\$ 72.80	\$ 72.80
93985 TC	Medicine	6.43	6.43	\$ 417.95	\$ 417.95
93986 00	Medicine	4.49	4.49	\$ 291.85	\$ 291.85
93986 26	Medicine	0.71	0.71	\$ 46.15	\$ 46.15
93986 TC	Medicine	3.78	3.78	\$ 245.70	\$ 245.70
93990 00	Medicine	4.44	4.44	\$ 288.60	\$ 288.60
93990 26	Medicine	0.70	0.70	\$ 45.50	\$ 45.50
93990 TC	Medicine	3.74	3.74	\$ 243.10	\$ 243.10
93998 00	Medicine	0.00	0.00	BR	BR
94002 00	Medicine	2.70	2.70	\$ 175.50	\$ 175.50
94003 00	Medicine	1.90	1.90	\$ 123.50	\$ 123.50
94004 00	Medicine	1.41	1.41	\$ 91.65	\$ 91.65
94005 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
94010 00	Medicine	0.79	0.79	\$ 51.35	\$ 51.35
94010 26	Medicine	0.24	0.24	\$ 15.60	\$ 15.60
94010 TC	Medicine	0.55	0.55	\$ 35.75	\$ 35.75
94011 00	Medicine	2.51	2.51	\$ 163.15	\$ 163.15
94012 00	Medicine	4.11	4.11	\$ 267.15	\$ 267.15
94013 00	Medicine	0.57	0.57	\$ 37.05	\$ 37.05
94014 00	Medicine	1.62	1.62	\$ 105.30	\$ 105.30
94015 00	Medicine	0.90	0.90	\$ 58.50	\$ 58.50
94016 00	Medicine	0.72	0.72	\$ 46.80	\$ 46.80
94060 00	Medicine	1.15	1.15	\$ 74.75	\$ 74.75
94060 26	Medicine	0.30	0.30	\$ 19.50	\$ 19.50
94060 TC	Medicine	0.85	0.85	\$ 55.25	\$ 55.25
94070 00	Medicine	1.82	1.82	\$ 118.30	\$ 118.30
94070 26	Medicine	0.82	0.82	\$ 53.30	\$ 53.30
94070 TC	Medicine	1.00	1.00	\$ 65.00	\$ 65.00
94150 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
94150 26	Medicine	0.00	0.00	Bundled Code	Bundled Code
94150 TC	Medicine	0.00	0.00	Bundled Code	Bundled Code
94200 00	Medicine	0.45	0.45	\$ 29.25	\$ 29.25
94200 26	Medicine	0.09	0.09	\$ 5.85	\$ 5.85
94200 TC	Medicine	0.36	0.36	\$ 23.40	\$ 23.40
94375 00	Medicine	1.13	1.13	\$ 73.45	\$ 73.45
94375 26	Medicine	0.42	0.42	\$ 27.30	\$ 27.30
94375 TC	Medicine	0.71	0.71	\$ 46.15	\$ 46.15
94450 00	Medicine	1.89	1.89	\$ 122.85	\$ 122.85
94450 26	Medicine	0.52	0.52	\$ 33.80	\$ 33.80
94450 TC	Medicine	1.37	1.37	\$ 89.05	\$ 89.05
94452 00	Medicine	1.45	1.45	\$ 94.25	\$ 94.25
94452 26	Medicine	0.42	0.42	\$ 27.30	\$ 27.30
94452 TC	Medicine	1.03	1.03	\$ 66.95	\$ 66.95
94453 00	Medicine	1.97	1.97	\$ 128.05	\$ 128.05
94453 26	Medicine	0.55	0.55	\$ 35.75	\$ 35.75
94453 TC	Medicine	1.42	1.42	\$ 92.30	\$ 92.30

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
94610 00	Medicine	1.62	1.62	\$ 105.30	\$ 105.30
94617 00	Medicine	2.60	2.60	\$ 169.00	\$ 169.00
94617 26	Medicine	0.94	0.94	\$ 61.10	\$ 61.10
94617 TC	Medicine	1.66	1.66	\$ 107.90	\$ 107.90
94618 00	Medicine	0.98	0.98	\$ 63.70	\$ 63.70
94618 26	Medicine	0.65	0.65	\$ 42.25	\$ 42.25
94618 TC	Medicine	0.33	0.33	\$ 21.45	\$ 21.45
94619 00	Medicine	2.03	2.03	\$ 131.95	\$ 131.95
94619 26	Medicine	0.66	0.66	\$ 42.90	\$ 42.90
94619 TC	Medicine	1.37	1.37	\$ 89.05	\$ 89.05
94621 00	Medicine	4.58	4.58	\$ 297.70	\$ 297.70
94621 26	Medicine	2.02	2.02	\$ 131.30	\$ 131.30
94621 TC	Medicine	2.56	2.56	\$ 166.40	\$ 166.40
94625 00	Medicine	1.91	0.55	\$ 124.15	\$ 35.75
94626 00	Medicine	2.17	0.79	\$ 141.05	\$ 51.35
94640 00	Medicine	0.33	0.33	\$ 21.45	\$ 21.45
94642 00	Medicine	-	-	\$ 81.25	\$ 81.25
94644 00	Medicine	1.82	1.82	\$ 118.30	\$ 118.30
94645 00	Medicine	0.47	0.47	\$ 30.55	\$ 30.55
94660 00	Medicine	1.88	1.11	\$ 122.20	\$ 72.15
94662 00	Medicine	1.05	1.05	\$ 68.25	\$ 68.25
94664 00	Medicine	0.50	0.50	\$ 32.50	\$ 32.50
94667 00	Medicine	0.67	0.67	\$ 43.55	\$ 43.55
94668 00	Medicine	1.04	1.04	\$ 67.60	\$ 67.60
94669 00	Medicine	0.55	0.55	\$ 35.75	\$ 35.75
94680 00	Medicine	1.56	1.56	\$ 101.40	\$ 101.40
94680 26	Medicine	0.38	0.38	\$ 24.70	\$ 24.70
94680 TC	Medicine	1.18	1.18	\$ 76.70	\$ 76.70
94681 00	Medicine	1.43	1.43	\$ 92.95	\$ 92.95
94681 26	Medicine	0.29	0.29	\$ 18.85	\$ 18.85
94681 TC	Medicine	1.14	1.14	\$ 74.10	\$ 74.10
94690 00	Medicine	1.28	1.28	\$ 83.20	\$ 83.20
94690 26	Medicine	0.11	0.11	\$ 7.15	\$ 7.15
94690 TC	Medicine	1.17	1.17	\$ 76.05	\$ 76.05
94726 00	Medicine	1.61	1.61	\$ 104.65	\$ 104.65
94726 26	Medicine	0.35	0.35	\$ 22.75	\$ 22.75
94726 TC	Medicine	1.26	1.26	\$ 81.90	\$ 81.90
94727 00	Medicine	1.29	1.29	\$ 83.85	\$ 83.85
94727 26	Medicine	0.35	0.35	\$ 22.75	\$ 22.75
94727 TC	Medicine	0.94	0.94	\$ 61.10	\$ 61.10
94728 00	Medicine	1.17	1.17	\$ 76.05	\$ 76.05
94728 26	Medicine	0.36	0.36	\$ 23.40	\$ 23.40
94728 TC	Medicine	0.81	0.81	\$ 52.65	\$ 52.65
94729 00	Medicine	1.73	1.73	\$ 112.45	\$ 112.45
94729 26	Medicine	0.26	0.26	\$ 16.90	\$ 16.90
94729 TC	Medicine	1.47	1.47	\$ 95.55	\$ 95.55
94760 00	Medicine	0.07	0.07	\$ 4.55	\$ 4.55
94761 00	Medicine	0.10	0.10	\$ 6.50	\$ 6.50
94762 00	Medicine	0.78	0.78	\$ 50.70	\$ 50.70
94772 00	Medicine	-	-	\$ 563.55	\$ 563.55
94772 26	Medicine	-	-	\$ 225.55	\$ 225.55
94772 TC	Medicine	-	-	\$ 338.00	\$ 338.00
94774 00	Medicine	-	-	\$ 565.50	\$ 565.50
94775 00	Medicine	-	-	\$ 89.05	\$ 89.05
94776 00	Medicine	-	-	\$ 423.15	\$ 423.15
94777 00	Medicine	-	-	\$ 53.30	\$ 53.30
94780 00	Medicine	1.52	0.70	\$ 98.80	\$ 45.50
94781 00	Medicine	0.60	0.24	\$ 39.00	\$ 15.60
94799 00	Medicine	0.00	0.00	BR	BR
94799 26	Medicine	0.00	0.00	BR	BR
94799 TC	Medicine	0.00	0.00	BR	BR
95004 00	Medicine	0.12	0.12	\$ 7.80	\$ 7.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
95012 00	Medicine	0.56	0.56	\$ 36.40	\$ 36.40
95017 00	Medicine	0.26	0.11	\$ 16.90	\$ 7.15
95018 00	Medicine	0.61	0.21	\$ 39.65	\$ 13.65
95024 00	Medicine	0.25	0.03	\$ 16.25	\$ 1.95
95027 00	Medicine	0.15	0.15	\$ 9.75	\$ 9.75
95028 00	Medicine	0.38	0.38	\$ 24.70	\$ 24.70
95044 00	Medicine	0.15	0.15	\$ 9.75	\$ 9.75
95052 00	Medicine	0.19	0.19	\$ 12.35	\$ 12.35
95056 00	Medicine	1.45	1.45	\$ 94.25	\$ 94.25
95060 00	Medicine	1.08	1.08	\$ 70.20	\$ 70.20
95065 00	Medicine	0.80	0.80	\$ 52.00	\$ 52.00
95070 00	Medicine	1.05	1.05	\$ 68.25	\$ 68.25
95076 00	Medicine	3.51	2.16	\$ 228.15	\$ 140.40
95079 00	Medicine	2.47	1.98	\$ 160.55	\$ 128.70
95115 00	Medicine	0.28	0.28	\$ 18.20	\$ 18.20
95117 00	Medicine	0.34	0.34	\$ 22.10	\$ 22.10
95120 00	Medicine	-	-	\$ 21.45	\$ 21.45
95125 00	Medicine	-	-	\$ 27.95	\$ 27.95
95130 00	Medicine	-	-	\$ 38.35	\$ 38.35
95131 00	Medicine	-	-	\$ 48.75	\$ 48.75
95132 00	Medicine	-	-	\$ 58.50	\$ 58.50
95133 00	Medicine	-	-	\$ 70.85	\$ 70.85
95134 00	Medicine	-	-	\$ 84.50	\$ 84.50
95144 00	Medicine	0.50	0.09	\$ 32.50	\$ 5.85
95145 00	Medicine	1.02	0.09	\$ 66.30	\$ 5.85
95146 00	Medicine	1.87	0.09	\$ 121.55	\$ 5.85
95147 00	Medicine	1.80	0.09	\$ 117.00	\$ 5.85
95148 00	Medicine	2.67	0.09	\$ 173.55	\$ 5.85
95149 00	Medicine	3.55	0.09	\$ 230.75	\$ 5.85
95165 00	Medicine	0.46	0.09	\$ 29.90	\$ 5.85
95170 00	Medicine	0.34	0.09	\$ 22.10	\$ 5.85
95180 00	Medicine	3.99	2.99	\$ 259.35	\$ 194.35
95199 00	Medicine	0.00	0.00	BR	BR
95249 00	Medicine	1.73	1.73	\$ 112.45	\$ 112.45
95250 00	Medicine	4.38	4.38	\$ 284.70	\$ 284.70
95251 00	Medicine	1.02	1.02	\$ 66.30	\$ 66.30
95700 00	Medicine	-	-	\$ 471.25	\$ 471.25
95705 00	Medicine	-	-	\$ 352.30	\$ 352.30
95706 00	Medicine	-	-	\$ 708.50	\$ 708.50
95707 00	Medicine	-	-	\$ 813.80	\$ 813.80
95708 00	Medicine	-	-	\$ 490.75	\$ 490.75
95709 00	Medicine	-	-	\$ 1,422.20	\$ 1,422.20
95710 00	Medicine	-	-	\$ 1,760.85	\$ 1,760.85
95711 00	Medicine	-	-	\$ 374.40	\$ 374.40
95712 00	Medicine	-	-	\$ 858.65	\$ 858.65
95713 00	Medicine	-	-	\$ 1,078.35	\$ 1,078.35
95714 00	Medicine	-	-	\$ 551.85	\$ 551.85
95715 00	Medicine	-	-	\$ 1,563.25	\$ 1,563.25
95716 00	Medicine	-	-	\$ 2,202.20	\$ 2,202.20
95717 00	Medicine	2.97	2.94	\$ 193.05	\$ 191.10
95718 00	Medicine	3.98	3.92	\$ 258.70	\$ 254.80
95719 00	Medicine	4.61	4.57	\$ 299.65	\$ 297.05
95720 00	Medicine	6.13	6.03	\$ 398.45	\$ 391.95
95721 00	Medicine	6.12	6.00	\$ 397.80	\$ 390.00
95722 00	Medicine	7.46	7.32	\$ 484.90	\$ 475.80
95723 00	Medicine	7.52	7.37	\$ 488.80	\$ 479.05
95724 00	Medicine	9.47	9.30	\$ 615.55	\$ 604.50
95725 00	Medicine	8.64	8.45	\$ 561.60	\$ 549.25
95726 00	Medicine	12.03	11.81	\$ 781.95	\$ 767.65
95782 00	Medicine	27.96	27.96	\$ 1,817.40	\$ 1,817.40
95782 26	Medicine	3.65	3.65	\$ 237.25	\$ 237.25
95782 TC	Medicine	24.31	24.31	\$ 1,580.15	\$ 1,580.15

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
95783 00	Medicine	29.61	29.61	\$ 1,924.65	\$ 1,924.65
95783 26	Medicine	3.97	3.97	\$ 258.05	\$ 258.05
95783 TC	Medicine	25.64	25.64	\$ 1,666.60	\$ 1,666.60
95800 00	Medicine	4.74	4.74	\$ 308.10	\$ 308.10
95800 26	Medicine	1.20	1.20	\$ 78.00	\$ 78.00
95800 TC	Medicine	3.54	3.54	\$ 230.10	\$ 230.10
95801 00	Medicine	2.68	2.68	\$ 174.20	\$ 174.20
95801 26	Medicine	1.20	1.20	\$ 78.00	\$ 78.00
95801 TC	Medicine	1.48	1.48	\$ 96.20	\$ 96.20
95803 00	Medicine	4.33	4.33	\$ 281.45	\$ 281.45
95803 26	Medicine	1.25	1.25	\$ 81.25	\$ 81.25
95803 TC	Medicine	3.08	3.08	\$ 200.20	\$ 200.20
95805 00	Medicine	12.34	12.34	\$ 802.10	\$ 802.10
95805 26	Medicine	1.68	1.68	\$ 109.20	\$ 109.20
95805 TC	Medicine	10.66	10.66	\$ 692.90	\$ 692.90
95806 00	Medicine	2.70	2.70	\$ 175.50	\$ 175.50
95806 26	Medicine	1.30	1.30	\$ 84.50	\$ 84.50
95806 TC	Medicine	1.40	1.40	\$ 91.00	\$ 91.00
95807 00	Medicine	11.21	11.21	\$ 728.65	\$ 728.65
95807 26	Medicine	1.75	1.75	\$ 113.75	\$ 113.75
95807 TC	Medicine	9.46	9.46	\$ 614.90	\$ 614.90
95808 00	Medicine	19.81	19.81	\$ 1,287.65	\$ 1,287.65
95808 26	Medicine	2.56	2.56	\$ 166.40	\$ 166.40
95808 TC	Medicine	17.25	17.25	\$ 1,121.25	\$ 1,121.25
95810 00	Medicine	17.97	17.97	\$ 1,168.05	\$ 1,168.05
95810 26	Medicine	3.48	3.48	\$ 226.20	\$ 226.20
95810 TC	Medicine	14.49	14.49	\$ 941.85	\$ 941.85
95811 00	Medicine	18.76	18.76	\$ 1,219.40	\$ 1,219.40
95811 26	Medicine	3.61	3.61	\$ 234.65	\$ 234.65
95811 TC	Medicine	15.15	15.15	\$ 984.75	\$ 984.75
95812 00	Medicine	10.28	10.28	\$ 668.20	\$ 668.20
95812 26	Medicine	1.66	1.66	\$ 107.90	\$ 107.90
95812 TC	Medicine	8.62	8.62	\$ 560.30	\$ 560.30
95813 00	Medicine	12.72	12.72	\$ 826.80	\$ 826.80
95813 26	Medicine	2.53	2.53	\$ 164.45	\$ 164.45
95813 TC	Medicine	10.19	10.19	\$ 662.35	\$ 662.35
95816 00	Medicine	11.34	11.34	\$ 737.10	\$ 737.10
95816 26	Medicine	1.66	1.66	\$ 107.90	\$ 107.90
95816 TC	Medicine	9.68	9.68	\$ 629.20	\$ 629.20
95819 00	Medicine	13.31	13.31	\$ 865.15	\$ 865.15
95819 26	Medicine	1.67	1.67	\$ 108.55	\$ 108.55
95819 TC	Medicine	11.64	11.64	\$ 756.60	\$ 756.60
95822 00	Medicine	12.36	12.36	\$ 803.40	\$ 803.40
95822 26	Medicine	1.67	1.67	\$ 108.55	\$ 108.55
95822 TC	Medicine	10.69	10.69	\$ 694.85	\$ 694.85
95824 00	Medicine	-	-	\$ 189.80	\$ 189.80
95824 26	Medicine	1.14	1.14	\$ 74.10	\$ 74.10
95824 TC	Medicine	-	-	\$ 115.70	\$ 115.70
95829 00	Medicine	54.19	54.19	\$ 3,522.35	\$ 3,522.35
95829 26	Medicine	9.70	9.70	\$ 630.50	\$ 630.50
95829 TC	Medicine	44.49	44.49	\$ 2,891.85	\$ 2,891.85
95830 00	Medicine	21.47	2.68	\$ 1,395.55	\$ 174.20
95836 00	Medicine	3.13	3.13	\$ 203.45	\$ 203.45
95851 00	Medicine	0.61	0.23	\$ 39.65	\$ 14.95
95852 00	Medicine	0.51	0.16	\$ 33.15	\$ 10.40
95857 00	Medicine	1.87	0.84	\$ 121.55	\$ 54.60
95860 00	Medicine	3.39	3.39	\$ 220.35	\$ 220.35
95860 26	Medicine	1.49	1.49	\$ 96.85	\$ 96.85
95860 TC	Medicine	1.90	1.90	\$ 123.50	\$ 123.50
95861 00	Medicine	4.90	4.90	\$ 318.50	\$ 318.50
95861 26	Medicine	2.39	2.39	\$ 155.35	\$ 155.35
95861 TC	Medicine	2.51	2.51	\$ 163.15	\$ 163.15

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CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
95863 00	Medicine	6.40	6.40	\$ 416.00	\$ 416.00
95863 26	Medicine	2.90	2.90	\$ 188.50	\$ 188.50
95863 TC	Medicine	3.50	3.50	\$ 227.50	\$ 227.50
95864 00	Medicine	7.15	7.15	\$ 464.75	\$ 464.75
95864 26	Medicine	3.10	3.10	\$ 201.50	\$ 201.50
95864 TC	Medicine	4.05	4.05	\$ 263.25	\$ 263.25
95865 00	Medicine	4.56	4.56	\$ 296.40	\$ 296.40
95865 26	Medicine	2.42	2.42	\$ 157.30	\$ 157.30
95865 TC	Medicine	2.14	2.14	\$ 139.10	\$ 139.10
95866 00	Medicine	3.90	3.90	\$ 253.50	\$ 253.50
95866 26	Medicine	1.88	1.88	\$ 122.20	\$ 122.20
95866 TC	Medicine	2.02	2.02	\$ 131.30	\$ 131.30
95867 00	Medicine	3.23	3.23	\$ 209.95	\$ 209.95
95867 26	Medicine	1.22	1.22	\$ 79.30	\$ 79.30
95867 TC	Medicine	2.01	2.01	\$ 130.65	\$ 130.65
95868 00	Medicine	4.28	4.28	\$ 278.20	\$ 278.20
95868 26	Medicine	1.83	1.83	\$ 118.95	\$ 118.95
95868 TC	Medicine	2.45	2.45	\$ 159.25	\$ 159.25
95869 00	Medicine	2.97	2.97	\$ 193.05	\$ 193.05
95869 26	Medicine	0.58	0.58	\$ 37.70	\$ 37.70
95869 TC	Medicine	2.39	2.39	\$ 155.35	\$ 155.35
95870 00	Medicine	2.57	2.57	\$ 167.05	\$ 167.05
95870 26	Medicine	0.57	0.57	\$ 37.05	\$ 37.05
95870 TC	Medicine	2.00	2.00	\$ 130.00	\$ 130.00
95872 00	Medicine	6.28	6.28	\$ 408.20	\$ 408.20
95872 26	Medicine	4.44	4.44	\$ 288.60	\$ 288.60
95872 TC	Medicine	1.84	1.84	\$ 119.60	\$ 119.60
95873 00	Medicine	2.27	2.27	\$ 147.55	\$ 147.55
95873 26	Medicine	0.57	0.57	\$ 37.05	\$ 37.05
95873 TC	Medicine	1.70	1.70	\$ 110.50	\$ 110.50
95874 00	Medicine	2.39	2.39	\$ 155.35	\$ 155.35
95874 26	Medicine	0.57	0.57	\$ 37.05	\$ 37.05
95874 TC	Medicine	1.82	1.82	\$ 118.30	\$ 118.30
95875 00	Medicine	4.09	4.09	\$ 265.85	\$ 265.85
95875 26	Medicine	1.71	1.71	\$ 111.15	\$ 111.15
95875 TC	Medicine	2.38	2.38	\$ 154.70	\$ 154.70
95885 00	Medicine	1.92	1.92	\$ 124.80	\$ 124.80
95885 26	Medicine	0.54	0.54	\$ 35.10	\$ 35.10
95885 TC	Medicine	1.38	1.38	\$ 89.70	\$ 89.70
95886 00	Medicine	2.98	2.98	\$ 193.70	\$ 193.70
95886 26	Medicine	1.33	1.33	\$ 86.45	\$ 86.45
95886 TC	Medicine	1.65	1.65	\$ 107.25	\$ 107.25
95887 00	Medicine	2.57	2.57	\$ 167.05	\$ 167.05
95887 26	Medicine	1.10	1.10	\$ 71.50	\$ 71.50
95887 TC	Medicine	1.47	1.47	\$ 95.55	\$ 95.55
95905 00	Medicine	1.14	1.14	\$ 74.10	\$ 74.10
95905 26	Medicine	0.08	0.08	\$ 5.20	\$ 5.20
95905 TC	Medicine	1.06	1.06	\$ 68.90	\$ 68.90
95907 00	Medicine	2.72	2.72	\$ 176.80	\$ 176.80
95907 26	Medicine	1.55	1.55	\$ 100.75	\$ 100.75
95907 TC	Medicine	1.17	1.17	\$ 76.05	\$ 76.05
95908 00	Medicine	3.39	3.39	\$ 220.35	\$ 220.35
95908 26	Medicine	1.94	1.94	\$ 126.10	\$ 126.10
95908 TC	Medicine	1.45	1.45	\$ 94.25	\$ 94.25
95909 00	Medicine	4.07	4.07	\$ 264.55	\$ 264.55
95909 26	Medicine	2.33	2.33	\$ 151.45	\$ 151.45
95909 TC	Medicine	1.74	1.74	\$ 113.10	\$ 113.10
95910 00	Medicine	5.32	5.32	\$ 345.80	\$ 345.80
95910 26	Medicine	3.11	3.11	\$ 202.15	\$ 202.15
95910 TC	Medicine	2.21	2.21	\$ 143.65	\$ 143.65
95911 00	Medicine	6.40	6.40	\$ 416.00	\$ 416.00
95911 26	Medicine	3.86	3.86	\$ 250.90	\$ 250.90

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
95911 TC	Medicine	2.54	2.54	\$ 165.10	\$ 165.10
95912 00	Medicine	7.45	7.45	\$ 484.25	\$ 484.25
95912 26	Medicine	4.60	4.60	\$ 299.00	\$ 299.00
95912 TC	Medicine	2.85	2.85	\$ 185.25	\$ 185.25
95913 00	Medicine	8.62	8.62	\$ 560.30	\$ 560.30
95913 26	Medicine	5.46	5.46	\$ 354.90	\$ 354.90
95913 TC	Medicine	3.16	3.16	\$ 205.40	\$ 205.40
95921 00	Medicine	2.64	2.64	\$ 171.60	\$ 171.60
95921 26	Medicine	1.31	1.31	\$ 85.15	\$ 85.15
95921 TC	Medicine	1.33	1.33	\$ 86.45	\$ 86.45
95922 00	Medicine	3.01	3.01	\$ 195.65	\$ 195.65
95922 26	Medicine	1.37	1.37	\$ 89.05	\$ 89.05
95922 TC	Medicine	1.64	1.64	\$ 106.60	\$ 106.60
95923 00	Medicine	3.75	3.75	\$ 243.75	\$ 243.75
95923 26	Medicine	1.31	1.31	\$ 85.15	\$ 85.15
95923 TC	Medicine	2.44	2.44	\$ 158.60	\$ 158.60
95924 00	Medicine	4.46	4.46	\$ 289.90	\$ 289.90
95924 26	Medicine	2.53	2.53	\$ 164.45	\$ 164.45
95924 TC	Medicine	1.93	1.93	\$ 125.45	\$ 125.45
95925 00	Medicine	5.49	5.49	\$ 356.85	\$ 356.85
95925 26	Medicine	0.84	0.84	\$ 54.60	\$ 54.60
95925 TC	Medicine	4.65	4.65	\$ 302.25	\$ 302.25
95926 00	Medicine	4.75	4.75	\$ 308.75	\$ 308.75
95926 26	Medicine	0.81	0.81	\$ 52.65	\$ 52.65
95926 TC	Medicine	3.94	3.94	\$ 256.10	\$ 256.10
95927 00	Medicine	4.47	4.47	\$ 290.55	\$ 290.55
95927 26	Medicine	0.78	0.78	\$ 50.70	\$ 50.70
95927 TC	Medicine	3.69	3.69	\$ 239.85	\$ 239.85
95928 00	Medicine	7.05	7.05	\$ 458.25	\$ 458.25
95928 26	Medicine	2.32	2.32	\$ 150.80	\$ 150.80
95928 TC	Medicine	4.73	4.73	\$ 307.45	\$ 307.45
95929 00	Medicine	7.25	7.25	\$ 471.25	\$ 471.25
95929 26	Medicine	2.32	2.32	\$ 150.80	\$ 150.80
95929 TC	Medicine	4.93	4.93	\$ 320.45	\$ 320.45
95930 00	Medicine	1.94	1.94	\$ 126.10	\$ 126.10
95930 26	Medicine	0.54	0.54	\$ 35.10	\$ 35.10
95930 TC	Medicine	1.40	1.40	\$ 91.00	\$ 91.00
95933 00	Medicine	2.53	2.53	\$ 164.45	\$ 164.45
95933 26	Medicine	0.92	0.92	\$ 59.80	\$ 59.80
95933 TC	Medicine	1.61	1.61	\$ 104.65	\$ 104.65
95937 00	Medicine	3.19	3.19	\$ 207.35	\$ 207.35
95937 26	Medicine	1.01	1.01	\$ 65.65	\$ 65.65
95937 TC	Medicine	2.18	2.18	\$ 141.70	\$ 141.70
95938 00	Medicine	10.78	10.78	\$ 700.70	\$ 700.70
95938 26	Medicine	1.33	1.33	\$ 86.45	\$ 86.45
95938 TC	Medicine	9.45	9.45	\$ 614.25	\$ 614.25
95939 00	Medicine	16.29	16.29	\$ 1,058.85	\$ 1,058.85
95939 26	Medicine	3.47	3.47	\$ 225.55	\$ 225.55
95939 TC	Medicine	12.82	12.82	\$ 833.30	\$ 833.30
95940 00	Medicine	0.95	0.95	\$ 61.75	\$ 61.75
95941 00	Medicine	0.00	0.00	BR	BR
95954 00	Medicine	12.04	12.04	\$ 782.60	\$ 782.60
95954 26	Medicine	3.18	3.18	\$ 206.70	\$ 206.70
95954 TC	Medicine	8.86	8.86	\$ 575.90	\$ 575.90
95955 00	Medicine	6.07	6.07	\$ 394.55	\$ 394.55
95955 26	Medicine	1.56	1.56	\$ 101.40	\$ 101.40
95955 TC	Medicine	4.51	4.51	\$ 293.15	\$ 293.15
95957 00	Medicine	7.72	7.72	\$ 501.80	\$ 501.80
95957 26	Medicine	2.98	2.98	\$ 193.70	\$ 193.70
95957 TC	Medicine	4.74	4.74	\$ 308.10	\$ 308.10
95958 00	Medicine	18.66	18.66	\$ 1,212.90	\$ 1,212.90
95958 26	Medicine	6.66	6.66	\$ 432.90	\$ 432.90

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
95958 TC	Medicine	12.00	12.00	\$ 780.00	\$ 780.00
95961 00	Medicine	9.63	9.63	\$ 625.95	\$ 625.95
95961 26	Medicine	4.73	4.73	\$ 307.45	\$ 307.45
95961 TC	Medicine	4.90	4.90	\$ 318.50	\$ 318.50
95962 00	Medicine	7.91	7.91	\$ 514.15	\$ 514.15
95962 26	Medicine	5.06	5.06	\$ 328.90	\$ 328.90
95962 TC	Medicine	2.85	2.85	\$ 185.25	\$ 185.25
95965 00	Medicine	-	-	\$ 3,945.50	\$ 3,945.50
95965 26	Medicine	12.14	12.14	\$ 789.10	\$ 789.10
95965 TC	Medicine	-	-	\$ 3,156.40	\$ 3,156.40
95966 00	Medicine	-	-	\$ 2,008.50	\$ 2,008.50
95966 26	Medicine	6.18	6.18	\$ 401.70	\$ 401.70
95966 TC	Medicine	-	-	\$ 1,606.80	\$ 1,606.80
95967 00	Medicine	-	-	\$ 1,758.25	\$ 1,758.25
95967 26	Medicine	5.41	5.41	\$ 351.65	\$ 351.65
95967 TC	Medicine	-	-	\$ 1,406.60	\$ 1,406.60
95970 00	Medicine	0.56	0.55	\$ 36.40	\$ 35.75
95971 00	Medicine	1.44	1.17	\$ 93.60	\$ 76.05
95972 00	Medicine	1.65	1.19	\$ 107.25	\$ 77.35
95976 00	Medicine	1.19	1.17	\$ 77.35	\$ 76.05
95977 00	Medicine	1.57	1.54	\$ 102.05	\$ 100.10
95980 00	Medicine	1.34	1.34	\$ 87.10	\$ 87.10
95981 00	Medicine	1.13	0.52	\$ 73.45	\$ 33.80
95982 00	Medicine	1.73	1.07	\$ 112.45	\$ 69.55
95983 00	Medicine	1.50	1.47	\$ 97.50	\$ 95.55
95984 00	Medicine	1.31	1.29	\$ 85.15	\$ 83.85
95990 00	Medicine	2.69	2.69	\$ 174.85	\$ 174.85
95991 00	Medicine	3.26	1.18	\$ 211.90	\$ 76.70
95992 00	Medicine	1.28	1.07	\$ 83.20	\$ 69.55
95999 00	Medicine	0.00	0.00	BR	BR
96000 00	Medicine	2.51	2.51	\$ 163.15	\$ 163.15
96001 00	Medicine	3.28	3.28	\$ 213.20	\$ 213.20
96002 00	Medicine	0.64	0.64	\$ 41.60	\$ 41.60
96003 00	Medicine	0.49	0.49	\$ 31.85	\$ 31.85
96004 00	Medicine	3.24	3.24	\$ 210.60	\$ 210.60
96020 00	Medicine	0.00	0.00	BR	BR
96020 26	Medicine	4.65	4.65	\$ 302.25	\$ 302.25
96020 TC	Medicine	0.00	0.00	BR	BR
96040 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
96105 00	Medicine	2.89	2.89	\$ 187.85	\$ 187.85
96110 00	Medicine	0.31	0.31	\$ 20.15	\$ 20.15
96112 00	Medicine	3.73	3.69	\$ 242.45	\$ 239.85
96113 00	Medicine	1.76	1.65	\$ 114.40	\$ 107.25
96116 00	Medicine	2.77	2.39	\$ 180.05	\$ 155.35
96121 00	Medicine	2.31	2.07	\$ 150.15	\$ 134.55
96125 00	Medicine	3.06	3.06	\$ 198.90	\$ 198.90
96127 00	Medicine	0.14	0.14	\$ 9.10	\$ 9.10
96130 00	Medicine	3.51	3.16	\$ 228.15	\$ 205.40
96131 00	Medicine	2.61	2.32	\$ 169.65	\$ 150.80
96132 00	Medicine	3.83	3.09	\$ 248.95	\$ 200.85
96133 00	Medicine	2.97	2.30	\$ 193.05	\$ 149.50
96136 00	Medicine	1.30	0.70	\$ 84.50	\$ 45.50
96137 00	Medicine	1.17	0.54	\$ 76.05	\$ 35.10
96138 00	Medicine	1.02	1.02	\$ 66.30	\$ 66.30
96139 00	Medicine	1.04	1.04	\$ 67.60	\$ 67.60
96146 00	Medicine	0.06	0.06	\$ 3.90	\$ 3.90
96156 00	Medicine	2.82	2.51	\$ 183.30	\$ 163.15
96158 00	Medicine	1.94	1.72	\$ 126.10	\$ 111.80
96159 00	Medicine	0.66	0.58	\$ 42.90	\$ 37.70
96160 00	Medicine	0.08	0.08	\$ 5.20	\$ 5.20
96161 00	Medicine	0.08	0.08	\$ 5.20	\$ 5.20
96164 00	Medicine	0.29	0.26	\$ 18.85	\$ 16.90

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
96165 00	Medicine	0.13	0.12	\$ 8.45	\$ 7.80
96167 00	Medicine	2.06	1.83	\$ 133.90	\$ 118.95
96168 00	Medicine	0.73	0.64	\$ 47.45	\$ 41.60
96170 00	Medicine	2.32	2.19	\$ 150.80	\$ 142.35
96171 00	Medicine	0.84	0.79	\$ 54.60	\$ 51.35
96360 00	Medicine	1.01	1.01	\$ 65.65	\$ 65.65
96361 00	Medicine	0.38	0.38	\$ 24.70	\$ 24.70
96365 00	Medicine	2.00	2.00	\$ 130.00	\$ 130.00
96366 00	Medicine	0.62	0.62	\$ 40.30	\$ 40.30
96367 00	Medicine	0.89	0.89	\$ 57.85	\$ 57.85
96368 00	Medicine	0.60	0.60	\$ 39.00	\$ 39.00
96369 00	Medicine	4.27	4.27	\$ 277.55	\$ 277.55
96370 00	Medicine	0.45	0.45	\$ 29.25	\$ 29.25
96371 00	Medicine	1.73	1.73	\$ 112.45	\$ 112.45
96372 00	Medicine	0.42	0.42	\$ 27.30	\$ 27.30
96373 00	Medicine	0.53	0.53	\$ 34.45	\$ 34.45
96374 00	Medicine	1.16	1.16	\$ 75.40	\$ 75.40
96375 00	Medicine	0.47	0.47	\$ 30.55	\$ 30.55
96376 00	Medicine	-	-	\$ 19.50	\$ 19.50
96377 00	Medicine	0.56	0.56	\$ 36.40	\$ 36.40
96379 00	Medicine	0.00	0.00	BR	BR
96401 00	Medicine	2.25	2.25	\$ 146.25	\$ 146.25
96402 00	Medicine	0.98	0.98	\$ 63.70	\$ 63.70
96405 00	Medicine	2.51	0.84	\$ 163.15	\$ 54.60
96406 00	Medicine	3.97	1.31	\$ 258.05	\$ 85.15
96409 00	Medicine	3.12	3.12	\$ 202.80	\$ 202.80
96411 00	Medicine	1.70	1.70	\$ 110.50	\$ 110.50
96413 00	Medicine	4.05	4.05	\$ 263.25	\$ 263.25
96415 00	Medicine	0.86	0.86	\$ 55.90	\$ 55.90
96416 00	Medicine	3.97	3.97	\$ 258.05	\$ 258.05
96417 00	Medicine	1.97	1.97	\$ 128.05	\$ 128.05
96420 00	Medicine	3.20	3.20	\$ 208.00	\$ 208.00
96422 00	Medicine	4.87	4.87	\$ 316.55	\$ 316.55
96423 00	Medicine	2.25	2.25	\$ 146.25	\$ 146.25
96425 00	Medicine	5.24	5.24	\$ 340.60	\$ 340.60
96440 00	Medicine	23.27	3.89	\$ 1,512.55	\$ 252.85
96446 00	Medicine	5.89	0.79	\$ 382.85	\$ 51.35
96450 00	Medicine	5.02	2.24	\$ 326.30	\$ 145.60
96521 00	Medicine	4.11	4.11	\$ 267.15	\$ 267.15
96522 00	Medicine	3.62	3.62	\$ 235.30	\$ 235.30
96523 00	Medicine	0.79	0.79	\$ 51.35	\$ 51.35
96542 00	Medicine	3.93	1.24	\$ 255.45	\$ 80.60
96549 00	Medicine	-	-	\$ 0.65	\$ 0.65
96567 00	Medicine	4.29	4.29	\$ 278.85	\$ 278.85
96570 00	Medicine	1.51	1.51	\$ 98.15	\$ 98.15
96571 00	Medicine	0.75	0.75	\$ 48.75	\$ 48.75
96573 00	Medicine	6.97	6.97	\$ 453.05	\$ 453.05
96574 00	Medicine	8.51	8.51	\$ 553.15	\$ 553.15
96900 00	Medicine	0.71	0.71	\$ 46.15	\$ 46.15
96902 00	Medicine	0.00	0.00	Bundled Code	Bundled Code
96904 00	Medicine	2.12	2.12	\$ 137.80	\$ 137.80
96910 00	Medicine	3.50	3.50	\$ 227.50	\$ 227.50
96912 00	Medicine	3.00	3.00	\$ 195.00	\$ 195.00
96913 00	Medicine	4.50	4.50	\$ 292.50	\$ 292.50
96920 00	Medicine	4.67	1.86	\$ 303.55	\$ 120.90
96921 00	Medicine	5.10	2.09	\$ 331.50	\$ 135.85
96922 00	Medicine	6.94	3.38	\$ 451.10	\$ 219.70
96931 00	Medicine	5.11	5.11	\$ 332.15	\$ 332.15
96932 00	Medicine	3.82	3.82	\$ 248.30	\$ 248.30
96933 00	Medicine	1.29	1.29	\$ 83.85	\$ 83.85
96934 00	Medicine	3.56	3.56	\$ 231.40	\$ 231.40
96935 00	Medicine	2.32	2.32	\$ 150.80	\$ 150.80

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
96936 00	Medicine	1.24	1.24	\$ 80.60	\$ 80.60
96999 00	Medicine	0.00	0.00	BR	BR

Historical Note

New Appendix A, Medicine Codes 2019-2020 made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Medicine Codes 2019-2020 will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Medicine Codes 2019-2020 repealed; new Appendix A, Medicine Codes 2020-2021 made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Medicine Codes 2020-2021 repealed; new Appendix A, Medicine Codes 2021-2022 made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Medicine Codes 2021-2022 repealed; new Appendix A, Medicine Codes 2022-2023 made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

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PHYSICAL MEDICINE AND REHABILITATION GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2022 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT® are preceded by an AZ identifier and numbered in the following format: AZxxx. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to physical medicine and rehabilitation services. To the extent that a conflict may exist between an adopted portion of the CPT® and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

General requirements in reporting services are found in the Introduction of the Fee Schedule. In addition to the definitions and commonalities preceding the coded medical procedures, several other requirements unique to this Section (Physical Medicine and Rehabilitation) are defined or identified as follows:

- A. Physical therapy (PT) evaluation codes (97161-97163) and occupational therapy (OT) evaluation codes (97165-97167) are billed at the initial visit and a re-evaluation code (97164 for PT, 97168 for OT) may be billed once every two calendar weeks following an initial evaluation. Additional billing for PT and OT evaluation services may be allowed when specific additional services are warranted. Approval of the payer must be obtained prior to performing additional services. Criteria to select the appropriate evaluation and re-evaluation codes are outlined in the current CPT® publication.

NOTE: These limitations do **not** apply to referring healthcare providers or to providers who treat patients once per month.

- B. When multiple modalities (untimed 97012-97028 and/or time-based 97032-97036) are performed, the first modality (or the first unit of a time-based modality) is reported as listed. The second modality (or the second unit of a time-based modality) is identified by adding modifier -51 to the code number. The second and each subsequent modality (or unit(s) of a time-based modality) should be valued at 50% of its listed value.

First modality reported or first unit of a time-based modality -100%
Second, third, and additional approved modality or unit(s) - 50%

Any more than three modalities or more than three units of a time-based modality or any combination of time-based and untimed modalities equaling three billed units per body part being treated must have prior approval from the payer. The time a healthcare provider bills for a time-based modality (97032-97036) does not count towards the total timed therapeutic procedure maximum of four units or 67 minutes. However, the time spent performing time-based modalities counts towards the total treatment time and should be used to determine the number of units a provider bills (see Section E and Example 5).

NOTE: 97010 is a bundled service and not separately reportable.

Example:

During a visit, a patient receives the following services:

45 minutes therapeutic exercise 97110
15 minutes mechanical traction 97012

15 minutes unattended electrical stimulation 97014
10 minutes ultrasound 97035
15 minutes moist heat 97010 while receiving the electric stimulation

Under the multiple modality rule, the healthcare provider would bill:

97110 3 units at 100% of value (therapeutic procedure, timed code)
97012 1 unit at 100% of value (untimed code)
97014 1 unit at 50% of value (untimed code)
97035 1 unit at 50% of value (timed code)

97010 is bundled into the above services and not paid as a separate service. The total time spent performing time-based codes (97110 and 97035) is 55 minutes and justifies billing four units of time-based services (see Section E).

- C. CPT® codes describing therapeutic procedures (97110-97150 and 97530-97546) are not subject to the multiple modality rule and shall be paid at 100% of their listed value. When performing therapeutic procedure(s), (excluding work hardening/conditioning, 97545-97546, and physical test or measures for functional capacity evaluation, 97750), a maximum of four units or 67 minutes is allowed each day. Approval must be

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obtained from the payer prior to performing therapeutic procedures in excess of this maximum (*e.g.*, when multiple body parts are treated in a single visit).

- D. The values for the codes in this section include the time and work of the provider, the equipment required to provide the service, and the cost of the healthcare provider's liability insurance. Medications and disposable electrodes used in these procedures should be considered supplies, code 99070, (see Section A in the Medicine Guidelines and Subsection (I)(4) of the Fee Schedule Introduction regarding billing for supplies).
- E. Time-Based Physical Medicine and Rehabilitation CPT® codes are billed according to guidance from the Centers for Medicare and Medicaid Services (CMS), as published in the Medicare Claims Processing Manual, Chapter 5, Section 20.2, C. Counting Minutes for Timed Codes in 15 Minute Units.

When only one service is provided in a day, healthcare providers should not bill for services provided for less than 8 minutes. For any single 15-minute timed CPT code in the same day, healthcare providers bill a single 15-minute unit for treatment of greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, two units should be billed. Please refer to the table below, which outlines how to bill for up to four units or 67 minutes, without payer approval.

Units	Number of Minutes
0	< 8 minutes
1	≥ 8 minutes and ≤ 22 minutes
2	≥ 23 minutes and ≤ 37 minutes
3	≥ 38 minutes and ≤ 52 minutes
4	≥ 53 minutes and ≤ 67 minutes

If additional therapeutic procedures and/or time-based modalities are approved by the payer, the pattern for determining time/units is continued.

When more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service determines the number of timed units billed (as noted in the chart above). For any service represented by a 15-minute timed code that is performed for 7 minutes or less on the same day as another service also represented by a 15-minute timed code performed for 7 minutes or less, and the total time of these two services is 8 minutes or greater, the provider may bill one unit of service that was performed for the most minutes. The same logic is applied if three or more different services are performed on the same day for 7 minutes or less.

The expectation, based on the work values assigned to these codes, is that a provider's direct patient contact time for each unit will average 15 minutes in length. If more than one 15-minute timed CPT® code is billed during a single calendar day, the total number of units billed is constrained by the total treatment time for that day.

When documenting to support the billing of timed CPT® codes, the provider should **document the total number of timed minutes and the total time of the treatment provided that day**. Total treatment time includes the minutes for timed code treatment and untimed code treatment. Total treatment time does not include time for services that are not billable (*e.g.*, rest periods). **The amount of time for each specific intervention/modality provided to the patient is not required to be documented in the treatment note.**

It is important that the total number of timed treatment minutes support the billing of units on the invoice and that the total treatment time also reflects the services billed as untimed codes. The billing and the total timed code treatment minutes documented must be consistent. Additional guidance for documentation of timed codes is found in the CMS Benefit Policy Manual, Chapter 15, 220.3, E. Treatment Note Examples on how to count the appropriate number of minutes for the total therapy minutes provided:

Example 1

During a visit, the patient receives the following services:

45 minutes therapeutic exercise 97110

5 minutes manual therapy 97140

7 minutes therapeutic activities 97530

Total Timed Codes – 57 minutes

The healthcare provider would bill: 4 units

97110 3 units

97530 1 unit

Since the total time spent providing manual therapy and therapeutic exercises is greater than 8 minutes, one unit is billed of the service which was performed for more time.

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Example 2

During a visit, the patient receives the following services:

24 minutes neuromuscular reeducation 97112

23 minutes therapeutic exercise 97110

Total Timed Codes: 47 minutes

The healthcare provider would bill: 3 units

97112 2 units

97110 1 unit

Each service is provided for more than 15 minutes, so at least one unit is appropriate for each. Two units are billed for Neuromuscular reeducation since that service was performed for more time.

Example 3

During a visit, the patient receives the following services:

20 minutes therapeutic activities 97530

20 minutes therapeutic exercise 97110

Total Timed Codes: 40 minutes

The healthcare provider would bill: 3 units

97530 2 units

97110 1 unit

OR

97110 2 units

97530 1 unit

Each service was provided for 20 minutes, which would allow for one unit for each service. However, the total time of 40 minutes allows for three units to be billed. Since the time for each service is the same, the provider can choose which code to bill for two units and which code to bill for one unit.

Example 4

During a visit, the patient receives the following services:

33 minutes therapeutic exercise 97110

7 minutes manual therapy 97140

Total Timed Codes: 40 minutes

The healthcare provider would bill: 3 units

97110 2 units

97140 1 unit

The first 30 minutes of therapeutic exercise is 2 units. The remaining 3 minutes is added to the 7 minutes of manual therapy and then is billed for one unit of manual therapy. The time for manual therapy is greater than the remaining time from the therapeutic exercise.

Example 5

During a visit, the patient receives the following services:

18 minutes therapeutic exercise 97110

13 minutes manual therapy 97140

10 minutes gait training 97116

8 minutes ultrasound 97035

Total Timed Codes: 49 minutes

The healthcare provider would bill: 3 units

97110 1 unit

97140 1 unit

97116 1 unit

Bill the procedures that the most time was spent performing. One unit each of 97110, 97140, and 97116. Although the ultrasound should be documented, it cannot be billed, as the healthcare provider is constrained by the total timed codes minutes. Since the total for the timed codes is 49 minutes, only three units would be billed.

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- F. A work hardening program is limited to 6 1/2 hours per day, not to exceed a 6 week period of time.
- G. The payer has the right to require documentation to establish that a modality or therapeutic procedure was performed. Inasmuch as these Guidelines allow for re-evaluations to be performed every two weeks, it is at that time the healthcare provider should address and document the status of the treatment protocol.

It is not appropriate for the payer on a per billing basis to require a healthcare provider to provide unnecessary detailed documentation to justify payment. A healthcare provider is required to comply with A.R.S. § 23-1062.01 when submitting a bill. For example, the purpose of modalities like hot and cold packs, paraffin baths, and whirlpools are straightforward. Modalities are utilized as a sub-element of the over-all treatment protocol to prepare the injured worker for therapy or to minimize the impact of the therapy on the injured worker. Other than a statement that certain modalities were performed, any additional documentation such as the purpose of the application of modalities, resulting flexibility or comfort is unnecessary. Additionally, listing the amount of weight an individual is lifting, repetitions, and sets is, again, unnecessary. During a re-evaluation visit, the healthcare provider should provide documentation regarding changes in strength, stamina, and flexibility.

Documentation of each treatment shall include the following elements:

- Date of treatment.
- Identification of each specific intervention/modality provided and billed, both timed and untimed services in a manner that it can be compared with the billing record to verify correct coding.
- Total timed code treatment minutes and total treatment time in minutes (the amount of time for each specific intervention/modality provided is not required).
- Signatures (written or electronic) and professional designation of the qualified healthcare provider who furnished or supervised the services provided.

Historical Note

New Appendix A, Physical Medicine Guidelines made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Physical Medicine Guidelines will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Physical Medicine Guidelines repealed; new Appendix A, Physical Medicine Guidelines made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Physical Medicine Guidelines repealed; new Appendix A, Physical Medicine and Rehabilitation Guidelines made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Physical Medicine Guidelines repealed; new Appendix A, Physical Medicine and Rehabilitation Guidelines made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

ARIZONA PHYSICIANS' FEE SCHEDULE					
Physical Medicine Codes 2022					
Physical Medicine Conversion Factor \$65.00					
Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
97010 00	Physical Medicine	0.18	0.18	\$ 11.70	\$ 11.70
97012 00	Physical Medicine	0.42	0.42	\$ 27.30	\$ 27.30
97014 00	Physical Medicine	0.37	0.37	\$ 24.05	\$ 24.05
97016 00	Physical Medicine	0.35	0.35	\$ 22.75	\$ 22.75
97018 00	Physical Medicine	0.17	0.17	\$ 11.05	\$ 11.05
97022 00	Physical Medicine	0.51	0.51	\$ 33.15	\$ 33.15
97024 00	Physical Medicine	0.21	0.21	\$ 13.65	\$ 13.65
97026 00	Physical Medicine	0.19	0.19	\$ 12.35	\$ 12.35
97028 00	Physical Medicine	0.24	0.24	\$ 15.60	\$ 15.60
97032 00	Physical Medicine	0.43	0.43	\$ 27.95	\$ 27.95
97033 00	Physical Medicine	0.58	0.58	\$ 37.70	\$ 37.70
97034 00	Physical Medicine	0.43	0.43	\$ 27.95	\$ 27.95
97035 00	Physical Medicine	0.42	0.42	\$ 27.30	\$ 27.30
97036 00	Physical Medicine	1.01	1.01	\$ 65.65	\$ 65.65
97039 00	Physical Medicine	-	-	\$ 24.70	\$ 24.70
97110 00	Physical Medicine	0.87	0.87	\$ 56.55	\$ 56.55
97112 00	Physical Medicine	1.01	1.01	\$ 65.65	\$ 65.65
97113 00	Physical Medicine	1.09	1.09	\$ 70.85	\$ 70.85
97116 00	Physical Medicine	0.87	0.87	\$ 56.55	\$ 56.55
97124 00	Physical Medicine	0.88	0.88	\$ 57.20	\$ 57.20
97129 00	Physical Medicine	0.67	0.67	\$ 43.55	\$ 43.55

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
97130 00	Physical Medicine	0.65	0.64	\$ 42.25	\$ 41.60
97139 00	Physical Medicine	-	-	\$ 33.80	\$ 33.80
97140 00	Physical Medicine	0.80	0.80	\$ 52.00	\$ 52.00
97150 00	Physical Medicine	0.52	0.52	\$ 33.80	\$ 33.80
97151 00	Physical Medicine	0.00	0.00	BR	BR
97152 00	Physical Medicine	0.00	0.00	BR	BR
97153 00	Physical Medicine	0.00	0.00	BR	BR
97154 00	Physical Medicine	0.00	0.00	BR	BR
97155 00	Physical Medicine	0.00	0.00	BR	BR
97156 00	Physical Medicine	0.00	0.00	BR	BR
97157 00	Physical Medicine	0.00	0.00	BR	BR
97158 00	Physical Medicine	0.00	0.00	BR	BR
97161 00	Physical Medicine	2.96	2.96	\$ 192.40	\$ 192.40
97162 00	Physical Medicine	2.96	2.96	\$ 192.40	\$ 192.40
97163 00	Physical Medicine	2.96	2.96	\$ 192.40	\$ 192.40
97164 00	Physical Medicine	2.04	2.04	\$ 132.60	\$ 132.60
97165 00	Physical Medicine	2.98	2.98	\$ 193.70	\$ 193.70
97166 00	Physical Medicine	2.98	2.98	\$ 193.70	\$ 193.70
97167 00	Physical Medicine	2.98	2.98	\$ 193.70	\$ 193.70
97168 00	Physical Medicine	2.05	2.05	\$ 133.25	\$ 133.25
97169 00	Physical Medicine	-	-	\$ 101.40	\$ 101.40
97170 00	Physical Medicine	-	-	\$ 101.40	\$ 101.40
97171 00	Physical Medicine	-	-	\$ 101.40	\$ 101.40
97172 00	Physical Medicine	-	-	\$ 50.70	\$ 50.70
97530 00	Physical Medicine	1.10	1.10	\$ 71.50	\$ 71.50
97533 00	Physical Medicine	1.91	1.91	\$ 124.15	\$ 124.15
97535 00	Physical Medicine	0.97	0.97	\$ 63.05	\$ 63.05
97537 00	Physical Medicine	0.94	0.94	\$ 61.10	\$ 61.10
97542 00	Physical Medicine	0.94	0.94	\$ 61.10	\$ 61.10
97545 00	Physical Medicine	-	-	\$ 325.65	\$ 325.65
97546 00	Physical Medicine	-	-	\$ 128.70	\$ 128.70
97597 00	Physical Medicine	3.03	1.06	\$ 196.95	\$ 68.90
97598 00	Physical Medicine	1.35	0.74	\$ 87.75	\$ 48.10
97602 00	Physical Medicine	-	-	\$ 172.90	\$ 172.90
97605 00	Physical Medicine	1.25	0.73	\$ 81.25	\$ 47.45
97606 00	Physical Medicine	1.48	0.80	\$ 96.20	\$ 52.00
97607 00	Physical Medicine	11.47	0.66	\$ 745.55	\$ 42.90
97608 00	Physical Medicine	11.32	0.74	\$ 735.80	\$ 48.10
97610 00	Physical Medicine	13.55	0.53	\$ 880.75	\$ 34.45
97750 00	Physical Medicine	0.99	0.99	\$ 64.35	\$ 64.35
97755 00	Physical Medicine	1.12	1.12	\$ 72.80	\$ 72.80
97760 00	Physical Medicine	1.44	1.44	\$ 93.60	\$ 93.60
97761 00	Physical Medicine	1.23	1.23	\$ 79.95	\$ 79.95
97763 00	Physical Medicine	1.60	1.60	\$ 104.00	\$ 104.00
97799 00	Physical Medicine	0.00	0.00	BR	BR
97802 00	Physical Medicine	1.08	0.95	\$ 70.20	\$ 61.75
97803 00	Physical Medicine	0.94	0.81	\$ 61.10	\$ 52.65
97804 00	Physical Medicine	0.50	0.45	\$ 32.50	\$ 29.25
97810 00	Physical Medicine	1.16	0.92	\$ 75.40	\$ 59.80
97811 00	Physical Medicine	0.87	0.78	\$ 56.55	\$ 50.70
97813 00	Physical Medicine	1.36	0.99	\$ 88.40	\$ 64.35
97814 00	Physical Medicine	1.12	0.85	\$ 72.80	\$ 55.25
98925 00	Physical Medicine	0.93	0.69	\$ 60.45	\$ 44.85
98926 00	Physical Medicine	1.31	1.03	\$ 85.15	\$ 66.95
98927 00	Physical Medicine	1.71	1.36	\$ 111.15	\$ 88.40

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
98928 00	Physical Medicine	2.10	1.72	\$ 136.50	\$ 111.80
98929 00	Physical Medicine	2.49	2.07	\$ 161.85	\$ 134.55
98940 00	Physical Medicine	0.81	0.64	\$ 52.65	\$ 41.60
98941 00	Physical Medicine	1.16	0.99	\$ 75.40	\$ 64.35
98942 00	Physical Medicine	1.52	1.34	\$ 98.80	\$ 87.10
98943 00	Physical Medicine	0.78	0.68	\$ 50.70	\$ 44.20
98960 00	Physical Medicine	0.85	0.85	\$ 55.25	\$ 55.25
98961 00	Physical Medicine	0.40	0.40	\$ 26.00	\$ 26.00
98962 00	Physical Medicine	0.30	0.30	\$ 19.50	\$ 19.50
98966 00	Physical Medicine	0.38	0.33	\$ 24.70	\$ 21.45
98967 00	Physical Medicine	0.70	0.64	\$ 45.50	\$ 41.60
98968 00	Physical Medicine	0.99	0.93	\$ 64.35	\$ 60.45
98970 00	Physical Medicine	0.34	0.34	\$ 22.10	\$ 22.10
98971 00	Physical Medicine	0.60	0.59	\$ 39.00	\$ 38.35
98972 00	Physical Medicine	0.93	0.92	\$ 60.45	\$ 59.80
98975 00	Physical Medicine	0.56	0.56	\$ 36.40	\$ 36.40
98976 00	Physical Medicine	1.61	1.61	\$ 104.65	\$ 104.65
98977 00	Physical Medicine	1.61	1.61	\$ 104.65	\$ 104.65
98980 00	Physical Medicine	1.45	0.91	\$ 94.25	\$ 59.15
98981 00	Physical Medicine	1.18	0.91	\$ 76.70	\$ 59.15

Historical Note

New Appendix A, Physical Medicine Codes 2019-2020 made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Physical Medicine Codes 2019-2020 will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Physical Medicine Codes 2019-2020 repealed; new Appendix A, Physical Medicine Codes 2020-2021 made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Physical Medicine Codes 2020-2021 repealed; new Appendix A, Physical Medicine Codes 2021-2022 made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Physical Medicine Codes 2021-2022 repealed; new Appendix A, Physical Medicine Codes 2022-2023 made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

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SPECIAL SERVICES GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2022 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT® are preceded by an AZ identifier and numbered in the following format: AZxxx. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

To the extent that a conflict may exist between an adopted portion of the CPT® and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

Historical Note

New Appendix A, Special Services Guidelines made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Special Services Guidelines will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Special Services Guidelines repealed; new Appendix A, Special Services Guidelines made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Special Services Guidelines repealed; new Appendix A, Special Services Guidelines made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Special Services Guidelines repealed; new Appendix A, Special Services Guidelines made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

ARIZONA PHYSICIANS' FEE SCHEDULE**Special Services Codes 2022****Special Services Conversion Factor \$65.00**

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
99000 00	Special Service	-	-	\$ 10.40	\$ 10.40
99001 00	Special Service	-	-	\$ 12.35	\$ 12.35
99002 00	Special Service	0.00	0.00	Bundled Code	Bundled Code
99024 00	Special Service	0.00	0.00	Bundled Code	Bundled Code
99026 00	Special Service	0.00	0.00	BR	BR
99027 00	Special Service	0.00	0.00	BR	BR
99050 00	Special Service	-	-	\$ 35.10	\$ 35.10
99051 00	Special Service	0.00	0.00	Bundled Code	Bundled Code
99053 00	Special Service	0.00	0.00	Bundled Code	Bundled Code
99056 00	Special Service	0.00	0.00	Bundled Code	Bundled Code
99058 00	Special Service	-	-	\$ 41.60	\$ 41.60
99060 00	Special Service	0.00	0.00	Bundled Code	Bundled Code
99070 00	Special Service	0.00	0.00	BR	BR
99071 00	Special Service	0.00	0.00	Bundled Code	Bundled Code
99072 00	Special Service	0.00	0.00	BR	BR
99075 00	Special Service	0.00	0.00	BR	BR
99078 00	Special Service	0.00	0.00	Bundled Code	Bundled Code
99080 00	Special Service	0.00	0.00	BR	BR
99082 00	Special Service	-	-	\$ 53.95	\$ 53.95
99091 00	Special Service	1.63	1.63	\$ 105.95	\$ 105.95
99100 00	Special Service	0.00	0.00	See Anesthesia Section	See Anesthesia Section
99116 00	Special Service	0.00	0.00	See Anesthesia Section	See Anesthesia Section
99135 00	Special Service	0.00	0.00	See Anesthesia Section	See Anesthesia Section
99140 00	Special Service	0.00	0.00	See Anesthesia Section	See Anesthesia Section
99151 00	Special Service	2.06	0.73	\$ 133.90	\$ 47.45
99152 00	Special Service	1.51	0.37	\$ 98.15	\$ 24.05
99153 00	Special Service	0.32	0.32	\$ 20.80	\$ 20.80
99155 00	Special Service	2.43	2.43	\$ 157.95	\$ 157.95
99156 00	Special Service	2.23	2.23	\$ 144.95	\$ 144.95
99157 00	Special Service	1.82	1.82	\$ 118.30	\$ 118.30
99170 00	Special Service	4.79	2.51	\$ 311.35	\$ 163.15
99172 00	Special Service	-	-	\$ 33.80	\$ 33.80

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
99173 00	Special Service	0.09	0.09	\$ 5.85	\$ 5.85
99174 00	Special Service	0.17	0.17	\$ 11.05	\$ 11.05
99175 00	Special Service	0.85	0.85	\$ 55.25	\$ 55.25
99177 00	Special Service	0.14	0.14	\$ 9.10	\$ 9.10
99183 00	Special Service	3.14	3.14	\$ 204.10	\$ 204.10
99184 00	Special Service	6.36	6.36	\$ 413.40	\$ 413.40
99188 00	Special Service	0.35	0.30	\$ 22.75	\$ 19.50
99190 00	Special Service	-	-	\$ 835.25	\$ 835.25
99191 00	Special Service	-	-	\$ 585.00	\$ 585.00
99192 00	Special Service	-	-	\$ 417.95	\$ 417.95
99195 00	Special Service	3.01	3.01	\$ 195.65	\$ 195.65
99199 00	Special Service	0.00	0.00	BR	BR
99500 00	Special Service	0.00	0.00	BR	BR
99501 00	Special Service	0.00	0.00	BR	BR
99502 00	Special Service	0.00	0.00	BR	BR
99503 00	Special Service	0.00	0.00	BR	BR
99504 00	Special Service	0.00	0.00	BR	BR
99505 00	Special Service	0.00	0.00	BR	BR
99506 00	Special Service	0.00	0.00	BR	BR
99507 00	Special Service	0.00	0.00	BR	BR
99509 00	Special Service	0.00	0.00	BR	BR
99510 00	Special Service	0.00	0.00	BR	BR
99511 00	Special Service	0.00	0.00	BR	BR
99512 00	Special Service	0.00	0.00	BR	BR
99600 00	Special Service	0.00	0.00	BR	BR
99601 00	Special Service	0.00	0.00	BR	BR
99602 00	Special Service	0.00	0.00	BR	BR
99605 00	Special Service	0.00	0.00	BR	BR
99606 00	Special Service	0.00	0.00	BR	BR
99607 00	Special Service	0.00	0.00	BR	BR
AZ001 00 Peer-to-Peer interprofessional telephone consultations between treating physician or medical provider and Peer Reviewer; 5-10 minutes of medical consultative discussion and review.	Special Service	1.15	1.15	\$ 75.00	\$ 75.00
AZ002 00 Peer-to-Peer interprofessional telephone consultations between treating physician or medical provider and Peer Reviewer; 11-30 minutes of medical consultative discussion and review.	Special Service	1.54	1.54	\$ 100.00	\$ 100.00
AZ003 00 Meeting with NCM with patient.	Special Service	1.15	1.15	\$ 75.00	\$ 75.00
AZ004 00 Meeting with NCM without patient.	Special Service	1.54	1.54	\$ 100.00	\$ 100.00

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
AZ005 00 Completion of workers' compensation insurance forms (i.e. return-to-work status, work restrictions, supportive care restrictions) which are requested or required either by the Commission, the applicable payer (insurance, self-insured employer, or the Special Fund of the Commission), or a third-party administrator of the applicable payer, not to exceed more than one billing in a thirty (30) day period. The applicable form must be attached to the billing.	Special Service	0.62	0.62	\$ 40.00	\$ 40.00
AZ026 00 Mileage charge, within a radius of 7 miles, for a collection and handling service performed outside the physician's office or laboratory.	Special Service	0.00	0.00	BR	BR
AZ027 00 Over 7 miles, per mile.	Special Service	0.00	0.00	BR	BR
AZ028 00 When more than one patient seen, apportion mileage charge among total number of patients.	Special Service	0.00	0.00	BR	BR
AZ030 00 Mileage round-trip: each mile in excess of 8 miles of travel by physician.	Special Service	0.00	0.00	BR	BR
AZ031 00 Within large metropolitan areas a travel time basis may be appropriate. Code AZ031 00 would apply to Arizona's major metropolitan areas, to include Phoenix, Tucson, Flagstaff, Kingman and Yuma. This code would only be used when travel times are 45 minutes or more.	Special Service	0.00	0.00	BR	BR
AZ044 00 Services rendered in a night medical care facility: a charge in addition to the usual value of the procedure may be warranted.	Special Service	0.00	0.00	BR	BR
AZ099 00 Expert testimony at hearing for the initial hour (or any portion thereof), prorated for each additional 20 minute increment (or any portion thereof).	Special Service	2.31	2.31	\$ 150.00	\$ 150.00

Historical Note

New Appendix A, Special Services Codes 2019-2020 made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Special Services Codes 2019-2020 will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Special Services Codes 2019-2020 repealed; new Appendix A, Special Services Codes 2020-2021 made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Special Services Codes 2020-2021 repealed; new Appendix A, Special Services Codes 2021-2022 made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Special Services Codes 2021-2022 repealed; new Appendix A, Special Services Codes 2022-2023 made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA
EVALUATION AND MANAGEMENT GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2022 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT® are preceded by an AZ identifier and numbered in the following format: AZxxx. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The evaluation and management guidelines adopted by reference may be found in the *Current Procedural Terminology*® (CPT®) published by the AMA and is reprinted, in part, below with permission. To the extent that a conflict may exist between an adopted portion of the CPT® and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

Documentation and review of records is inclusive to the performance of the appropriate E/M service. A health care provider shall only be reimbursed for time that is not accounted for in the E/M service code by billing codes 99354, 99355, 99356, 99357, 99358, or 99359. Proper documentation must justify the use of these codes and accompany the invoice.

Two HCPCS codes are included in this section of the 2022/2023 Fee Schedule:

G2010 – Remote evaluation of recorded video and/or images submitted by an established patient (*e.g.*, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

G2012 – Brief communication technology-based service, *e.g.*, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

A. CLASSIFICATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES.

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, *e.g.*, office consultation. Third, the content of the service is defined. Fourth, time is specified. A detailed discussion of time is provided in Section C.

B. DEFINITIONS OF COMMONLY USED TERMS.

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians. The definitions in the E/M Guidelines are provided solely for the basis of code selection.

Some definitions are common to all categories of services and others are specific to one or more categories only.

C. GUIDELINES COMMON TO ALL E/M SERVICES.

- Levels of E/M Services: Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are NOT interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians.
- New and Established Patient: Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians who may report evaluation and management services reported by a specific CPT® code(s). A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.

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No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

- Time: The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT® codebook. The inclusion of time as an explicit factor beginning in CPT® 1992 is done to assist in selecting the most appropriate level of E/M services. Beginning with CPT® 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician. For office or other outpatient services, if the physician's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified health care professional jointly provide face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (*i.e.*, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

Unit/floor time (hospital observation services [99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236], hospital inpatient services [99221, 99222, 99223, 99231, 99232, 99233], inpatient consultations [99521, 99522, 99523, 99524, 99525], nursing facility services [99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318]): For coding purposes, time for these services is defined as unit/floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.

Total time on the date of the encounter (office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215]): For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician on the day of the encounter (includes time in activities that require the physician and does not include time in activities normally performed by clinical staff).

Physician time includes the following activities when performed:

- Preparing to see the patient (*e.g.*, review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medical examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Do not count time spent on the following:

- The performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient

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- **Concurrent Care and Transfer of Care:** Concurrent care is the provision of similar services (*e.g.*, hospital visits) to the same patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required. Transfer of care is the process whereby a physician who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. The physician transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate. Consultation codes should not be reported by the physician who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.
- **Counseling:** Counseling is a discussion with a patient and/or family concerning one or more of the following areas:
 - Diagnostic results, impressions, and/or recommended diagnostic studies;
 - Prognosis;
 - Risks and benefits of management (treatment) options;
 - Instructions for management (treatment) and/or follow-up;
 - Importance of compliance with chosen management (treatment) options;
 - Risk factor reduction; and
 - Patient and family education.
 (For psychotherapy, see 90832-90834, 90836-90840)
- **Services Reported Separately:** Any specifically identifiable procedure or service (*i.e.*, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician reporting the E/M service. Tests that do not require separate interpretation (*e.g.*, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (*i.e.*, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code, and, if required, with modifier 26 appended. If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of the MDM.

The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or conditions for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same day.

D. GUIDELINES FOR HOSPITAL OBSERVATION, HOSPITAL INPATIENT, CONSULTATIONS, EMERGENCY DEPARTMENT, NURSING FACILITY, DOMICILIARY REST HOME, OR CUSTODIAL CARE, AND HOME E/M SERVICES.

- The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:
 - History;
 - Examination;
 - Medical decision making;
 - Counseling;
 - Coordination of care;
 - Nature of presenting problem;
 - Time.

The first three of these components (history, examination, and medical decision making) are considered the **key** components in selecting a level of E/M services. (See "Determine the Extent of History Obtained.")

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter.

Coordination of care with other physicians, other health care professionals, or agencies without a patient encounter on that day is reported using the case management codes.

The final component, time, is discussed in detail in section C.

- **Chief Complaint:** A chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient's words.

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- **History of Present Illness:** A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s).
- **Nature of Presenting Problem:** A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

Minimal - A problem that may not require the presence of the physician, but service is provided under the physician's supervision.

Self-limited or Minor - A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Low severity - A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.

Moderate severity - A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.

High severity - A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

- **Past History:** A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:
 - Prior major illnesses and injuries;
 - Prior operations;
 - Prior hospitalizations;
 - Current medications;
 - Allergies (*e.g.*, drug, food);
 - Age appropriate immunization status;
 - Age appropriate feeding/dietary status.
- **Family History:** A review of medical events in the patient's family that includes significant information about:
 - The health status or cause of death of parents, siblings and children;
 - Specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review;
 - Diseases of family members which may be hereditary or place the patient at risk.
- **Social History:** An age appropriate review of past and current activities that includes significant information about:
 - Marital status and/or living arrangements;
 - Current employment;
 - Occupational history;
 - Military history;
 - Use of drugs, alcohol, and tobacco;
 - Level of education;
 - Sexual history;
 - Other relevant social factors.
- **System Review (Review of Systems):** An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. For the purposes of CPT®, the following elements of a system review have been identified:
 - Constitutional symptoms (fever, weight loss, etc.);
 - Eyes;
 - Ears, nose, mouth, throat;
 - Cardiovascular;
 - Respiratory;
 - Gastrointestinal;
 - Genitourinary;
 - Musculoskeletal;
 - Integumentary (skin and/or breast);
 - Neurological;
 - Psychiatric;
 - Endocrine;
 - Hematologic/Lymphatic;
 - Allergic/Immunologic.

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The review of systems helps define the problem, clarify the differential diagnosis, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

E. INSTRUCTIONS FOR SELECTING A LEVEL OF E/M SERVICE FOR HOSPITAL OBSERVATION, HOSPITAL INPATIENT, CONSULTATIONS, EMERGENCY DEPARTMENT, NURSING FACILITY, DOMICILIARY REST HOME, OR CUSTODIAL CARE, AND HOME E/M SERVICES.

- Review the Level of E/M Service Descriptors and Examples in the Selected Category or Subcategory: The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:
 - History;
 - Examination;
 - Medical decision making;
 - Counseling;
 - Coordination of care;
 - Nature of presenting problem;
 - Time.

The first three components (*i.e.*, history, examination, and medical decision making) should be considered the **key** components in selecting the level of E/M services. An exception to this rule is in the case of visits that consist predominately of counseling or coordination of care.

The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M service.

- Determine the Extent of History Obtained: The extent of the history is dependent upon clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of history that are defined as follows:

Problem Focused - Chief complaint; brief history of present illness or problem.

Expanded Problem Focused - Chief complaint; brief history of present illness; problem pertinent system review.

Detailed - Chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family, and/or social history directly related to the patient's problems.

Comprehensive - Chief complaint; extended history of present illness; review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history.

The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors.

- Determine the Extent of Examination Performed: The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of examination that are defined as follows:

Problem Focused - A limited examination of the affected body area or organ system.

Expanded Problem Focused - A limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

Detailed - An extended examination of the affected body area(s) and other symptomatic or related organ system(s).

Comprehensive - A general multisystem examination or a complete examination of a single organ system. Note: The comprehensive examination performed as part of the preventive medicine E/M service is multisystem, but its extent is based on age and risk factors identified.

For the purposes of these CPT® definitions, the following body areas are recognized:

- Head, including the face;
- Neck;
- Chest, including breasts and axilla;
- Abdomen;
- Genitalia, groin, buttocks;
- Back;

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- Each extremity;

For the purposes of these CPT® definitions, the following organ systems are recognized:

- Eyes;
- Ears, nose, mouth, and throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Skin;
- Neurologic;
- Psychiatric;
- Hematologic/Lymphatic/Immunologic.

- Determine the Complexity of Medical Decision Making:

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity; and high complexity. To qualify for a given type of decision making, two of the three elements in Table 1, Complexity of Medical Decision Making, must be met or exceeded.

Table 1 – Complexity of Medical Decision Making

Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Type of Decision Making
Minimal	Minimal or none	Minimal	Straightforward
Limited	Limited	Low	Low complexity
Multiple	Moderate	Moderate	Moderate complexity
Extensive	Extensive	High	High complexity

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision making.

- Select the Appropriate Level of E/M Services Based on the Following:
 1. For the following categories/subcategories, **all of the key components** *i.e.*, history, examination, and medical decision making, must meet or exceed the stated requirements to qualify for a particular level of E/M service: initial observation care; initial hospital care; observation or inpatient hospital care (including admission and discharge services); office or other outpatient consultations, inpatient consultations; emergency department services; initial nursing facility care; other nursing facility services; domiciliary care, new patient; and home services, new patient.
 2. For the following categories/subcategories, **two of the three key components** (*i.e.*, history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: subsequent observation care; subsequent hospital care; subsequent nursing facility care; domiciliary care, established patient; and home services, established patient.
 3. When counseling and/or coordination of care dominates (more than 50%) the encounter with the patient and/or family (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** shall be considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (*e.g.*, foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.

F. GUIDELINES FOR OFFICE OR OTHER OUTPATIENT E/M SERVICES.

- History and/or Examination: Office or other outpatient services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician reporting the service. The care team may collect information and the patient or caregiver may supply information directly (*e.g.*, by electronic health

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record [EHR] portal or questionnaire) that is reviewed by the reporting physician. The extent of history and physical examination is not an element in the selection of the office or other outpatient codes.

- **Number and Complexity of Problems Addressed at the Encounter:** One element used in selecting the level of office or other outpatient services is the number and complexity of the problems that are addressed at an encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms that are unlikely to represent a highly morbid condition may “drive” MDM even when the ultimate diagnosis is not highly morbid. The evaluation and/or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term “risk” as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of management.

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) for other office or other outpatient services are:

Problem: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient’s medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician reporting the service.

Minimal problem: A problem that may not require the presence of the physician, but the service is provided under the physician’s supervision (see 99211).

Self-limiting or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (*e.g.*, uncontrolled diabetes and controlled diabetes are a single chronic condition). “Stable” for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, in a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic, the risk of morbidity **without** treatment is significant. Examples may include well-controlled hypertension, non-insulin-dependent diabetes, cataract, or benign prostatic hyperplasia.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects but that does not require consideration of hospital level of care.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness, or to prevent complications, see the definitions for *self-limited or minor problem* or *acute, uncomplicated illness or injury*. Systemic symptoms may not be general but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with a risk of morbidity. An example may be a head injury with brief loss of consciousness.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.

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Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, and acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Examples may include myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

Analyzed: the process of using the data as part of the MDM. The data element itself may not be subject to analysis (*e.g.*, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (*e.g.*, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT® code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT® code set. When multiple results of the same unique test (*e.g.*, serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT® codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC, without differential, and platelet count. A unique source is defined as a physician in a distinct group or different specialty or subspecialty, or a unique entity. Review of all the materials from any unique source counts as one element toward MDM.

Combination of Data Elements: A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.

External physician or other qualified health care professional: An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (*e.g.*, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be synchronous (*i.e.*, does not need to be in person), but it must be initiated and completed within a short time period (*e.g.*, within a day or two).

Independent historian(s): An individual (*e.g.*, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (*e.g.*, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretations: The interpretation of a test for which there is a CPT® code and an interpretation or report is customary. This does not apply when the physician is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: For the purpose of the discussion of management data element (see Table 2, levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (*e.g.*, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.

One element used in selecting the level of service is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

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Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician in the same specialty. Trained clinicians apply common language usage meanings to terms such as *high*, *medium*, *low*, or *minimal* risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician as part of the reported encounter.

Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Surgery (minor or major, elective, emergency, procedure or patient risk):

Surgery - Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by a surgical package classification.

Surgery – Elective or Emergency: Elective procedures and emergent or urgent procedures describe the timing of the procedure when the timing is related to the patient’s condition. An elective procedure is typically planned in advance (e.g., scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.

Surgery – Risk Factors, Patient or Procedure: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. Examples may include monitoring for cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

G. INSTRUCTIONS FOR SELECTING A LEVEL OF OFFICE OR OTHER OUTPATIENT E/M SERVICES.

- Select the Appropriate Level of E/M Services Based on the Following:
 1. The level of the MDM as defined for each service, **or**
 2. The total time for E/M services performed on the date of the encounter.
- Medical Decision Making: MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM in the office or other outpatient services codes is defined by three elements:
 - The number and complexity of problem(s) that are addressed during the encounter.
 - The amount and/or complexity of data to be reviewed and analyzed. These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to the risk for a specific patient it is not ordered. Data are divided into three categories:
 1. Tests, documents, orders or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
 2. Independent interpretation of tests.
 3. Discussion of management or test interpretation with an external physician or appropriate source.

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- The risk of complications and/or morbidity or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), and/or treatment(s). This includes the possible management options selected and those considered but not selected, after shared MDM with the patient and/or family. For example, a decision about hospitalization includes alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211.

Shared MDM involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician is reporting a separate CPT® code that includes interpretation and/or report, the interpretation and/or report should not count toward the MDM when selecting a level of office or other outpatient services. When the physician is reporting a separate service for discussion of management with a physician, the discussion is not counted toward the MDM when selecting a level of office or other outpatient services.

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an office or other outpatient E/M services code. The table includes the four levels of MDM (*i.e.*, straightforward, low, moderate, high) and the three elements of MDM (*i.e.*, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded. See Table 2: Levels of Medical Decision Making (MDM).

Table 2: Levels of Medical Decision Making (MDM)
Elements of Medical Decision Making

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below</i>	Risk or Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal 1 self-limited or minor problem	Minimal or more	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low 2 or more self-limited or minor problems; or 1 stable, chronic illness; or 1 acute, uncomplicated illness or injury	Limited (Must meet the requirements of at least 1 out of the 2 categories) Category 1: Tests and documents Any Combination of 2 from the following: Review of prior external note(s) from each unique source*; Review of the result(s) of each unique test*; Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity form additional diagnostic testing or treatment
99204 99214	Moderate	Moderate 1 or more chronic illnesses with exacerbation, progression, or side effects treatment; or 2 or more stable, chronic illnesses; or 1 undiagnosed new problem with uncertain prognosis; or	Moderate (Must meet the requirements of at least 1 of the 3 categories) Category 1: Tests, Documents, or independent historian(s) Any combination of 3 from the following: Review of prior external note(s) form each unique source*; Review of the result(s) of each unique test*; Ordering of each unique test*; Assessment requiring an independent historian(s)	Moderate risk of morbidity from additional diagnostic testing or treatment <i>Examples only:</i> Prescription drug management Decision regarding minor surgery with identified patient or procedure risk forms

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		1 acute illness with systemic symptoms; or 1 acute, complicated injury	or Category 2: Independent interpretation of tests Independent interpretation of a test performed by another physician (not separately reported); or Category 3: Discussion of management or test interpretation Discussion of management or test interpretation with external physician/appropriate source (not separately reported)	Decision regarding elective major surgery without identified patient or procedure risk factors Diagnosis or treatment significantly limited by social determinants of health
99205 99215	High	High 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive <i>(Must meet the requirements of at least 2 out of the 3 categories)</i> Category 1: Tests, documents, or independent historian(s) Any combination of 3 from the following: Review of prior external notes(s) from each unique source*; Review of the result(s) of each unique test*; Ordering of each unique test*; Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests Independent interpretation of a test performed by another physician (not separately reported); or Category 3: Discussion of management or test interpretation Discussion of management or test interpretation with external physician/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment <i>Examples only:</i> Drug therapy requiring intensive monitoring for toxicity Decision regarding elective major surgery with identified patient or procedure risk factors Decision regarding emergency major surgery Decision regarding hospitalization Decision not to resuscitate or to de-escalate care because of poor prognosis

H. TIME.

For instructions on using time to select the level of office or other outpatient E/M services code, see the **Time** subsection in Item C (*Guidelines Common to all E/M Services*).

I. UNLISTED SERVICE.

An E/M service may be provided that is not listed in this section of CPT® codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by “Special Report,” as discussed in item J. The “Unlisted Services” and accompanying codes for the E/M section are as follows:

- 99429 Unlisted preventive medicine service
- 99499 Unlisted evaluation and management service

J. SPECIAL REPORT.

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

K. CLINICAL EXAMPLES.

Clinical examples of the codes for E/M services are provided to assist in understanding the meaning of the descriptors and selecting the correct code. The clinical examples are listed in Appendix C. (*Appendix C of the CPT® has not been reprinted in this text.*) Each example was developed by the specialties shown.

The same problem, when seen by different specialties, may involve different amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptors rather than the examples.

Historical Note New

Appendix A, Evaluation and Management Guidelines made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Evaluation and Management Guidelines will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Evaluation and Management Guidelines repealed; new Appendix A, Evaluation and Management Guidelines made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Evaluation and Management Guidelines repealed; new Appendix A, Evaluation and Management Guidelines made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Evaluation and Management Guidelines repealed; new Appendix A, Evaluation and Management Guidelines made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

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ARIZONA PHYSICIANS' FEE SCHEDULE E&M Codes 2022 E&M Conversion Factor \$65.00					
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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
99202 00	E&M	2.14	1.43	\$ 139.10	\$ 92.95
99203 00	E&M	3.29	2.44	\$ 213.85	\$ 158.60
99204 00	E&M	4.90	3.95	\$ 318.50	\$ 256.75
99205 00	E&M	6.48	5.36	\$ 421.20	\$ 348.40
99211 00	E&M	0.68	0.26	\$ 44.20	\$ 16.90
99212 00	E&M	1.66	1.06	\$ 107.90	\$ 68.90
99213 00	E&M	2.66	1.95	\$ 172.90	\$ 126.75
99214 00	E&M	3.75	2.86	\$ 243.75	\$ 185.90
99215 00	E&M	5.29	4.25	\$ 343.85	\$ 276.25
99217 00	E&M	2.07	2.07	\$ 134.55	\$ 134.55
99218 00	E&M	2.83	2.83	\$ 183.95	\$ 183.95
99219 00	E&M	3.83	3.83	\$ 248.95	\$ 248.95
99220 00	E&M	5.17	5.17	\$ 336.05	\$ 336.05
99221 00	E&M	2.91	2.91	\$ 189.15	\$ 189.15
99222 00	E&M	3.91	3.91	\$ 254.15	\$ 254.15
99223 00	E&M	5.73	5.73	\$ 372.45	\$ 372.45
99224 00	E&M	1.13	1.13	\$ 73.45	\$ 73.45
99225 00	E&M	2.05	2.05	\$ 133.25	\$ 133.25
99226 00	E&M	2.92	2.92	\$ 189.80	\$ 189.80
99231 00	E&M	1.12	1.12	\$ 72.80	\$ 72.80
99232 00	E&M	2.06	2.06	\$ 133.90	\$ 133.90
99233 00	E&M	2.96	2.96	\$ 192.40	\$ 192.40
99234 00	E&M	3.77	3.77	\$ 245.05	\$ 245.05
99235 00	E&M	4.78	4.78	\$ 310.70	\$ 310.70
99236 00	E&M	6.12	6.12	\$ 397.80	\$ 397.80
99238 00	E&M	2.08	2.08	\$ 135.20	\$ 135.20
99239 00	E&M	3.04	3.04	\$ 197.60	\$ 197.60
99241 00	E&M	1.35	0.93	\$ 87.75	\$ 60.45
99242 00	E&M	2.55	1.96	\$ 165.75	\$ 127.40
99243 00	E&M	3.51	2.76	\$ 228.15	\$ 179.40
99244 00	E&M	5.23	4.41	\$ 339.95	\$ 286.65
99245 00	E&M	6.38	5.46	\$ 414.70	\$ 354.90
99251 00	E&M	1.41	1.41	\$ 91.65	\$ 91.65
99252 00	E&M	2.13	2.13	\$ 138.45	\$ 138.45
99253 00	E&M	3.31	3.31	\$ 215.15	\$ 215.15
99254 00	E&M	4.77	4.77	\$ 310.05	\$ 310.05
99255 00	E&M	5.77	5.77	\$ 375.05	\$ 375.05
99281 00	E&M	0.64	0.64	\$ 41.60	\$ 41.60
99282 00	E&M	1.24	1.24	\$ 80.60	\$ 80.60
99283 00	E&M	2.11	2.11	\$ 137.15	\$ 137.15
99284 00	E&M	3.56	3.56	\$ 231.40	\$ 231.40
99285 00	E&M	5.17	5.17	\$ 336.05	\$ 336.05
99288 00	E&M	0.00	0.00	Bundled Code	Bundled Code
99291 00	E&M	8.16	6.33	\$ 530.40	\$ 411.45
99292 00	E&M	3.56	3.18	\$ 231.40	\$ 206.70
99304 00	E&M	2.57	2.57	\$ 167.05	\$ 167.05
99305 00	E&M	3.71	3.71	\$ 241.15	\$ 241.15
99306 00	E&M	4.76	4.76	\$ 309.40	\$ 309.40
99307 00	E&M	1.26	1.26	\$ 81.90	\$ 81.90
99308 00	E&M	1.99	1.99	\$ 129.35	\$ 129.35
99309 00	E&M	2.62	2.62	\$ 170.30	\$ 170.30
99310 00	E&M	3.86	3.86	\$ 250.90	\$ 250.90
99315 00	E&M	2.09	2.09	\$ 135.85	\$ 135.85
99316 00	E&M	2.99	2.99	\$ 194.35	\$ 194.35

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Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
99318 00	E&M	2.75	2.75	\$ 178.75	\$ 178.75
99324 00	E&M	1.56	1.56	\$ 101.40	\$ 101.40
99325 00	E&M	2.28	2.28	\$ 148.20	\$ 148.20
99326 00	E&M	3.95	3.95	\$ 256.75	\$ 256.75
99327 00	E&M	5.32	5.32	\$ 345.80	\$ 345.80
99328 00	E&M	6.26	6.26	\$ 406.90	\$ 406.90
99334 00	E&M	1.75	1.75	\$ 113.75	\$ 113.75
99335 00	E&M	2.75	2.75	\$ 178.75	\$ 178.75
99336 00	E&M	3.89	3.89	\$ 252.85	\$ 252.85
99337 00	E&M	5.57	5.57	\$ 362.05	\$ 362.05
99339 00	E&M	0.00	0.00	Bundled Code	Bundled Code
99340 00	E&M	0.00	0.00	Bundled Code	Bundled Code
99341 00	E&M	1.56	1.56	\$ 101.40	\$ 101.40
99342 00	E&M	2.22	2.22	\$ 144.30	\$ 144.30
99343 00	E&M	3.61	3.61	\$ 234.65	\$ 234.65
99344 00	E&M	5.20	5.20	\$ 338.00	\$ 338.00
99345 00	E&M	6.30	6.30	\$ 409.50	\$ 409.50
99347 00	E&M	1.58	1.58	\$ 102.70	\$ 102.70
99348 00	E&M	2.40	2.40	\$ 156.00	\$ 156.00
99349 00	E&M	3.70	3.70	\$ 240.50	\$ 240.50
99350 00	E&M	5.13	5.13	\$ 333.45	\$ 333.45
99354 00	E&M	3.71	3.47	\$ 241.15	\$ 225.55
99355 00	E&M	2.68	2.45	\$ 174.20	\$ 159.25
99356 00	E&M	2.61	2.61	\$ 169.65	\$ 169.65
99357 00	E&M	2.62	2.62	\$ 170.30	\$ 170.30
99358 00	E&M	3.20	3.20	\$ 208.00	\$ 208.00
99359 00	E&M	1.56	1.56	\$ 101.40	\$ 101.40
99360 00	E&M	1.76	1.76	\$ 114.40	\$ 114.40
99366 00	E&M	1.25	1.22	\$ 81.25	\$ 79.30
99367 00	E&M	1.62	1.62	\$ 105.30	\$ 105.30
99368 00	E&M	1.07	1.07	\$ 69.55	\$ 69.55
99374 00	E&M	0.00	0.00	Bundled Code	Bundled Code
99375 00	E&M	2.99	2.52	\$ 194.35	\$ 163.80
99377 00	E&M	0.00	0.00	Bundled Code	Bundled Code
99378 00	E&M	2.99	2.52	\$ 194.35	\$ 163.80
99379 00	E&M	0.00	0.00	Bundled Code	Bundled Code
99380 00	E&M	0.00	0.00	Bundled Code	Bundled Code
99381 00	E&M	0.00	0.00	BR	BR
99382 00	E&M	0.00	0.00	BR	BR
99383 00	E&M	0.00	0.00	BR	BR
99384 00	E&M	0.00	0.00	BR	BR
99385 00	E&M	0.00	0.00	BR	BR
99386 00	E&M	0.00	0.00	BR	BR
99387 00	E&M	0.00	0.00	BR	BR
99391 00	E&M	0.00	0.00	BR	BR
99392 00	E&M	0.00	0.00	BR	BR
99393 00	E&M	0.00	0.00	BR	BR
99394 00	E&M	0.00	0.00	BR	BR
99395 00	E&M	0.00	0.00	BR	BR
99396 00	E&M	0.00	0.00	BR	BR
99397 00	E&M	0.00	0.00	BR	BR
99401 00	E&M	0.00	0.00	BR	BR
99402 00	E&M	0.00	0.00	BR	BR
99403 00	E&M	0.00	0.00	BR	BR
99404 00	E&M	0.00	0.00	BR	BR
99406 00	E&M	0.00	0.00	BR	BR
99407 00	E&M	0.00	0.00	BR	BR
99408 00	E&M	0.00	0.00	BR	BR

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99409 00	E&M	0.00	0.00	BR	BR
99411 00	E&M	0.00	0.00	BR	BR
99412 00	E&M	0.00	0.00	BR	BR
99415 00	E&M	0.30	0.30	\$ 19.50	\$ 19.50
99416 00	E&M	0.17	0.17	\$ 11.05	\$ 11.05
99417 00	E&M	0.93	0.90	\$ 60.45	\$ 58.50
99421 00	E&M	0.44	0.38	\$ 28.60	\$ 24.70
99422 00	E&M	0.86	0.75	\$ 55.90	\$ 48.75
99423 00	E&M	1.40	1.21	\$ 91.00	\$ 78.65
99424 00	E&M	2.41	2.18	\$ 156.65	\$ 141.70
99425 00	E&M	1.74	1.52	\$ 113.10	\$ 98.80
99426 00	E&M	1.83	1.46	\$ 118.95	\$ 94.90
99427 00	E&M	1.40	1.03	\$ 91.00	\$ 66.95
99429 00	E&M	0.00	0.00	BR	BR
99437 00	E&M	1.77	1.51	\$ 115.05	\$ 98.15
99439 00	E&M	1.40	1.05	\$ 91.00	\$ 68.25
99441 00	E&M	1.64	1.04	\$ 106.60	\$ 67.60
99442 00	E&M	2.65	1.94	\$ 172.25	\$ 126.10
99443 00	E&M	3.75	2.86	\$ 243.75	\$ 185.90
99446 00	E&M	0.54	0.54	\$ 35.10	\$ 35.10
99447 00	E&M	1.06	1.06	\$ 68.90	\$ 68.90
99448 00	E&M	1.59	1.59	\$ 103.35	\$ 103.35
99449 00	E&M	2.13	2.13	\$ 138.45	\$ 138.45
99450 00	E&M	0.00	0.00	BR	BR
99451 00	E&M	1.05	1.05	\$ 68.25	\$ 68.25
99452 00	E&M	1.07	1.07	\$ 69.55	\$ 69.55
99453 00	E&M	0.55	0.55	\$ 35.75	\$ 35.75
99454 00	E&M	1.61	1.61	\$ 104.65	\$ 104.65
99455 00	E&M	5.23	5.23	\$ 339.95	\$ 339.95
99456 00	E&M	6.87	6.87	\$ 446.55	\$ 446.55
99457 00	E&M	1.45	0.90	\$ 94.25	\$ 58.50
99458 00	E&M	1.18	0.90	\$ 76.70	\$ 58.50
99460 00	E&M	2.75	2.75	\$ 178.75	\$ 178.75
99461 00	E&M	2.70	1.82	\$ 175.50	\$ 118.30
99462 00	E&M	1.22	1.22	\$ 79.30	\$ 79.30
99463 00	E&M	3.17	3.17	\$ 206.05	\$ 206.05
99464 00	E&M	2.16	2.16	\$ 140.40	\$ 140.40
99465 00	E&M	4.21	4.21	\$ 273.65	\$ 273.65
99466 00	E&M	6.87	6.87	\$ 446.55	\$ 446.55
99467 00	E&M	3.46	3.46	\$ 224.90	\$ 224.90
99468 00	E&M	26.50	26.50	\$ 1,722.50	\$ 1,722.50
99469 00	E&M	11.48	11.48	\$ 746.20	\$ 746.20
99471 00	E&M	22.94	22.94	\$ 1,491.10	\$ 1,491.10
99472 00	E&M	11.70	11.70	\$ 760.50	\$ 760.50
99473 00	E&M	0.34	0.34	\$ 22.10	\$ 22.10
99474 00	E&M	0.44	0.26	\$ 28.60	\$ 16.90
99475 00	E&M	16.49	16.49	\$ 1,071.85	\$ 1,071.85
99476 00	E&M	9.89	9.89	\$ 642.85	\$ 642.85
99477 00	E&M	10.03	10.03	\$ 651.95	\$ 651.95
99478 00	E&M	3.96	3.96	\$ 257.40	\$ 257.40
99479 00	E&M	3.61	3.61	\$ 234.65	\$ 234.65
99480 00	E&M	3.46	3.46	\$ 224.90	\$ 224.90
99483 00	E&M	8.18	5.70	\$ 531.70	\$ 370.50
99484 00	E&M	1.29	0.88	\$ 83.85	\$ 57.20
99485 00	E&M	0.00	0.00	Bundled Code	Bundled Code
99486 00	E&M	0.00	0.00	Bundled Code	Bundled Code
99487 00	E&M	3.88	2.68	\$ 252.20	\$ 174.20
99489 00	E&M	2.04	1.48	\$ 132.60	\$ 96.20

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99490 00	E&M	1.85	1.49	\$ 120.25	\$ 96.85
99491 00	E&M	2.49	2.24	\$ 161.85	\$ 145.60
99492 00	E&M	4.44	2.72	\$ 288.60	\$ 176.80
99493 00	E&M	4.30	2.99	\$ 279.50	\$ 194.35
99494 00	E&M	1.84	1.22	\$ 119.60	\$ 79.30
99495 00	E&M	6.04	4.18	\$ 392.60	\$ 271.70
99496 00	E&M	8.14	5.66	\$ 529.10	\$ 367.90
99497 00	E&M	2.47	2.25	\$ 160.55	\$ 146.25
99498 00	E&M	2.14	2.12	\$ 139.10	\$ 137.80
99499 00	E&M	0.00	0.00	BR	BR
G2010 00	E&M	0.35	0.27	\$ 22.75	\$ 17.55
G2012 00	E&M	0.42	0.37	\$ 27.30	\$ 24.05

Historical Note

New Appendix A, Evaluation and Management Codes 2019-2020 made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Evaluation and Management Codes 2019-2020 will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Evaluation and Management Codes 2019-2020 repealed; new Appendix A, Evaluation and Management Codes 2020-2021 made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Evaluation and Management Codes 2020-2021 repealed; new Appendix A, Evaluation and Management Codes 2021-2022 made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Evaluation and Management Codes 2021-2022 repealed; new Appendix A, Evaluation and Management Codes 2022-2023 made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

CATEGORY III CODES GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2022 Edition of the American Medical Association's Current Procedural Terminology (CPT®) publication, including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT® are preceded by an AZ identifier and numbered in the following format: AZxxx. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

Category III Codes are temporary codes developed to allow collection of data for emerging technology, services, and procedures. The five character alphanumeric codes contain four numbers with one alpha character in the fifth place. If a Category III Code is available, this code must be reported instead of a Category I unlisted code.

To the extent that a conflict may exist between an adopted portion of the CPT® and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

Historical Note

New Appendix A, Category III Guidelines made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Category III Guidelines will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Category III Guidelines; new Appendix A, Category III Guidelines made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20-3). Appendix A, Category III Guidelines repealed; new Appendix A, Category III Codes Guidelines made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Category III Code Guidelines repealed; new Appendix A, Category III Codes Guidelines made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

ARIZONA PHYSICIANS' FEE SCHEDULE Category III Codes 2022

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
0042T 00	Category III	0.00	0.00	RNE	RNE
0054T 00	Category III	0.00	0.00	RNE	RNE
0055T 00	Category III	0.00	0.00	RNE	RNE
0071T 00	Category III	0.00	0.00	RNE	RNE
0072T 00	Category III	0.00	0.00	RNE	RNE
0075T 00	Category III	0.00	0.00	RNE	RNE
0075T 26	Category III	0.00	0.00	RNE	RNE
0075T TC	Category III	0.00	0.00	RNE	RNE

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
0076T 00	Category III	0.00	0.00	RNE	RNE
0076T 26	Category III	0.00	0.00	RNE	RNE
0076T TC	Category III	0.00	0.00	RNE	RNE
0095T 00	Category III	0.00	0.00	RNE	RNE
0098T 00	Category III	0.00	0.00	RNE	RNE
0100T 00	Category III	0.00	0.00	RNE	RNE
0101T 00	Category III	0.00	0.00	RNE	RNE
0102T 00	Category III	0.00	0.00	RNE	RNE
0106T 00	Category III	0.00	0.00	RNE	RNE
0107T 00	Category III	0.00	0.00	RNE	RNE
0108T 00	Category III	0.00	0.00	RNE	RNE
0109T 00	Category III	0.00	0.00	RNE	RNE
0110T 00	Category III	0.00	0.00	RNE	RNE
0163T 00	Category III	0.00	0.00	RNE	RNE
0164T 00	Category III	0.00	0.00	RNE	RNE
0165T 00	Category III	0.00	0.00	RNE	RNE
0174T 00	Category III	0.00	0.00	RNE	RNE
0175T 00	Category III	0.00	0.00	RNE	RNE
0184T 00	Category III	0.00	0.00	RNE	RNE
0191T 00	Category III	0.00	0.00	RNE	RNE
0198T 00	Category III	0.00	0.00	RNE	RNE
0200T 00	Category III	0.00	0.00	RNE	RNE
0201T 00	Category III	0.00	0.00	RNE	RNE
0202T 00	Category III	0.00	0.00	RNE	RNE
0207T 00	Category III	0.00	0.00	RNE	RNE
0208T 00	Category III	0.00	0.00	RNE	RNE
0209T 00	Category III	0.00	0.00	RNE	RNE
0210T 00	Category III	0.00	0.00	RNE	RNE
0211T 00	Category III	0.00	0.00	RNE	RNE
0212T 00	Category III	0.00	0.00	RNE	RNE
0213T 00	Category III	0.00	0.00	RNE	RNE
0214T 00	Category III	0.00	0.00	RNE	RNE
0215T 00	Category III	0.00	0.00	RNE	RNE
0216T 00	Category III	0.00	0.00	RNE	RNE
0217T 00	Category III	0.00	0.00	RNE	RNE
0218T 00	Category III	0.00	0.00	RNE	RNE
0219T 00	Category III	0.00	0.00	RNE	RNE
0220T 00	Category III	0.00	0.00	RNE	RNE
0221T 00	Category III	0.00	0.00	RNE	RNE
0222T 00	Category III	0.00	0.00	RNE	RNE
0232T 00	Category III	0.00	0.00	RNE	RNE
0234T 00	Category III	0.00	0.00	RNE	RNE
0235T 00	Category III	0.00	0.00	RNE	RNE
0236T 00	Category III	0.00	0.00	RNE	RNE
0237T 00	Category III	0.00	0.00	RNE	RNE
0238T 00	Category III	0.00	0.00	RNE	RNE
0253T 00	Category III	0.00	0.00	RNE	RNE
0263T 00	Category III	0.00	0.00	RNE	RNE
0264T 00	Category III	0.00	0.00	RNE	RNE
0265T 00	Category III	0.00	0.00	RNE	RNE
0266T 00	Category III	0.00	0.00	RNE	RNE
0267T 00	Category III	0.00	0.00	RNE	RNE
0268T 00	Category III	0.00	0.00	RNE	RNE
0269T 00	Category III	0.00	0.00	RNE	RNE
0270T 00	Category III	0.00	0.00	RNE	RNE
0271T 00	Category III	0.00	0.00	RNE	RNE
0272T 00	Category III	0.00	0.00	RNE	RNE
0273T 00	Category III	0.00	0.00	RNE	RNE

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
0274T 00	Category III	0.00	0.00	RNE	RNE
0275T 00	Category III	0.00	0.00	RNE	RNE
0278T 00	Category III	0.00	0.00	RNE	RNE
0290T 00	Category III	0.00	0.00	RNE	RNE
0308T 00	Category III	0.00	0.00	RNE	RNE
0312T 00	Category III	0.00	0.00	RNE	RNE
0313T 00	Category III	0.00	0.00	RNE	RNE
0314T 00	Category III	0.00	0.00	RNE	RNE
0315T 00	Category III	0.00	0.00	RNE	RNE
0316T 00	Category III	0.00	0.00	RNE	RNE
0317T 00	Category III	0.00	0.00	RNE	RNE
0329T 00	Category III	0.00	0.00	RNE	RNE
0330T 00	Category III	0.00	0.00	RNE	RNE
0331T 00	Category III	0.00	0.00	RNE	RNE
0332T 00	Category III	0.00	0.00	RNE	RNE
0333T 00	Category III	0.00	0.00	RNE	RNE
0335T 00	Category III	0.00	0.00	RNE	RNE
0338T 00	Category III	0.00	0.00	RNE	RNE
0339T 00	Category III	0.00	0.00	RNE	RNE
0342T 00	Category III	0.00	0.00	RNE	RNE
0345T 00	Category III	0.00	0.00	RNE	RNE
0347T 00	Category III	0.00	0.00	RNE	RNE
0348T 00	Category III	0.00	0.00	RNE	RNE
0349T 00	Category III	0.00	0.00	RNE	RNE
0350T 00	Category III	0.00	0.00	RNE	RNE
0351T 00	Category III	0.00	0.00	RNE	RNE
0352T 00	Category III	0.00	0.00	RNE	RNE
0353T 00	Category III	0.00	0.00	RNE	RNE
0354T 00	Category III	0.00	0.00	RNE	RNE
0355T 00	Category III	0.00	0.00	RNE	RNE
0356T 00	Category III	0.00	0.00	RNE	RNE
0358T 00	Category III	0.00	0.00	RNE	RNE
0362T 00	Category III	0.00	0.00	RNE	RNE
0373T 00	Category III	0.00	0.00	RNE	RNE
0376T 00	Category III	0.00	0.00	RNE	RNE
0378T 00	Category III	0.00	0.00	RNE	RNE
0379T 00	Category III	0.00	0.00	RNE	RNE
0394T 00	Category III	0.00	0.00	RNE	RNE
0395T 00	Category III	0.00	0.00	RNE	RNE
0397T 00	Category III	0.00	0.00	RNE	RNE
0398T 00	Category III	0.00	0.00	RNE	RNE
0402T 00	Category III	0.00	0.00	RNE	RNE
0403T 00	Category III	0.00	0.00	RNE	RNE
0404T 00	Category III	0.00	0.00	RNE	RNE
0408T 00	Category III	0.00	0.00	RNE	RNE
0409T 00	Category III	0.00	0.00	RNE	RNE
0410T 00	Category III	0.00	0.00	RNE	RNE
0411T 00	Category III	0.00	0.00	RNE	RNE
0412T 00	Category III	0.00	0.00	RNE	RNE
0413T 00	Category III	0.00	0.00	RNE	RNE
0414T 00	Category III	0.00	0.00	RNE	RNE
0415T 00	Category III	0.00	0.00	RNE	RNE
0416T 00	Category III	0.00	0.00	RNE	RNE
0417T 00	Category III	0.00	0.00	RNE	RNE
0418T 00	Category III	0.00	0.00	RNE	RNE
0419T 00	Category III	0.00	0.00	RNE	RNE
0420T 00	Category III	0.00	0.00	RNE	RNE
0421T 00	Category III	0.00	0.00	RNE	RNE

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
0422T 00	Category III	0.00	0.00	RNE	RNE
0423T 00	Category III	0.00	0.00	RNE	RNE
0424T 00	Category III	0.00	0.00	RNE	RNE
0425T 00	Category III	0.00	0.00	RNE	RNE
0426T 00	Category III	0.00	0.00	RNE	RNE
0427T 00	Category III	0.00	0.00	RNE	RNE
0428T 00	Category III	0.00	0.00	RNE	RNE
0429T 00	Category III	0.00	0.00	RNE	RNE
0430T 00	Category III	0.00	0.00	RNE	RNE
0431T 00	Category III	0.00	0.00	RNE	RNE
0432T 00	Category III	0.00	0.00	RNE	RNE
0433T 00	Category III	0.00	0.00	RNE	RNE
0434T 00	Category III	0.00	0.00	RNE	RNE
0435T 00	Category III	0.00	0.00	RNE	RNE
0436T 00	Category III	0.00	0.00	RNE	RNE
0437T 00	Category III	0.00	0.00	RNE	RNE
0439T 00	Category III	0.00	0.00	RNE	RNE
0440T 00	Category III	0.00	0.00	RNE	RNE
0441T 00	Category III	0.00	0.00	RNE	RNE
0442T 00	Category III	0.00	0.00	RNE	RNE
0443T 00	Category III	0.00	0.00	RNE	RNE
0444T 00	Category III	0.00	0.00	RNE	RNE
0445T 00	Category III	0.00	0.00	RNE	RNE
0446T 00	Category III	0.00	0.00	RNE	RNE
0447T 00	Category III	0.00	0.00	RNE	RNE
0448T 00	Category III	0.00	0.00	RNE	RNE
0449T 00	Category III	0.00	0.00	RNE	RNE
0450T 00	Category III	0.00	0.00	RNE	RNE
0451T 00	Category III	0.00	0.00	RNE	RNE
0452T 00	Category III	0.00	0.00	RNE	RNE
0453T 00	Category III	0.00	0.00	RNE	RNE
0454T 00	Category III	0.00	0.00	RNE	RNE
0455T 00	Category III	0.00	0.00	RNE	RNE
0456T 00	Category III	0.00	0.00	RNE	RNE
0457T 00	Category III	0.00	0.00	RNE	RNE
0458T 00	Category III	0.00	0.00	RNE	RNE
0459T 00	Category III	0.00	0.00	RNE	RNE
0460T 00	Category III	0.00	0.00	RNE	RNE
0461T 00	Category III	0.00	0.00	RNE	RNE
0462T 00	Category III	0.00	0.00	RNE	RNE
0463T 00	Category III	0.00	0.00	RNE	RNE
0464T 00	Category III	0.00	0.00	RNE	RNE
0464T 00	Category III	0.00	0.00	RNE	RNE
0465T 00	Category III	0.00	0.00	RNE	RNE
0465T 00	Category III	0.00	0.00	RNE	RNE
0466T 00	Category III	0.00	0.00	RNE	RNE
0466T 00	Category III	0.00	0.00	RNE	RNE
0467T 00	Category III	0.00	0.00	RNE	RNE
0467T 00	Category III	0.00	0.00	RNE	RNE
0468T 00	Category III	0.00	0.00	RNE	RNE
0468T 00	Category III	0.00	0.00	RNE	RNE
0469T 00	Category III	0.00	0.00	RNE	RNE
0470T 00	Category III	0.00	0.00	RNE	RNE
0471T 00	Category III	0.00	0.00	RNE	RNE
0472T 00	Category III	0.00	0.00	RNE	RNE
0473T 00	Category III	0.00	0.00	RNE	RNE
0474T 00	Category III	0.00	0.00	RNE	RNE
0475T 00	Category III	0.00	0.00	RNE	RNE

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
0476T 00	Category III	0.00	0.00	RNE	RNE
0477T 00	Category III	0.00	0.00	RNE	RNE
0478T 00	Category III	0.00	0.00	RNE	RNE
0479T 00	Category III	0.00	0.00	RNE	RNE
0480T 00	Category III	0.00	0.00	RNE	RNE
0481T 00	Category III	0.00	0.00	RNE	RNE
0483T 00	Category III	0.00	0.00	RNE	RNE
0484T 00	Category III	0.00	0.00	RNE	RNE
0485T 00	Category III	0.00	0.00	RNE	RNE
0486T 00	Category III	0.00	0.00	RNE	RNE
0487T 00	Category III	0.00	0.00	RNE	RNE
0488T 00	Category III	0.00	0.00	RNE	RNE
0489T 00	Category III	0.00	0.00	RNE	RNE
0490T 00	Category III	0.00	0.00	RNE	RNE
0491T 00	Category III	0.00	0.00	RNE	RNE
0492T 00	Category III	0.00	0.00	RNE	RNE
0493T 00	Category III	0.00	0.00	RNE	RNE
0494T 00	Category III	0.00	0.00	RNE	RNE
0495T 00	Category III	0.00	0.00	RNE	RNE
0496T 00	Category III	0.00	0.00	RNE	RNE
0497T 00	Category III	0.00	0.00	RNE	RNE
0498T 00	Category III	0.00	0.00	RNE	RNE
0499T 00	Category III	0.00	0.00	RNE	RNE
0500T 00	Category III	0.00	0.00	RNE	RNE
0501T 00	Category III	0.00	0.00	RNE	RNE
0502T 00	Category III	0.00	0.00	RNE	RNE
0503T 00	Category III	0.00	0.00	RNE	RNE
0504T 00	Category III	0.00	0.00	RNE	RNE
0505T 00	Category III	0.00	0.00	RNE	RNE
0506T 00	Category III	0.00	0.00	RNE	RNE
0506T 26	Category III	0.00	0.00	RNE	RNE
0506T TC	Category III	0.00	0.00	RNE	RNE
0507T 00	Category III	0.00	0.00	RNE	RNE
0507T 26	Category III	0.00	0.00	RNE	RNE
0507T TC	Category III	0.00	0.00	RNE	RNE
0508T 00	Category III	0.00	0.00	RNE	RNE
0508T 26	Category III	0.00	0.00	RNE	RNE
0508T TC	Category III	0.00	0.00	RNE	RNE
0509T 00	Category III	0.00	0.00	RNE	RNE
0509T 26	Category III	0.00	0.00	RNE	RNE
0509T TC	Category III	0.00	0.00	RNE	RNE
0510T 00	Category III	0.00	0.00	RNE	RNE
0511T 00	Category III	0.00	0.00	RNE	RNE
0512T 00	Category III	0.00	0.00	RNE	RNE
0513T 00	Category III	0.00	0.00	RNE	RNE
0514T 00	Category III	0.00	0.00	RNE	RNE
0515T 00	Category III	0.00	0.00	RNE	RNE
0516T 00	Category III	0.00	0.00	RNE	RNE
0517T 00	Category III	0.00	0.00	RNE	RNE
0518T 00	Category III	0.00	0.00	RNE	RNE
0519T 00	Category III	0.00	0.00	RNE	RNE
0520T 00	Category III	0.00	0.00	RNE	RNE
0521T 00	Category III	0.00	0.00	RNE	RNE
0521T 26	Category III	0.00	0.00	RNE	RNE
0521T TC	Category III	0.00	0.00	RNE	RNE
0522T 00	Category III	0.00	0.00	RNE	RNE
0522T 26	Category III	0.00	0.00	RNE	RNE
0522T TC	Category III	0.00	0.00	RNE	RNE

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
0523T 00	Category III	0.00	0.00	RNE	RNE
0524T 00	Category III	0.00	0.00	RNE	RNE
0525T 00	Category III	0.00	0.00	RNE	RNE
0526T 00	Category III	0.00	0.00	RNE	RNE
0527T 00	Category III	0.00	0.00	RNE	RNE
0528T 00	Category III	0.00	0.00	RNE	RNE
0528T 26	Category III	0.00	0.00	RNE	RNE
0528T TC	Category III	0.00	0.00	RNE	RNE
0529T 00	Category III	0.00	0.00	RNE	RNE
0529T 26	Category III	0.00	0.00	RNE	RNE
0529T TC	Category III	0.00	0.00	RNE	RNE
0530T 00	Category III	0.00	0.00	RNE	RNE
0531T 00	Category III	0.00	0.00	RNE	RNE
0532T 00	Category III	0.00	0.00	RNE	RNE
0533T 00	Category III	0.00	0.00	RNE	RNE
0533T 26	Category III	0.00	0.00	RNE	RNE
0533T TC	Category III	0.00	0.00	RNE	RNE
0534T 00	Category III	0.00	0.00	RNE	RNE
0534T 26	Category III	0.00	0.00	RNE	RNE
0534T TC	Category III	0.00	0.00	RNE	RNE
0535T 00	Category III	0.00	0.00	RNE	RNE
0535T 26	Category III	0.00	0.00	RNE	RNE
0535T TC	Category III	0.00	0.00	RNE	RNE
0536T 00	Category III	0.00	0.00	RNE	RNE
0536T 26	Category III	0.00	0.00	RNE	RNE
0536T TC	Category III	0.00	0.00	RNE	RNE
0537T 00	Category III	0.00	0.00	RNE	RNE
0538T 00	Category III	0.00	0.00	RNE	RNE
0539T 00	Category III	0.00	0.00	RNE	RNE
0540T 00	Category III	0.00	0.00	RNE	RNE
0541T 00	Category III	0.00	0.00	RNE	RNE
0542T 00	Category III	0.00	0.00	RNE	RNE
0543T 00	Category III	0.00	0.00	RNE	RNE
0544T 00	Category III	0.00	0.00	RNE	RNE
0545T 00	Category III	0.00	0.00	RNE	RNE
0546T 00	Category III	0.00	0.00	RNE	RNE
0547T 00	Category III	0.00	0.00	RNE	RNE
0548T 00	Category III	0.00	0.00	RNE	RNE
0549T 00	Category III	0.00	0.00	RNE	RNE
0550T 00	Category III	0.00	0.00	RNE	RNE
0551T 00	Category III	0.00	0.00	RNE	RNE
0552T 00	Category III	0.00	0.00	RNE	RNE
0553T 00	Category III	0.00	0.00	RNE	RNE
0554T 00	Category III	0.00	0.00	RNE	RNE
0555T 00	Category III	0.00	0.00	RNE	RNE
0556T 00	Category III	0.00	0.00	RNE	RNE
0557T 00	Category III	0.00	0.00	RNE	RNE
0558T 00	Category III	0.00	0.00	RNE	RNE
0559T 00	Category III	0.00	0.00	RNE	RNE
0560T 00	Category III	0.00	0.00	RNE	RNE
0561T 00	Category III	0.00	0.00	RNE	RNE
0562T 00	Category III	0.00	0.00	RNE	RNE
0563T 00	Category III	0.00	0.00	RNE	RNE
0564T 00	Category III	0.00	0.00	RNE	RNE
0565T 00	Category III	0.00	0.00	RNE	RNE
0566T 00	Category III	0.00	0.00	RNE	RNE
0567T 00	Category III	0.00	0.00	RNE	RNE
0568T 00	Category III	0.00	0.00	RNE	RNE

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
0569T 00	Category III	0.00	0.00	RNE	RNE
0570T 00	Category III	0.00	0.00	RNE	RNE
0571T 00	Category III	0.00	0.00	RNE	RNE
0572T 00	Category III	0.00	0.00	RNE	RNE
0573T 00	Category III	0.00	0.00	RNE	RNE
0574T 00	Category III	0.00	0.00	RNE	RNE
0575T 00	Category III	0.00	0.00	RNE	RNE
0576T 00	Category III	0.00	0.00	RNE	RNE
0577T 00	Category III	0.00	0.00	RNE	RNE
0578T 00	Category III	0.00	0.00	RNE	RNE
0579T 00	Category III	0.00	0.00	RNE	RNE
0580T 00	Category III	0.00	0.00	RNE	RNE
0581T 00	Category III	0.00	0.00	RNE	RNE
0582T 00	Category III	0.00	0.00	RNE	RNE
0583T 00	Category III	0.00	0.00	RNE	RNE
0584T 00	Category III	0.00	0.00	RNE	RNE
0585T 00	Category III	0.00	0.00	RNE	RNE
0586T 00	Category III	0.00	0.00	RNE	RNE
0587T 00	Category III	0.00	0.00	RNE	RNE
0588T 00	Category III	0.00	0.00	RNE	RNE
0589T 00	Category III	0.00	0.00	RNE	RNE
0590T 00	Category III	0.00	0.00	RNE	RNE
0591T 00	Category III	0.00	0.00	RNE	RNE
0592T 00	Category III	0.00	0.00	RNE	RNE
0593T 00	Category III	0.00	0.00	RNE	RNE
0594T 00	Category III	0.00	0.00	RNE	RNE
0596T 00	Category III	0.00	0.00	RNE	RNE
0597T 00	Category III	0.00	0.00	RNE	RNE
0598T 00	Category III	0.00	0.00	RNE	RNE
0599T 00	Category III	0.00	0.00	RNE	RNE
0600T 00	Category III	0.00	0.00	RNE	RNE
0601T 00	Category III	0.00	0.00	RNE	RNE
0602T 00	Category III	0.00	0.00	RNE	RNE
0603T 00	Category III	0.00	0.00	RNE	RNE
0604T 00	Category III	0.00	0.00	RNE	RNE
0605T 00	Category III	0.00	0.00	RNE	RNE
0606T 00	Category III	0.00	0.00	RNE	RNE
0607T 00	Category III	0.00	0.00	RNE	RNE
0608T 00	Category III	0.00	0.00	RNE	RNE
0609T 00	Category III	0.00	0.00	RNE	RNE
0610T 00	Category III	0.00	0.00	RNE	RNE
0611T 00	Category III	0.00	0.00	RNE	RNE
0612T 00	Category III	0.00	0.00	RNE	RNE
0613T 00	Category III	0.00	0.00	RNE	RNE
0614T 00	Category III	0.00	0.00	RNE	RNE
0615T 00	Category III	0.00	0.00	RNE	RNE
0616T 00	Category III	0.00	0.00	RNE	RNE
0617T 00	Category III	0.00	0.00	RNE	RNE
0618T 00	Category III	0.00	0.00	RNE	RNE
0619T 00	Category III	0.00	0.00	RNE	RNE
0620T 00	Category III	0.00	0.00	RNE	RNE
0621T 00	Category III	0.00	0.00	RNE	RNE
0622T 00	Category III	0.00	0.00	RNE	RNE
0623T 00	Category III	0.00	0.00	RNE	RNE
0624T 00	Category III	0.00	0.00	RNE	RNE
0625T 00	Category III	0.00	0.00	RNE	RNE
0626T 00	Category III	0.00	0.00	RNE	RNE
0627T 00	Category III	0.00	0.00	RNE	RNE

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

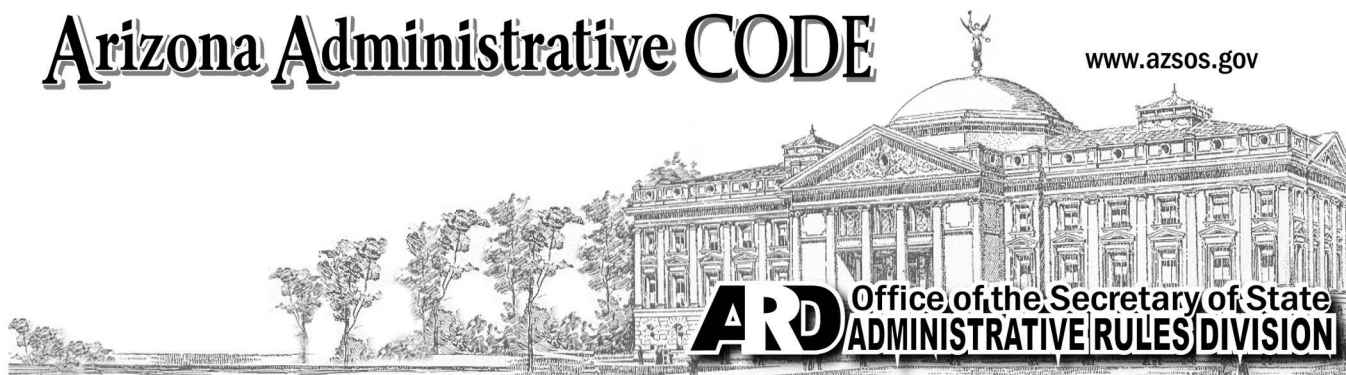
CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
0628T 00	Category III	0.00	0.00	RNE	RNE
0629T 00	Category III	0.00	0.00	RNE	RNE
0630T 00	Category III	0.00	0.00	RNE	RNE
0631T 00	Category III	0.00	0.00	RNE	RNE
0632T 00	Category III	0.00	0.00	RNE	RNE
0633T 00	Category III	0.00	0.00	RNE	RNE
0634T 00	Category III	0.00	0.00	RNE	RNE
0635T 00	Category III	0.00	0.00	RNE	RNE
0636T 00	Category III	0.00	0.00	RNE	RNE
0637T 00	Category III	0.00	0.00	RNE	RNE
0638T 00	Category III	0.00	0.00	RNE	RNE
0639T 00	Category III	0.00	0.00	RNE	RNE

Historical Note

New Appendix A, Category III Codes 2019-2020 made by exempt rulemaking at 25 A.A.R. 2624, effective October 1, 2019; Appendix A, Category III Codes 2019-2020 will remain in effect through September 30, 2020 (Supp. 19-3). Appendix A, Category III Codes 2019-2020 repealed; new Appendix A, Category III Codes 2020-2021 made by exempt rulemaking at 26 A.A.R. 2119, effective October 1, 2020 (Supp. 20- 3). Appendix A, Category III Codes 2020-2021 repealed; new Appendix A, Category III Codes 2021-2022 made by exempt rulemaking at 27 A.A.R. 1685, effective October 1, 2021 (Supp. 21-3). Appendix A, Category III Codes 2021-2022 repealed; new Appendix A, Category III Codes 2022-2023 made by exempt rulemaking at 28 A.A.R. 2645 (October 7, 2022), effective October 1, 2022 (Supp. 22-3).

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20 A.A.C. 6

Supp. 23-1

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE
CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS - INSURANCE
DIVISION

The table of contents on page one contains links to the referenced page numbers in this Chapter.
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of
January 1, 2023 through March 31, 2023

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Questions about these rules? Contact:

Department: Department of Insurance and Financial Institutions
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Telephone: (602) 364-3476
[Email:](#) mary.kosinski@difi.az.gov

The release of this Chapter in Supp. 23-1 replaces Supp. 22-4, 1-171 pages.

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, www.azsos.gov under Services-> Legislative Filings.

EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at www.azsos.gov/rules, click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

PERSONAL USE/COMMERCIAL USE

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Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.

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Administrative Rules Division

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TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE**CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS -
INSURANCE DIVISION**

Authority: A.R.S. § 20-101 et seq.

Supp. 23-1**CHAPTER TABLE OF CONTENTS**

Editor's Note: The name of the Arizona Department of Insurance was changed to the Department of Insurance and Financial Institutions - Insurance Division under Laws 2019, Ch. 252, effective July 1, 2020 (Supp. 22-2).

Editor's Note: 20 A.A.C. 6, consisting of R20-6-101 through R20-6-159, R20-6-201 through R20-6-218, R20-6-301 through R20-6-308, R20-6-401 through R20-6-409, R20-6-501, R20-6-601 through R20-6-607, R20-6-701 through R20-6-709, R20-6-801 through R20-6-802, R20-6-901, R20-6-1001 through R20-6-1016, R20-6-1101 through R20-6-1120, R20-6-1201 through R20-6-1205, R20-6-1401 through R20-6-1408, R20-6-1601 through R20-6-1607, and R20-6-1701 through R20-6-1704 recodified from 4 A.A.C. 14, consisting of R4-14-101 through R4-14-159, R4-14-301 through R4-14-308, R4-14-401 through R4-14-409, R4-14-501, R4-14-601 through R4-14-607, R4-14-701 through R4-14-709, R4-201 through R4-14-218, R4-14-801 through R4-14-802, R4-14-901, R4-14-1001 through R4-14-1016, R4-14-1101 through R4-14-1120, R4-14-1201 through R4-14-1205, R4-14-1401 through R4-14-1408, R4-14-1601 through R4-14-1607, and R4-14-1701 through R4-14-1704, pursuant to R1-1-102 (Supp. 95-1).

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Article 11, consisting of Sections R20-6-1101 through R20-6-1121 and Appendices A through F, repealed; new Section R20-6-1101 made by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Article 11, consisting of Sections R4-14-1101 through R4-14-1120 and Appendices A through E, adopted again by emergency effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1).

Article 11, consisting of Sections R4-14-1101 through R4-14-1120 and Appendices A through E, adopted by emergency effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). R20-6-1101 through R20-6-1120 recodified from

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Article 16, consisting of Sections R20-6-1601 through R20-6-1608, renumbered to Article 16, Part 1, R20-6A1601 through R20-6A1608; Article 16, consisting of Sections R20-6-1610 through R20-6-1612, renumbered to Article 16, Part 2; by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

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ARTICLE 1. RULES OF PRACTICE AND PROCEDURE BEFORE THE DIRECTOR**R20-6-101. Scope of Article; Definitions****A. Scope.**

1. Administrative Hearings. This Article and Title 20 of the Arizona Revised Statutes govern administrative hearings before the Department. The Department shall use the authority of A.R.S. Title 41, Chapter 6, Article 10, the Office of Administrative Hearings' procedural rules, and this Article to govern the initiation and conduct of administrative hearings. In an administrative hearing, special procedural requirements in state statute or another Section in this Article shall also govern the proceedings unless the requirements are inconsistent with either A.R.S. Title 41, Chapter 6, Article 10, the Office of Administrative Hearings' rules or this Article.
2. Director's Hearings. Director's Hearings are governed by this Article and Title 20 of the Arizona Revised Statutes.
3. Rulemaking and Investigative Proceedings. Except as otherwise provided in Section R20-6-160 for rulemaking petitions, this Article does not apply to rulemaking or investigative proceedings before the Director.
4. Arizona Rules of Civil Procedure. Unless expressly applicable by rule or statute, the Arizona Rules of Civil Procedure do not apply to administrative or Director's hearings.

B. Definitions. In addition to the definitions provided in A.R.S. §§ 41-1001 and 41-1092, the following terms apply to this Article:

1. "Administrative Hearing" means an appealable agency action as defined by A.R.S. § 41-1092(3) or a contested case as defined by A.R.S. § 41-1001(5) subject to A.R.S. § 20-161 and A.R.S. Title 41, Chapter 6, Article 10.
2. "Attorney General" means the Attorney General of Arizona, and the Attorney General's assistants or special agents.
3. "Department" means the Arizona Department of Insurance and Financial Institutions, Division of Insurance.
4. "Director" has the meaning stated at A.R.S. § 20-102 or a Hearing Officer or any deputy, assistant, or examiner of the Director acting in the Director's name in accordance with A.R.S. § 20-150.
5. "Director's Hearing" means a hearing required by Title 20 to be conducted by the Director that is not an administrative hearing. A Director's hearing is not subject to the Arizona Open Meeting law. Director's hearings are required for, but not limited to, the following:
 - a. Taking comments to determine whether the cooperation among rating organizations and insurers is unfair or unreasonable or otherwise inconsistent with the provisions of Title 20 under A.R.S. § 20-365;
 - b. Taking comments to determine whether a reasonable degree of price competition exists at the consumer level with respect to a particular class of business or to determine an allowable percentage of increase in a proposed rate level for a particular line, subline, or class of business under A.R.S. § 20-383(B);
 - c. Taking comments to exempt rate filings or to find that a particular market is noncompetitive for purposes of rate filing under A.R.S. §§ 20-385(F) and (G);
 - d. Taking comments to determine recognized surplus lines under A.R.S. § 20-409;

- e. Taking comments regarding acquisitions within a holding company system if the acquisition would require the approval of other states under A.R.S. § 20-481.07(G);
 - f. Taking comments to establish criteria for third parties who are eligible to provide credit enhancement for separate accounts and to accept assets that are pledged under A.R.S. § 20-536.01(C);
 - g. Taking comments to prescribe standards to allow investments in separate accounts to exceed established limits under A.R.S. § 20-536.01(D);
 - h. Taking comments in order to prescribe an investment grade rating, to recognize rating agencies for purposes of investment, or to prescribe standards by which obligations of insurers who have not received an investment grade rating may be eligible for investment under A.R.S. §§ 20-544 and 20-545;
 - i. Taking comments from parties affected by a proposed corporate acquisition, merger or consolidation of title insurers under A.R.S. §§ 20-1576(A)(1) and 20-1577(A);
 - j. Taking comments to establish a loss ratio standard for credit property and credit unemployment insurance under A.R.S. § 10-1621.05(B);
 - k. Taking comments for the purpose of exempting certain forms from the application of Title 20, Chapter 6, Article 14: Cancellation or Non-Renewal of Commercial Insurance under A.R.S. § 20-1671(12); and
 - l. Taking comments to establish prima facie rates for credit life and credit disability insurance under Section R20-6-604.03(A).
6. "Hearing Officer" means a person appointed by the Director to conduct a Director's hearing.
 7. "Party" has the meaning prescribed at A.R.S. § 41-1001(16) and includes any person or entity subject to the jurisdiction of the Department under A.R.S. Title 20.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-101 recodified from R4-14-101 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 28 A.A.R. 3626 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

R20-6-102. Appearance and Practice before the Director for Administrative and Director's Hearings

- A.** A party may appear in their own behalf or through counsel. An insurer may appear through legal counsel or through a duly authorized officer of the corporation.
- B.** When an attorney other than the Attorney General appears or intends to appear before the Director or the Department, they shall promptly disclose their name and contact information and the name and contact information of the person on whose behalf they intend to appear.
- C.** Conduct at any Director's hearing which, in the discretion of the Director or Hearing Officer is deemed contemptuous shall be grounds for exclusion from the hearing. Contemptuous conduct shall include willful disruption or obstruction of any Director's hearing, or any other willful conduct during any Director's hearing which lessens the dignity or authority of the Director or Hearing Officer.
- D.** Notice of a Director's Hearing is subject to Title 20 and shall contain at a minimum:

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1. The subject matter on which the Director intends to take comments including the specific statutory sections authorizing the Director to conduct the hearing;
 2. The date, time and place of the Director's hearing;
 3. The guidelines for interested parties to submit comments to the Director and to participate in the hearing; and
 4. Any other information the Director deems appropriate.
- E. Notice of a Director's Hearing shall be posted on the Department's website and in compliance with A.R.S. § 38-431.02. The Director may additionally notify interested persons as the Director deems appropriate.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-102 recodified from R4-14-102 (Supp. 95-1). Amended by final rulemaking at 28 A.A.R. 3626 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

R20-6-103. Filing; Service

- A. A document filed by a party with the Department is filed on the date it is received by the Department as established by the Department's earliest stamped date on the face of the document or by some other method of affixing a received date by the Department.
- B. If a party is represented by an attorney, service is effectuated by service upon the attorney unless additional service upon the represented party is required by an administrative law judge or the Department.
- C. A document is served upon a party as provided for under A.R.S. § 41-1092.04 and Section R2-19-108. A party effectuating service is responsible for producing proof of service if requested by the Department.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-103 recodified from R4-14-103 (Supp. 95-1). Amended by final rulemaking at 28 A.A.R. 3626 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

R20-6-104. Expired**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-104 recodified from R4-14-104 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-105. Expired**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-105 recodified from R4-14-105 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-106. Answer to Notice of an Administrative Hearing

- A. The Department may, in a notice of hearing, direct one or more parties to file a written answer to the allegations contained in the notice of hearing. Even if not directed to do so, any party to the proceeding may file an answer.
- B. A party directed to file an answer shall do so within 20 days after issuance of a notice of hearing, unless the notice of hearing states a different period for the answer. The Department may require any party to answer, in a reasonable time, amendments to the assertions in the notice made after service of the original notice.
- C. An answer filed under this Section shall briefly state the party's position or defense to the proceeding and shall specifi-

cally admit or deny each of the allegations in the notice of hearing. An answering party who does not have, or cannot easily obtain, knowledge or information sufficient to admit or deny an allegation shall state that inability which shall have the effect of a denial. Any allegation not denied is admitted. A party who intends to deny only a part of an allegation shall expressly admit as much of that allegation as is true and shall deny the remainder.

- D. A party who fails to file an answer required by this Section within the time allowed is in default. The Director may resolve the proceeding against the defaulting party. In doing so, the Director may regard any allegations in the notice of hearing as admitted by the defaulting party.

- E. Defenses not raised in the answer are waived.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-106 recodified from R4-14-106 (Supp. 95-1). Amended by final rulemaking at 28 A.A.R. 3626 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

R20-6-107. Expired**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-107 recodified from R4-14-107 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-108. Expired**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-108 recodified from R4-14-108 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-109. Expired**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-109 recodified from R4-14-109 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-110. Expired**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-110 recodified from R4-14-110 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-111. Expired**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-111 recodified from R4-14-111 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 3374, effective May 31, 2016 (Supp. 16-4).

R20-6-112. Expired**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-112 recodified from R4-14-112 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 3374, effective May 31, 2016 (Supp. 16-4).

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R20-6-113. Expired**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-113 recodified from R4-14-113 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-114. Request for Rehearing or Review

- A. Any party aggrieved by an administrative decision may file with the Director, within time limits and other procedural guidelines contained in A.R.S. § 41-1092.09, a written motion for a rehearing or review of the decision specifying the particular reason for the request.
- B. A party filing a motion under this Section may amend the motion at any time before a response to the motion is filed. An amended motion tolls the time for filing a response and the time for rendering a decision on the motion.
- C. A request for rehearing or review which is not timely filed is deemed waived for the purpose of judicial review.
- D. A motion for rehearing shall specify which of the grounds listed in subsection (G) it is based upon and shall set forth the specific facts and laws in support of the motion. A motion may cite relevant portions of testimony from the hearing if a transcript is provided with the motion and may cite hearing exhibits by reference to the exhibit number. The motion shall specify the relief sought by the request, such as a different finding of fact, conclusion of law or order and may seek multiple forms of relief in the alternative. When a motion for rehearing or review is based on an affidavit, the moving party shall attach the affidavit to the motion.
- E. A party may file a separate request for a stay of the Director's decision pursuant to A.R.S. § 20-162(B). Filing a stay request or a motion for rehearing does not stay an order filed by the Director. The Director may stay an order pending the resolution of a motion for rehearing or review.
- F. Each party served with a motion for rehearing or review shall be permitted to file a written response within 15 days after the motion has been filed. Affidavits may be attached to and filed with a response. A response may cite relevant portions of testimony from the hearing if a transcript is provided with the response and may cite hearing exhibits by reference to the exhibit number. The Director has the discretion to hear oral argument to consider a request for rehearing or review.
- G. The Director may grant a motion for rehearing or review for any of the following causes:
 1. Irregularity in the proceedings before the Department, in any order, or any abuse of discretion that deprives the moving party of a fair hearing;
 2. Misconduct by the Department, the administrative law judge, or the prevailing party;
 3. Accident or surprise that could not have been prevented by ordinary care;
 4. Newly discovered material evidence that could not reasonably have been discovered and produced at the original hearing;
 5. Excessive or insufficient penalties;
 6. Error in admitting or rejecting evidence or other legal errors occurring at the hearing; and
 7. The decision is not justified by the evidence or is contrary to law.
- H. The Director may affirm or modify the decision or grant a rehearing as to all or any of the parties and on all or part of the issues for any reason listed in subsection (G). An order grant-

ing a rehearing shall specify the reason for granting the rehearing, and the rehearing shall cover only those matters specified.

- I. The Director, within the time for filing a motion for rehearing, may without a motion for rehearing, order a rehearing for any reason that would allow the granting of a motion for rehearing by a party. The order for rehearing, granted without a motion, shall specify the reason for granting the rehearing.
- J. The Director may grant a motion for rehearing, timely served, for a reason not stated in the motion. The order for rehearing, granted for a reason not stated in the motion, shall specify the reason for granting the rehearing.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-114 recodified from R4-14-114 (Supp. 95-1). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 28 A.A.R. 3626 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

R20-6-115. Repealed**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-115 recodified from R4-14-115 (Supp. 95-1). Amended effective June 15, 1998 (Supp. 98-2). Repealed by final rulemaking at 28 A.A.R. 3626 (November 25, 2022), effective January 6, 2023 (Supp. 22-4).

- R20-6-116. Reserved**
- R20-6-117. Reserved**
- R20-6-118. Reserved**
- R20-6-119. Reserved**
- R20-6-120. Reserved**
- R20-6-121. Reserved**
- R20-6-122. Reserved**
- R20-6-123. Reserved**
- R20-6-124. Reserved**
- R20-6-125. Reserved**
- R20-6-126. Reserved**
- R20-6-127. Reserved**
- R20-6-128. Reserved**
- R20-6-129. Reserved**
- R20-6-130. Reserved**
- R20-6-131. Reserved**
- R20-6-132. Reserved**
- R20-6-133. Reserved**
- R20-6-134. Reserved**
- R20-6-135. Reserved**
- R20-6-136. Reserved**
- R20-6-137. Reserved**
- R20-6-138. Reserved**
- R20-6-139. Reserved**
- R20-6-140. Reserved**
- R20-6-141. Reserved**

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- R20-6-142. Reserved
- R20-6-143. Reserved
- R20-6-144. Reserved
- R20-6-145. Reserved
- R20-6-146. Reserved
- R20-6-147. Reserved
- R20-6-148. Reserved
- R20-6-149. Reserved
- R20-6-150. Reserved
- R20-6-151. Reserved
- R20-6-152. Reserved
- R20-6-153. Reserved
- R20-6-154. Reserved
- R20-6-155. Reserved
- R20-6-156. Reserved
- R20-6-157. Reserved
- R20-6-158. Reserved
- R20-6-159. Repealed

Historical Note

Adopted effective February 17, 1977 (Supp. 77-1). R20-6-159 recodified from R4-14-159 (Supp. 95-1). Repealed effective June 15, 1998 (Supp. 98-2).

R20-6-160. Petition for Rulemaking Action

- A. The following definitions apply in this Section.
 - 1. "Petitioner" means a person who petitions the Department for Rulemaking action as authorized under A.R.S. § 41-1033(A).
 - 2. "Rule" has the meaning stated at A.R.S. § 41-1001 and is enforceable by the Department.
 - 3. "Rulemaking action" means the process for formulation and finalization of a new rule, or amendment or repeal of an existing rule.
 - 4. "Substantive Policy Statement" has the meaning stated at A.R.S. § 41-1001, is advisory only, and is not enforceable by the Department.
- B. Any person may petition the Department under A.R.S. § 41-1033(A) to either:
 - 1. Make, amend, or repeal a final Rule;
 - 2. Review an existing agency practice or Substantive Policy Statement that the Petitioner alleges to constitute a Rule.
- C. A person who files a petition pursuant to A.R.S. § 41-1033(A), shall include the following information in the petition:
 - 1. The Petitioner's name and contact information;
 - 2. The name and address of any organization the Petitioner represents;
 - 3. Whether the Petitioner is petitioning the Department to:
 - a. Make, amend, or repeal a final Rule; or
 - b. Review an existing agency practice or Substantive Policy Statement that the Petitioner alleges to constitute a Rule;
 - 4. A detailed explanation of Petitioner's basis for submitting the petition;
 - 5. If the Petitioner is petitioning the Department to make a Rule, the language of the proposed new Section and the specific authority for the requested Rulemaking action;

- 6. If the Petitioner is petitioning the Department to amend an existing Rule, a citation to the existing Section to be amended, the language of the proposed Rule amendment, and the specific authority for the requested Rulemaking action;
- 7. If the Petitioner is petitioning the Department to repeal an existing Rule, a citation to the existing Section or subsection to be repealed, and an explanation of why the Rule should be repealed including, if applicable, how the Rule does not meet the requirements of A.R.S. § 41-1030;
- 8. If the Petitioner is petitioning the Department to review an existing agency practice that the Petitioner alleges to constitute a Rule, a description of the Department's practice, an explanation of how the Department's practice constitutes a Rule being enforced by the Department, the language of the proposed new Rule, and the specific authority for the requested Rulemaking action;
- 9. If the Petitioner is petitioning the Department to review a Substantive Policy Statement that the Petitioner alleges to constitute a Rule, a citation to the Substantive Policy Statement, an explanation of how the Substantive Policy Statement is being enforced by the Department as a Rule, the language of the proposed new Rule, and the specific authority for the requested Rulemaking action; and
- 10. The Petitioner's dated signature.
- D. The petitioner may submit additional supporting information, including:
 - 1. Statistical data; and
 - 2. A list of other persons and entities likely to be affected by the proposed Rulemaking action, with an explanation of the likely effects.
- E. Within 60 days of the date the Department receives the petition, the Department shall send the Petitioner a written decision indicating whether the Department is denying the petition or will initiate the requested Rulemaking action, with the reasons for the decision.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1). Section heading corrected at Department Request, Office File No. M11-401, filed October 27, 2011 (Supp. 11-3). Amended by final rulemaking at 28 A.A.R. 3626 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

ARTICLE 2. TRANSACTION OF INSURANCE**R20-6-201. Advertisements of Health**

- A. Definitions. The following definitions apply to this Section and to R20-6-201.01, R20-6-201.02, and R20-6-203:
 - 1. "Advertisement" means materials and information used by an insurer to generate insurance business.
 - a. Advertisement includes the following information:
 - i. Printed and published material, audio visual material, or other forms of electronic communication that an insurer uses or displays in direct mail, newspapers, magazines, radio, television, billboards, Internet web sites, and similar media to inform the public about the insurer or its products;
 - ii. Descriptive literature and sales aids an insurer issues or releases for presentation to members of the public, including circulars, leaflets, booklets, depictions, illustrations, and form letters;

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- iii. Prepared sales talks and presentations and material for use by an insurer or prepared by an insurer for use by authorized producers; and
- iv. Material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements;
- b. "Advertisement" does not include the following:
 - i. Material used solely for training and educating an insurer's employees or producers;
 - ii. Material used in-house by insurers;
 - iii. Communications within an insurer's own organization not intended for dissemination to the public;
 - iv. Individual communications with current policy holders regarding a member's personal information other than material urging the policyholders to increase or expand coverages;
 - v. Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;
 - vi. Court-approved material ordered by a court to be disseminated to policyholders;
 - vii. Material in connection with promotion or sponsorship of a charitable event in which only the name of the insurer is displayed;
 - viii. A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged. The announcement shall clearly indicate that it is preliminary to the issuance of a booklet and that does not describe the specific benefits under the contract or program nor the advantages as to the purchase of the contract or program;
 - ix. A general announcement by the sponsor that endorses the program;
 - x. Health and wellness material with general health and wellness information; or
 - xi. Press releases and news releases not intended to generate business.
- 2. "Disability insurance" has the same meaning prescribed in A.R.S. § 20-253.
- 3. "Elimination period" means the time between the date a loss occurs and the date that benefits begin to accrue for that loss.
- 4. "Exclusion" means a policy term stating a risk that an insurer has not assumed.
- 5. "Health insurance" means:
 - a. Disability insurance;
 - b. Insurance provided by a service corporation regulated under A.R.S. § 20-821 et seq.;
 - c. Insurance provided by a prepaid dental plan organization regulated under A.R.S. § 20-1001 et seq.; and
 - d. Insurance provided by a health care services organization regulated under A.R.S. § 20-1051 et seq.
- 6. "Insurance administrator" or "administrator" has the meaning prescribed in A.R.S. § 20-485(A)(1).
- 7. "Insurer" has the same meaning prescribed in A.R.S. § 20-104.
- 8. "Limitation" means a policy term, other than an exclusion or reduction, that decreases the risk assumed by the insurer or the insurer's obligation to provide benefits.
- 9. "Person" has the meaning in A.R.S. § 20-105.
- 10. "Policy" means any plan, certificate, contract, agreement, statement of coverage, evidence of coverage, subscription contract, membership coverage, rider, or endorsement that provides disability benefits, health insurance, medical, surgical or hospital expense benefits, long-term care benefits, or Medicare supplement benefits in the form of a cash indemnity, reimbursement, or service.
- 11. "Reduction" means a policy term that reduces the amount of an insured's benefits. A reduction means that the insurer has assumed the risk of a particular loss, but the amount or period of the insurer's coverage is less than what the insurer would have paid for the loss without the reduction.
- 12. "Spokesperson" means a person making a testimonial about or an endorsement of an insurer's product who:
 - a. Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or independent contractor;
 - b. Has been formed by the insurer, is owned or controlled by the insurer or its employees, or is a person who owns or controls an insurer;
 - c. Is in a policy-making position and affiliated with the insurer in any capacity described in subsections (a) or (b); or
 - d. Is directly or indirectly compensated for making the testimonial or endorsement.
- B. Scope.**
 - 1. This Section applies to all advertisements for health insurance.
 - 2. This Section applies to the conduct of insurers, producers, and third-party administrators.
- C. General requirements.** Insurers, producers, and third-party administrators shall ensure that health insurance advertisements meet the requirements of this Section.
 - 1. Advertisements shall be truthful and not misleading. The insurer shall not use words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology.
 - 2. An advertisement shall not omit information or use words, phrases, statements, references, or illustrations if the omission of information or use of words, phrases, statements, references, or illustrations may mislead or deceive purchasers or prospective purchasers.
 - 3. The words and phrases used to describe a policy shall accurately describe the benefits of the policy and not exaggerate any benefit through the use of phrases such as "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will pay your hospital and surgical bills" or "this policy will replace your income," or similar words and phrases.
 - 4. If a policy covers only one disease or a list of specified diseases, any advertisement for the policy shall not imply coverage beyond the specified diseases.
 - 5. If a policy pays varying amounts for the same loss occurring under different conditions or pays benefits only when a loss occurs under certain conditions, any advertisement for the policy shall disclose the limited conditions.
 - 6. If an advertisement specifies payment of a particular dollar amount for hospital room and board expenses, the advertisement shall also include the maximum daily benefit and the maximum time limit for which those expenses are covered.

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7. An advertisement that refers to any dollar amount, period of time for which a benefit is payable, cost of policy, or specific policy benefit or the loss for which a benefit is payable shall also disclose any related exclusions, reductions, and limitations without which the advertisement would have the capacity and tendency to mislead or deceive.
 8. An advertisement covered by subsection (C)(7) shall disclose the existence of a waiting period if a policy contains a period between the effective date of the policy and the effective date of coverage under the policy. The advertisement shall disclose the existence of an elimination period.
 9. An advertisement shall disclose any exclusion, reduction, or limitation applicable to a pre-existing condition; however, an insurer is not required to make disclosure in an advertisement that does not reference specific product information, benefit level, or dollar amounts.
 10. If a policy has an exclusion, reduction, or limitation applicable to a preexisting condition, an advertisement shall not state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim and shall not use the phrase "no medical examination required" or other similar phrase.
 11. If an advertisement refers to renewability, cancellation, or termination of a policy, or states or illustrates time or age in connection with eligibility of applicants or continuation of the policy, the advertisement shall disclose the provisions relating to renewability, cancellation, and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner that does not minimize or obscure the qualifying conditions.
 12. An advertisement shall not make any offer prohibited under A.R.S. § 20-452(4).
 13. An advertisement shall not advertise any health insurance policy or form that has not been approved by the Department, unless the policy or form being advertised is exempt from approval or not subject to approval by order or statute.
 14. An advertisement shall not state or imply that a product being offered is an introductory, special, or initial offer that will entitle the applicant to receive advantages not described in the policy by accepting the offer.
 15. An advertisement designed to produce leads either by use of a coupon, a request to write or call the company, or subsequent advertisement before contact, shall disclose that a producer may contact the potential applicant.
- D.** Method of disclosure of required information. If an insurer is required by law to disclose particular information, the information shall be conspicuous and in close proximity to the statements to which the information relates, or under a prominent caption so that the required disclosure is not minimized, obscured, presented in an ambiguous fashion, or intermingled with the content of the advertisement.
- E.** Testimonials.
1. Testimonials used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer shall provide the Department with the full name of the author and a copy of the full testimonial if the advertisement is filed with the Department or requested by the Department. If an insurer uses a testimonial, the insurer adopts the statements in the testimonial as the insurer's own statements. If a testimonial or endorsement is used more than one year after it is given, the insurer shall obtain a written confirmation from the author that the testimonial represents the current opinion of the author.
 2. The insurer shall disclose that a spokesperson has a financial interest or the proprietary or representative capacity of a spokesperson in an advertisement in the introductory portion of a testimonial or endorsement in the same form and with equal prominence as the endorsement. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the insurer shall disclose that fact in the advertisement by language that states, "Paid Endorsement," or words of similar import in type, style, and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. For television or radio advertising, the insurer shall place the required disclosure prominently in the introductory portion of the advertisement.
- F.** Statistics. An advertisement with information on the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use facts that are irrelevant to the sale of insurance and shall accurately reflect all of the relevant facts specific to the advertised policy or insurer. An advertisement shall not state or imply that statistics are derived from the policy being advertised unless that is true. The insurer shall identify in the advertisement the source of any statistics used.
- G.** Inspection of policy. An offer in an advertisement of free inspection of a policy or offer of a premium refund does not cure misleading or deceptive statements in the advertisement.
- H.** Identification of plan or number of policies.
1. If an advertisement offers a choice in the amount of benefits the advertisement shall disclose that the amount of benefits depends on the policy selected and that the premium will vary with the amount of the benefits.
 2. If an advertisement refers to benefits contained in more than one policy, other than a group master policy, the advertisement shall disclose that the benefits are provided only if multiple policies are purchased.
- I.** Disparaging comparisons and statements. An advertisement shall not make unfair, incomplete, or unsubstantiated comparisons of other insurers' policies or benefits or falsely disparage other insurers' policies, services, or business methods. A comparison is unsubstantiated if the insurer has no empirical study, analysis, or documentation supporting the comparative statement or comparison of policies or benefits.
- J.** Jurisdictional limits. If an insurer has an advertisement that is meant to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed, the advertisement shall indicate that the insurer is licensed in a specified state or states only, or is not licensed in a specified state or states, by use of language such as "This Company is licensed only in State A" or "This Company is not licensed in State B."
- K.** Identity of insurer. The insurer shall state the name of the actual insurer in all of its advertisements. An advertisement shall clearly identify the insurer and shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device that may mislead or deceive the public as to the insurer's identity.

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- L.** Group insurance. An advertisement shall not state or imply that prospective policyholders become group or quasi-group members and enjoy special rates or underwriting privileges, unless it is true. An advertisement to join an association, trust, or group that is also an invitation to contract for insurance coverage shall disclose that the applicant will be purchasing both membership in the association, trust, or group and insurance coverage.
- M.** Government approval. An advertisement shall not state or imply any of the following:
 1. That a governmental agency or regulator is connected with or has provided or endorsed a policy or endorsed an insurer;
 2. That a governmental agency or regulator has examined an insurer's financial condition and found it satisfactory. This subsection does not apply if an insurer is responding to a specific documented, public, false allegation about its financial condition.
- N.** Endorsements. An advertisement may state that an individual, group, society, association, or other organization has approved or endorsed the insurer or its policy if the organization or group has done so in writing and if any proprietary relationship between the organization and the insurer is disclosed.
- O.** Claims handling. An advertisement shall not contain false statements about the time within which claims are paid or statements that imply that claim settlements will be liberal or generous beyond the terms of the policy.
- P.** Statements about the insurer. An advertisement shall not contain false or misleading statements about an insurer's assets, corporate structure, financial standing, length of time in business, or relative position in the insurance business.

Historical Note

Former General Rule Number 2. R20-6-201 recodified from R4-14-201 (Supp. 95-1). Amended by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-201.01. Insurer Advertising Responsibility and Records

- A.** An insurer shall establish, and at all times maintain, a system of control over the content, form, and method of dissemination of all advertisements. The insurer whose policies are advertised is responsible for the advertisements, regardless of who writes, creates, designs, or presents the advertisement, except the insurer is not responsible for any advertisement placed by a person to whom the insurer gave no actual or apparent authority. Before using an advertisement about an insurer or its products, a producer shall get written approval from the insurer for use of advertisements that were not supplied by the insurer.
- B.** An insurer shall maintain, at its home or principal office, the following:
 1. Advertisements disseminated by the insurer in Arizona or any other state, including:
 - a. Each printed, published, recorded, or prepared advertisement of individual policies; and
 - b. Typical printed, published, recorded, or prepared advertisements of blanket, franchise, and group policies.
 2. A notation attached to each advertisement specifying the manner and extent of distribution and the form number of any policy advertised; and
 3. Documentation supporting any testimonials, statistical claims, or comparisons shown in the advertising.

- C.** An insurer shall maintain the advertisements, notations, and supporting documentation for at least three years from the date of first dissemination.

Historical Note

New Section made by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-201.02. Procedures for Filing Advertising Materials; Transmittal Form

- A.** An insurer that is required to file a health insurance advertisement with the Department as specified in A.R.S. §§ 20-826(T), 20-1018, 20-1057(X), 20-1110(E), or 20-1662 shall file the advertisement with a transmittal form prescribed by the Department.
- B.** The transmittal form shall include the following information:
 1. Identifying information of the insurer, including name, address, National Association of Insurance Commissioners' identification number, and type of insurer;
 2. A contact person at the insurer with whom the Department can communicate about the advertisement;
 3. Description of the type of advertisement being filed;
 4. Planned use and dissemination of the advertisement, including date of first use, or a statement that the advertisement will not be used any earlier than a specified date;
 5. Description of product being advertised;
 6. Form number and name for the advertised product;
 7. A certification from an officer of the insurer that the advertisement complies with applicable laws; and
 8. The dated signature of the insurer's officer.

Historical Note

New Section made by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-202. Advertising, Solicitation, and Transaction of Life Insurance

- A.** The definitions in R20-6-201(A) and the following definition apply in this Section:

"Life insurance" means a life insurance contract, including all benefits payable under the policy.
- B.** Applicability
 1. This Section applies to:
 - a. All persons subject to regulation under A.R.S. Title 20; and
 - b. Advertising, promotion, solicitation, negotiation, and sale of life insurance policies, regardless of the form of dissemination.
 2. This Section does not apply to group insurance, franchise insurance, or to annuities without life contingencies.
- C.** General provisions. A life insurance advertisement shall not mislead the public by:
 1. Omitting information that fairly describes the subject matter as a life insurance policy and the benefits available under the policy;
 2. Placing undue emphasis on facts that, even if true, are not relevant to the sale of life insurance; or
 3. Placing undue emphasis on features of incidental or secondary importance to the life insurance aspects of the policy.
- D.** The Department deems the following acts misleading and deceptive:
 1. Using any statement, including phrases such as "investment," "investment plan," "founders plan," "charter plan," "expansion plan," "profit," "profits," or "profit sharing," in a context or under circumstances or condi-

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- tions that may mislead a purchaser or prospective purchaser to believe that the insurer is selling something other than a life insurance policy or will provide some benefit not included in the policy, or not available to other persons of the same class and equal expectation of life;
2. Using any phrase as the name or title of a life insurance policy if the phrase does not include the words "life insurance," unless other language in the same document expressly provides that the contract is a life insurance policy;
 3. Making any statement relating to the growth or earnings of the life insurance industry or to the tax status of life insurance companies in a context that would reasonably be understood as attempting to interest a prospective applicant in the purchase of shares of stock in the insurance company rather than in the purchase of a life insurance policy;
 4. Making any statement that reasonably tends to imply that the insured will enjoy a status common to a stockholder or will acquire a stock ownership interest in the insurance company by purchasing the policy, unless the statement is made with reference to policies of domestic life insurers engaged in a program allowed under A.R.S. § 20-453;
 5. Providing a policyholder with a premium receipt book, policy jacket, return envelope, or other printed or electronic material referring to the insurer's "investment department," "insured investment department," or similar terminology in a manner implying that the policy is sold, issued, or serviced by the insurer's investment department;
 6. Making any statement that reasonably tends to imply that, by purchasing a policy, the purchaser or prospective purchaser will become a member of a limited group of persons who may receive the payment of dividends, special advantages, benefits, or favored treatment unless the insurance contract specifically provides for the described payment of dividend, special advantages, benefits, or favored treatment;
 7. Stating or implying that only a limited number of persons or limited class of persons may buy a particular kind of policy, unless the limitation is related to recognized underwriting practices or specifically stated in the policy or rider;
 8. Describing premium payments in language that states the payment is a "deposit," unless:
 - a. The payment establishes a debtor-creditor relationship between the insurance company and the policyholder; or
 - b. The term is used with the word "premium" in a manner as to clearly indicate the true character of the payment;
 9. Providing any illustration or projection of future dividends that:
 - a. Is not based on the company's actual scale for payment of current dividends, and
 - b. Does not clearly indicate that the dividends are not guarantees;
 10. Using the words "dividends," "cash dividends," "surplus," or similar phrases in a manner that states or implies that the payment of dividends is guaranteed or certain to occur;
 11. Stating, without qualification, that a purchaser of a policy will share in a stated percentage or portion of the insurer's earnings;
 12. Making any statement that projected dividends under a participating policy will be or can be sufficient at any future time to assure the receipt of benefits such as a paid-up policy without further payment of premiums unless the statement also explains:
 - a. The benefits or coverage that would be provided at the future time, and
 - b. The conditions under which the receipt of benefits without further payment of premiums would occur;
 13. Describing a life insurance policy or premium payments in terms of "units of participation," unless accompanied by other language clearly indicating that the references are to a life insurance policy or to premium payments, as applicable.
 14. Advising producers to avoid disclosing that life insurance is the subject of the solicitation or sale;
 15. Stating that an insured is guaranteed certain benefits if the policy is allowed to lapse, without explaining the non-forfeiture benefits;
 16. Using a dollar amount in printed material to be shown to a prospective policyholder, unless the amount is accompanied by language that:
 - a. States the nature of the dollar amount,
 - b. Prohibits including the use of dollar amounts not related to guaranteed values and properly projected dividend figures, and
 - c. Prohibits the use of figures showing growth of stock values, or other values not a part of the life insurance contract.
 17. Stating that a policy provides features not found in any other insurance policy, unless the insurer can demonstrate that other policies do not have the same feature;
 18. Making any statement or implication about an insurance policy that cannot be verified by reference to the policy contract, a sample of the policy being described, or the company's officially published rate book and dividend illustrations;
 19. Stating that life insurance is "loss proof" or "depression proof," except that an insurer may make statements that life insurance benefits, other than dividends, are guaranteed by the company regardless of economic conditions;
 20. Making any statement that a company makes a profit as a result of policy lapses or surrenders;
 21. Making comparisons to the past experience of other life insurance companies as a means of projecting possible experience for the company issuing the advertising; and
 22. Conduct or statements designed to mislead a prospective applicant or purchaser.

Historical Note

Former General Rule Number 68-14. R20-6-202 recodified from R4-14-202 (Supp. 95-1). Amended by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-203. Form Filings; Translations

- A. An insurer, rate service organization, or rating organization shall provide to the Department, at the time of filing, an English language translation of each form, advertisement, or other document or material that the insurer is required by statute or rule to file with the Department, if the filed document or material contains communication in a language other than English.
- B. The translation filed under subsection (A) shall compare the foreign language version in a side-by-side format with the

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English language translation. An insurer, rate service organization, or rating organization shall ensure that the translation is performed by a person with formal college-level or specialized training in the foreign language, including training in grammar and sentence syntax.

- C. With each translation, an insurer, rate service organization, or rating organization shall also provide to the Department a sworn statement signed by the translator who translated the document that includes the qualifications of the translator under subsection (B) and attests that the translation is identical in substance to the English document or material.
- D. If an insurer, rate service organization, or rating organization files a foreign language version of a document or material that the insurer has previously filed in English, the insurer is not required to refile the English version, but shall identify the English version, provide the side-by-side comparison under subsection (B), and file the sworn statement required under subsection (C).

Historical Note

Former General Rule Number 71-23; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-203 recodified from R4-14-203 (Supp. 95-1). New Section made by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-204. Expired**Historical Note**

Former General Rule Number 71-24; Former Section R4-14-204 repealed, new Section R4-14-204 adopted effective January 1, 1981 (Supp. 80-6). R20-6-204 recodified from R4-14-204 (Supp. 95-1). Amended effective July 14, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 475, effective January 5, 2000 (Supp. 00-1). Amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 136, effective December 15, 2016 (Supp. 16-4).

R20-6-205. Local or Regional Retaliatory Tax Information**A. Definitions.**

1. "Addition to the rate of tax" means the tax rate determined under subsection (D) to be applied under A.R.S. 20-230(A) and this Section to foreign or alien insurers domiciled in a foreign country or other state that impose local or regional taxes.
2. "Alien insurer" has the meaning prescribed in A.R.S. § 20-201.
3. "Arizona life insurer" means a domestic insurer authorized to issue life insurance policies in this state within the meaning of A.R.S. § 20-254 or annuities within the meaning of A.R.S. § 20-254.01, regardless of whether the insurer is authorized to transact disability insurance in this state.
4. "Department" means the Arizona Department of Insurance.
5. "Director" has the meaning prescribed in A.R.S. § 20-102.
6. "Domestic insurer" has the meaning prescribed in A.R.S. § 20-203.
7. "Foreign insurer" has the meaning prescribed in A.R.S. § 20-204.
8. "Foreign or alien life insurer" means a foreign or alien insurer authorized to issue life insurance policies in this state within the meaning of A.R.S. § 20-254 or annuities

within the meaning of A.R.S. § 20-254.01, regardless of whether the insurer is authorized to transact disability insurance in this state.

9. "Local or regional taxes" means any tax, license, or other obligation imposed upon domestic insurers or their producers by any:
 - a. City, county, or other political subdivision of a foreign country or other state; or
 - b. Combination of cities, counties, or other political subdivisions of a foreign country or other state.
 10. "Other Arizona insurer" means a domestic insurer authorized to transact one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.
 11. "Other foreign or alien insurer" means a foreign or alien insurer authorized to transact one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.
 12. "Other state" means any state in the United States, the District of Columbia, and territories or possessions of the United States, excluding Arizona.
 13. "Premium Tax and Fees Report," includes the "Survey of Arizona Domestic Insurers" and the "Retaliatory Taxes and Fees Worksheet," and means the form prescribed by the Director and filed annually by insurers under A.R.S. § 20-224.
- B. Scope.** This Section applies to all foreign, alien, and domestic insurers and to Premium Tax and Fees Reports filed by all insurers.
- C. Data to be reported by domestic insurers.** As a part of its Premium Tax and Fees Report, each domestic insurer shall file a Survey of Arizona Domestic Insurers that reports the following data for the calendar year covered by the insurer's Premium Tax and Fees Report with respect to each foreign country or other state in which the insurer was required to pay any local or regional taxes:
1. Total local or regional taxes paid; and
 2. Total premiums taxed under the premium taxing statute of the foreign country or other state, as reported by the insurer in any premium tax report filed under the laws of the foreign country or other state.
- D. Computation of statewide and foreign countrywide additions to the rate of tax.** For each foreign country or other state having one or more local or regional taxes on domestic insurers, the Department shall compute on a statewide or foreign countrywide basis an addition to the rate of tax. The Department shall compute the addition to the rate of tax payable by Arizona life insurers separately from the addition to the rate of tax payable by other Arizona insurers. The addition to the rate of tax payable by each category of Arizona domestic insurers shall be the quotient of:
1. The aggregate local or regional taxes reported as paid to the foreign country or other state by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report divided by,
 2. The aggregate statewide or foreign countrywide premiums taxed under the premium taxing statute of the other state or foreign country reported by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report.
- E. Publication of additions to the rate of tax.** The Department shall publish additions to the rate of tax determined under A.R.S. § 20-230(A) and this Section, based upon the survey information gathered from domestic insurers for the preceding

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calendar year under subsection (C). The Department shall publish the information annually on the Department web site, on or before November 1, and in the Retaliatory Taxes and Fees Worksheet for the next year's Premium Tax and Fees Report.

- F.** Foreign and Alien Insurers' Report of the Effect of Local or Regional Taxes. Each foreign or alien insurer domiciled in a foreign country or other state for which the Department publishes an addition to the rate of tax shall include in the "State or Country of Incorporation" column of its Retaliatory Taxes And Fees Worksheet for the calendar year covered by its Premium Tax and Fees Report an amount equal to:
1. The total premiums received in Arizona that would be taxed under the laws of the domiciliary jurisdiction, as reported in the "State or Country of Incorporation" column of its premium tax and fees report multiplied by,
 2. The applicable addition to the rate of tax published by the Department for the calendar year covered by the insurer's Premium Tax and Fees Report.
- G.** Contesting computation. A foreign or alien insurer subject to this Section may preserve the right to contest the computation of the addition to the rate of tax by submitting a notice of appeal under A.R.S. Title 41, Chapter 6, Article 10 before or at the time the retaliatory tax is paid. Subject to A.R.S. § 20-162, the filing of a notice of appeal to contest the computation of the applicable addition to the rate of tax does not relieve a foreign or alien insurer of the obligation to timely pay the retaliatory tax, and does not stay accrual of any applicable interest and penalties.

Historical Note

Former General Rule Number 71-25; Repealed effective March 19, 1976 (Supp. 76-2). R20-6-205 recodified from R4-14-205 (Supp. 95-1). Section R20-6-205 renumbered from R20-6-206 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-206. Expired**Historical Note**

Former General Rule Number 72-30. Repealed effective February 22, 1993 (Supp. 93-1). R20-6-206 recodified from R4-14-206 (Supp. 95-1). New Section adopted effective December 29, 1995 (Supp. 95-4). Amended effective November 5, 1998 (Supp. 98-4). Former R20-6-206 renumbered to R20-6-205; new R20-6-206 renumbered from R20-6-207 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 3374, effective May 31, 2016 (Supp. 16-4).

R20-6-207. Gender Discrimination

- A.** The following definitions apply to this Section:
1. "Applicant" means a person who is applying for a policy.
 2. "Policy" means an insurance policy, plan, contract, certificate, evidence of coverage, subscription contract, or binder, including a rider or endorsement offered by an insurer.
 3. "Insurer" means any company that issues a policy.
- B.** Applicability and scope. This Section applies to any policy or certificate delivered or issued for delivery in this state.
- C.** Availability requirements.
1. An insurer shall not deny availability of any insurance policy on the basis of the gender or marital status of the insured or prospective insured.
 2. An insurer shall not restrict, modify, exclude, reduce, or limit the amount of benefits payable, or any term, condi-

tions or type of coverage on the basis of an applicant's or insured's gender or marital status, except to the extent the amount of benefits, term, conditions, or type of coverage vary as a result of the application of rate differentials permitted under A.R.S. Title 20.

3. An insurer may consider marital status to determine whether a person is eligible for dependent coverage or benefits.
- D.** Prohibited practices. The following practices and any other practice that treats similarly situated persons differently based on gender unless the different treatment is specifically allowed by law, is prohibited.
1. Denying coverage to a person of one gender who is self-employed, employed part-time, or employed by relatives, if coverage is offered to a person of the opposite gender who is similarly employed;
 2. Denying a policy rider to a person of one gender if the rider is available to a person of the opposite gender;
 3. Denying maternity benefits to an applicant or insured who buys a policy for individual coverage if the insurer offers comparable family coverage policies with maternity benefits;
 4. Denying, under group policies, dependent coverage to an employee of one gender if dependent coverage is available to an employee of the opposite gender;
 5. Denying a disability income policy to an employed person of one gender if a policy is offered to a person of the opposite gender who is similarly employed;
 6. Treating complications of pregnancy differently from any other illness or sickness covered under a policy;
 7. Restricting, reducing, modifying, or excluding benefits relating to coverage involving the genital organs of only one gender;
 8. Offering lower maximum monthly benefits to a person of one gender than to a person of the opposite gender who is in the same classification under a disability income policy;
 9. Offering more restrictive benefit periods or more restrictive definitions of disability to a person of one gender than to a person of the opposite gender who is in the same classification under a disability income policy;
 10. Establishing different conditions for a policyholder of one gender to exercise benefit options contained in the policy than for a person of the opposite gender;
 11. Limiting the amount of coverage an insured or prospective insured may purchase based upon the insured's or prospective insured's marital status unless the limitation is for the purpose of defining persons eligible for dependent's benefits; and
 12. Otherwise restricting, modifying, excluding or reducing the availability of any insurance contract, the amount of benefits payable, or any term, condition or type of coverage on account of gender or marital status in all lines of insurance.

Historical Note

Former General Rule Number 73-32. R20-6-207 recodified from R4-14-207 (Supp. 95-1). Former R20-6-207 renumbered to R20-6-206; new R20-6-207 renumbered from R20-6-209 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

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R20-6-208. Group Coverage Discontinuance and Replacement**A. Definitions.** The following definitions apply in this Section:

1. "Group insurance" means an insurance benefit that meets all the following conditions:
 - a. Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership;
 - b. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the particular organization or group;
 - c. Coverage is paid for by bulk payment of premiums to the insurer; and
 - d. An employer, union, or association sponsors the plan.
 2. "Health insurance coverage" means a hospital and medical expense incurred policy, a nonprofit health care service plan contract, a health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, but does not include the following:
 - a. Coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
 - b. Coverage issued as a supplement to liability insurance;
 - c. Liability insurance, including general liability insurance and automobile liability insurance;
 - d. Workers' compensation or similar insurance;
 - e. Automobile medical payment insurance;
 - f. Credit-only insurance;
 - g. Coverage for onsite medical clinics; and
 - h. Other insurance coverage similar to the coverage specified in subsections (2)(a) through (g), of the Health Insurance Portability and Accountability Act of 1996 (Pub.L.No. 104-191) (HIPAA), under which benefits for medical care are secondary or incidental to other insurance benefits.
 - i. The following benefits, if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the coverage:
 - i. Limited-scope dental or vision benefits;
 - ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those benefits;
 - iii. Other similar, limited benefits specified in federal regulations issued under HIPAA.
 - j. The following benefits if provided under a separate policy, certificate, or contract of insurance with no coordination between provision of benefits and any exclusion of benefits under a group health plan maintained by the same plan sponsor and if the benefits are paid for an event regardless of whether the benefits are provided under a group health plan maintained by the same plan sponsor:
 - i. Coverage only for a specified disease or illness, or
 - ii. Hospital indemnity or other fixed indemnity insurance.
 - k. The following benefits if the benefits are offered as a separate policy, certificate, or contract of insurance:
 - i. Medicare supplemental policy as defined under § 1882(g)(1) of the Social Security Act, 42 U.S.C. 1395ss;
 - ii. Coverage supplemental to the coverage provided under, 10 U.S.C. Title 10, Chapter 55; or
 - iii. Similar supplemental coverage provided to coverage under a group health plan.
 3. "Health status-related factor" means any of the following:
 - a. Health status;
 - b. Medical condition, including a physical or mental illness;
 - c. Claims experience;
 - d. Receipt of health care;
 - e. Medical history;
 - f. Genetic information;
 - g. Evidence of insurability, including conditions arising out of acts of domestic violence; or
 - h. Disability.
 4. "Insurer" means an insurer that offers or provides group health insurance coverage, and includes an insurer that issues disability insurance as defined in A.R.S. § 20-253, a medical, dental, or optometric service corporation as defined in A.R.S. § 20-822, and a health care services organization as defined in A.R.S. § 20-1051.
- B.** This Section applies to all group insurance issued by an insurer.
- C.** Effective date of discontinuance for non-payment of premium.
1. If a group insurance policy provides for automatic discontinuance of the policy after a premium remains unpaid through the grace period allowed for payment, the insurer is liable for valid claims for covered losses incurred before the end of the grace period.
 2. If the insurer's actions after the end of the grace period indicate that the insurer considers the group insurance policy as continuing in force beyond the end of the grace period the insurer is liable for valid claims for losses beginning before the effective date of written notice of discontinuance to the policyholder or other entity responsible for paying premiums.
 - a. The following actions indicate that the insurer considers the policy in force:
 - i. Continued recognition, acknowledgement, or payment of subsequently incurred claims, or
 - ii. Continued enrollment of employees or dependents.
 - b. The following actions shall not indicate that the insurer considers that policy in force:
 - i. Recognition, payment, or acknowledgement of a claim by an insurer or processing a denial based on eligibility or other denial reasons set forth in the group benefit plan booklet; or
 - ii. Recognition, payment, or acknowledgement of claims due to the group's failure to notify the insurer that the employee or member is no longer eligible for coverage or the group policy is terminated.
 3. The effective date of discontinuance shall not be before midnight at the end of the third scheduled work day after the date on which the notice of discontinuance is delivered.
- D.** Requirements for notice of discontinuance.

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1. An insurer's notice of discontinuance shall include a request to the group policyholder to notify covered employees of the date when the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy or contract, the insurer is not liable for claims for losses incurred after the date of discontinuance. If the plan involves employee contributions, the notice of discontinuance shall also advise that if the policyholder continues to collect employee contributions beyond the date of discontinuance, the policyholder is solely liable for benefits for the period which contributions were collected.
 2. The insurer shall also provide the policyholder with a supply of notice forms that the policyholder can distribute to the covered employees. The notice forms shall explain the discontinuance and the effective date, and advise employees to refer to their certificates or contracts to determine their rights on discontinuance.
- E. Extension of benefits.
1. A group policy shall provide a reasonable provision for extension of benefits for an employee or dependent who is totally disabled on the date of discontinuance as follows:
 - a. For a group life plan with a disability benefit extension of any type such as a premium waiver extension, extended death benefit in the event of total disability, or payment of income for a specified period during total disability, the discontinuance of the group policy shall not terminate the benefit extension.
 - b. For a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability or hospital confinement shall not effect benefits payable for that disability or hospital confinement.
 - c. A hospital or medical expense coverage, other than dental and maternity expense, shall include a reasonable extension of benefits or accrued liability provision. A provision is reasonable if:
 - i. It provides an extension of at least 12 months under "major medical" and "comprehensive medical" type coverage; or
 - ii. Under other types of hospital or medical expense coverage, it provides either an extension of at least 90 days or an accrued liability for expenses incurred during a period of disability or during a period of at least 90 days starting with a specific event that occurred while coverage was in force, such as an accident.
 2. An insurer shall ensure that the policy and group insurance certificates includes a description of the extension of benefits or accrued liability provision.
 3. An insurer shall ensure that benefits payable during a period of extension or accrued liability are subject to the policy's regular benefit limits, such as benefits ceasing at exhaustion of a benefit period or of maximum benefits.
 4. For hospital or medical expense coverage, an insurer may limit benefit payments to payments applicable to the disabling condition only.
- F. Continuance of coverage in situations involving replacement of one plan by another.
1. When a group policyholder secures replacement coverage with a new insurer, self-insures, or foregoes provision of coverage, the replaced insurer is liable only to the extent of its accrued liabilities and extensions of benefits after the date of discontinuance.
 2. The succeeding insurer shall cover each individual who:
 - a. Was eligible for coverage under the prior plan on the date of discontinuance, and
 - b. Is eligible for coverage according to the succeeding insurer's plan of benefits with respect to a class of individuals eligible for coverage.
 3. For the purpose of successive health insurance coverage under subsection (F)(2), a succeeding insurer's plan of benefits shall:
 - a. Not have any non-confinement rules; and
 - b. Provide, as to any actively-at-work rules, that absence from work due to a health status-related factor is treated as being actively-at-work.
 4. Nothing in subsection (F)(2) prohibits an insurer from performing coordination of benefits.
 5. A succeeding insurer shall cover each individual not covered under the succeeding insurer's plan of benefits under subsection (F)(2) according to subsections (a) and (b) if the individual was validly covered, including benefit extension, under the prior plan on the date of discontinuance and is a member of a class of individuals eligible for coverage under the succeeding insurer's plan. Any reference in subsection (a) or (b) to an individual who was or was not totally disabled is a reference to the individual's status immediately before the effective date of coverage for the succeeding insurer.
 - a. The minimum level of benefits to be provided by the succeeding insurer shall be the level of benefits of the prior insurer's plan reduced by any benefits payable by the prior plan.
 - b. The succeeding insurer shall provide coverage until at least the earliest of the following dates:
 - i. The date the individual becomes eligible under the succeeding insurer's plan as described in subsection (F)(2);
 - ii. The date the individual's coverage would terminate according to the succeeding insurer's plan provisions applicable to individual termination of coverage such as at termination of employment or ceasing to be eligible dependent; or
 - iii. For an individual who was totally disabled, and covered by a type of coverage for which subsection (E) requires an extension of accrued liability, the end of any period of extension of benefits or accrued liability that is required of the prior insurer under subsection (E), or if the prior insurer's policy is not subject to subsection (E), would have been required of the insurer had its policy been subject to subsection (E) at the time the prior plan was discontinued and replaced by the succeeding insurer's plan;
 - c. For health insurance coverage, if an individual who was totally disabled at the time the prior insurer's plan was discontinued and replaced by the succeeding insurer's plan, and if subsection (E) requires an extension of benefits or accrued liability, the minimum level of benefits to be provided by the succeeding insurer shall be the level of benefits of the prior

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- insurer's plan, reduced by any benefits paid by the prior plan.
- d. If the succeeding insurer's plan has a preexisting conditions limitation, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding insurer's plan according to subsection (F) during the period the limitation applies under the new plan shall be the lesser of:
 - i. The benefits of the new plan determined without application of the preexisting conditions limitation, or
 - ii. The benefits of the prior plan.
 - e. The succeeding insurer, in applying any deductibles, coinsurance amounts applicable to out-of-pocket maximums, or waiting periods, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. For deductibles or coinsurance amounts applicable to out-of-pocket maximums, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior plan during the 90 days before the effective date of the succeeding insurer's plan but only to the extent these expenses are recognized under the terms of the succeeding insurer's plan and are subject to similar deductible or coinsurance provisions.
 - f. If the succeeding insurer is required under this Section to make a determination about the benefits in the prior plan, the succeeding insurer may ask the prior plan to provide a statement of the benefits available or other pertinent information sufficient to permit the succeeding insurer to verify the benefit determination. For the purposes of this Section, all definitions, conditions, and covered-expense provisions of the prior plan shall govern the benefit determination. The benefit determination is made as if the succeeding insurer had not replaced coverage.
- e. Variable life insurance under which the death benefits and cash values vary according to unit values of investments held in a separate account.
- B.** In this Section, the following apply:
1. "Buyer's Guide" means a document that contains the language in the Appendix to this Section or language approved by the Director.
 2. "Cash dividend" means the current illustrated dividend that can be applied toward payment of the gross premium.
 3. "Equivalent Level Annual Dividend" is calculated as follows:
 - a. Accumulate the annual cash dividends at 5% interest compounded annually to the end of the 10th and 20th policy years;
 - b. Divide each accumulation in subsection (a) by an interest factor that converts the accumulation into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in subsection (a) over the periods stipulated in subsection (a). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
 - c. Divide the results in subsection (b) by the number of thousands of the Equivalent Level Death Benefit to arrive at the "Equivalent Level Annual Dividend."
 4. "Equivalent Level Death Benefit" means the amount of benefit of a policy or term life insurance rider calculated as follows:
 - a. Accumulate the guaranteed amount payable upon death, regardless of the cause of death, at the beginning of each policy year for 10 and 20 years at 5% interest compounded annually to the end of the 10th and 20th policy years, respectively.
 - b. Divide each accumulation in subsection (a) by an interest factor that converts the accumulation into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subsection (a) over the periods stipulated in subsection (a). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
 5. "Generic name" means a short title that is descriptive of the premium and benefit patterns of a policy or a rider.
 6. "Life Insurance Surrender Cost Index" means the cost index that is calculated as follows:
 - a. Determine the guaranteed cash surrender value, if any, available at the end of the 10th and 20th policy years.
 - b. For policies participating in dividends, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual Cash Dividends at 5% interest compounded annually to the end of the period selected and add this sum to the amount determined in subsection (a).
 - c. Divide the result in subsection (b) (subsection (a) for guaranteed-cost policies) by an interest factor that converts into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subsection (b) or subsection (a) for guaranteed cost policies, over the periods stipulated in subsection (a)). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.

Historical Note

Former General Rule Number 73-34. R20-6-208 recodified from R4-14-208 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1). Section R20-6-208 renumbered from R20-6-210 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-209. Life Insurance Solicitation**A. Scope.**

1. This Section applies to any solicitation, negotiation, or procurement of life insurance occurring in Arizona. This Section applies to any issuer of life insurance contracts, including fraternal benefit societies.
2. Unless otherwise specifically included, the Section does not apply to:
 - a. Annuities,
 - b. Credit life insurance,
 - c. Group life insurance,
 - d. Life insurance policies issued in connection with a pension and welfare plan as defined by and subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq.; or

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- d. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at 5% interest compounded annually to the end of the period stipulated in subsection (a) and dividing the result by the respective factors stated in subsection (c). This amount is the annual premium payable for a level premium plan.
- e. Subtract the result of subsection (c) from subsection (d).
- f. Divide the result of subsection (e) by the number of thousands of the Equivalent Level Death Benefit to arrive at the Live Insurance Surrender Cost Index.
- 7. The Life Insurance Net Payment Cost Index is calculated in the same manner as the comparable Life Insurance Cost Index except that the cash surrender value and any terminal dividend are set at zero.
- 8. "Policy Summary" means a written statement describing elements of the policy, including:
 - a. The following prominently placed title: Statement of Policy Cost and Benefit Information.
 - b. The name and address of the insurance producer, or, if no producer is involved, a statement of the procedure to be followed to receive responses to inquiries regarding the Policy Summary.
 - c. The full name and home office or administrative office address of the company by which the life insurance policy is to be or has been written.
 - d. The generic name of the basic policy and each rider.
 - e. For the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including the years for which Life Insurance Cost Indexes are displayed and at least one age from 60 through 65 or maturity, whichever is earlier, the following amounts, where applicable:
 - i. The annual premium for the basic policy;
 - ii. The annual premium for each optional rider;
 - iii. Guaranteed amount payable upon death at the beginning of the policy year regardless of the cause of death except for suicide, or other specifically enumerated exclusions provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately;
 - iv. Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider;
 - v. Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. Dividends need not be displayed beyond the twentieth policy year; and
 - vi. Guaranteed endowment amounts payable under the policy that are not included under guaranteed cash surrender values in subsection (iv).
 - f. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether the rate is applied in advance or in arrears. If the policy loan interest rate is variable, the Policy Summary shall include the maximum annual percentage rate.
 - g. Life Insurance Cost Indexes for 10 and 20 years but not beyond the premium-paying period. Separate indexes shall be displayed for the basic policy and for each optional term life insurance rider. The indexes need not be included for optional riders that are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months, and guaranteed insurability benefits, nor for basic policies or optional riders covering more than one life.
 - h. The Equivalent Level Annual Dividend in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which Life Insurance Cost Indexes are displayed.
 - i. If the Policy Summary includes dividends, a statement that dividends are based on the insurer's current dividend scale and are not guaranteed and a statement in close proximity to the Equivalent Level Annual Dividend as follows: "An explanation of the intended use of the Equivalent Level Annual Dividend is included in the Life Insurance Buyer's Guide."
 - j. A statement in close proximity to the Life Insurance Cost Indexes as follows: "An explanation of the intended use of these indexes is provided in the Life Insurance Buyer's Guide."
 - k. The date on which the Policy Summary is prepared. The Policy Summary shall consist of a separate document. All information required to be disclosed shall not be minimized or obscure. Any amounts that remain level for two or more years of the policy may be represented by a single number that clearly indicates the amounts that are applicable for each policy year. Amounts in subsection (8)(e) shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insured if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.
- C. Disclosure requirements.
 - 1. The insurer shall provide to all prospective purchasers, a Buyer's Guide and a Policy Summary before accepting the applicant's initial premium or premium deposit, unless the policy for which application is made contains an unconditional refund provision of at least 10 days or unless the Policy Summary contains an unconditional refund offer, in which case the Buyer's Guide and Policy Summary shall be delivered with the policy or before delivery of the policy.
 - 2. The insurer shall provide a Buyer's Guide and a Policy Summary to any prospective purchaser upon request.
 - 3. If the Equivalent Level Death Benefit of a policy does not exceed \$5,000, the requirement for providing a Policy Summary is satisfied by delivery of a written statement containing the information described in subsections (D)(8)(b), (c), (d), (e)(i) through (e)(iii), (f), (g), (j), and (k).
- D. General rules.
 - 1. Each insurer shall maintain at its home office or principal office for at least three years after its last authorized use a copy of each form the insurer authorized for use.
 - 2. A producer shall inform a prospective purchaser, before commencing a life insurance sales presentation, that the producer is acting as a life insurance producer and inform the prospective purchaser of the full name of the insurer.

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ance company that the producer is representing. If an insurance producer is not involved in the sale, the insurer shall inform the prospective purchaser of the insurance company's full name.

3. An insurer or producer shall not use terms such as financial planner, investment advisor, financial consultant, or financial counseling to imply that the insurance producer is generally engaged in an advisory business in which compensation is unrelated to sales unless that is true.
 4. If an insurer or producer refers to policy dividends, the reference shall include a statement that dividends are not guaranteed.
 5. An insurer shall not use a system or presentation that does not recognize the time value of money through the use of appropriate interest adjustments for comparing the cost of two or more life insurance policies unless the system or presentation is used to demonstrate the cash flow pattern of a policy and the presentation is accompanied by a statement disclosing that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today.
 6. In a presentation of benefits, an insurer shall not display guaranteed and non-guaranteed benefits as a single sum unless they are shown separately and in close proximity.
 7. An insurer shall include with a statement regarding the use of the Life Insurance Cost Indexes an explanation that the indexes are useful only for the comparison of the relative costs of two or more similar policies.
 8. An insurer shall include with a Life Insurance Cost Index that reflects dividends or an Equivalent Level Annual Dividend a statement that it is based on the company's current dividend scale and is not guaranteed.
 9. If an insurer reserves the right to change the premium for a basic policy or rider, the annual premium shall be the maximum annual premium.
- E. An insurer's failure to provide or deliver a Buyer's Guide or a Policy Summary as provided in subsection (C) constitutes an omission that misrepresents the benefits, advantages, conditions, or terms of an insurance policy.

Appendix. Life Insurance Buyers Guide**Life Insurance Buyer's Guide**

The face page of the Buyer's Guide shall read as follows:

Life Insurance Buyer's Guide

This guide can show you how to save money when you shop for life insurance. It helps you to:

- Decide how much life insurance you should buy,
- Decide what kind of life insurance policy you need, and
- Compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by (Company Name)

(Month and year of printing)

The Buyer's Guide shall contain the following language at the bottom of page 2:

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for

the benefit of all consumers. You are urged to use this Guide in making a life insurance purchase.

Buying Life Insurance

When you buy life insurance, you want a policy that fits your needs without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes that are described in this guide. A good life insurance producer or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand what kinds are available. If one kind does not seem to fit your needs, ask about the other kinds that are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance producer or company or books on life insurance in your public library.

This guide does not endorse any company or policy.

The remaining text of the buyer's guide shall begin on page 3 as follows:

Choosing the Amount

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

Choosing the Right Kind

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance.

1. Term insurance
2. Whole life insurance
3. Endowment insurance

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the producer or company if it combines more than one kind of life insurance. The following is a brief description of the three basic kinds:

Term Insurance

Term insurance is death protection of a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible." This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you

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are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Whole Life Insurance

Whole life insurance gives death protection for as long as you live. The most common type is called “straight life” or “ordinary life” insurance, for which you pay the same premiums for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop “cash values” which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called “nonforfeiture benefits.” This refers to benefits you do not lose (or “forfeit”) when you stop paying premiums. The amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash values may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money that you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

Endowment Insurance

An endowment insurance policy pays a sum or income to you – the policyholder – if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than the same amount of whole life insurance. Thus endowment insurance gives you the least amount of death protection for your premium dollar.

Finding a Low Cost Policy

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the “Surrender Cost Index” and the other is the “Net Payment Cost Index.” It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. **LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.**

What is Cost?

“Cost” is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called “participating” policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called “guaranteed cost” or “non participating” policies. Every feature of a guaranteed

cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What Are Cost Indexes?

In order to compare the cost of policies, you need to look at:

1. Premiums
2. Cash values
3. Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance producers and companies:

1. Life Insurance Surrender Cost Index. This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.

Life Insurance Net Payment Cost Index. This Index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy’s Equivalent Level Annual Dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a non participating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the non participating policy will not change.

How Do I Use Cost Indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

- (1) Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.
- (2) Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a “Shopper’s Guide” tells you that one company’s policy is a good buy for a particular age and

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amount, you should not assume that all of that company's policies are equally good buys.

- (3) Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its producer. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.
- (4) In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or producer will provide service in the future, to you as a policyholder.
- (5) These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for awhile, in favor of a new one. If such a replacement is suggested, you should ask for information from the company that issued the old policy before you take action.

Important Things To Remember – A Summary

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums must closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy. If you compare Surrender Cost Indexes and Net Payment Cost Indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. REMEMBER, LOOK FOR POLICIES WITH LOWER COST INDEX NUMBERS. A good life insurance producer can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the producer or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.

Historical Note

Adopted effective June 13, 1977 (Supp. 77-3). R20-6-209 recodified from R4-14-209 (Supp. 95-1). Former R20-6-209 renumbered to R20-6-207; new R20-6-209 renumbered from R20-6-211 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-210. Readable and Understandable Policy: Private Passenger Automobile, Homeowner, Personal Line Dwelling, and Mobile Homeowner

- A. Definitions. The following definitions apply in this Section:
 1. "Readable insurance policy" means a policy that can be read and reasonably understood by a person without special knowledge or training.
 2. "Policy" means a contract or agreement for insurance, or an insurance certificate regardless of the name used, and includes all clauses, endorsements, and papers attached or incorporated.
- B. Scope. This Section applies to private passenger motor vehicle policies, homeowner policies, personal line dwelling policies,

for four family units or less, and mobile homeowner policies delivered or issued for delivery in Arizona.

- C. Compliance.
 1. An insurer shall test the readability of its policy by use of the Flesch Readability Formula as set forth in Rudolf Flesch, *The Art of Readable Writing* (1949, as revised 1974).
 2. An insurer shall not use a policy unless the policy has a total readability score of 40 or more on the Flesch scale.
 3. An insurer shall include with each policy form filing required to be filed with the Director a checklist for the line of insurance setting forth the Flesch score.
- D. Readability guidelines.
 1. General organization of text.
 - a. A policy shall be divided into logically arranged sections for ease of locating content.
 - b. Each section shall be self-contained as to provisions relating solely to that section (for example, an exclusion section shall not be mixed with other parts of a policy).
 - c. General policy provisions applying to all or several like coverages shall be located in a common area.
 - d. The policy shall not contain non-essential provisions.
 - e. Defined words and terms shall be placed in a separate section at the beginning of the policy.
 2. Visual aids to readability. The insurer shall ensure that each policy meets the following format requirements:
 - a. Type size shall be at least eight point.
 - b. The font shall be block print rather than script, and legible.
 - c. Captions and headings shall be distinguishable from the general text.
 - d. White space separating coverages, policy sections, and columns shall be sufficient to make a distinct separation.
 - e. Defined words and terms shall be distinguishable from the general text.
 3. Language usage. The insurer shall ensure that each policy:
 - a. Is written in everyday, conversational language;
 - b. Uses short, simple sentences and words in common usage;
 - c. Uses an easy-to-read style, personal pronouns, and present tense active verbs.

Historical Note

Adopted effective May 28, 1979 (Supp. 79-1). R20-6-210 recodified from R4-14-210 (Supp. 95-1). Former R20-6-210 renumbered to R20-6-208; new R20-6-210 renumbered from R20-6-212 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-211. Discrimination on the Basis of Blindness or Partial Blindness

- A. Definitions. The following definitions apply in this Section:
 1. "Policy" means a contract or agreement for or effecting insurance, or a certificate of insurance, regardless of the name used, and includes all clauses, riders, endorsements, and attached papers.
 2. "Person" has the same meaning prescribed in A.R.S. § 20-105.
- B. Scope. This Section applies to all policies delivered or issued for delivery in this state.

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- C. Prohibition. An insurer shall not engage in the following prohibited acts or practices that constitute unfair discrimination between individuals of the same class:
1. Refusal to insure or refusal to continue to insure, or limiting the amount, extent, or kind of coverage available to an individual solely because of blindness or partial blindness; or
 2. Charging an individual a different rate for the same coverage solely because of blindness or partial blindness.
- D. In this subsection, “refusal to insure” includes denial by an insurer of disability insurance coverage on the grounds that the policy defines “disability” as being presumed if the insured loses eyesight. An insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness if the insured was blind or partially blind when the policy was issued.
- E. For all other conditions, including the underlying cause of the blindness or partial blindness, a person who is blind or partially blind is subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as a sighted person.

Historical Note

Adopted effective August 1, 1977 (Supp. 77-4).
Amended effective March 27, 1976 (Supp. 78-2). Correction, Historical Note for Supp. 77-4 should read adopted effective January 1, 1979 filed August 1, 1977. Historical Note for Supp. 78-2 should read Appendix amended effective January 1, 1979 filed March 27, 1978 (Supp. 79-5). Editorial correction, (D)(7)(a), title now shown in italics (Supp. 81-1). R20-6-211 recodified from R4-14-211 (Supp. 95-1). Former R20-6-211 renumbered to R20-6-209; new R20-6-211 renumbered from R20-6-213 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-212. Forms for Replacement of Life Insurance Policies and Annuities

An insurer shall use the following forms of the National Association of Insurance Commissioners Model Regulations (and no future editions or amendments), which are incorporated by reference and available at the Department of Insurance and Financial Institutions, Division of Insurance, 100 N. 15th Ave., Suite 261, Phoenix, AZ 85007-2630 and the National Association of Insurance Commissioners, Publications Department, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197:

1. For the purposes of meeting the requirements of A.R.S. § 20-1241.03(C): Life Insurance and Annuities Replacement Model Regulation (MDL 613), Appendix A – Important Notice: Replacement of Life Insurance or Annuities, 2015, and no future editions.
2. For the purposes of meeting the requirements of A.R.S. § 20-1241.07(A): Life Insurance and Annuities Replacement Model Regulation (MDL 613), Appendix B – Notice Regarding Replacing Your Life Insurance Policy or Annuity?, 2015, and no future editions.
3. For the purpose of meeting the requirements of A.R.S. § 20-1241.07(B)(2): Life Insurance and Annuities Replacement Model Regulation (MDL 613), Appendix C – Important Notice: Replacement of Life Insurance or Annuities, 2015, and no future editions.

Historical Note

Adopted effective March 27, 1978 (Supp. 78-2). Editorial correction see subsection (A) citation to A.R.S. (Supp. 78-4). Editorial correction see subsections (B) and (F)

citation to A.R.S. (Supp. 78-6). R20-6-212 recodified from R4-14-212 (Supp. 95-1). Former R20-6-212 renumbered to R20-6-210; new R20-6-212 renumbered from R20-6-215 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2). Amended by final rulemaking at 28 A.A.R. 454 (February 25, 2022), effective April 5, 2022 (Supp. 22-1).

R20-6-212.01. Buyer’s Guide for Annuities

An insurer shall use the following publication of the National Association of Insurance Commissioners (and no future editions), which are incorporated by reference and available at the Department of Insurance and Financial Institutions, Division of Insurance, 100 N. 15th Ave., Suite 261, Phoenix, AZ 85007-2630 and the National Association of Insurance Commissioners, Publications Department, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197:

For the purpose of meeting the requirements of A.R.S. § 20-1242.02 regarding a Buyer’s Guide: Buyer’s Guide for Deferred Annuities, - Fixed, 2013, and no future editions.

Historical Note

Section R20-6-212.01 renumbered from R20-6-215.01 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2). Amended by final rulemaking at 28 A.A.R. 454 (February 25, 2022), effective April 5, 2022 (Supp. 22-1).

R20-6-212.02. Standards for Annuity Illustrations

- A. Definitions. The definitions in A.R.S. § 20-1242 and this subsection apply to this Section.

“Illustration” means a personalized presentation or depiction prepared for and provided to an individual consumer that includes non-guaranteed elements of an annuity contract over a period of years.

“Indexing Method” means point-to-point, dialing averaging or monthly averaging.

“Index Term” means the period over which indexed-based interest is calculated.

“Market Value Adjustment” or “MVA” means a feature that is a positive or negative adjustment that may be applied to the account value and/or cash value of the annuity upon withdrawal, surrender, contract annuitization or death benefit payment based on either the movement of an external index or on the company’s current guaranteed interest rate being offered on new premiums or new rates for renewal periods, if that withdrawal, surrender, contract annuitization or death benefit payment occurs at a time other than on a specified guaranteed benefit date.

“Registered product” means an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

- B. An insurer or producer may elect to provide a consumer an illustration at any time, provided that the illustration is in compliance with this Section and:

1. Is clearly labeled as an illustration;
2. Includes a statement referring customers to the disclosure document and buyer’s guide provided to them at time of purchase for additional information about their annuity; and
3. Is prepared by the insurer or third party using software that is authorized by the insurer prior to its use, provided that the insurer maintains a system of control over the use of the illustration.

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- C. An illustration furnished to an applicant for a group annuity contract or contracts issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.
- D. The illustration shall not be provided unless accompanied by the disclosure document referenced in A.R.S. § 20-1242.02.
- E. When using an illustration, the illustration shall not:
 - 1. Describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;
 - 2. State or imply that the payment or amount of non-guaranteed elements is guaranteed; or
 - 3. Be incomplete.
- F. Costs and fees of any type shall be individually noted and explained.
- G. An illustration shall conform to the following requirements:
 - 1. The illustration shall be labeled with the date on which it was prepared;
 - 2. Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the disclosure document (e.g., the fourth page of a seven-page disclosure document shall be labeled "page 4 of 7 pages");
 - 3. The assumed dates of premium receipt and benefit payout within a contract year shall be clearly identified;
 - 4. If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue-age plus the number of years the contract is assumed to have been in force;
 - 5. The assumed premium on which the illustrated benefits and values are based shall be clearly identified, including rider premium for any benefits being illustrated;
 - 6. Any charges for riders or other contract features assessed against the account value or the crediting rate shall be recognized in the illustrated values and shall be accompanied by a statement indicating the nature of the rider benefits or the contract features, and whether or not they are included in the illustration;
 - 7. Guaranteed death benefits and values available upon surrender, if any, for the illustrated contract premium shall be shown and clearly labeled guaranteed;
 - 8. Except as provided in subsection (G)(22) of this Section, the non-guaranteed elements underlying the non-guaranteed illustrated values shall be no more favorable than current non-guaranteed elements and shall not include any assumed future improvement of such elements. Additionally, non-guaranteed elements used in calculating non-guaranteed illustrated values at any future duration shall reflect any planned changes, including any planned changes that may occur after expiration of an initial guaranteed or bonus period;
 - 9. In determining the non-guaranteed illustrated values for a fixed indexed annuity, the index-based interest rate and account value shall be calculated for three different scenarios: one to reflect historical performance of the index for the most recent 10 calendar years; one to reflect the historical performance of the index for the continuous period of 10 calendar years out of the last 20 calendar years that would result in the least index value growth (the "low scenario"); one to reflect the historical performance of the index for the continuous period of 10 calendar years out of the last 20 calendar years that would result in the most index value growth (the "high scenario"). The following requirements apply:
 - a. The most recent 10 calendar years and the last 20 calendar years are defined to end on the prior December 31, except for illustrations prepared during the first three months of the year, for which the end date of the calendar year period may be the December 31 prior to the last full calendar year;
 - b. If any index utilized in determination of an account value has not been in existence for at least 10 calendar years, indexed returns for that index shall not be illustrated. If the fixed indexed annuity provides an option to allocate account value to more than one indexed or fixed declared rate account, and one or more of these indexes has not been in existence for at least 10 calendar years, the allocation to such indexed account or accounts shall be assumed to be zero;
 - c. If any index utilized in determination of an account value has been in existence for at least 10 calendar years but less than 20 calendar years, the 10 calendar year periods that define the low and high scenarios shall be chosen from the exact number of years the index has been in existence;
 - d. The non-guaranteed element or elements, such as caps, spreads, participation rates, or other interest crediting adjustments, used in calculating the non-guaranteed index-based interest rate shall be no more favorable than the corresponding current element or elements;
 - e. If a fixed indexed annuity provides an option to allocate the account value to more than one indexed or fixed declared rate account:
 - i. The allocation used in the illustration shall be the same for all three scenarios; and
 - ii. The 10 calendar year periods resulting in the least and greatest index growth periods shall be determined independently for each indexed account option.
 - f. The geometric mean annual effective rate of the account value growth over the 10 calendar year period shall be shown for each scenario;
 - g. If the most recent 10 calendar year historical period experience of the index is shorter than the number of years needed to fulfill the requirement of subsection (I) of this Section, the most recent 10 calendar year historical experience of the index shall be used for each subsequent 10 calendar year period beyond the initial period for the purpose of calculating the account value for the remaining years of the illustration;
 - h. The low and high scenarios:
 - i. Need not show surrender values (if different than account values);
 - ii. Shall not extend beyond 10 calendar years (and therefore are not subject to the requirements of subsection (I) of this Section beyond subsection (I)(1)(a) of this Section); and
 - iii. May be shown on a separate page;
 - i. For the low and high scenarios, a graphical presentation shall also be included comparing the movement of the account value over the 10 calendar year period for the low scenario, the high scenario and the most recent 10 calendar year scenario; and
 - j. The low and high scenarios should reflect the irregular nature of the index performance and should trigger

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- every type of adjustment to the index-based interest rate under the contract. The effect of the adjustments should be clear; for example, additional columns showing how the adjustment applied may be included. If an adjustment to the index-based interest rate is not triggered in the illustration (because no historical values of the index in the required illustration range would have triggered it), the illustration shall so state;
10. The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (e.g., "see page 1 for guaranteed elements");
 11. The account or accumulation value of a contract, if shown, shall be identified by the name this value is given in the contract being illustrated and shown in close proximity to the corresponding value available upon surrender;
 12. The value available upon surrender shall be identified by the name this value is given in the contract being illustrated and shall be the amount available to the contract owner in a lump sum after deduction of surrender charges, bonus forfeitures, contract loans, contract loan interest, and application of any market value adjustment, as applicable;
 13. Illustrations may show contract benefits and values in graphic or chart form in addition to the tabular form;
 14. Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:
 - a. The benefits and values are not guaranteed;
 - b. The assumptions on which they are based are subject to change by the insurer; and
 - c. Actual results may be higher or lower;
 15. Illustrations based on non-guaranteed credited interest and non-guaranteed annuity income rates shall contain equally prominent comparisons to guaranteed credited interest and guaranteed annuity income rates, including any guaranteed and non-guaranteed participation rates, caps, or spreads for fixed indexed annuities;
 16. The annuity income rate illustrated shall not be greater than the current annuity income rate unless the contract guarantees are in fact more favorable;
 17. Illustrations shall be concise and easy to read;
 18. Key terms shall be defined and then used consistently throughout the illustration;
 19. Illustrations shall not depict values beyond the maximum annuitization age or date;
 20. Annuitization benefits shall be based on contract values that reflect surrender charges or any other adjustments, if applicable; and
 21. Illustrations shall show both annuity income rates per \$1,000.00 and the dollar amounts of the periodic income payable.
 22. For participating immediate and deferred income annuities:
 - a. Illustrations may not assume any future improvement in the applicable dividend scale (or scales, if more than one dividend scale applies, such as for a flexible premium annuity);
 - b. Illustrations must reflect the equitable apportionment of dividends, whether performance meets, exceeds, or falls short of expectations;
 - c. If the dividend scale is based on a portfolio rate method, the portfolio rate underlying the illustrated dividend scale shall not be assumed to increase;
 - d. If the dividend scale is based on an investment cohort method, the illustrated dividend scale should assume that reinvestment rates grade to long-term interest rates, subject to the following conditions:
 - i. Any assumptions as to future investment performance in the dividend formula must be consistent with assumptions that are reflected in the marketplace within the normal range of analyst forecasts and investor behavior; these assumptions may not be changed arbitrarily, notwithstanding changes in markets or economic conditions, and must be consistent with assumptions that the issuer uses with respect to other lines of business; and
 - ii. The illustrated dividend scale should assume that reinvestment rates grade to long-term interest rates, based on U.S. Treasury bonds. For the purposes of this grading, the assumed long-term rates should not exceed the rates calculated using the formula in subsection (G)(22)(d)(iii), based on the time to maturity or reinvestment (the "Tenor") of the investments supporting the cohort of policies.
 - iii. Maximum long-term interest rates should be calculated for tenors of three months (or less), five years, 10 years, and 20 years (or more), using U.S. Treasury rates. For each tenor, the maximum long-term interest rate will vary over time, based on historical interest rates as they emerge. The formula for the maximum long-term interest rate is the average of the median bond rate over the last 600 months and the average bond rate over the last 120 months, rounded to the nearest quarter of one percent (0.25%).
 - iv. The maximum long-term interest rate for a tenor should be recalculated once per year, in January, using historical rates as of December 31 of the calendar year two years prior to the calendar year of the calculation date. The historical rate for each month is the rate reported for the last business day of the month.
 - v. Grading to the maximum long-term interest rates should take place over no less than 20 years from issue if U.S. Treasury rates as of the illustration date are below the long-term rates, or, no more than 20 years from issue if U.S. Treasury rates as of the illustration date are above the long-term rates.
 - vi. When the 10-year U.S. Treasury rate is less than the 10-year maximum long-term interest rate, an additional illustrated dividend scale should be presented. This additional illustrated dividend scale shall assume that reinvestment U.S. Treasury rates do not exceed the initial investment U.S. Treasury rates and illustrate dividends no less than half of the dividends illustrated under the current dividend scales. If the assumption that reinvestment U.S. Treasury rates do not exceed the initial investment U.S. Treasury rates conflicts with the illustration, i.e.

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half of the current dividends are greater than would be permitted by the assumption, then the reinvestment U.S. Treasury rates should equal the initial investment U.S. Treasury rates.

- vii. The illustration should include a disclosure that is substantially similar to the following:

The illustrated current dividend scale is based on interest rates that are assumed to gradually [increase/decrease] from current rates to long-term interest rates, over a period of [20] years. By regulation, the long-term assumed interest rates cannot not and do not exceed the rates listed in column (c) of the table below.

- viii. If the illustration contains an additional dividend scale pursuant to subsection (G)(22)(d)(vi), then the illustration should also include a disclosure that is substantially similar to the following:

The additional illustrated dividend scale is based on interest rates that are assumed not to increase and do not exceed the interest rates in column (b) of the table below.

Column A	Column B	Column C
Tenor	Current Interest Rate	Long Term
	Treasury Rate as of 12/31/2016	Mean Reversed Treasury Rate
3 Month (or less)	0.51%	3.00%
5 Year	1.93%	4.50%
10 Year	2.45%	5.00%
20 Years (or more)	3.06%	5.50%

- H. An annuity illustration shall include a narrative summary that includes all the following unless provided at the same time in a disclosure statement:

1. A brief description of any contract features, riders or options, guaranteed and/or non-guaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the contract;
2. A brief description of any other optional benefits or features that are selected, but not shown in the illustration and the impact they have on the benefits and values of the contract;
3. Identification and a brief definition of column headings and key terms used in the illustration;
4. A statement containing in substance the following:

- a. For other than fixed indexed annuities:
This illustration assumes the annuity's current non-guaranteed elements will not change. It is likely that they will change and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer's Guide provided with your Annuity Contract for more detailed information;

- b. For fixed indexed annuities:
This illustration assumes the index will repeat historical performance and that the annuity's current

non-guaranteed elements, such as caps, spreads, participation rates or other interest crediting adjustments, will not change. It is likely that the index will not repeat historical performance, the non-guaranteed elements will change, and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer's Guide provided with your Annuity Contract for more detailed information;

5. Additional explanations as follows:
 - a. Minimum guarantees shall be clearly explained;
 - b. The effect on contract values of contract surrender prior to maturity shall be explained;
 - c. Any conditions on the payment of bonuses shall be explained;
 - d. For annuities sold as an IRA, qualified plan or in another arrangement subject to the required minimum distribution (RMD) requirements of the Internal Revenue Code, the effect of RMDs on the contract values shall be explained;
 - e. For annuities with recurring surrender charge schedules, a clear and concise explanation of what circumstances will cause the surrender charge to recur; and
 - f. A brief description of the types of annuity income options available shall be explained, including:
 - i. The earliest or only maturity date for annuitization (as the term is defined in the contract);
 - ii. For contracts with an optional maturity date, the periodic income amount for at least one of the annuity income options available based on the guaranteed rates in the contract, at the later of age 70 or 10 years after issue, but in no case later than the maximum annuitization age or date in the contract;
 - iii. For contracts with a fixed maturity date, the periodic income amount for at least one of the annuity income options available, based on the guaranteed rates in the contract at the fixed maturity date; and
 - iv. The periodic income amount based on the currently available periodic income rates for the annuity income option in subsection (H)(5)(f)(ii) or in subsection (H)(5)(f)(iii), if desired.

- I. Following the narrative summary, an illustration shall include a numeric summary which shall include at minimum, numeric values at the following durations:

1. The first 10 contract years or the surrender charge period if longer than 10 years, including any renewal surrender charge period or periods;
2. Every tenth contact year up to the later of 30 years or age 70; and
3. Required annuitization age or required annuitization date.

- J. If the annuity contains a market value adjustment ("MVA"), the following provisions apply to the illustration:

1. The MVA shall be referred to as such throughout the illustration;
2. The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the value available upon surrender;

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3. The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the death benefit;
 4. A statement, containing in substance the following, shall be included:

When you make a withdrawal, the amount you receive may be increased or decreased by a Market Value Adjustment (MVA). If the interest rates on which the MVA is based go up after you buy your annuity, the MVA likely will decrease the amount you receive. If interest rates go down, the MVA will likely increase the amount you receive.
 5. Illustrations shall describe both the upside and the downside aspects of the contract features relating to the MVA;
 6. The illustrative effect of the MVA shall be shown under at least one positive and one negative scenario. This demonstration shall appear on a separate page and be clearly labeled that it is information demonstrating the potential impact of a MVA;
 7. Actual MVA floors and ceilings as listed in the contract shall be illustrated; and
 8. If the MVA has significant characteristics not addressed by subsections (J)(1) through (J)(6), the effect of such characteristics shall be shown in the illustration.
- K.** A narrative summary for a fixed indexed annuity illustration also shall include the following unless provided at the same time as the disclosure statement:
1. An explanation, in simple terms, of the elements used to determine the index-based interest, including but not limited to, the following elements:
 - a. The index(es) which will be used to determine the index-based interest;
 - b. The Indexing Method;
 - c. The Index Term;
 - d. The participation rate, if applicable;
 - e. The cap, if applicable; and
 - f. The spread, if applicable;
 2. The narrative shall include an explanation, in simple terms, of how index-based interest is credited in the indexed annuity;
 3. The narrative shall include a brief description of the frequency with which the company can re-set the elements used to determine the index-based credits, including the participation rate, the cap, and the spread, if applicable; and
 4. If the product allows the contract holder to make allocations to a declared-rate segment, then the narrative shall include a brief description of:
 - a. Any options to make allocations to a declared-rate segment, both for new premiums and for transfers from the index-based segments; and
 - b. Differences in guarantees applicable to the declared-rate segment and the index-based segments.
- L.** A numeric summary for a fixed indexed annuity illustration shall include, at a minimum, the following elements:
1. The assumed growth rate of the index in accordance with subsection (G)(9);
 2. The assumed values for the participation rate, cap and spread, if applicable; and
 3. The assumed allocation between index-based segments and the declared-rate segment, if applicable, in accordance with subsection (G)(9).
- M.** If the contract is issued other than as applied for, a revised illustration conforming to the contract as issued shall be sent with the contract, except that non-substantive changes, including but not limited to, changes in the amount of expected initial or additional premiums and any changes in amounts of exchanges pursuant to Section 1053 of the Internal Revenue Code, rollovers and transfers, which do not alter the key benefits and features of the annuity as applied for will not require a revised illustration unless requested by the applicant.
- N.** Annuity Illustration Examples. Illustrations A through C are examples only and do not reflect specific characteristics of any actual product for sale by any company.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 454 (February 25, 2022), effective April 5, 2022 (Supp. 22-1).

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Illustration A. Annuity Illustration Example**ABC Life Insurance Company***Company Product Name*

Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)

An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy

(Contact us at Policyownerservice@ABCLife.com or 555-555-5555)

Sex: Male	Initial Premium Payment: \$100,000.00
Age at Issue: 54	Planned Annual Premium Payments: None
Annuitant: John Doe	Tax Status: Nonqualified
Oldest Age at Which Annuity Payments Can Begin: 95	Withdrawals: None Illustrated

Initial Interest Guarantee Period	5 Years
Initial Guaranteed Interest Crediting Rates	
<i>First Year (reflects first year only interest bonus credit of 0.75%):</i>	4.15%
<i>Remainder of Initial Interest Guarantee Period:</i>	3.40%
Market Value Adjustment Period:	5 Years
Minimum Guaranteed Interest Rate after Initial Interest Guarantee Period*:	3%

* After the Initial Interest Guarantee Period, a new interest rate will be declared annually. This rate cannot be lower than the Minimum Guaranteed Interest Rate.

Annuity Income Options and Illustrated Monthly Income Values

This annuity is designed to pay an income that is guaranteed to last as long as the Annuitant lives. When annuity income payments are to begin, the income payment amounts will be determined by applying an annuity income rate to the annuity Account Value.

Annuity income options include the following:

- Periodic payments for Annuitant's life
- Periodic payments for Annuitant's life with payments guaranteed for a certain number of years
- Periodic payments for Annuitant's life with payments continuing for the life of a survivor annuitant

Illustrated Annuity Income Option: Monthly payments for annuitant's life with payments guaranteed for 10-year period.

Assumed Age When Payments Start: 70

	Account Value	Monthly Annuity Income Rate/\$1,000 of Account Value*	Monthly Annuity Income
Based on Rates Guaranteed in the Contract	\$164,798	\$5.00	\$823.99
Based on Rates Currently Offered by the Company	\$171,976	\$6.50	\$1,117.84

*If, at the time of annuitization, the annuity income rates currently offered by the company are higher than the annuity income rates guaranteed in the contract, the current rates will apply.

Historical Note

New Appendix A made by final rulemaking at 28 A.A.R. 454 (February 25, 2022), effective April 5, 2022 (Supp. 22-1).

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Illustration B. Annuity Illustration Example

ABC Life Insurance Company

Company Product Name

Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)

An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy

Contact us at Policyownerservice@ABCLife.com or 555-555-5555

Contract Year/Age	Premium Payment	Values Based on Guaranteed Rates				Value Based on Assumption that Initial Guaranteed Rates Continue		
		Interest Crediting Rate	Account Value	Cash Surrender Value Before MVA	Minimum Cash Surrender Value After MVA	Interest Crediting Rate	Account Value	Cash Surrender Value Before and After MVA
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1 / 55	\$100,000	4.15%	\$104,150	\$95,818	\$92,000	4.15%	\$104,150	\$95,818
2 / 56	0	3.40%	107,691	100,153	93,000	3.40%	107,691	100,153
3 / 57	0	3.40%	111,353	104,671	95,614	3.40%	111,353	104,671
4 / 58	0	3.40%	115,139	109,382	98,482	3.40%	115,139	109,382
5 / 59	0	3.40%	119,053	114,291	114,291	3.40%	119,053	114,291
6 / 60	0	3.00%	122,625	118,946	118,946	3.40%	123,101	119,408
7 / 61	0	3.00%	126,304	123,778	123,778	3.40%	127,287	124,741
8 / 62	0	3.00%	130,093	130,093	130,093	3.40%	131,614	131,614
9 / 63	0	3.00%	133,996	133,996	133,996	3.40%	136,089	136,089
10 / 64	0	3.00%	138,015	138,015	138,015	3.40%	140,716	140,716
11 / 65	0	3.00%	142,156	142,156	142,156	3.40%	145,501	145,501
16 / 70	0	3.00%	164,798	164,798	164,798	3.40%	171,976	171,976
21 / 75	0	3.00%	191,046	191,046	191,046	3.40%	203,268	203,268
26 / 80	0	3.00%	221,474	221,474	221,474	3.40%	240,255	240,255
31 / 85	0	3.00%	256,749	256,749	256,749	3.40%	283,972	283,972
36 / 90	0	3.00%	297,643	297,643	297,643	3.40%	335,643	335,643
41 / 95	0	3.00%	345,050	345,050	345,050	3.40%	396,717	396,717

Column Descriptions

- (1) **Ages** shown are measured from the Annuitant's age at issue.
- (2) **Premium Payments** are assumed to be made at the beginning of the Contract Year shown.

Values Based on Guaranteed Rates

- (3) **Interest Crediting Rates** shown are annual rates; however, interest is credited daily. During the Initial Interest Guarantee Period, values developed from the Initial Premium Payment are illustrated using the Initial Guaranteed Interest Rate(s) declared by the insurance company, which include an additional first year only interest bonus credit of 0.75%. The interest rates will be guaranteed for the Initial Interest Guarantee Period, subject to an MVA. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually, but can never be less than the Minimum Guaranteed Interest Rate shown.
- (4) **Account Value** is the amount you have at the end of each year if you leave your money in the contract until you start receiving annuity payments. It is also the amount available upon the Annuitant's death if it occurs before annuity payments begin. The death benefit is not affected by surrender charges or the MVA.
- (5) **Cash Surrender Value Before MVA** is the amount available at the end of each year if you surrender the contract (after deduction of any Surrender Charge) but before the application of any MVA. Surrender charges are applied to the Account Value according to the schedule below until the surrender charge period ends, which may be after the Initial Interest Guarantee Period has ended.

Years Measured from Premium Payment:	1	2	3	4	5	6	7	8+
Surrender Charges:	8%	7%	6%	5%	4%	3%	2%	0%

- (6) **Minimum Cash Surrender Value After MVA** is the minimum amount available at the end of each year if you surrender your contract before the end of five years, no matter what the MVA is. The minimum is set by law. The amount you receive may be higher or lower than the cash surrender value due to the application of the MVA, but never lower than this minimum. Otherwise the MVA works as follows: If the interest rate available on new contracts offered by the company is LOWER than your Initial Guaranteed Interest Rate, the MVA will INCREASE the amount you receive. If the interest rate available on new contracts offered by the company is HIGHER than your initial guaranteed interest rate, the MVA will DECREASE the amount you receive. The charts below provide additional information concerning the MVA.

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Values Based on Assumption that Initial Guaranteed Rates Continue

- (7) **Interest Crediting Rates** are the same as in Column (3) for the Initial Interest Guarantee Period. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually. For the purposes of calculating the values in this column, it is assumed that the Initial Guaranteed Interest Rate (without the bonus) will continue as the new renewal interest rate in all years. The actual renewal interest rates are not subject to an MVA and will very likely NOT be the same as the illustrated renewal interest rates.
- (8) **Account Value** is calculated the same way as Column (4).
- (9) **Cash Surrender Value Before and after MVA** is the Cash Surrender Value at the end of each year assuming that Initial Guaranteed Interest Rates continue, and that the continuing rates are the rates offered by the company on new contracts. In this case the MVA would be zero, and Cash Surrender Values before and after the MVA would be the same.

Important Note: This illustration assumes you will take no withdrawals from your annuity before you begin to receive periodic income payments. **Withdrawals will reduce both the annuity Account Value and the Cash Surrender Value.** You may make partial withdrawals of up to 10% of your account value each contract year without paying surrender charges. Excess withdrawals (above 10%) and full withdrawals will be subject to surrender charges.

This illustration assumes the annuity's current interest crediting rates will not change. It is likely that they will change and actual values may be higher or lower than those in the illustrations.

The values in this illustration are not guaranteed or even estimates of the amounts you can expect from your annuity. For more information, read the annuity disclosure and annuity buyer's guide.

Historical Note

New Appendix B made by final rulemaking at 28 A.A.R. 454 (February 25, 2022), effective April 5, 2022 (Supp. 22-1).

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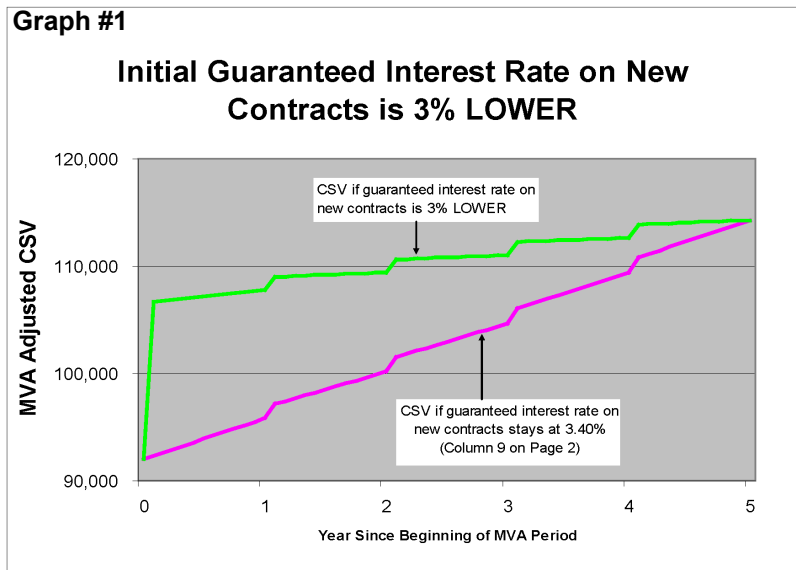
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Illustration C. MVA-adjusted Cash Surrender Values (CSVs) Under Sample Scenarios

MVA-adjusted Cash Surrender Values (CSVs) Under Sample Scenarios

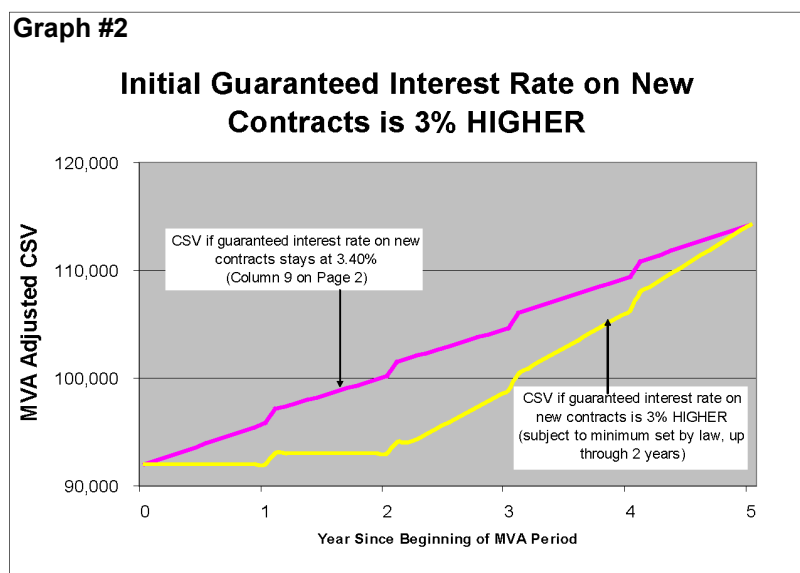
The graphs below show MVA-adjusted Cash Surrender Values (CSVs) during the first five years of the contract, as illustrated on the illustration spreadsheet above (\$100,000 single premium, a 5-year MVA Period) under two sample scenarios, as described below.

Graph #1 shows if the interest rate on new contracts is 3% LOWER than your Initial Guaranteed Interest Rate, the MVA will increase the amount you receive (upper line). The lower line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on the illustration spreadsheet above (referenced as Page 2 in the graph)).



Graph #2 shows if the interest rate on new contracts is 3% HIGHER than your Initial Guaranteed Interest Rate, the MVA will decrease the amount you receive, but not below the minimum set by law (Column (6) on the illustration spreadsheet above (referenced as Page 2 in the graph)), which in this scenario's limits the decrease for the first 2 years (lower line). The upper line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on the illustration spreadsheet above).

These graphs and the sample guaranteed interest rates on new contracts used are for demonstration purposes only and are not intended to be a projection of how guaranteed interest rates on new contracts are likely to behave.



Historical Note

Appendix C made by final rulemaking at 28 A.A.R. 454 (February 25, 2022), effective April 5, 2022 (Supp. 22-1).

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R20-6-213. Life and Disability Insurance Policy Language Simplification**A. Definitions.** The following definitions apply in this Section:

1. "Company" or "insurer" means any life or disability insurance company, benefit insurer, benefit stock insurer, prepaid dental plan organizations, health care service organizations, and all similar type organizations.
2. "Director" means the Director of Insurance of Arizona.
3. "Policy" or "policy form" means any policy, contract, plan or agreement of life or disability insurance, including credit life insurance and credit disability insurance, delivered or issued for delivery in the state by any company subject to this rule; and any certificate issued under a group insurance policy delivered or issued for delivery in this state.

B. Applicability.

1. This Section and R20-6-212 apply to all life and disability insurance policies delivered or issued for delivery in this state by any company but do not apply to:
 - a. Any policy that is a security subject to federal jurisdiction;
 - b. Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy or a group credit disability insurance policy however, this shall not exempt any certificate issued under a group policy delivered or issued for delivery in this state; or
 - c. Any group annuity contract that serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans;
2. Except as provided in R20-6-210, no other rule of this state setting language simplification standards shall apply to any policy forms.

C. Minimum policy language simplification standards.

1. Except as stated in subsection (B), an insurer shall not deliver or issue for delivery a policy form that has not been approved by the Director unless:
 - a. The text achieves a minimum score of 40 on the Flesch reading ease test or an equivalent score on any other comparable test as provided in subsection (3);
 - b. It is printed, except for specification pages, schedules, and tables, in no less than 10 point type, one point leaded;
 - c. The style, arrangement and overall appearance of the policy do not give undue prominence to any portion of the text of the policy or to any endorsements or riders; and
 - d. The policy, if the policy has more than 3,000 words printed on three or fewer pages of text or if the policy has more than three pages regardless of the number of words, contains a table of contents or an index of the principal sections of the policy.
2. An insurer shall measure a Flesch reading ease test score as follows:
 - a. For policy forms containing 10,000 words or less of text, an insurer shall analyze the entire form. For policy forms containing more than 10,000 words, an insurer may analyze the readability of two, 200-word samples per page instead of the entire form. The insurer shall separate the samples by at least 20 printed lines.
 - b. The insurer shall count the number of words and sentences in the text, then divide the total number of

words by the total number of sentences, then multiply that figure by a factor of 1.015.

- c. The insurer shall count and divide the total number of syllables by the total number of words, then multiply that figure by a factor of 84.6.
 - d. The sum of the figures computed under subsections (b) and (c) subtracted from 206.835 equals the Flesch reading ease score for the policy form.
 - e. For subsections (b), (c), and (d), the insurer shall use the following procedures:
 - i. A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word;
 - ii. A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence; and
 - iii. A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. If the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.
 - f. The term "text" as used in this subsection shall include all printed matter except the following:
 - i. The name and address of the insurer, the name, number or title of the policy, the table of contents or index, captions and subcaptions, specification pages, schedules or tables; and
 - ii. Policy language that is drafted to conform to the requirements of a federal law, regulation, or agency interpretation, policy language required by a collectively bargained agreement, medical terminology, words defined in the policy, and policy language required by law or regulation, if the insurer identifies the language or terminology excepted by this subsection and certifies, in writing, that the language or terminology is entitled to be excepted by this subsection.
 3. Any other reading test may be approved by the Director for use as an alternative to the Flesch reading test if it is comparable in result to the Flesch reading ease test.
 4. Filings subject to this subsection shall be accompanied by a certificate signed by an officer of the insurer stating that the filing meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved under subsection (G) of this Section. To confirm the accuracy of any certification, the Director may require the submission of further information to verify the certification in question.
 5. At the option of the insurer, riders, endorsements, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.
- D.** The Director may authorize a lower score than the Flesch reading ease score required in subsection (C)(1)(a) if a lower score:
1. Provides a more accurate reflection of readability of a policy form;
 2. Is warranted by the nature of a particular policy form or type or class of policy forms; or
 3. Is caused by certain policy language drafted to conform to the requirements of any state statute, rule, or agency interpretation of law.

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Historical Note

Adopted effective November 21, 1977 (Supp. 77-6).

Amended effective March 27, 1978 (Supp. 78-2).

Amended subsection (E), deleted subsection (F) and added new subsections (F) and (G) effective December 3, 1986 (Supp. 86-6). R20-6-213 recodified from R4-14-213 (Supp. 95-1). Former R20-6-213 renumbered to R20-6-211; new R20-6-213 renumbered from R20-6-216 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2). Corrected error in R20-6-213(D) that referenced subsection (E)(1)(a), which was relabeled as (C)(1)(a) in Supp. 07-2 (Supp. 08-1).

R20-6-214. Coordination of Benefits**A. Applicability.**

1. This Section applies to all:
 - a. Group disability insurance policies;
 - b. Group subscriber contracts of hospital and medical service corporations and health care services organizations;
 - c. Group disability policies of benefit insurers; and
 - d. Group-type contracts that contain a coordination of benefits provision, are not available to the general public, and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization. Group-type contracts that meet this description are included regardless of whether denominated as "franchise," "blanket," or some other designation.
2. This Section does not apply to:
 - a. Individual or family policies or individual or family subscriber contracts except as provided for in subsection (A)(1);
 - b. Group or group-type hospital indemnity benefits, written on a non-expense incurred basis, of \$30 per day or less unless characterized as reimbursement-type benefits and designed or administered to give the insured the right to elect indemnity-type benefits, instead of the reimbursement type benefits at the time of claim; or
 - c. School accident type coverages, written on a blanket, group, or franchise basis.

B. Definitions. In this Section, the following definitions apply:

1. "Allowable expense" means any necessary, reasonable, and customary item of expense, at least a portion of which is covered under one or more of the plans covering the person for whom claim is made or service provided.
 - a. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered is deemed to be both an allowable expense and a benefit paid.
 - b. A plan that takes Medicare or similar government benefits into consideration when determining the application of its coordination of benefits provision does not expand the definition of an allowable expense.
2. "Claim determination period" means an appropriate period of time such as "calendar year" or "benefit period" as defined in the policy.
3. "Plan," within the coordination of benefits provisions of a group policy or subscriber contract, means the types of coverage that the insurer may consider in determining whether overinsurance exists with respect to a specific claim.

4. "School accident-type coverage" means coverage of grammar school and high school students for accidents only, including athletic injuries, either on a 24-hour basis or "to-and-from school," for which the parent pays the entire premium.

C. Order-of-benefit determination.

1. When a claim under a plan with a coordination of benefit provision involves another plan that also has a coordination of benefit provision, the insurer shall make the order-of-benefit determination as follows:
 - a. The plan that covers the person claiming benefits other than as a dependent shall determine benefits before those of the plan that covers the person as a dependent.
 - b. The plan of a parent whose birthday occurs earlier in a calendar year shall cover a dependent child before the benefits of a plan of a parent whose birthday occurs later in a calendar year. The word "birthday" as used in this subsection refers only to month and day in a calendar year, not the year in which the person was born.
 - c. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in the following order:
 - i. First, the plan of the parent with custody of the child;
 - ii. Then, the plan of the spouse of the parent with custody of the child; and
 - iii. Finally, the plan of the parent not having custody of the child.
 - d. Notwithstanding subsection (c), if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first.
2. The benefits of a plan that covers a person as an employee (or as that employee's dependent) are determined before those of a plan that covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this provision and if, as a result, the plans do not agree on the order of benefits, this subsection does apply.
3. If none of the provisions of subsection (C) determines the order of benefits, the benefits of the plan that covered a claimant longer are determined before those of the plan that covered that person for the shorter time.
4. If one of the plans is issued out of this state and determines the order of benefits based upon the gender of a parent and, as a result, the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.

D. Excess and other nonconforming provisions. A plan with an order of benefit determination provision that complies with this Section, a complying plan, may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses an order-of-benefit determination provision that is inconsistent with this Section, a noncomplying plan, on the following basis:

1. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis.
2. If the complying plan is the secondary plan, it shall pay or provide its benefits first, as the secondary plan. The pay-

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ment shall be the limit of the complying plan's liability, except as provided in subsection (4).

3. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay benefits accordingly. The complying plan shall adjust any payments it makes based on the assumption whether information becomes available as the actual benefits of the noncomplying plan.
4. If the noncomplying plan pays benefits so that the claimant receives less in benefits than the claimant would have received had the noncomplying plan paid or provided its benefits as the primary plan, the complying plan shall advance to or on behalf of the claimant an amount equal to the difference. The complying plan shall not have a right to reimbursement from the claimant.

Historical Note

Adopted effective October 26, 1979 (Supp. 79-5). R20-6-214 recodified from R4-14-214 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1). Section R20-6-214 renumbered from R20-6-217 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-215. Renumbered**Historical Note**

Adopted effective September 7, 1981 (Supp. 81-3). Amended subsections (D) through (H), deleted Agent's Statement and Exhibit D effective March 30, 1983 (Supp. 83-2). R20-6-215 recodified from R4-14-215 (Supp. 95-1). Amended by exempt rulemaking at 9 A.A.R. 5595, effective January 1, 2004 (Supp. 03-4). Former R20-6-215 renumbered to R20-6-212 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-215.01. Renumbered**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 5595, effective January 1, 2004 (Supp. 03-4). Former R20-6-215.01 renumbered to R20-6-212.01 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-216. Renumbered**Historical Note**

Adopted effective as set forth in subsection (H) (Supp. 80-6). R20-6-216 recodified from R4-14-216 (Supp. 95-1). Former R20-6-216 renumbered to R20-6-213 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-217. Renumbered**Historical Note**

Adopted effective September 14, 1982 (Supp. 82-3). Amended subsections (C) and (D), deleted (F) effective January 1, 1987, filed December 16, 1986 (Supp. 86-6). R20-6-217 recodified from R4-14-217 (Supp. 95-1). Former R20-6-217 renumbered to R20-6-214 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

Editor's Note: The following Section expired under A.R.S. § 41-1056(E) on September 30, 2001 at 8 A.A.R. 491. The Notice of Rule Expiration was not received until January 9, 2002. Therefore, the repeal of the rule noted in the Historical Note is moot (Supp. 02-1).

R20-6-218. Repealed**Historical Note**

Adopted effective November 9, 1984 (Supp. 84-6). R20-6-218 recodified from R4-14-218 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 5443, effective November 16, 2001 (Supp. 01-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1); refer to the Editor's Note before the Section.

ARTICLE 3. FINANCIAL PROVISIONS AND PROCEDURES**R20-6-301. Expired****Historical Note**

Former General Rule Number 3. R20-6-301 recodified from R4-14-301 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

R20-6-302. Expired**Historical Note**

Former General Rule 62-11. R20-6-302 recodified from R4-14-302 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

R20-6-303. Termination of Certificate of Authority and Release of Deposit

A. Domestic Insurers. To request termination of a certificate of authority and, if applicable, release of statutory deposit, a domestic insurer shall file all of the following with the director:

1. A written request for termination of certificate of authority and release of deposit;
2. The insurer's original certificate of authority or an affidavit of lost certificate of authority;
3. A statement of the insurer's financial condition as of a date within 60 days of the filing date of the request for termination that includes a written statement, signed by two officers of the insurer as authorized on the jurat page of the insurer's most recent annual statement, verifying that the statement of financial condition reflects the insurer's financial position as of the date signed.
4. A plan of extinguishment for its outstanding liabilities that satisfies the requirements of subsection (C) or a sworn affidavit stating that the insurer has no outstanding liabilities to policyholders or claimants under subsection (C);
5. A certified copy of the insurer's Board of Directors resolution or other documentation of the insurer's official action taken according to the insurer's statutorily required organizational documents approving the insurer's:
 - a. Withdrawal from the insurance business,
 - b. Dissolution of the insurer,
 - c. Merger with an insurer authorized in Arizona to transact the insurer's previously written and active lines of business of the insurer requesting termination, or
 - d. Transfer of domicile to another state or country.

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6. A copy of the insurer's Articles of Dissolution, Articles of Merger, Articles of Amendment, Articles of Redomestication, or other documentation that the insurer intends to file with the Arizona Corporation Commission after issuance of the Director's order as provided in subsection (D)(2);
 7. If requested by the director, a written agreement that guarantees payment of substantially all liabilities of the domestic insurer, other than obligations extinguished under subsection (C).
- B. Foreign and Alien Insurers.** To request termination of its certificate of authority and, if applicable, release of its deposit, a foreign or alien insurer shall file all of the following with the director:
1. A written request for termination of certificate of authority and release of deposit;
 2. The insurer's original certificate of authority or an affidavit of lost certificate of authority;
 3. A statement of the insurer's financial condition as of a date within 60 days of the filing date of the request for termination that includes a written statement, signed by two officers of the insurer as authorized on the jurat page of the insurer's most recent annual statement, verifying that the statement of financial condition reflects the insurer's financial position as of the date signed.
 4. A plan of extinguishment for its Arizona liabilities that satisfies the requirements of subsection (C) or a sworn affidavit stating that the insurer has no Arizona liabilities under subsection (C);
 5. A copy of an order issued by the insurance director or other appropriate regulatory authority in the insurer's state or country of domicile that approves or authorizes either the insurer's:
 - a. Withdrawal from the insurance business,
 - b. Dissolution of the insurer,
 - c. Merger (approval of the merger from the states of domicile of the insurers), or
 - d. Transfer of domicile, if applicable.
 6. A copy of the insurer's Articles of Dissolution, Articles of Merger, Articles of Amendment, Articles of Redomestication or other required documentation that the insurer filed in its state of domicile; and
 7. If requested by the director, a written agreement that guarantees payment of substantially all Arizona liabilities of the insurer, other than obligations extinguished under subsection (C).
- C. Insurer's Plan for Extinguishment of Liabilities.**
1. To extinguish substantially all liabilities under subsection (A)(4) or subsection (B)(4) as applicable, an insurer may:
 - a. Reinsure the insurer's business in force with another insurer by entering into an agreement of bulk reinsurance that shall be effective when filed with and approved in writing by the director.
 - i. The agreement shall provide for assumption of all policyholder claims by the reinsurer including claims incurred but unreported as of the effective date of the agreement.
 - ii. The agreement may include recapture provisions exercisable by the insurer in the event the termination of its certificate of authority is not completed.
 - iii. Unless the director otherwise approves, the agreement shall provide that the reinsurer be licensed in Arizona for the particular lines of business reinsured.
 - b. Merge with another insurer that:
 - i. Assumes the liabilities of the non-surviving insurer; and
 - ii. Is authorized in Arizona for the previously written and active lines of business assumed, unless otherwise approved by the director.
 - c. Use its deposit, any additional security deposit or both to secure payment of former policyholder, policyholder, or claimant liabilities that are not reinsured or otherwise secured.
 2. For purposes of this Section, "substantially all liabilities" under Title 20 means all policyholder and claimant obligations reported by the insurer in the statement of financial condition, whether or not liquidated in amount, and shall include former policyholder claims and rights to refunds.
- D. Consideration of the Request for Termination of Certificate of Authority and Release of Deposit under subsections (A) and (B).**
1. If the director determines that the insurer has extinguished substantially all liabilities as required under this Section and has otherwise demonstrated compliance with this Section and A.R.S. Title 20, the director shall grant the request to terminate the certificate of authority and, if appropriate, release the insurer's deposit, provided:
 - a. The insurer has no fees, taxes, assessments or filings outstanding to the Department; and
 - b. The insurer is not subject of any pending investigation or examination under Title 20 by the Department.
 2. The director's order shall condition the release of a domestic insurer's deposit upon receipt by the director of evidence of the official filing with the Arizona Corporation Commission of the documentation described in subsection (A)(6).
 3. If the director determines that the insurer is unable to extinguish substantially all liabilities as required under this Section, or otherwise has not complied with this Section or with A.R.S. Title 20, the director shall notify the insured in writing that the request has been denied and the reasons for the denial.
- E. Exclusions.** This Section does not apply to:
1. An insurer's exchange and substitution of cash or eligible securities under A.R.S. § 20-586;
 2. An insurer's withdrawal of excess deposits, either cash or eligible securities, under A.R.S. §§ 20-587 and 20-588(A)(2); or
 3. Releases of deposits made under A.R.S. § 20-588(A)(3).

Historical Note

Former General Rule 72-29. R20-6-303 recodified from R4-14-303 (Supp. 95-1). Section R20-6-303 repealed; new Section R20-6-303 made by final rulemaking at 14 A.A.R. 3432, effective October 4, 2008 (Supp 08-3).

R20-6-304. Reserved

R20-6-305. Expired

Historical Note

Adopted effective September 13, 1978, except that it shall apply to the accounting treatment for unearned premium reserves and reinsurance premium receivables for credit life disability insurance on January 1, 1979, and all

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annual statements filed for periods on or after that date (Supp. 78-5). R20-6-305 recodified from R4-14-305 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

R20-6-306. Reserved**R20-6-307. Life and Disability Reinsurance Agreements**

A. Scope. This rule applies to all domestic life and disability insurers and reinsurers, and to all other licensed life and disability insurers and accredited reinsurers that are not subject to a substantially similar rule in their jurisdictions of domicile. This rule applies to the disability business of licensed property and casualty insurers. This rule does not apply to assumption reinsurance, yearly renewable term reinsurance, or nonproportional stop loss or catastrophe reinsurance, or similar forms of nonproportional reinsurance.

B. Definitions

1. "Agreement" means a reinsurance agreement and any amendment to a reinsurance agreement.
2. "Credit Quality" means the risk that invested assets supporting the reinsured business will decrease in value but excludes decreases to changes in interest rate.
3. "Department" means the Arizona Department of Insurance and Financial Institutions – Insurance Division.
4. "Director" has the same meaning as A.R.S. § 20-102.
5. "Disintermediation" means the risk that interest rates will rise and policy loans and surrenders will increase or maturing contracts will not renew at anticipated rates of renewal.
6. "Lapse" means the risk that a policy will voluntarily terminate before the recoupment of a statutory surplus strain experienced at issuance of the policy.
7. "Reinvestment" means the risk that interest rates will fall and funds reinvested will therefore earn less than expected.

C. Accounting Requirements

1. Unless authorized by the Director, an insurer shall not, for reinsurance ceded, reduce any liability, or establish any asset in any statutory financial statement filed with the Department if, by the terms of the agreement, or in effect, any of the following conditions exist:
 - a. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period are not sufficient to cover the ceding insurer's allocable renewal expenses anticipated at the time the business is reinsured on the portion of the business reinsured, unless a liability is established for the present value of the shortfall using assumptions equal to the applicable statutory reserve basis on the business reinsured.
 - b. The ceding insurer is required to reimburse the reinsurer for negative experience under the agreement. Neither the offset of the ceding insurer's experience refunds against current and prior years' losses, nor payment by the ceding insurer of an amount equal to the reinsurer's current and prior years' losses upon voluntary termination of in-force reinsurance by the ceding insurer, shall be considered a reimbursement to the reinsurer for negative experience.
 - c. The ceding insurer may be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of a specified event, including the insolvency of the ceding insurer. Termination of the

agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due shall not be considered a deprivation of surplus or assets within the meaning of this subsection.

- d. The ceding insurer is required, at scheduled times, to terminate the agreement or recapture automatically all or part of the reinsurance ceded.
 - e. The ceding insurer may be required to pay the reinsurer amounts other than from income reasonably expected from the reinsured policies.
 - f. Significant risks inherent in the business reinsured are not transferred to the reinsurer. Table A identifies the risks deemed significant for representative types of business.
 - g. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not transfer the underlying assets to the reinsurer, segregate the underlying assets in a trust or escrow account, or otherwise segregate the underlying assets. The assets that support the reserves for classes of business that do not have a significant credit quality, reinvestment, or disintermediation risk, or for long-term care or long-term disability insurance, traditional non-par permanent, traditional par permanent, adjustable premium permanent, indeterminate premium permanent, or universal life fixed premium with no dump-in premiums allowed, may be held by the ceding company without segregation. To determine the reserves for classes of business, the supporting assets of which may be held without being segregated, the reserve interest rate adjustment formula shall reflect the ceding company's investment earnings and incorporate all realized and unrealized gains and losses reported in the ceding insurer's statutory financial statement.
 - h. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days of the settlement date.
 - i. The ceding insurer is required to make representations or warranties unrelated to the business reinsured.
 - j. The ceding insurer is required to make representations or warranties related to future performance of the business reinsured.
2. An agreement entered into after the effective date of this rule to reinsure business issued before the effective date of the agreement shall be filed by the ceding insurer with the Director within 30 days after execution of the agreement. Each filing shall be accompanied by a description of the corresponding reduction in liabilities or other credit for reinsurance, and any other financial impact of the agreement, reported in the ceding insurer's statutory financial statements. When an increase in surplus net of federal income tax results from an agreement falling under this subsection, the ceding insurer shall separately identify the increase as a surplus item in the aggregate write-ins for gains and losses in surplus in the Capital and Surplus account of the ceding insurer's statutory financial statement. As earnings emerge from the business reinsured, the ceding insurer shall report in its statutory financial statement recognition of surplus increase as income on a net of tax basis as reinsurance ceded.

D. Written Agreements

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1. A ceding insurer shall not reduce any liability or establish any asset in any statutory financial statement filed with the Department, unless the ceding insurer and the reinsurer have executed an agreement or a binding letter of intent by the "as of" date of the statutory financial statement.
2. A ceding insurer shall not be allowed a credit for the reinsurance ceded based on a letter of intent unless the ceding insurer and the reinsurer execute an agreement within 90 days from the execution date of the letter of intent.
3. The agreement shall provide that:
 - a. The agreement constitutes the entire contract between the parties with respect to the business reinsured, and there are no understandings between the parties other than as expressed in the agreement; and
 - b. Any change or modification to the agreement shall be void unless made by written amendment signed by all parties.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-307 recodified from R4-14-307 (Supp. 95-1). Amended effective December 7, 1995 (Supp. 95-4). Amended by final rulemaking at 29 A.A.R. 739 (March 17, 2023), effective May 8, 2023 (Supp. 23-1).

Table A. Risk Categories

Risk Categories:

- | | |
|----------------|------------------------|
| (a). Morbidity | (d). Credit Quality |
| (b). Mortality | (e). Reinvestment |
| (c). Lapse | (f). Disintermediation |

	a	b	c	d	e	f
Disability Insurance, other than long-term care or long-term disability insurance	+	0	+	0	0	0
Long-term care or long-term disability insurance	+	0	+	+	+	0
Immediate Annuities	0	+	0	+	+	0
Single Premium Deferred Annuities	0	0	+	+	+	+
Flexible Premium Deferred Annuities	0	0	+	+	+	+
Guaranteed Interest Contracts	0	0	0	+	+	+
Other Annuity Deposit Business	0	0	+	+	+	+
Single Premium Whole Life	0	+	+	+	+	+
Traditional Non-par Permanent Life	0	+	+	+	+	+
Traditional Non-par Term Life	0	+	+	0	0	0
Traditional Par Permanent Life	0	+	+	+	+	+
Traditional Par Term Life	0	+	+	0	0	0
Adjustable Premium Permanent Life	0	+	+	+	+	+
Indeterminate Premium Permanent Life	0	+	+	+	+	+
Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium, with dump-in premiums allowed	0	+	+	+	+	+

+ - Significant

0 - Insignificant

Historical Note

Adopted effective December 7, 1995 (Supp. 95-4). Corrected misspelled word "adjustable" as submitted in final rule (Supp. 98-3).

R20-6-308. Expired

expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

Historical Note

Adopted effective March 22, 1993 (Supp. 93-1). R20-6-308 recodified from R4-14-308 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 3374, effective May 31, 2016 (Supp. 16-4).

R20-6-309. Expired**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

R20-6-309.01. Expired**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section

R20-6-309.02. Expired**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

R20-6-309.03. Expired**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

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R20-6-309.04. Expired**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

R20-6-310. Corporate Governance

The purpose of Sections R20-6-310.01 through R20-6-310.03 is to set forth procedures for filing and the required contents of the Corporate Governance Annual Disclosure (CGAD) deemed necessary by the Director to carry out the provisions of Title 20, Chapter 2, Article 16 on Corporate Governance.

Historical Note

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

R20-6-310.01. Definitions

The definitions in A.R.S. § 20-492 and this Section apply to Sections R20-6-310.02 through R20-6-310.04.

“CGAD” means Corporate Governance Annual Disclosure.

“NAIC” means National Association of Insurance Commissioners.

“Senior Management” means any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the Chief Executive Officer (“CEO”), Chief Financial Officer (“CFO”), Chief Operations Officer (“COO”), Chief Procurement Officer (“CPO”), Chief Legal Officer (“CLO”), Chief Information Officer (“CIO”), Chief Technology Officer (“CTO”), Chief Revenue Officer (“CRO”), Chief Visionary Officer (“CVO”), or any other “C” level executive.

Historical Note

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

R20-6-310.02. Filing Procedures

- A. Deadline to file. An insurer, or the insurance group of which the insurer is a member, required to file a CGAD by A.A.C. Title 20, Chapter 2, Article 16 shall, no later than June 1 of each calendar year, submit to the Director a CGAD that contains the information described in Section R20-6-310.03.
- B. Attestation. The CGAD must include a signature of the insurer’s or insurance group’s CEO or corporate secretary attesting to the best of that person’s belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that the copy of the CGAD has been provided to the insurer’s or insurance group’s Board of Directors or appropriate committee of the Board of Directors.
- C. Format of the CGAD. The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required and is permitted to customize the CGAD to provide the most relevant information necessary to permit the Director to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer or insurance group.
- D. Insurer or insurance group to determine level of reporting.
 1. For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate con-

trolling parent level, an intermediate holding company level and/or the individual legal entity level, depending on how the insurer or insurance group has structured its system of corporate governance.

2. The insurer or insurance group is encouraged to make the CGAD disclosures at:
 - a. The level at which the insurer’s or insurance group’s risk appetite is determined,
 - b. The level at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or
 - c. The level at which legal liability for failure of general corporate governance duties would be placed.
3. If the insurer or insurance group determines the level of reporting based on the criteria in subsection (D)(2), it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in the level of reporting.
- E. CGAD completed at the insurance group level. Notwithstanding subsection (A) and as outlined in A.R.S. § 20-492.01, if the CGAD is completed at the insurance group level, then it must be filed with the lead state of the group as determined by the procedures outlined in the NAIC’s Financial Analysis Handbook 2018 Annual/2019 Quarterly, pp. 771 through 774, and no future editions. In these instances, a copy of the CGAD must also be provided, upon request, to the chief regulatory official of any state in which the insurance group has a domestic insurer.
- F. Reference to other existing documents. An insurer or insurance group may comply with this Section by referencing other existing documents (e.g., ORSA Summary Report, Holding Company Form B or F Filings, Securities and Exchange Commission (SEC) Proxy Statements, foreign regulatory reporting requirements, etc.) if the documents provide information that is comparable to the information described in R20-6-310.03. The insurer or insurance group shall clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed or available to the Director.
- G. Subsequent filings of the CGAD. Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where changes have been made to the previously filed CGAD. The filing shall also state if no changes are made to the information or activities previously reported by the insurer or insurance group.

Historical Note

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

R20-6-310.03. Contents of CGAD

- A. Inclusion of attachments. The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices.
- B. Board. The CGAD shall describe the insurer’s or insurance group’s corporate governance framework and structure including consideration of the following:
 1. The Board and its various committees ultimately responsible for overseeing the insurer or insurance group and

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the level or levels at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current Board size and structure; and

2. The duties of the Board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the Board's leadership is structured, including a discussion of the roles of the Chief Executive Officer (CEO) and Chairman of the Board within the organization.
- C. Senior Governing Entity. The insurer or insurance group shall describe the policies and practices of the most senior governing entity and its significant committees, including a discussion of the following factors:
1. How the qualifications, expertise and experience of each Board member meet the needs of the insurer or insurance group.
 2. How an appropriate amount of independence is maintained on the Board and its significant committees.
 3. The number of meetings held by the Board and its significant committees over the past year as well as information on director attendance.
 4. How the insurer or insurance group identifies, nominates and elects members of the Board and its committees. The discussion should include, for example:
 - a. Whether a nomination committee is in place to identify and select individuals for consideration.
 - b. Whether term limits are placed on directors.
 - c. How the election and re-election processes function.
 - d. Whether a Board diversity policy is in place and if so, how it functions.
 5. The processes in place for the Board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any Board or committee training programs that have been put in place).
- D. Senior Management. The insurer or insurance group shall describe the policies and practices for directing Senior Management, including a description of the following factors:
1. Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:
 - a. Identification of the specific positions for which suitability standards have been developed and a description of the standards employed.
 - b. Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.
 2. The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:
 - a. Compliance with laws, rules, and regulations; and
 - b. Proactive reporting of any illegal or unethical behavior.
 3. The insurer's or insurance group's processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the Director to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk-taking. Elements to be discussed may include, for example:
 - a. The Board's role in overseeing management compensation programs and practices.
 - b. The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;
 - c. How compensation programs are related to both company and individual performance over time;
 - d. Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;
 - e. Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted;
 - f. Any other factors relevant to understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees.
 4. The insurer's or insurance group's plans for CEO and Senior Management succession.
- E. Oversight. The insurer or insurance group shall describe the processes by which the Board, its committees and Senior Management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of:
1. How oversight and management responsibilities are delegated between the Board, its committees and Senior Management;
 2. How the Board is kept informed of the insurer's strategic plans, the associated risks, and steps the Senior Management is taking to monitor and manage those risks;
 3. How reporting responsibilities are organized for each critical risk area. The description should allow the Director to understand the frequency at which information on each critical risk area is reported to and reviewed by Senior Management and the Board. This description may include, for example, the following critical risk areas of the insurer:
 - a. Risk management processes (an ORSA Summary Report filer may refer to its ORSA Summary Report submitted pursuant to A.R.S. § 20-491.03);
 - b. Actuarial function;
 - c. Investment decision-making processes;
 - d. Reinsurance decision-making processes;
 - e. Business strategy/finance decision-making processes;
 - f. Compliance function;
 - g. Financial reporting/internal auditing; and
 - h. Market conduct decision-making processes.

Historical Note

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

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R20-6-310.04. Severability Clause

If any provision of this Section, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of this Section which can be given effect without the invalid provision or application, and to that end the provisions of this Section are severable.

Historical Note

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

Appendix A. Expired**Table 1. Expired****Table 2. Expired****Table 3. Expired****Table 4. Expired****Table 5. Expired****Table 6. Expired****Historical Note**

Appendix A adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Appendix A (including Tables 1 through 6) expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

ARTICLE 4. TYPES OF INSURANCE COMPANIES**R20-6-401. Proxies, Consents, and Authorizations of Domestic Stock Insurers**

- A. The Department incorporates by reference National Association of Insurance Commissioners Model Laws, Regulations and Guidelines, Volume III, pp. 490-1 through 490-40, Regulation Regarding Proxies, Consents, and Authorization of Domestic Stock Insurers, April 1995 (and no future editions or amendments), which is on file with and available from the Department of Insurance, 100 N. 15th Ave., Suite 102, Phoenix, AZ 85007-2624 and the National Association of Insurance Commissioners, Publications Department, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197, modified as follows:

Section 1 A is modified to read: "No domestic stock insurer that has any class of equity securities held of record by 100 or more persons, or any director, officer or employee of that insurer, or any other person, shall solicit, or permit the use of the person's name to solicit, by mail or otherwise, any proxy, consent, or authorization in respect to any class of equity securities in contravention of this regulation and Schedules A and B, hereby made a part of this regulation."

- B. Domestic stock insurance companies shall comply with this Section as required under A.R.S. § 20-143(B).

Historical Note

Former General Rule 57-3. R20-6-401 recodified from R4-14-401 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3). New Section made by final rulemaking at 9 A.A.R. 1086, effective March 6, 2003 (Supp. 03-1). Section amended by final expedited rulemaking with an immediate effective date of September 16, 2019 (Supp. 19-3).

R20-6-402. Expired**Historical Note**

Former General Rule 69-19. R20-6-402 recodified from R4-14-402 (Supp. 95-1). Section expired under A.R.S. §

41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Exhibit A. Expired**Historical Note**

Former General Rule 69-19. R20-6-402 recodified from R4-14-402 (Supp. 95-1). Exhibit expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Exhibit B. Expired**Historical Note**

Former General Rule 69-19. R20-6-402 recodified from R4-14-402 (Supp. 95-1). Exhibit expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

R20-6-403. Expired**Historical Note**

Former General Rule 69-21. R20-6-403 recodified from R4-14-403 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Appendix A. Expired**Historical Note**

R20-6-403, Appendix A recodified from R4-14-403, Appendix A (Supp. 95-1). Appendix expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Appendix B. Expired**Historical Note**

R20-6-403, Appendix B recodified from R4-14-403, Appendix B (Supp. 95-1). Appendix expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

Appendix C. Expired**Historical Note**

R20-6-403, Appendix C recodified from R4-14-403, Appendix C (Supp. 95-1). Appendix expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

R20-6-404. Repealed**Historical Note**

Former General Rule 73-31; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-404 recodified from R4-14-404 (Supp. 95-1).

R20-6-405. Health Care Services Organization

- A. Authority. This rule is adopted pursuant to A.R.S. §§ 20-142, 20-143, 20-106 and 20-1051 through 20-1068.
- B. Purpose. The purpose of this rule is to implement the legislative intent, as expressed in Chapter 128, Laws of 1973, to regulate and control Health Care Services Organizations in the State of Arizona, (including, but not limited to Certificate of Authority, licensing, fees for licensing, disciplinary procedures for agents and control of solicitation of members and evidences of coverage).
- C. Scope
1. The scope of this Rule is the scope of A.R.S. Title 20 as it relates to Insurers or Hospital or Medical Service Corporations. As it relates to Health Care Services Organiza-

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tions, the scope of this rule is the scope of Title 20, Chapter 1 and Title 20, Chapter 4, Article 9, as provided in A.R.S. § 20-1068. This rule is applicable to agents of persons, and persons operating or proposing to operate Health Care Services Organizations in the State of Arizona.

2. The statutory authority for this rule, A.R.S. Title 20, Chapter 4, Article 9, does not provide for exemptions therefrom for persons or agents of persons subject thereto, and no such exemption is intended or should be presumed by this rule or any provision thereof.
- D. Repeal.** This rule does not repeal any known prior rule, memorandum, bulletin, directive or opinion on this subject matter. If such prior rule or directive exists and is in conflict herewith, the same is repealed hereby.
- E. Definitions.** As used in this rule, unless the context otherwise requires:
1. "Agent" has the meaning of A.R.S. § 20-282.
 2. "Basic Health Care Services" has the meaning of A.R.S. § 20-1051.
 3. "Certificate of Authority" means a Certificate authorizing operation of a Health Care Services Organization.
 4. "Director" means the Director of Insurance of the State of Arizona.
 5. "Enrollee" has the meaning of A.R.S. § 20-1051.
 6. "Evidence of coverage" has the meaning of A.R.S. § 20-1051.
 7. "Health Care Plan" has the meaning of A.R.S. § 20-1051.
 8. "Health Care Services" has the meaning of A.R.S. § 20-1051.
 9. "Health Care Services Organizations" has the meaning of A.R.S. § 20-1051.
 10. "Hospital Service Corporation" has the meaning of A.R.S. § 20-822.
 11. "Insurer" has the meaning of A.R.S. § 20-106(C).
 12. "License" means the authority to act as an agent of a Health Care Services Organization.
 13. "Medical Service Corporation" has the meaning of A.R.S. § 20-822.
 14. "Net charges" means the total of all sums prepaid by or for all enrollees, less approved refunds, adjustments and deductions, as consideration for Health Care Services of a Health Care Plan under an Evidence of Coverage.
 15. "Person" has the meaning of A.R.S. § 20-1051.
 16. "Physician and patient relationship" has the meaning of A.R.S. § 20-833.
 17. "Prepaid Health Plans" means any Health Care Plan to pay or make reimbursement for Health Care Services on a prepaid basis other than insured plans otherwise authorized and approved under A.R.S. Title 20.
 18. "Prepaid Group Practice Plan" means a person authorized and approved under A.R.S. Title 20.
 19. "Provider" has the meaning of A.R.S. § 20-1051.
 20. "Transact" has the meaning of A.R.S. § 20-106(A) and (B).
 21. "Unqualified agent" means a person directly or indirectly representing or acting for a Health Care Services Organization and not qualified as an agent thereof.
- F. Certificate of Authority**
1. Policy. Persons and agents of persons operating Health Care Services Organizations as of May 7, 1973, shall comply with the application requirements of A.R.S. § 20-1052 on or before August 7, 1973.
2. A Certificate of Authority shall not be granted until the Director is satisfied that the requirements of A.R.S. §§ 20-1052, 20-1053 and 20-1054 are met and will continue to be met.
 3. An examination of an applicant at the expense of the applicant for a Certificate of Authority may be ordered to be made if the applicant is not a resident, is controlled by a non-resident, or maintains a head or principal office out of its service area, and will be ordered to be made if the applicant contracts with providers, or for services outside a reasonable area, or has contract obligations under its evidence of coverage that are, or appear to be, inequitable or unreasonable as to the enrollees.
- G. Certificate of Authority – Application**
1. A person required to be qualified to do business in this State as a Health Care Services Organization, pursuant to A.R.S. § 20-1052 shall file an application for Certificate of Authority on Department Form E-104.
 2. Applications failing to comply with the requirements of A.R.S. § 20-1053 will be denied without prejudice to the filing of an application complying with such requirements.
 3. Health Care Services Organizations operating in this State as of May 7, 1973, and having submitted a sufficient application for Certificate of Authority as required by this rule, including the disclosure filings of paragraph (7) of this subsection, may continue to operate as an organization until the Director acts upon the application.
 4. The application for Certificate of Authority shall be verified by an authorized and qualified officer of the Health Care Services Organization.
 5. The application for Certificate of Authority shall be accompanied by the fees required for a hospital or medical service corporation by A.R.S. § 20-167 and a tax return or returns on Department Form E-162, for the calendar year previous to the calendar year of application during which the applicant has done business in this State as a Health Care Services Organization, and the amount of tax due thereon after the effective date hereof, if any, as provided by A.R.S. § 20-1060. The filing of such returns or payment of such tax may be adjusted or waived by the Director upon application and affirmative showing in writing therefor justifying the adjustment or waiver.
 6. The Director may, upon written request accompanied by supporting documentation justifying the request, authorize the substitution of public information filed by an applicant under similar statutes or regulations in another state, or under federal requirements, or may waive such information or additional information.
 7. Pursuant to the authority of A.R.S. § 20-1053(13), the Director finds that biographical information disclosing the past activities, employment and financial transactions or principals, principal officers, controlling persons, and agents of applicant Health Care Services Organizations is necessary for the protection of residents of this State.
 8. Pursuant to the authority of A.R.S. § 20-1053(13), the Director finds that records of fingerprints of principal officers and agents of applicant Health Care Services Organizations may be necessary for the protection of citizens of this state and may be required prior to licensing or approval of a Certificate of Authority.
- H. Certificate of Authority – Application.** The application for Certificate of Authority shall be accompanied by a power of

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attorney as required by A.R.S. § 20-1053(A)(10) on Department Form E-128.

I. Certificate of Authority – Grounds for denial

1. Policy. A Certificate of Authority to operate a Health Care Services Organization shall not be granted until the Director is satisfied by the affirmative showing, verified by the applicant, that all of the requirements of A.R.S. §§ 20-1052, 20-1053 and 20-1054 are met and will continue to be met.
2. Guidelines. The guidelines and standards for determination of appropriate mechanisms to achieve an effective Health Care Plan include, but are not limited to the following:
 - a. Ability to provide basic Health Care Services without undue restrictions, limitations, discrimination, unreasonable fee schedules, or unreasonable administrative costs; an affirmative showing that the form of organization does not evidence any coercion, duress or other compulsion over members;
 - b. The form of organization does not lend itself to practices prohibited by A.R.S. §§ 20-441 through 20-459, and
 - c. The evidence of coverage does not contain provisions or statements which are unjust, inequitable, misleading, deceptive or untrue or encourage misrepresentation.
3. Failure to pay obligations. Applications for a Certificate of Authority to operate a Health Care Services Organization may be denied or rejected if the applicant has failed after 30 days from the entry of final judgment, to pay obligations within the provisions of an evidence of coverage issued by such applicant. The provisions of this Section may be waived by the Director upon a clear affirmative showing that the applicant is defending an action or appealing a judgment at law or equity in a court of this state, or is required to obtain a Certificate of Authority so as to maintain such action.
4. Unauthorized agents. Applications for a Certificate of Authority to operate a Health Care Services Organization may be denied or rejected, after stated cause and opportunity to answer, if the applicant has, 90 days after the effective date, permitted transactions by an unauthorized agent.

J. Solicitation requirements

1. Forms for evidences of coverage, advertising matter, sales material and amendments thereto, will not be approved until the Director is satisfied by filing of Department Form P-107 accompanying the filing of such form and the payment of necessary fees, that the requirements of A.R.S. §§ 20-1057, 20-1054(2), and 20-1061 have been met and will continue to be met.
2. Each Health Care Services Organization shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement brochure, form letter of solicitation, evidence of coverage, certificate, agreement or contract, and a copy of all radio and television forms of the above hereafter disseminated in this or any other State with a notation attached to each such solicitation or inducement to indicate the manner and extent of distribution and the date of approval by the Department of such solicitation. Such advertising file shall be maintained for a period of not less than three years.

- K. Annual report.** Each Health Care Services Organization required to file an annual statement, shall, on or before March 1 of each year, file with the Director, together with its annual statement on Department Form E-13, a certificate executed by an authorized officer of the Health Care Services Organization stating that to the best of his knowledge, information and belief, all written solicitations disseminated during the preceding statement year complied or were made to comply with the provisions of Title 20, Chapter 4, Article 9, and this rule, and that no forms of solicitation were disseminated without the prior approval of the Director.

L. Taxes

1. All Health Care Services Organizations operating and transacting business in the State of Arizona shall on or before March 1 and with the filing of the Annual Report, file a tax return on Department Form E-162, and pay the tax due on such return pursuant to A.R.S. § 20-1060.
2. A tax return required to be filed and filed with an application for Certificate of Authority may cover a period of time of less than a calendar year as specified in the return and approved by the Director. Annual tax returns required to be filed coincident with the annual report shall be for the full calendar year next preceding the date of filing the annual report.
3. Net charges, as in this rule defined, shall represent the net charges received during the calendar year next preceding the date of filing the annual report and tax return.

M. Deposit requirements

1. In the event a Health Care Services Organization determines to maintain statutory deposits by a surety bond, such surety bond shall be in form as approved by the Director guaranteeing the payment of Health Care Services furnished to enrollees, and shall be deposited with the State Treasurer.
2. In the event a Health Care Services Organization determines to maintain the deposit requirements by filing securities with the State Treasurer, a full and complete statement of the securities proposed to be deposited, together with sufficient information to permit a determination of eligibility of such securities shall be filed with the Director on Department Form E-123, and such securities shall not be deposited until such securities are approved by the Director in writing.
3. No securities deposited as herein provided shall be exchanged or substituted for similar securities, except upon the prior written approval of the Director.
4. Health Care Services Organizations claiming to be exempt from the deposit requirement, pursuant to A.R.S. § 20-1055(f) shall submit to the Director an affirmative showing or certification executed by an authorized federal, state or municipal government or political subdivision thereof, demonstrating operational commitments equivalent to the statutory deposit requirements.
5. Statutory deposits shall not be withdrawn or a surety bond cancelled until all contingent and perfected liens, including judgments, debts, and other liabilities for payment of Health Care Services to which the enrollee is entitled under the evidence of coverage shall have been paid and the Director has given his authority in writing to withdraw such deposits or cancel such bonds.

- N. Reserve requirements.** Reserves required by A.R.S. § 20-1056 shall be deposited or maintained as cash, as Certificates of Deposit, or as securities eligible for investment of the capital

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of domestic insurers, pursuant to A.R.S. §§ 20-537 and 20-538.

O. Insurers and hospital and medical service corporations – Certificate of Authority

1. Insurers, Hospital Service Corporation, Medical Service Corporations, and Hospital and Medical Service Corporations, holding current Certificates of Authority to do business in this state may organize and operate Health Care Services Organizations jointly or severally without compliance with the deposit and reserve requirements of the statute, if the application contains an affirmative showing that the applicant organization has complied with comparable provisions of Title 20, and is an appropriate mechanism to achieve an effective Health Care Plan.
2. The provisions of statute and this rule applying to Certificates of Authority and Application therefor, shall apply to all insurers, Hospital Service Corporations, Medical Service Corporations, and Hospital and Medical Service Corporations doing business in this state.
3. Organizations claiming exemption or partial exemption pursuant to A.R.S. § 20-1063(c) shall file with the Director simultaneously with the application for Certificate of Authority, a statement affirmatively showing that the applicant has complied with provisions of Title 20 A.R.S. comparable to or more restrictive than the provisions of Title 20, Chapter 4, Article 9, and shall have received the written approval of the Director for such exemption or partial exemption.

P. Application, examination and licensing of agents

1. No agent of a Health Care Services Organization shall be eligible for transactions of a Health Care Services Organization, unless, prior to making any solicitation or transaction, he has been appointed agent by a Health Care Services Organization holding a current valid Certificate of Authority and has been licensed as herein provided. Persons directly or indirectly representing or acting for a Health Care Services Organization and not licensed as herein provided, or otherwise qualified under A.R.S. Title 20, shall be an unqualified agent.
2. Any person applying for a license as an agent of a Health Care Services Organization shall do so by filing with the Department of Insurance the following:
 - a. An application for such license on a form approved by the Director of the Department of Insurance;
 - b. The required fees for such license;
 - c. Such additional information as the Director may deem necessary.
3. The licensing of an agent of a Health Care Services Organization shall not become effective until such applicant shall have satisfactorily passed a written examination in accordance with A.R.S. § 20-292 as supplemented by A.R.S. § 20-167.
4. The examination shall be given in such places and at such times as the Director shall from time to time designate.
5. The form of examination and the manual may be altered and amended from time to time, so as to represent a fair test of the applicant's qualifications.
6. Every applicant for license shall satisfactorily complete the examination given with a grade of at least 70%, or such other percentage as may be fixed from time to time by the Director prior to the examination commensurate with the nature of the examination given.
7. License and examination fees shall be in accordance with A.R.S. § 20-167.

8. Report of the results of any examination given pursuant to this rule shall be mailed to the applicant and to the applicant's Health Care Services Organization at the address shown on the application.
9. Except as modified by this rule, the provisions for examination, licensing, annual fees and disciplinary procedures of Chapter 2, Article 3 of Title 20, shall apply.
10. Any agent licensed in this state shall immediately report to the Director any judgment or injunction entered against him on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or other violation affecting his license and all complaints or charges of misconduct lodged with his employer, any public agency of the state, or another state.
11. The Director may reject any application or suspend or revoke, or refuse to renew any agent's license for inducements or statements which are unjust, unfair, inequitable, misleading or deceptive, or which encourage misrepresentation, or are untrue or misleading.
12. The rules, standards and guidelines governing any proceeding relating to the suspension or revocation of the license of a life insurance agent, where applicable, shall also govern any proceedings for suspension or revocation of the license of an agent of a Health Care Services Organization.
13. Renewal of a license of an agent shall follow the same procedure as heretofore established for renewal of insurance agents' licenses in this state.
14. Renewal of a license of an agent shall follow the same procedure as heretofore established for renewal of insurance agents' licenses in this state.

Q. Forms

1. The forms prescribed by this rule and the instructions applicable thereto are adopted as requirements of the Director and necessary for the protection of citizens of this state. Such forms, instructions, manuals or examinations are those currently in use, but the same may be amended without reference to this rule and when approved as amended are incorporated in this rule by reference. The form of manual or examination of agents, or any form adopted by the Director may be reproduced for the purpose of reporting or for other purposes.
2. For good cause shown, the Director may authorize the filing of forms and reports on dates other than required by this rule, if applied for in writing not less than 10 days prior to the due date of such report and statement, exhibit, return or accounting.

R. Severability. In any provision of this rule or the forms, statements, returns or reports made part of this rule, or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions of applications of this rule, which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

S. Effective date. This rule became effective on the 7th day of May, 1973. Amendments to this rule shall become effective upon filing with the Secretary of State.

Historical Note

Former General Rule 73-33; Amended subsections (E), (P), (R), (S), and (T) effective August 12, 1981 (Supp. 81-4). R20-6-405 recodified from R4-14-405 (Supp. 95-1).

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R20-6-406. Expired**Historical Note**

Adopted effective May 18, 1978 (Supp. 78-3). R20-6-406 recodified from R4-14-406 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

R20-6-407. Service Companies

A. Scope. This rule shall apply to all service companies except those that are exempt under A.R.S. § 20-1095.02.

B. Definitions. The definitions in A.R.S. § 20-1095 apply to this rule.

1. "Contract Holder" has the same meaning as "consumer" as defined in A.R.S. § 20-1095(1).
2. "Department" means the Arizona Department of Insurance and Financial Institutions, Insurance Division.
3. "Director" means the Director of the Department.
4. "Insolvent" as used in A.R.S. § 20-1095.08(3) means total liabilities are equal to or exceed total assets.
5. "Provider" means a person who is contractually obligated to the service contract holder under the terms of a service contract. "Provider" is synonymous with "service company" and "obligor" as defined in A.R.S. § 20-1095(6).
6. "Reasonable time" or "Reasonable period of time:"
 - a. As used in A.R.S. § 20-1095.06(C)(2), means at the time of purchase or mailed or electronically delivered but not more than 10 business days after the purchase date of the contract. The service company must be able to provide proof of delivery if requested by the Department.
 - b. As used in A.R.S. § 20-1095.09(A)(4), is what an ordinary person would consider "reasonable" under the totality of the circumstances.
7. "Solvent" as used in A.R.S. § 20-1095.03(A)(1) means total assets exceed total liabilities.
8. "Subcontractor" means a person or business having a contractual relationship with a service company to provide work or services which a service company has agreed to perform under a service contract. If required by the type of work being performed, all subcontractors must be licensed.

C. Application for a service company permit.

1. Application form. The application for a service company permit shall be on a form designated by the Department and shall be transmitted through an electronic online system if such a system is designated on the Department's web site. An application must be complete and have all attachments to be considered by the Department.
2. Application. The application shall contain the following information:
 - a. Applicant's full legal name;
 - b. Applicant's federal employer identification number (EIN);
 - c. Applicant's trade name or names, if applicable;
 - d. Applicant's state of domicile;
 - e. Applicant's form of business entity (corporation, limited liability company, etc.);
 - f. Applicant's addresses, phone numbers, e-mail address or addresses and website or addresses;
 - g. Name, address, and phone number or e-mail address for each contact person of the applicant;
 - h. A list of the applicant's officers, directors, LLC managers, and persons owning 25% or more of the service company, and for each officer, director, man-

ager, or person owning 25% or more of an entity that owns the service company;

- i. If the applicant intends to use a service contract administrator, the name and contact information for the applicant's service contract administrator;
 - j. The applicant's fiscal year end date;
 - k. A summary of the applicant's financial position including current assets, current liabilities, equity and income;
 - l. The name and signature of an officer of the applicant; and
 - m. Any other information the Department deems necessary to aid in the approval of the application.
3. Application attachments. The applicant shall include the following as part of the application:
- a. A copy of the service company's most recent financial statement sworn to and certified by the owner, duly elected officer or a certified public accountant.
 - b. Evidence of compliance with the financial security requirements of A.R.S. § 20-1095.03(A)(3).
 - c. A biographical affidavit, on a form approved by the Department, for each officer, director, LLC manager, or person owning 25% or more of the service company, and for each officer, director, manager, or person owning 25% or more of an entity that owns the service company.
 - d. A list of any actions taken against the applicant in any jurisdiction by a regulatory agency or state attorney general.
4. Application fee. At the time of filing the application, the applicant shall pay the nonrefundable application fee prescribed by A.R.S. § 20-167 and fixed by the Department.

D. Term of the service company permit.

1. Term of permit. A service company permit shall have a term that begins on the date that the Department either grants or renews a service company permit and expires at midnight on the last day of the month, three months after the service company's fiscal year-end date.
2. The Department is not required to issue a paper copy of the service company permit. However, the Department will make a copy of the service company permit available by electronic or other means.
3. Expiration of a service company permit.
 - a. Unless the Department receives an application and full payment of fees for renewal prior to the end of the service company permit term, the service company permit expires.
 - b. A service company whose permit term has expired shall not offer, extend, or renew a service contract.
 - c. A service company whose permit has expired shall continue to fulfill the obligations of its in-force contracts and shall maintain the security required under A.R.S. § 20-1095.03(3) until such time that all of the service company's contractual obligations to contract holders are fulfilled.

E. Service company permit renewal and late-renewal.

1. Timely renewal. A service company seeking to renew its permit shall file with the Department a renewal application, consisting of the renewal application form, all required attachments and the renewal fee after the end of its fiscal year but before the expiration of its permit term. A service company shall transmit the renewal application through an electronic online system if such a system is designated on the Department's website. A renewal appli-

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- cation must be complete, have all required attachments and the renewal fee to be considered as having been received by the Department.
2. Renewal form. A service company shall use the renewal form designated by the Department. The renewal shall contain the following information:
 - a. Service company name appearing on the permit, and the service company's Arizona license number and EIN;
 - b. Any additions or deletions to the service company's trade name or trade names, addresses, phone numbers and website addresses;
 - c. Any changes to the service company's contact person or persons or service contract administrator, or their contact information;
 - d. A summary of the applicant's financial position including current assets, current liabilities, equity and income; and
 - e. Any other information the Department deems necessary to aid in the renewal of the permit.
 3. Renewal attachments. The service company shall attach the following to the renewal:
 - a. A copy of the service company's financial statement as of the end of the service company's most recently completed fiscal year, sworn to and certified by the owner, duly elected officer or a certified public accountant.
 - b. Evidence of continuing compliance with the financial security requirements of A.R.S. § 20-1095.03(A)(3).
 - c. Any additions or deletions to the officers, directors, LLC managers, or persons owning 25% or more of the service company, or to an entity that owns the service company since the last report to the Department.
 - d. A biographical affidavit, on a form approved by the Department, for each new person identified in subsection (3)(c).
 - e. Any actions taken against the service company in any jurisdiction by a regulatory agency or state attorney general not previously reported to the Department.
 4. Renewal fee. At the time of filing the renewal, the service company shall pay a nonrefundable renewal fee as prescribed by A.R.S. § 20-167 and fixed by the Department.
 5. Late-renewed application and fee.
 - a. Late-renewal period. A service company whose permit term has expired may file a renewal application up to ninety days after the expiration of the permit term. After the ninety-day period, a renewal application will not be accepted by the Department and the service company must file a service company permit application with the Department pursuant to subsection (C) of this Section.
 - b. A service company whose permit term has expired shall not offer, extend, or renew a service contract until the permit is renewed or a new permit is issued by the Department.
 - c. Fee. In addition to the nonrefundable renewal fee required under subsection (E)(4) of this Section, the service company shall pay a nonrefundable additional fee of \$25 per day starting the calendar day after the permit term expiration and ending on the date the service company files a complete renewal application.
 - d. Term of a late-renewed permit. The term of a late-renewed permit shall begin on the date the Department renews the permit and shall end on the last day of the permit term.
- F. Deposits of cash or alternatives to cash.**
1. Contracts issued, renewed, or extended on or after August 3, 2018. For any contract that a service company issues, extends, or renews from and after August 3, 2018, a service company may not satisfy the financial responsibility requirements of A.R.S. § 20-1095.04 by means of providing a deposit of cash or alternatives to cash.
 2. Contracts issued, renewed, or extended before August 3, 2018. If a service company provided a deposit of cash or alternatives to cash covering service contracts that were issued, last extended, or last renewed prior to August 3, 2018, the service company shall maintain the deposit in the amount required to cover those contracts and the deposit shall not be encumbered.
 3. Release of deposits of cash or alternatives to cash. As it relates to financial responsibility requirements fulfilled by a deposit of cash or alternatives to cash, the Director shall only release the deposit upon one of the following:
 - a. The service company provides a surety bond or mechanical reimbursement policy that covers the outstanding service contract liabilities secured by the cash or alternatives to cash.
 - b. The Department has approved the assumption of outstanding service contracts and liabilities by another service company that has acknowledged the assumption of the outstanding contracts and that shall provide each affected contract holder an endorsement issued by the mechanical reimbursement insurer or surety.
 - c. The service company provides evidence satisfactory to the Department that:
 - i. The outstanding service contracts and liabilities have expired or have been cancelled in accordance with the service contract terms;
 - ii. All claims under the service contracts have been settled; and
 - iii. The service company is financially able and agrees to be financially responsible for any valid unreported claims.
- G. Filing of forms.**
1. Contracts to be submitted for approval. A service company shall submit contracts for the Department's approval pursuant to A.R.S. § 20-1095.06. A service company is not required to submit advertisements or marketing materials for approval by the Department but shall abide by the provisions of Title 20, Chapter 2 - Article 6, Chapter 4 - Article 11, and this Section regarding misrepresentations in the sales of service contracts.
 2. Requirements for approval. No service contract form shall be approved unless it:
 - a. Complies with A.R.S. § 20-1095.06;
 - b. Identifies the covered products under the contract and, in bold-faced type, preferably in a larger font, the specific items or components of those products which are excluded;
 - c. States the service fee or deductible charge, if any, to be charged, or applied, for service calls and/or each covered repair;

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- d. Specifies in clear and easily understood language the specific circumstances under which a contract holder may engage a subcontractor who is not recommended by the service company without becoming financially responsible under the contract and whether pre-authorization is required prior to engaging a subcontractor who is not recommended by the service company;
 - e. Specifies in clear and easily understood language the service company's financial responsibilities to the contract holder when any of the systems, products or appliances covered by the contract cannot be replaced or repaired;
 - f. If applicable, states the conditions under which the service contract or coverage may be reinstated;
 - g. States the dates of coverage under the service contract including any delay in coverage that differs from the purchase date of the contract which would extend the coverage term of the contract and any terms that govern renewal of the service contract; and
 - h. If providing a pro rata refund upon cancellation of the service contract before the end of the coverage period of the service contract, the service contract shall contain language in conformance with A.R.S. § 20-1095.06(D)(9).
3. Disapproval of contracts. The Department may disapprove any service contract that is in violation of Title 20, Chapter 4 - Article 11, or this subsection (G). The service company may request a hearing to appeal the disapproval pursuant to A.R.S. § 20-161.
 3. R20-6-210. Group coverage discontinuance and replacement.
 4. R20-6-213. Unfair discrimination on the basis of blindness, partial blindness, or physical disability.
 5. R20-6-216. Life and disability insurance policy language simplification.
 6. R20-6-302. Valuation of reserves for disability policies.
 7. R20-6-606. Medicare supplement insurance disclosure and minimum standards.
 8. R20-6-607. Reasonableness of benefits in relation to premium charged.
 - C. Severability. If any provision of this rule or the application thereof to any person or circumstance is for any reason held invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.

Historical Note

Adopted effective July 9, 1982 (Supp. 82-4). Former Section R4-14-408 renumbered without change as Section R4-14-409 effective July 15, 1987 (Supp. 87-3). R20-6-409 recodified from R4-14-409 (Supp. 95-1).

ARTICLE 5. THE INSURANCE CONTRACT**R20-6-501. Ten-day Period to Examine Disability Insurance Policy**

For the purpose of implementing A.R.S. §§ 20-442, 20-443, 20-826, 20-1111 and 20-1113 and to make more specific the regulation therein provided relative to policies of individual disability insurance (accident and sickness, hospitalization, medical, surgical and loss of time) issued in the State of Arizona and further to provide satisfactory public remedy against the hazards of misunderstanding by an applicant, of deception and coercion by an agent and of certain policy exclusions and limitations that cheapen the value of coverage, the Insurance Department of Arizona adopts the following rule:

1. Each policy of individual disability insurance, except one for which no provision for renewal is made, issued for delivery in the State of Arizona on or after October 1, 1961, by an insurance company or by a hospital or medical service corporation shall have printed on the first page thereof or attached thereto or endorsed thereupon in prominent style a notice declaring that, during a period of 10 days (or, at the insurer's option, a longer period) from the date of delivery to the policyholder, such policy may be returned for cancellation to the insurer at its home office (or, at the insurer's option, to its branch office or to the agent through whom it was purchased) and declaring further that in the event of such return the insurer will refund the entirety of any premium paid therefor, including any policy fees or other charges, and that the policy shall be deemed void from the beginning and that the parties shall be returned to their original position as if no policy had been issued.
2. The Insurance Department does not specify the particular language the notice shall contain but prefers usage of a phraseology approximately along the lines of either the longer (Form A) or shorter (Form B) sample below:

Historical Note

Adopted effective April 30, 1981 (Supp. 81-2). Former Section R4-14-407 repealed and a new Section R4-14-407 adopted effective July 2, 1987 (Supp. 87-3). R20-6-407 recodified from R4-14-407 (Supp. 95-1). Section amended by final rulemaking at 28 A.A.R. 3968 (December 30, 2022), effective February 6, 2023 (Supp. 22-4).

R20-6-408. Expired**Historical Note**

Former Section R4-14-408 renumbered as Section R4-14-409; a new Section R4-14-408 adopted effective July 15, 1987 (Supp. 87-3). R20-6-408 recodified from R4-14-408 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 24 A.A.R. 3106, effective October 9, 2018 (Supp. 18-4).

R20-6-409. Hospital, Medical, Dental, and Optometric Service Corporations

- A. Applicability. This rule applies to all subscription contracts issued by hospital, medical, dental and optometric service corporations.
- B. Subscription contract provision. Subscription contracts of hospital, medical, dental and optometric service corporations subject to the provisions of Article 3, Chapter 4 of Title 20, A.R.S., shall meet the requirements of the following rules:
 1. R20-6-201. Advertisements of disability insurance.
 2. R20-6-209. Unfair sex discrimination.

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Sample Form A**NOTICE OF TEN-DAY RIGHT TO EXAMINE POLICY**

The _____ Insurance Company urges you to read this policy carefully and trusts that upon doing so you will fully understand, and will be pleased with, its coverage. If, however, questions arise or information is desired, do not hesitate to consult the selling agent. In addition, should the policy for any reason be unsatisfactory, by surrendering it within ten days following receipt to our office at _____ or to the selling agent, immediately full premium will be refunded and the policy will be cancelled and deemed void and as never in force and effect.

Sample Form B**IMPORTANT NOTICE**

If for any reason this policy is unsatisfactory, it may be returned for cancellation within ten days following receipt – in which case the entire premium will be refunded.

(Insurer's name and address)

Historical Note

Former General Rule 61-7. R20-6-501 recodified from R4-14-501 (Supp. 95-1).

ARTICLE 6. TYPES OF INSURANCE CONTRACTS**R20-6-601. Regulations Governing Bail Transactions****A. General provisions**

1. Effective date
 - a. These regulations are effective November 1, 1960. On and after date, no bail transaction or severable portion thereof shall be conducted, directly or indirectly except in full conformity herewith.
 - b. No surety insurer shall furnish for use and no bail bond agent shall use any forms or documents which contain any provisions contrary to these regulations on or after the effective date hereof.
2. Authority. Authority for these regulations is A.R.S. §§ 20-142, 20-143 and 20-257 and A.R.S. Chapter 2, Article 3.
3. Public interest served. These regulations serve the public interest by prohibiting inequities in bail transactions and by establishing standards of licensing and conduct for bail bond agents.
4. Regulations as severable. These regulations shall be construed as severable, such that, where one or more Sections are held invalid, such remaining Sections will not be adversely affected.
5. Penalty. Violation of these regulations will subject the guilty party to the penalties of A.R.S. §§ 20-114, 20-220 and 20-316 and to the enforcement procedures of A.R.S. §§ 20-152 and 20-160 through 20-166.

B. Definitions

1. "Bail transaction" defined. As used in these regulations, the term "bail transaction" includes solicitation and inducement, preliminary negotiation and effectuation of a contract of surety insurance and the transaction of matters subsequent thereto and arising therefrom – all in connection with the release of persons arrested or confined.
2. "Bail bond agent" defined. As used in these regulations, the term "bail bond agent" means any person who engages in a bail transaction on behalf of a surety insurer or representative thereof.
3. "Arrestee" defined. As used in these regulations, the term "arrestee" means any person arrested or detained whose release on bail is solicited or procured or concerning whose release negotiations are commenced.
4. "Director" defined. As used in these regulations, the term "Director" means the Director of Insurance of the state.

C. Licensing

1. Application for license. Each application for original or renewal license as a bail bond agent shall be on a form furnished by the Director, and each applicant for such license shall furnish such supplementary information and supporting statements as the Director may require.
2. Prohibited associations. A bail bond license shall not be issued to, renewed for or maintained by any person who associates regularly with criminals, gamblers or persons of poor repute – except to the extent such association is required by business or professional duty and responsibility.
3. Transactions by unlicensed persons prohibited. No bail bond agent shall directly or indirectly permit any person on his behalf to solicit or negotiate bail transactions unless such person is duly licensed by the Director.
4. Employees. Employees of bail bond agents performing only clerical duties need not be licensed hereunder and shall be deemed not engaged in bail transactions.

D. Conduct of bail bond agents

1. Disclosure of business. Every bail bond agent shall conduct his business in such a manner that the public and those dealing with him shall be aware of the capacity in which he is acting.
2. Control of employees. A bail bond agent shall exercise direct supervision over his employees and keep informed of their actions as his employees.
3. Prohibited employees. No bail bond agent shall have in his employ at any time any criminal, gambler or person of poor repute.
4. Acting for attorney. No bail bond agent shall receive, or collect for an attorney any money or other item of value for attorney's fee, costs or any other purpose on behalf of an arrestee, unless a receipt is given therefor.
5. Informants prohibited. No bail bond agent shall for any purpose, directly or indirectly, enter into an arrangement of any kind or have an understanding with a law enforcement officer, with a newspaper employee, with a messenger service or employee thereof, with a trusty in a jail, with other person incarcerated in a jail, or with any person whatever, to inform or notify any bail bond agent directly or indirectly of:
 - a. The existence of a criminal complaint;
 - b. The fact of an arrest; or

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- c. The fact that an arrest of any person is pending or contemplated; or
- d. Any information pertaining to matters set forth in (a), (b), and (c) hereof or to the persons involved therewith.
- 6. Compliance with rules of public authority. No bail bond agent shall solicit any person in a bail transaction in a prison or jail or other place of detention, court or public institution connected with the administration of justice unless said bail bond agent has fully complied with every rule, regulation and ordinance issued by each public authority governing the conduct of persons in or about said premises.
- 7. Representations to public authority
 - a. No bail bond agent shall make any misleading or untrue representation to a court or to a public official with respect to a bail transaction, nor for the purpose of avoiding or preventing a forfeiture of bail or of having set aside a forfeiture which has occurred.
 - b. Every bail bond agent shall truthfully and fully answer every question asked him by the Director or his representative respecting his bail transactions and matters relating to the conduct of his bail business. Any bail bond agent may have his attorney present when he answers any such question.
- 8. Maintenance of records. Every bail bond agent shall keep complete records of all business done under authority of his license. Such records shall be open to inspection or examination by the Director or his representatives at all reasonable times at the principal place of business of the bail bond agent as designated in his license.
- E. Charges, collateral, refunds and rebates
 - 1. Rates
 - a. No bail bond agent shall issue or deliver a bail bond except at the premium rates most recently filed and approved by the Director in accordance with A.R.S. § 20-357.
 - b. Every bail bond agent shall post the premium rates of the surety insurer he represents in a conspicuous manner at his place of business.
 - 2. Charges permitted. No bail bond agent shall, in any bail transaction or in connection therewith, directly or indirectly, charge or collect money or other valuable consideration from any person except for the following purposes:
 - a. To pay the premium at the rates established by the surety insurer and approved by the Director.
 - b. To provide collateral.
 - c. To reimburse himself for actual and reasonable expenses incurred in connection with the individual bail transaction, including:
 - i. Guard fees after the first 12 hours following release of an arrestee on bail;
 - ii. Notary fees, recording fees, necessary long distance telephone expenses, telegram charges, and travel expenses for other than local community travel.
 - iii. Any other actual expenditure necessary to the bail transaction which is not usually and customarily incurred in connection with the ordinary operation and conduct of bail transactions.
 - 3. Delivery of documents to arrestee
 - a. Every bail bond agent shall, at the time of obtaining the release of an arrestee on bail or immediately thereafter, deliver to such arrestee or to the principal person with whom negotiations were made, if other than the arrestee, a copy of the bail bond premium agreement, which shall include:
 - i. The name of the surety insurer and the name and business address of the bail bond agent.
 - ii. The amount of bail and the premium thereof.
 - b. The bail bond agent shall also deliver at such time a statement detailing all charges in addition to the premium, the amount received on account, the unpaid balance if any, and a description of and a receipt for any collateral received.
 - 4. Collateral
 - a. Any bail bond agent who receives collateral in connection with a bail transaction shall do so in a fiduciary capacity and, prior to any forfeiture of bail, shall keep such collateral separate and apart from any other funds, assets or property of such bail bond agent.
 - b. Any collateral received shall be returned to the person who deposited it with the bail bond agent or any assignee as soon as the obligation, the satisfaction of which was secured by the collateral, is discharged. Where such collateral has been deposited to secure the obligation of a bond, it shall be returned immediately upon the entry of any order by an authorized official by virtue of which liability under the bond is terminated, or, if any bail bond agent fails to cooperate fully with any authorized official to secure the termination of such liability, immediately upon the accrual of any right to secure an order of termination of liability.
 - c. When such collateral has been deposited as security for unpaid premium or charges and, if such premium or charges remained unpaid at the time of exoneration and after demand therefor has thereafter been made by the bail bond agent, collateral other than cash may be levied upon in the manner provided by law and cash collateral up to the amount of such unpaid premium on charges may be applied in payment thereof.
 - d. If collateral received by a bail bond agent is in excess of the bail forfeited, such excess shall be returned to the depositor immediately upon application of the collateral to the forfeiture subject, however, to any claim of the bail bond agent for unpaid premium or charges as provided in subparagraph (c) of paragraph (4) of subsection (E), or as agreed to in writing by the bail bond agent and arrestee or his indemnitor.
 - 5. Premium refund upon surrender of arrestee. No bail bond agent shall surrender an arrestee to custody prior to the time specified in the bail bond for the appearance of the arrestee, or prior to any other occasion when the presence of the arrestee in court is lawfully required, without returning all premium paid therefor, unless as a result of judicial action, or material misrepresentation by the arrestee or his indemnitor with respect to the execution of the bail bond agreement, or a material and substantial increase in the hazard assumed. Failure of the arrestee to pay the premium, or charges permitted under these regulations or any part thereof, and failure to furnish collateral required by the bail bond agent, shall not be considered a material and substantial increase in the hazard assumed.

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6. Rebating prohibited. No bail bond agent shall pay or allow in any manner, directly or indirectly, to any person who is not also a bail bond agent any commission or valuable consideration on or in connection with a bail transaction. This Section shall not prohibit payments by a bail bond agent to an unlicensed person of charges by such persons for services of the kind specified in paragraph (2) subsection (E) of this Section.

Historical Note

Former General Rule 60-5. R20-6-601 recodified from R4-14-601 (Supp. 95-1).

R20-6-602. Nationwide Inland Marine Definition

- A. Applicability. This rule applies to risks and coverages which may be classified or identified as Marine, Inland Marine or Transportation insurance but shall not be construed to mean that the kinds of risks and coverages are solely Marine, Inland Marine or Transportation insurance in all instances. This rule shall not be construed to restrict or limit in any way the exercise of any insuring powers granted under charters and license whether used separately, in combination or otherwise.
- B. Marine and/or transportation policies may cover under the following conditions:
 1. Imports.
 - a. Imports may be covered wherever the property may be and without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation.
 - b. An import, as a proper subject of marine or transportation insurance, shall be deemed to maintain its character as such so long as the property remains segregated in such a way that it can be identified and has not become incorporated and mixed with the general mass of property in the United States, and shall be deemed to have been completed when such property has been:
 - i. Sold and delivered by the importer, factor or consignee; or
 - ii. Removed from place of storage and placed on sale as part of the importer's stock in trade at a point of sale or distribution; or
 - iii. Delivered for manufacture, processing or change in form to premises of the importer or of another for any such purposes.
 2. Exports.
 - a. Exports may be covered wherever the property may be located without restriction as to time, provided the coverage of each issuing company includes hazards of transportation.
 - b. An export, as a proper subject of marine or transportation insurance, shall be deemed to acquire its character as such when designated or while being prepared for export and retain that character unless diverted for domestic trade, and when so diverted, the provisions of this rule respecting domestic shipments shall apply, provided, however, that this provision shall not apply to long established methods of insuring certain commodities, e.g., cotton.
 3. Domestic shipments.
 - a. Domestic shipments on consignment, for sale or distribution, exhibit, or trial, or approval or auction, while in transit, while in the custody of others and while being returned, provided the coverage of each issuing company includes hazards of transportation,

- and further provided that in no event shall the policy cover domestic shipments on consignment on premises owned, leased or operated by the consignor.
- b. Domestic shipments not on consignment, provided the coverage of the issuing companies includes hazards of transportation, beginning and ending within the United States, and further provided that such shipments shall not be covered at manufacturing premises nor after arrival at premises owned, leased or operated by assured or purchaser.
4. Bridges, tunnels and other instrumentalities of transportation and communication excluding buildings, their improvements and betterments, their furniture and furnishings, fixed contents and supplies held in storage. The foregoing includes:
 - a. Bridges, tunnels, other similar instrumentalities, including auxiliary facilities and equipment attendant thereto.
 - b. Piers, wharves, docks, slips, dry docks and marine railways.
 - c. Pipelines, including on-line propulsion, regulating and other equipment appurtenant to such pipelines, but excluding all property at manufacturing, producing, refining, converting, treating or conditioning plants.
 - d. Power transmission and telephone and telegraph lines, excluding all property at generating, converting or transforming stations, substations and exchanges.
 - e. Radio and television communication equipment in use as such including towers and antennae with auxiliary equipment, and appurtenant electrical operating and control apparatus.
 - f. Outdoor cranes, loading bridges and similar equipment used to load, unload and transport.
5. Personal Property Floater Risks covering individuals and/or generally
 - a. Personal Effects Floater Policies
 - b. The Personal Property Floater
 - c. Government Service Floater
 - d. Personal Fur Floaters
 - e. Personal Jewelry Floaters
 - f. Wedding Present Floaters for not exceeding 90 days after the date of the wedding.
 - g. Silverware Floaters.
 - h. Fine Arts Floaters, covering paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value or artistic merit.
 - i. Stamp and Coin Floaters.
 - j. Musical Instrument Floaters. Radios, televisions, record players and combinations thereof are not deemed musical instruments.
 - k. Mobile Articles, Machinery and Equipment Floaters, excluding vehicles designed for highway use and auto homes, trailers and semi-trailers except when hauled by tractors not designed for highway use, covering identified property of a mobile or floating nature pertaining to or usual to a household. Such policies shall not cover furniture and fixtures not customarily used away from premises where such property is usually kept.
 - l. Installment Sales and Leased Property Policies covering property pertaining to a household and sold

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under conditional contract of sale, partial payment contract or installment sales contract or leased, but excluding motor vehicles designed for highway use. Such policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest.

- m. Live Animal Floaters.
- 6. Commercial Property Floater Risks covering property pertaining to a business, profession or occupation.
 - a. Radium Floaters.
 - b. Physicians' and Surgeons Instrument Floaters. Such policies may include coverage of such furniture, fixtures and tenant assured's interest in such improvements and betterments of buildings as are located in that portion of the premises occupied by the assured in the practice of his profession.
 - c. Pattern and Die Floaters.
 - d. Theatrical Floaters, excluding buildings and their improvements and betterments, and furniture and fixtures that do not travel about with theatrical troupes.
 - e. Film Floaters, including builders' risk during the production and coverage on completed negatives and positives and sound records.
 - f. Salesmen's Samples Floaters.
 - g. Exhibition Policies on property while on exhibition and in transit to or from such exhibitions.
 - h. Live Animal Floaters.
 - i. Builders Risks and/or Installation Risks covering interest of owner, seller or contractor, against loss or damage to machinery, equipment, building materials or supplies, being used with and during the course of installation, testing, building, renovating or repairing. Such policies may cover at points or places where work is being performed, while in transit and during temporary storage or deposit, of property designated for and awaiting specific installation, building, renovating or repairing.
 - i. Such coverage shall be limited to Builders Risks or Installation Risks where Perils in addition to Fire and Extended Coverage are to be insured.
 - ii. If written for account of owner, the coverage shall cease upon completion and acceptance thereof; or if written for account of a seller or contractor the coverage shall terminate when the interest of the seller or contractor ceases.
 - j. Mobile Articles, Machinery and Equipment Floaters, excluding motor vehicles designed for highway use and auto homes, trailers and semi-trailers except when hauled by tractors not designed for highway use and snow plows constructed exclusively for highway use covering identified property of a mobile or floating nature, not on sale or consignment, or in course of manufacture, which has come into the custody or control of parties who intend to use such property for the purpose for which it was manufactured or created. Such policies shall not cover furniture and fixtures not customarily used away from premises where such property is usually kept.
 - k. Property in transit to and from and in custody of bailees not owned, controlled or operated by the bailor. Such policies shall not cover bailee's property at his premises.
 - l. Installment sales and leased property. Policies covering property sold under conditional contract of sale, partial payment contract, installment sales contract, or leased but excluding motor vehicles designed for highway use. Such policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest. This Section is not intended to include machinery and equipment under certain "lease-back" contracts.
 - m. Garment Contractors Floaters.
 - n. Furriers or Fur Storer's Customer's Policies, i.e., policies under which certificates or receipt are issued by furriers or fur storers covering specified articles the property of customers.
 - o. Accounts Receivable Policies, Valuable Papers and Records Policies.
 - p. Floor Plan Policies, covering property for sale while in possession of dealers under a Floor Plan or any similar plan under which the dealer borrows money from a bank or lending institution with which to pay the manufacturer, provided:
 - i. Such merchandise is specifically identifiable as encumbered to the bank or lending institution.
 - ii. The dealer's right to sell or otherwise dispose of such merchandise is conditioned upon its being released from encumbrance by the bank or lending institution.
 - iii. That such policies cover in transit and do not extend beyond the termination of the dealer's interest.
 - iv. That such policies shall not cover automobiles or motor vehicles; merchandise for which the dealer's collateral is the stock or inventory as distinguished from merchandise specifically identifiable as encumbered to the lending institution.
 - q. Sign and Street Clock Policies, including neon signs, automatic or mechanical signs, street clocks, while in use as such.
 - r. Fine Arts Policies covering paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value or artistic merit, for account of museums, galleries, universities, businesses, municipalities and other similar interests.
 - s. Policies covering personal property which, when sold to the ultimate purchaser, may be covered specifically, by the owner, under Inland Marine Policies including:
 - i. Musical Instrument Dealers Policies, covering property consisting principally of musical instruments and their accessories. Radios, televisions, record players and combinations thereof are not deemed musical instruments.
 - ii. Camera Dealers Policies, covering property consisting principally of cameras and their accessories.
 - iii. Furrier's Dealers Policies, covering property consisting principally of furs and fur garments.
 - iv. Equipment Dealers Policies, covering mobile equipment consisting of binders, reapers, tractors, harvesters, harrows, tedders and other

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similar agricultural equipment and accessories therefor; construction equipment consisting of bulldozers, road scrapers, tractors, compressors, pneumatic tools, and similar equipment and accessories therefor; but excluding motor vehicles designed for highway use.

- v. Stamp and Coin Dealers covering property of philatelic and numismatic nature.
- vi. Jewelers' Block Policies.
- vii. Fine Arts Dealers.

Such policies may include coverage of money in locked safes or vaults on the Assured's premises. Such policies also may include coverage of furniture, fixtures, tools, machinery, patterns, molds, dies and tenant insureds interest in improvements of buildings.

- t. Wool Growers Floaters.
- u. Domestic Bulk Liquids Policies, covering tanks and domestic bulk liquids stored therein.
- v. Difference in Conditions Coverage excluding fire and extended coverage perils.
- w. Electronic Data Processing Policies.

C. Unless otherwise permitted, nothing in the foregoing shall be construed to permit MARINE OR TRANSPORTATION POLICIES TO COVER:

1. Storage of assured's merchandise, except as hereinbefore provided.
2. Merchandise in course of manufacture, the property of and on the premises of the manufacturer.
3. Furniture and fixtures and improvements and betterments to buildings.
4. Monies and/or securities in safes, vaults, safety deposit vaults, bank or assured's premises, except while in course of transportation.

Historical Note

Former General Rule 59-4; Amended effective August 30, 1985 (Supp. 85-4). R20-6-602 recodified from R4-14-602 (Supp. 95-1).

R20-6-603. Repealed

Historical Note

Former General Rule 69-18; Repealed effective July 27, 1981 (Supp. 81-4). R20-6-603 recodified from R4-14-603 (Supp. 95-1).

R20-6-604. Definitions

The definitions in A.R.S. § 20-1603 and this Section apply to R20-6-604 through R20-6-604.10.

"Actual loss ratio" means incurred claims divided by earned premiums at rates in use.

"Actuarially equivalent" means of equal actuarial present value determined as of a given date with each value based on the same set of actuarial assumptions. When used in this Article in reference to rates and coverage, "actuarially equivalent" means a rate or coverage that is actuarially determined to yield loss ratios of 50% for credit life insurance and 60% for credit disability insurance.

"Credit insurance" means credit life insurance, credit disability insurance, or both, but does not include any insurance for which there is no identifiable charge.

"Earned premiums" means earned premiums at prima facie rates and earned premiums at rates in use.

"Earned premiums at prima facie rates" means an insurer's actual earned premiums, adjusted to the amount that the insurer would have earned if the insurer's premium rates had equaled the prima facie rates in effect during the experience period.

"Earned premiums at rates in use" means the premiums that an insurer actually earns on the premium rates the insurer charges during an experience period.

"Evidence of individual insurability" means information about a debtor's health status or medical history that a debtor provides as a condition of credit insurance becoming effective.

"Experience" means an insurer's earned premiums and incurred claims during an experience period.

"Experience period" means a period of time for which an insurer reports income and expense information on the insurer's credit insurance business.

"Final adjusted rates" means the prima facie rates referred to in R20-6-604.04 and R20-6-604.05, subject to any deviations approved under R20-6-604.08.

"Gross debt" means the sum of the remaining payments that a debtor owes a creditor.

"Identifiable charge" means a charge for credit insurance that is imposed on a debtor with credit insurance but not on a debtor without credit insurance, and includes a charge for insurance that is disclosed in the credit or other financial instrument furnished to the debtor, which sets forth the financial elements of a credit transaction, and any difference in finance, interest, service charges, or other similar charges made to a debtor in like circumstances except for the debtor's status as insured or noninsured.

"Incurred claims" means the total claims an insurer pays during an experience period, adjusted for the change in the claim reserves.

"Net debt" means the amount necessary to liquidate a debt in a single lump-sum payment excluding unearned interest and other unearned finance charges.

"Plan of credit insurance" means an insurance plan based on one of the following rate and coverage categories:

Credit life insurance, other than on revolving accounts, including joint and single life coverage, decreasing and level insurance, and outstanding balance and single premium;

Credit life insurance on revolving accounts;

Credit life insurance on an age-graded basis;

Credit disability insurance, other than on revolving accounts, including outstanding balance and single premium, and each combination of waiting period and retroactive or non-retroactive benefits;

Credit disability insurance on revolving accounts, including each combination of waiting period and retroactive or non-retroactive benefits.

"Preexisting condition" means a condition:

For which a debtor received medical advice, consultation, or treatment within six months before the effective date of credit insurance coverage; and

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From which the debtor dies, in the case of life insurance, or becomes disabled, in the case of disability insurance, within six months after the effective date of coverage.

“Prima facie adjusted loss ratio” means incurred claims divided by earned premiums at prima facie rates.

“Prima facie rates” means the rates established by the Director as prescribed in R20-6-604.03.

“Reasonableness standard” means the requirement in A.R.S. § 20-1610(B) that an insurer’s premiums for credit insurance shall not be excessive in relation to the benefits provided under the policy.

“Rule of Anticipation” means the product of the gross single premium per \$100 of indebtedness for a debtor’s remaining term of indebtedness, times the number of hundreds of dollars of remaining indebtedness.

Historical Note

Former General Rule 70-22; Correction, original publication did not include Exhibit C (Supp. 76-1). Amended effective January 8, 1980 (Supp. 80-1). Former Section R4-14-604 repealed, new Section R4-14-604 adopted effective April 1, 1982. See subsection (N) for further detail (Supp. 82-2). Amended subsection (N) and Exhibit A effective March 30, 1983 (Supp. 83-2). R20-6-604 recodified from R4-14-604 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

Exhibit A. Repealed**Historical Note**

Former General Rule 70-22; Correction, original publication did not include Exhibit C (Supp. 76-1). Amended effective January 8, 1980 (Supp. 80-1). Former Section R4-14-604 repealed, new Section R4-14-604 adopted effective April 1, 1982. See subsection (N) for further detail (Supp. 82-2). Amended subsection (N) and Exhibit A effective March 30, 1983 (Supp. 83-2). R20-6-604 recodified from R4-14-604 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.01. Rights and Treatment of Debtors**A. Creditor Obligations.**

1. Multiple plans of insurance. If a creditor makes more than one plan of credit insurance available to debtors, the creditor shall inform each debtor of each plan for which the debtor is eligible and of the premium and charges for each plan.
2. Substitution. If a creditor requires a debtor to have credit insurance as additional security for a debt, the creditor shall inform the debtor in writing of the debtor’s right to obtain alternative coverage as prescribed in A.R.S. § 20-1614 before the loan transaction is completed.
3. Remittance of premiums. If a creditor adds an insurance charge or premium to a debt, the creditor shall remit the insurance charge or premium to the insurer within 60 days after it is added to the debt.

B. Creditor and insurer obligations regarding insurance on refinanced debt.

1. If a debt is discharged because the debtor refinances the debt before the scheduled maturity date, the creditor shall notify the insurer that issued the credit insurance on the discharged debt.

2. An insurer shall not issue any credit insurance that covers the refinanced debt with an effective date preceding the termination date of the insurance on the original debt.
3. The insurer issuing the coverage on the discharged debt shall refund to or credit the debtor with all unearned insurance charges or premium according to R20-6-604.06.
4. If a debt is refinanced, the effective date of the policy provisions in any new insurance covering the refinanced debt shall be the first date on which the debtor became insured under the previous policy. An insurer may apply any new exclusion period or preexisting condition limitation only to the portion of the new loan that exceeds the previous loan.

C. Required policy provisions.

1. Termination provisions for group policies. A group credit insurance policy shall provide for continued coverage of debtors covered under the policy if the policy terminates, as follows:
 - a. For a policy with a single premium payment, or any other payment method that prepays coverage for more than one month, a provision requiring continued insurance coverage for the entire period for which the premium has been paid; and
 - b. For a policy with a monthly premium payment, a provision requiring the insurer to send the debtor a termination notice at least 30 days before the effective date of termination, unless an insurer is issuing replacement coverage in at least the same amount, without lapse of coverage.
2. Maximum aggregate provisions. A provision in an individual policy or group certificate that sets a maximum limit on total claim payments shall apply only to that individual policy or group certificate.

D. Creditor and insurer obligations when debtor prepays debt.

1. Except as provided in subsection (D)(2), if a debtor prepays a debt in full, any credit insurance covering the debt shall terminate on the date of prepayment. The creditor and insurer shall refund to or credit the debtor with any unearned premium according to R20-6-604.06.
2. If a debt is fully prepaid because of the debtor’s death or any other lump-sum credit insurance payment, a creditor or insurer is not required to refund premium for the coverage under which the lump sum was paid.
3. If a claim under credit disability coverage is in progress at the time of prepayment, the insurer:
 - a. May calculate the refund as if the prepayment did not occur until the end of the period for payment of benefits, and
 - b. Is not required to refund premiums for any period for which credit disability benefits are payable.

E. Benefits payable on revolving account. If a debtor is paying for credit insurance coverage on a revolving account and dies, the insurer shall pay a benefit amount equal to the amount of indebtedness outstanding on the date of death. The insurer may exclude preexisting conditions occurring within six months of any advance on the revolving account, running separately for each advance or charge.**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

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R20-6-604.02. Satisfying the Reasonableness Standard

- A. An insurer shall comply with all requirements of A.R.S. § 20-1610 regarding premium and insurance charges.
- B. An insurer may satisfy the reasonableness standard in A.R.S. § 20-1610(B) if the insurer's premium rate develops a loss ratio of not less than 50% for credit life insurance and not less than 60% for credit disability insurance.
- C. While in effect, the rates described in R20-6-604.04 and R20-6-604.05, subject to any deviations approved under R20-6-604.08 are conclusively presumed to develop the loss ratios described in subsection (B). For purposes of prospective effect, the Department may rebut this presumption by disapproving or withdrawing approval for the rates as prescribed in A.R.S. § 20-1610.
- D. An insurer may provide coverage other than the standard coverage described in R20-6-604.04 and R20-6-604.05. An insurer that wishes to provide nonstandard coverage shall:
 - 1. File the nonstandard coverage policy information as prescribed in A.R.S. § 20-1609, and
 - 2. Demonstrate that the rates for the coverage are reasonably expected to develop a loss ratio of not less than 50% for credit life insurance and not less than 60% for credit disability insurance.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.03. Determination of Prima Facie Rates

- A. The Director shall, by order, establish prima facie rates as prescribed in this Section.
- B. At least once every three years, the Director shall:
 - 1. Determine the rate of expected claims on a statewide basis;
 - 2. Compare the rate of expected claims with the rate of actual claims for the past three years determined from the incurred claims and earned premiums at prima facie rates; and
 - 3. If the Director determines that the prima facie rates require adjustment, issue a notice of hearing and proposed order adjusting the actual statewide prima facie rates. The hearing date on the proposed order shall be no earlier than 45 days from the date of the notice.
- C. The Director shall mail a copy of the notice and proposed order to:
 - 1. Each insurer that reported transaction of credit insurance on its annual statement immediately preceding the date of the notice, and
 - 2. Any other person who sends the Director a written request for notice of proceedings to adjust the prima facie rates.
- D. Any person may submit written comments to the Director or appear at the hearing and provide oral comments on the record. Written comments shall be received no later than the close of record date specified in the notice of hearing.
- E. The Director shall:
 - 1. Consider written and oral comments; and
 - 2. Issue a final order setting prima facie rates no later than 30 days after the close of record date specified in the notice of hearing.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.04. Credit Life Insurance Rates and Provisions

- A. Under the process prescribed in R20-6-604.03, the Director shall issue an order establishing prima facie rates for credit life insurance.
- B. The Department shall presume that an insurer meets the loss ratios prescribed in R20-6-604.02(B) if the insurer uses the prima facie rates, subject to the requirements in this Section and R20-6-604.08. An insurer may use the prima facie rates without filing additional actuarial support.
- C. A credit life insurance policy shall meet the requirements listed in this Section. The policy shall:
 - 1. Provide coverage for death, by whatever means caused, to all eligible debtors, with or without evidence of individual insurability for debtors that purchase coverage within 30 days of being eligible;
 - 2. Have no exclusions other than for:
 - a. Suicide within six months after the effective date of coverage, or
 - b. A preexisting condition;
 - 3. Have no age restrictions, except the following permissible exclusions:
 - a. An age restriction providing that no insurance will become effective on a debtor on or after the attainment of age 70 and that all insurance shall terminate on a debtor attaining age 70; and
 - b. An age restriction for a revolving credit life insurance policy that:
 - i. Excludes a class of debtors determined by age, or
 - ii. Provides for termination of insurance or reduction in the amount of insurance when a debtor reaches age 70; and
 - 4. For insurance on revolving accounts, have the date on which an advance or charge occurs as the effective date of coverage for each part of the insurance attributable to a different advance or a charge to the plan account. Any exclusion period or preexisting condition limitation shall run separately for each advance or charge.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.05. Credit Disability Insurance Rates and Provisions

- A. Under the process prescribed in R20-6-604.03, the Director shall issue an order establishing prima facie rates for credit disability insurance.
- B. The Department shall presume that an insurer meets the loss ratios prescribed in R20-6-604.02(B) if the insurer uses the prima facie rates, subject to the requirements in this Section and R20-6-604.08. An insurer may use the prima facie rates without filing additional actuarial support.
- C. A credit disability insurance policy shall meet the requirements listed in this Section. The policy shall:
 - 1. Provide coverage for disability, by whatever means caused, to all eligible debtors, with or without evidence of individual insurability for debtors that purchase coverage within 30 days of becoming eligible;
 - 2. Include a definition of disability that is no more restrictive than the following:
 - a. For the first 12 months of disability, the inability of the insured to perform the essential functions of the insured's occupation; and
 - b. After the first 12 months of disability, the inability of the insured to perform the essential functions of

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- any occupation for which the insured is reasonably suited by virtue of education, training, or experience;
3. Not include any employment requirement that a debtor be employed more than full-time on the effective date of coverage, with a definition of "full-time" as a regular work week of at least 30 hours;
 4. Have no exclusions other than for disabilities resulting from:
 - a. Normal pregnancy,
 - b. Intentionally self-inflicted injury, or
 - c. A preexisting condition;
 5. For insurance on revolving accounts, have the date on which an advance or charge occurs as the effective date of coverage for each part of the insurance attributable to a different advance or a charge to the plan account. Any exclusion period or preexisting condition limitation shall run separately for each advance or charge;
 6. Have no age restrictions, except the following permissible exclusion:
An age restriction providing that no insurance will become effective on a debtor on or after the attainment of age 65 and that all insurance shall terminate on a debtor attaining age 66; and
 7. Include a provision for a daily benefit of not less than one-thirtieth of the monthly benefit payable under the policy.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.06. Refund Methods

- A. When refunding premiums as prescribed in A.R.S. § 20-1611, an insurer shall use the following methods:
 1. For insurance paid by a single premium, the Rule of Anticipation method; and
 2. For insurance paid by other than a single premium, a method that refunds at least the pro rata gross unearned amount charged to the debtor.
- B. The Director may approve other refund methods similar to those described in subsection (A), that are actuarially equivalent to the type of coverage the debtor purchased.
- C. An insurer's refund method may recognize adjustments to a daily basis for interest or payments if the adjustments are consistent with the underlying credit transaction.
- D. An insurer is not required to refund any amount less than \$5.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.07. Experience Reports

- A. By April 1 of each year, an insurer that transacts credit insurance in this state shall file with the Director an experience report, on a form specified by the Director, for each class of business that the insurer transacts as provided in this Section.
 1. In this Section, a "class of business" means:
 - a. Credit unions;
 - b. Banks, savings and loan institutions, and mortgage companies;
 - c. Finance companies, small loan companies, and consumer lenders defined in A.R.S. § 6-601(5);
 - d. Dealers, including auto, truck, and boat dealers, retail stores, and other persons selling financed goods; and

- e. All other persons selling credit insurance not specifically listed in subsection (A)(1)(a) through (d).
2. The report shall include the following information:
 - a. Mode of premium payment,
 - b. Plan of benefits description,
 - c. Earned premiums,
 - d. Incurred claims,
 - e. Loss ratios, and
 - f. For credit life insurance, mean insurance in force.
- B. For each day a report is late, the Director may assess a penalty as prescribed in A.R.S. § 20-223.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.08. Use of Prima Facie Rates; Rate Deviations

- A. Use of rates greater than prima facie rates. An insurer may file for approval and use of any deviated rates that are higher than the prima facie rates referred to in R20-6-604.04 and R20-6-604.05 as prescribed in A.R.S. § 20-1610.
 1. The deviated rates shall meet the minimum loss ratio standards and other requirements prescribed by R20-6-604.02.
 2. The filing shall specify the accounts to which the rates apply.
 3. The rates may be:
 - a. Applied uniformly to all accounts of the insurer; or
 - b. Applied on an equitable basis approved by the Director to accounts of the insurer for which the insurer's experience has been less favorable than expected.
- B. Approval period of deviated rates. An insurer may use a deviated rate for the same period of time as the experience period used to establish the rate, not to exceed a period of three years from the date of approval. An insurer may file for a new deviated rate before the end of the approval period, but not more often than once in any 12 month period.
- C. Approval is non-transferable. The Director's approval of a deviated rate is not transferable to another insurer. If an insurer acquires an account for which another insurer obtained a deviated rate, the successor insurer may not charge the deviated rate without obtaining approval for the deviated rate as prescribed in subsection (B).
- D. Use of rates lower than filed rates. An insurer may use a rate that is less than its filed rate without notice to the Director.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.09. Supervision of Consumer Credit Insurance Operations

- A. At least once every three years, an insurer transacting credit insurance in Arizona shall review the credit insurance operations of each creditor with whom the insurer does business to ensure that each creditor is complying with applicable credit insurance laws. The insurer shall review the following:
 1. The creditor does not charge rates in excess of the prima facie rates or any deviated rates for which the insurer obtains approval;
 2. The creditor makes benefit payments as prescribed in the policy; and
 3. The creditor refunds unearned premiums as prescribed in R20-6-604.06.

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- B.** The insurer shall maintain for the Director's inspection a written record of each review and action the insurer takes to address any creditor noncompliance found by the insurer, for at least three years following the end of the review.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-604.10. Prohibited Transactions

- A.** The practices listed in this Section are deemed unfair trade practices under A.R.S. § 20-442. An insurer that commits any of the following practices is subject to penalties as prescribed in A.R.S. § 20-456:
1. Offering or providing a creditor with any special advantage or any service not set out in either the group insurance contract or in the agency contract, other than payment of commissions;
 2. Agreeing to deposit with a bank or financial institution, the insurer's money or securities as a substitute for a deposit of money or securities that the financial institution would otherwise require from the creditor as a compensating balance or deposit offset for a loan or other advancement; or
 3. Depositing money or securities without interest or at a lesser rate of interest than the creditor, bank, or financial institution is currently paying on other similar deposits.
- B.** This Section does not prohibit an insurer from maintaining demand deposits or premium deposit accounts that are reasonably necessary for use in the ordinary course of the insurer's business.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

R20-6-605. Emergency Expired**Historical Note**

Former General Rule 72-26. Repealed effective December 4, 1986 (Supp. 86-6). Adopted as an emergency effective January 9, 1990, pursuant to A.R.S. § 41-1026 valid for only 90 days; re-adopted as an emergency with changes effective March 26, 1990, pursuant to A.R.S. § 41-1026 valid for only 90 days (Supp. 90-1). Re-adopted as an emergency without change effective June 20, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. R20-6-605 recodified from R4-14-605 (Supp. 95-1).

R20-6-606. Repealed**Historical Note**

Adopted effective July 1, 1980 (Supp. 80-3). Amended effective June 1, 1981. See also subsection (G) (Supp. 81-1). Amended subsections (D), (E)(3)(a), (F)(2)(b), (3)(a), (4)(c), (G), and (H) effective January 11, 1982 (Supp. 82-1). Amended subsections (G) and (H) as an emergency effective August 1, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-3). Emergency expired. Amended and readopted as an emergency effective November 18, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Corrected and readopted as an emergency effective February 10, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Amended effective August 4, 1989 (Supp. 89-3). Amended and adopted as an emergency effective September 13, 1989 (Supp. 89-

3). Emergency expired (Supp. 89-4). Amended effective November 19, 1990 (Supp. 90-4). Repealed by emergency action effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Repealed again by emergency action effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Repealed effective May 28, 1992 (Supp. 92-2). R20-6-606 recodified from R4-14-606 (Supp. 95-1).

R20-6-607. Reasonableness of Benefits in Relation to Premium Charged

- A.** Applicability. This rule shall apply to individual disability insurance (as defined in A.R.S. § 20-253) policy forms and rates.
- B.** When rate filing is required. Every individual policy form, rider or endorsement form affecting benefits which is submitted for approval shall be accompanied by a rate filing unless such rider or endorsement form does not require a change in the rate. Any subsequent addition to or change in rates applicable to such policy, rider or endorsement form shall also be filed.
- C.** General contents of all rate filings. Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called "anticipated loss ratio," of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the rate filing is in compliance with applicable laws and regulations of this state and that the benefits are reasonable in relation to the premiums.
- D.** Previously approved forms. Filings of rate revisions for a previously approved policy, rider or endorsement form shall also include the following:
1. A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums including the anticipated loss ratio for the form.
 2. A statement as to whether the filing applies only to new business, only to in-force business, or both, and the reasons.
 3. A history of the experience under existing rates, including at least the data indicated in subsection (E). The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates. All additional data must be reconciled, as appropriate, to the required data. Additional data might include:
 - a. Substitution of actual claim run-offs for claim reserves and liabilities,
 - b. Determination of loss ratios with the increase in policy reserves (other than unearned premium reserves) added to benefits rather than subtracted from premiums,
 - c. Substitution of net level policy reserves for preliminary term policy reserves,
 - d. Adjustment of premiums to an annual mode basis, or
 - e. Other adjustments or schedules suited to the form and to the records of the company.
 4. The date and magnitude of each previous rate change, if any.
- E.** Experience records. Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for

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each policy form, including data for rider and endorsement forms which are used with the policy form, on the same basis, including all reserves, as required for the Accident and Health Policy Experience Exhibit to the NAIC annual statement convention blank. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under forms which provide substantially similar coverage may be combined. The data shall be for all years of issue combined, for each calendar year of experience since the year the form was first issued, except the data for calendar years prior to the most recent five years may be combined.

- F.** Evaluation experience data. In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:
1. Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency.
 2. Experienced and projected trends relative to the kind of coverage, e.g., inflation in medical expenses, economic cycles affecting disability income experience.
 3. The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations.
 4. The mix of business by risk classification.
- G.** Anticipated loss ratio standard. With respect to a new form or a currently approved form, except currently approved non-cancelable policy forms, under which the average annual premium (as defined below) is expected to be at least \$700, benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table:

Type of Coverage	Renewal Clause			
	OR	CR	GR	NC
Medical expense	60%	55%	55%	50%
Loss of income and other	60%	55%	50%	45%

For a policy form including riders and endorsements, under which the expected average annual premium per policy is \$200 or more but less than \$700, subtract 5 percentage points from the numbers in the table above, or if less than \$200, subtract 10 percentage points.

The average annual premium per policy shall be computed by the insurer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation.)

The above anticipated loss ratio standards do not apply to a class of business which is regulated by specific statutes or regulations mandating loss ratios for such business, e.g., Medicare Supplement and Credit Life and Disability.

Definitions of Renewal Clause

OR – Optionally Renewable: renewal is at the option of the insurance company.

CR – Conditionally Renewable: renewal can be declined by the insurance company only for stated reasons other than deterioration of health.

GR – Guaranteed Renewable: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

NC – Non-Cancelable: renewal cannot be declined nor can rates be revised by the insurance company.

- H.** Rate revisions. With respect to filings of rate revisions for a previously approved form, benefits shall be deemed reasonable in relation to premiums provided both the following loss ratios meet the standards in subsection (G) above.
1. The anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage;
 2. The anticipated loss ratio derived by dividing (a) by (b) where:
 - a. Is the sum of the accumulated benefits, from the original effective date of the form or the effective date of this regulation, whichever is later, to the effective date of the revision, and the present value of future benefits; and
 - b. Is the sum of the accumulated premiums from the original effective date of the form or the effective date of the regulation, whichever is later, to the effective date of the revision, and the present value of future premiums. Such present values shall be taken over the entire period for which the revised rates are computed to provide coverage, and such accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.
- I.** Anticipated loss ratios lower than those indicated in subsections (H)(1) and (H)(2) will require justification based on the special circumstances that may be applicable.
1. Examples of coverages requiring special consideration are as follows:
 - a. Accident only;
 - b. Short term nonrenewable, e.g., airline trip, student accident;
 - c. Specified peril, e.g., common carrier; and
 - d. Other special risks.
 2. Examples of other factors requiring special consideration are as follows:
 - a. Marketing methods, giving due consideration to acquisition and administration costs and to premium mode;
 - b. Extraordinary expenses;
 - c. High risk of claim fluctuation because of the low loss frequency of the catastrophic, or experimental nature of the coverage;
 - d. Product features such as long elimination periods, high deductibles and high maximum limits;
 - e. The industrial or debit method of distribution; and
 - f. Forms issued prior to the effective date of this rule. Companies are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid the necessity of later filing of exceptionally large rate increases.
 3. Notwithstanding the foregoing paragraphs to the contrary, hospital indemnity and cancer and other dread diseases policies shall develop the loss ratios pursuant to subsection (G).
- J.** Severability provision. If any provision of this rule or the application thereof to any person or circumstances is held

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invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.

- K. Effective date. This rule shall become effective upon filing with the Secretary of State and shall apply to all individual disability policy form and rate filings submitted on and after said date.

Historical Note

Adopted effective July 14, 1981 (Supp. 81-1). R20-6-607 recodified from R4-14-607 (Supp. 95-1). Amended by final rulemaking at 24 A.A.R. 103, effective February 17, 2018 (Supp. 17-4).

ARTICLE 7. LICENSING PROVISIONS AND PROCEDURES**R20-6-701. Repealed****Historical Note**

Former General Rule 56-1; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-701 recodified from R4-14-701 (Supp. 95-1).

R20-6-702. Expired**Historical Note**

Former General Rule 56-2. R20-6-702 recodified from R4-14-702 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-703. Expired**Historical Note**

Former General Rule 61-6. R20-6-703 recodified from R4-14-703 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-704. Expired**Historical Note**

Former General Rule 6-19. R20-6-704 recodified from R4-14-704 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-705. Expired**Historical Note**

Former General Rule 66-13. R20-6-705 recodified from R4-14-705 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-706. Expired**Historical Note**

Former General Rule 69-15; Repealed effective February 22, 1977 (Supp. 77-1). New Section R4-14-706 adopted effective November 5, 1980 (Supp. 80-5). R20-6-706 recodified from R4-14-706 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-707. Expired**Historical Note**

Former General Rule 69-18; Amended effective March 17, 1981 (Supp. 81-2). R20-6-707 recodified from R4-14-707 (Supp. 95-1). Section expired under A.R.S. § 41-

1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

R20-6-708. Licensing Time-frames

- A. Definitions. The definitions in A.R.S. § 41-1072 and the following definitions apply to this Article.

1. "Department" means the Insurance Division of the Department of Insurance and Financial Institutions.
2. "License" has the meaning prescribed in A.R.S. § 41-1001(13).

- B. The time-frames listed in Table A apply to licenses issued by the Department. The licensing time-frames consist of an administrative completeness review, a substantive review, and an overall review.

- C. Within the time-frame for the administrative completeness review set forth in Table A, the Department shall notify the applicant in writing whether the application is complete or deficient.

1. If the application is deficient, the Department shall issue a notice of deficiency to the applicant which shall include a comprehensive list of the specific deficiencies. If the Department issues a written notice of deficiency within the administrative completeness review time-frame, the administrative completeness review time-frame and the overall review time-frame are suspended from the date the notice is issued until the date that the Department receives an adequate response from the applicant.
2. The Department is not precluded from issuing additional notices of deficiency during an administrative completeness review.
3. If an applicant does not adequately respond to each specified deficiency in a notice of deficiency issued under subsection (C)(1) within 60 days after the date of a notice of deficiency, the application is deemed withdrawn, and the Department is not required to take further action with respect to the application.

- D. Within the time-frame for the substantive review set forth in Table A, the Department may issue one comprehensive written request for additional information to the applicant specifying each component or item of information required.

1. If the Department issues a comprehensive written request for additional information within the substantive review time-frame, the substantive review time-frame and the overall time-frame are suspended from the date the written request is issued until the date that the Department receives an adequate response from the applicant.
2. The Department is not precluded from issuing supplemental requests by mutual agreement for additional information, during the substantive review.
3. If an applicant does not adequately respond to each component or item of information required in a comprehensive written request or a supplemental request for additional information within 60 days after the date of a comprehensive written request, or within 60 days after the date of the supplemental request for additional information, the application is deemed withdrawn, and the Department is not required to take further action with respect to the application.

- E. Within the overall time-frames set forth in Table A, unless extended by mutual agreement under A.R.S. § 41-1075, the Department shall notify the applicant in writing that the application is granted or denied. If the application is denied, the Department shall provide to the applicant a written notice that complies with the provisions of A.R.S. § 41-1076.

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- F. In computing the time periods prescribed in these time-frame rules, the last day of a notice period is included in the computation, unless it is a Saturday, Sunday, or legal holiday.

Historical Note

Former General Rule 70-22; Correction, original publication did not include Exhibit C. (Supp. 76-1). Repealed

effective January 8, 1980 (Supp. 80-1). R20-6-708 recodified from R4-14-708 (Supp. 95-1). Amended effective January 1, 1999; filed in the Office of the Secretary of State December 4, 1998 (Supp. 98-4). Amended by final rulemaking at 29 A.A.R. 612 (February 24, 2023), effective April 10, 2023 (Supp. 23-1).

Table A. Licensing Time-frames

License	Relevant A.R.S.	Administrative Completeness	Substantive Review	Overall Time-frame
Insurance				
Captive Insurer	§ 20-1098.01	150	30*	180
Certificate of Authority	§ 20-216	210	90*	300
Certificate of Exemption	§ 20-401.05	92	30	122
Health Care Services Organization	§ 20-1052	210	90	300
Hospital, Medical, Dental, and Optometric Service Corporation	§ 20-825	210	90	300
Life Care Provider Permit	§ 20-1803	60*	30*	90
Life Settlement Provider	§ 20-3202	60	60	120
Mechanical Reimbursement Reinsurer	§ 20-1096.04	210	90	300
Prepaid Dental Plan Organization	§ 20-1004	210	90	300
Prepaid Legal Insurer*	§ 20-1097.02	45	15	60*
Qualifying Surplus Lines Insurer	§ 20-413	45	30	75
Reinsurance Intermediary	§ 20-486.01	120	60	180
Insurance Professional				
Adjuster	§ 20-321.01	60	60	120
Bail Bond Agent	§ 20-340.01	60	60	120
Certified Application Counselor	§ 20-336.04	60	60	120
Life Settlement Broker	§ 20-3202	60	60	120
Limited Travel Agent	§ 20-3553	60	60	120
Navigator	§ 20-336.03	60	60	120
Nonresident Insurance Producer (Agent/Broker)	§ 20-287	60	60	120
Portable Electronics Insurance Adjuster	§ 20-321.01	60	60	120
Portable Electronics Insurance Vendor	§ 20-1693.01	60	60	120
Rental Car Agent	§ 20-331	60	60	120
Resident Insurance Producer (Agent/Broker)	§ 20-285	60	60	120
Risk Management Consultant	§ 20-331.01	60	60	120
Self-service Storage Agents	§ 20-332	60	60	120
Surplus Lines Broker	§ 20-411	60	60	120
Temporary License	§ 20-294	60	60	120
Title Insurance Agent	§ 20-1580	60	60	120
Variable Contract Agent	§ 20-2662	60	60	120
Other				
Rating Organization*	§ 20-361	30	30	60*
Rate Service Organization	§ 20-389	60	60	120
Third Party Administrator	§ 20-485.12	45	45	90
Senior Residential Entrance Fee Contracts: Provider Registration	§ 44-6952	60	60	120
Service Company	§ 20-1095.01	30	30	60
Utilization Review Agent	§ 20-2505	30	90	120
Risk Retention Groups				
Risk Retention Group (Foreign)	§ 20-2403	60	0	60
Risk Purchasing Groups	§ 20-2407	30	30	60

* Statutory time-frames

Historical Note

Table A adopted effective January 1, 1999; filed in the Office of the Secretary of State December 4, 1998 (Supp. 98-4). Table A amended by final rulemaking at 29 A.A.R. 612 (February 24, 2023), effective April 10, 2023 (Supp. 23-1).

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R20-6-709. Repealed**Historical Note**

Former General Rule 71-23; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-709 recodified from R4-14-709 (Supp. 95-1).

ARTICLE 8. PROHIBITED PRACTICES, PENALTIES**R20-6-801. Unfair Claims Settlement Practices**

- A.** Applicability. This rule applies to all persons and to all insurance policies, insurance contracts and subscription contracts except policies of Worker's Compensation and title insurance. This rule is not exclusive, and other acts not herein specified, may also be deemed to be a violation of A.R.S. § 20-461, The Unfair Claims Settlement Practices Act.
- B.** Definitions
1. "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim.
 2. "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant.
 3. "Director" means the Director of Insurance of the State of Arizona.
 4. "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency of loss covered by such policy or contract.
 5. "Insurance policy or insurance contract" has the meaning of A.R.S. § 20-103.
 6. "Insurer" has the meaning of A.R.S. § 20-106(C).
 7. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.
 8. "Notification of claim" means any notification, whether in writing or other means, acceptable under the terms of any insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.
 9. "Person" has the meaning of A.R.S. § 20-105.
 10. "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.
 11. "Worker's compensation" includes, but is not limited to, Longshoremen's and Harbor Worker's Compensation.
- C.** File and record documentation. The insurer's claim files shall be subject to examination by the Director or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.
- D.** Misrepresentation of policy provisions
1. No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.
 2. No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.
3. No insurer shall deny a claim on the basis that the claimant has failed to exhibit the damaged property to the insurer, unless the insurer has requested the claimant to exhibit the property and the claimant has refused without a sound basis therefor.
 4. No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.
 5. No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.
 6. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language that releases the insurer or its insured from its total liability.
- E.** Failure to acknowledge pertinent communications
1. Every insurer, upon receiving notification of a claim shall, within 10 working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.
 2. Every insurer, upon receipt of any inquiry from the Department of Insurance respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry.
 3. An appropriate reply shall be made within 10 working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.
 4. Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within 10 working days of notification of a claim shall constitute compliance with subsection (E)(1).
- F.** Standards for prompt investigation of claims. Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless such investigation cannot reasonably be completed within such time.
- G.** Standards for prompt, fair and equitable settlements applicable to all insurers
1. Notice of acceptance of denial of claim.
 - a. Within fifteen working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.
 - b. If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall also notify the first party claimant within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the inves-

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tigation remains incomplete, the insurer shall, 45 days from the date of the initial notification and every 45 days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

- c. Where there is a reasonable basis supported by specific information available for review by the Director for suspecting that the first party claimant has fraudulently caused or contributed to the loss by arson, the insurer is relieved from the requirements of subsections (G)(1)(a) and (b). Provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.
 2. If a claim is denied for reasons other than those described in subsections (G)(1)(a), and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.
 3. Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions.
 4. Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's right. Such notice shall be given to first party claimants 30 days and to third party claimants 60 days before the date on which such time limit may expire.
 5. No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.
- H. Standards for prompt, fair and equitable settlements applicable to automobile insurance**
1. When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods must apply:
 - a. The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the insured, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.
 - b. The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be determined by:
 - i. The cost of a comparable automobile in the local market area when a comparable automobile is available in the local market area.
 - ii. One of two or more quotations obtained by the insurer from two or more qualified dealers located within the local market area when a comparable automobile is not available in the local market area.
 - c. When a first party automobile total loss is settled on a basis which deviates from the methods described in subsections (H)(1)(a) and (b), the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from such cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the first party claimant.
 2. Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid paying claims under such insurer's policy or insurance contract.
 3. Insurers shall not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.
 4. Insurers shall, upon the claimant's request, include the first party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.
 5. If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one or more conveniently located repair shops.
 6. When the amount claimed is reduced because of betterment or depreciation all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.
 7. When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.
 8. The insurer shall not use as a basis for cash settlement with a first party claimant an amount which is less than the amount which the insurer would pay if the repairs were made, other than in total loss situations, unless such amount is agreed to by the insured.
- I. Severability.** If any provision of this rule or the application thereof to any person or circumstances is held invalid, the remainder of the rule and the application of such provision to other persons and circumstances shall not be affected.
- J. Effective date.** This rule shall become effective 90 days from the date of filing with the Secretary of State.

Historical Note

Adopted effective January 12, 1982 (Supp. 81-5). R20-6-801 recodified from R4-14-801 (Supp. 95-1). The refer-

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ence to subsections as “subparagraphs” in this Section has been updated to current Chapter style (Supp. 22-1).

R20-6-802. Emergency Expired**Historical Note**

Emergency rule adopted effective May 31, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Emergency rule readopted without change effective September 5, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-3). Emergency expired. R20-6-802 recodified from R4-14-802 (Supp. 95-1).

ARTICLE 9. TERMINATION OR DISSOLUTION**R20-6-901. Reserved****ARTICLE 10. LONG-TERM CARE INSURANCE****R20-6-1001. Applicability and Scope**

Except as otherwise specifically provided, this Article applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care, delivered or issued for delivery in this state by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health care service organizations and all similar organizations.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1001 recodified from R4-14-1001 (Supp. 95-1). Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1002. Definitions

The definitions in A.R.S. § 20-1691 and the following definitions apply in this Article.

- A. “Benefit trigger,” for purposes of a tax-qualified long-term care insurance contract, as defined in Section 7702B(b) of the Internal Revenue Code of 1968, as amended, “benefit trigger” shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.
- B. “Exceptional increase” means only those rate increases that an insurer has filed as exceptional and that the Director determines the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this state; or due to increased and unexpected utilization that affects the majority of insurers of similar products.
 - 1. Except as provided in Sections R20-6-1014 and R20-6-1015, exceptional increases are subject to the same requirements as other premium rate schedule increases.
 - 2. The Director may request independent actuarial review on the issue of whether an increase should be deemed an exceptional increase.
 - 3. The Director may also determine whether there are any potential offsets to higher claims costs.
- C. “Incidental,” as used in R20-6-1014(L) and R20-6-1015(L), means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy, with value measured as of the date of issue.
- D. “Licensed health care professional” means an individual qualified by education and experience in an appropriate field, to determine, by record review, an insured’s actual functional or cognitive impairment.

- E. “Long-term care benefit classification” means one of the following:
 - 1. Institutional long-term care – benefits only;
 - 2. Non-institutional long-term care – benefits only; or
 - 3. Comprehensive long-term care benefits.
- F. “Managed care plan” means a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, use of specific provider networks, or a combination of these methods.
- G. “Personal information” has the same meaning prescribed in A.R.S. § 20-2102(19).
- H. “Privileged information” has the same meaning prescribed in A.R.S. § 20-2102(22).
- I. “Qualified actuary” means a member in good standing of the American Academy of Actuaries.
- J. “Similar policy forms” means all long-term care insurance policies and certificates that are issued by a particular insurer and that have the same long-term care benefit classification as a policy form being reviewed.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1002 recodified from R4-14-1002 (Supp. 95-1). Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1003. Policy Terms

- A. A long-term care insurance policy delivered or issued for delivery in this state shall not use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:
 - 1. “Activities of daily living” means eating, toileting, transferring, bathing, dressing, or continence.
 - 2. “Acute condition” means that an individual is medically unstable and requires frequent monitoring by medical professionals, such as physicians and registered nurses, to maintain the individual’s health status.
 - 3. “Adult day care” means a program of social and health-related services for six or more individuals, that is provided during the day in a community group setting, for the purpose of supporting frail, impaired, elderly, or other disabled adults who can benefit from the services and care in a setting outside the home.
 - 4. “Agent” means an insurance producer as defined in A.R.S. § 20-281(5).
 - 5. “Bathing” means washing oneself by sponge bath, or in a tub or shower, and includes the act of getting in and out of the tub or shower.
 - 6. “Chronically ill individual” has the meaning prescribed for this term by A.R.S. § 20-1691(3) and Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended.
 - a. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:
 - i. Being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to loss of functional capacity; or
 - ii. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

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- b. The term “chronically ill individual” does not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.
7. “Cognitive impairment” means a deficiency in a person’s:
 - a. Short or long-term memory;
 - b. Orientation as to person, place, or time;
 - c. Deductive or abstract reasoning; or
 - d. Judgment as it relates to safety awareness.
 8. “Continence” means the ability to maintain control of bowel and bladder function, or when unable to maintain control, the ability to perform associated personal hygiene, such as caring for a catheter or colostomy bag.
 9. “Dressing” means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
 10. “Eating” means feeding oneself by getting food into the body from a receptacle such as a plate, cup, or table, or by a feeding tube or intravenously.
 11. “Guaranteed renewable” means the insured has the right to continue a long-term-care insurance policy in force by the timely payment of premiums and the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that the insurer may revise rates on a class basis.
 12. “Hands-on assistance” means physical help to an individual who could not perform an activity of daily living without help from another individual, and includes minimal, moderate, or maximal help.
 13. “Home health services” means the services described at A.R.S. § 36-151.
 14. “Level premium” means that an insurer does not have any right to change the premium, even at renewal.
 15. “Licensed health care practitioner” has the same meaning as A.R.S. § 20-1691(7).
 16. “Maintenance or personal care services” has the same meaning as A.R.S. § 20-1691(10).
 17. “Medicare” means “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,” or “Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof,” or words of similar import.
 18. “Noncancellable” means the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally cancel or make any change in any provision of the insurance or in the premium rate.
 19. “Personal care” means the provision of hands-on assistance to help an individual with activities of daily living in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
 20. “Qualified long-term care services” has the meaning prescribed for this term under A.R.S. § 20-1691(14) and means services that meet the requirements of Section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.
 21. “Toileting” means getting to and from the toilet, getting on and off the toilet, and performing tasks associated with personal hygiene.
 22. “Transferring” means moving into or out of a bed, chair, or wheelchair.
- B.** Any long-term care policy delivered or issued for delivery in this state shall include the following policy terms and provisions as specified in this subsection:
1. “Home care” shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
 2. “Intermediate care” shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
 3. “Mental or nervous disorder” shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
 4. “Skilled nursing care,” “specialized care,” “assisted living care” and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care is delivered.
 5. Service providers, including “skilled nursing facility,” “extended care facility,” “convalescent nursing home,” “personal care facility,” “specialized care providers,” “assisted living facility” and “home care agency” shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1003 recodified from R4-14-1003 (Supp. 95-1).

Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1004. Required Policy Provisions**A. Renewability**

1. An individual long-term care insurance policy shall contain a renewability provision which shall be either “guaranteed renewable” or “noncancellable.” The renewability provision shall be appropriately captioned, shall appear on the first page of the policy, and shall state that the coverage is guaranteed renewable or noncancellable. This requirement does not apply to a long-term care insurance policy that is part of or combined with a life insurance policy that does not contain a renewability provision and that reserves the right not to renew solely to the policyholder.
2. An insurer shall not use the terms “guaranteed renewable” and “noncancellable” in any individual long-term care insurance policy without further explanatory lan-

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guage according to the disclosure requirements of this Article.

3. A qualified long-term care insurance policy shall have the guaranteed renewability provisions specified in Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended, in the policy.
4. A long-term care insurance policy or certificate shall include a statement that premium rates are subject to change, unless the policy does not afford the insurer the right to raise premiums.

B. Limitations and Exclusions

1. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."
2. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility not prohibited by A.R.S. §§ 20-1691.03 and 20-1691.05 shall describe the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label the paragraph "Limitations or Conditions on Eligibility for Benefits."
3. A policy shall not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:
 - a. Preexisting conditions or disease;
 - b. Mental or nervous disorders; however, this shall not permit exclusion or limitation of the benefits on the basis of Alzheimer's Disease;
 - c. Alcoholism and drug addiction;
 - d. Illness, treatment or medical condition arising out of:
 - i. War, declared or undeclared, or act of war;
 - ii. Participation in a felony, riot or insurrection;
 - iii. Service in the armed forces or auxiliary units;
 - iv. Suicide, attempted suicide, or intentionally self-inflicted injury; or
 - v. Aviation, if non-fare-paying passenger;
 - e. Treatment provided in a government facility, unless otherwise required by law;
 - f. Services for which benefits are available under Medicare or other governmental program, except Medicaid;
 - g. Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
 - h. Services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;
 - i. Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or
 - j. In the case of a qualified long-term care insurance policy, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be reimbursable but for the application of a deductible or coinsurance amount;
4. Subsection (B) does not prohibit exclusions and limitations by type of provider or territorial limitations. No long-term care issuer may deny a claim because services

are provided in a state other than the state of policy issued under the following conditions:

- a. When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or
 - b. When the state other than the state of policy issue licenses, certifies or registers the provider under another name.
5. "State of policy issue" means the state in which the insurer issued the individual policy or certificate.
- C. Extension of benefits.** A long-term care insurance policy shall provide that termination of long-term care insurance is without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. An insurer may limit this extension of benefits period to the duration of the benefit period, if any, or to payment of the maximum benefits and the insurer may still apply any policy waiting period and all other applicable provisions of the policy.
- D. Reinstatement.** A long-term care insurance policy shall include a provision for reinstatement of coverage if a lapse occurs if the insurer receives proof that the insured was cognitively impaired or had a loss of functional capacity before expiration of the grace period in the policy. The option to reinstate shall be available to the insured for at least five months after the date of termination and shall allow for the collection of past due premiums, as appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria for these conditions set forth in the original long-term care policy.
- E. Continuation or conversion.**
1. A group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion of coverage as specified in this subsection.
 2. The policy shall include a provision that maintains coverage under the existing group policy when the coverage would otherwise terminate, subject only to the continued timely payment of premiums when due. A group policy that restricts provision of benefits and services to, or has incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The Director shall make a determination as to the substantial equivalency of benefits and, in doing so, shall take into consideration the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels and administrative complexity.
 3. The policy shall include a provision that an individual, whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuation of the group policy in its entirety or with respect to an insured class, who has been continuously insured under the group policy (and any group policy which it replaced) for at least six months immediately prior to termination, is entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.
 4. A converted policy shall be an individual policy of long-term care insurance providing benefits identical to or ben-

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- efits that the Director determines to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the Director, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity, and other plan elements.
5. An insurer may require an individual seeking a conversion policy to make a written application for the converted policy and pay the first premium due, if any, as directed by the insurer not later than 31 days after termination of coverage under the group policy. The insurer shall issue the converted policy effective on the day following the termination of coverage under the group policy. The converted policy shall be renewable annually.
 6. Unless the group policy from which conversion is made replaced previous group coverage, the insurer shall calculate the premium for the converted policy on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. If the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.
 7. An insurer is required to provide continuation of coverage or issuance of a converted policy as provided in this subsection, unless:
 - a. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or
 - b. The terminating coverage is replaced not later than 31 days after termination, by group coverage that:
 - i. Is effective on the day following the termination of coverage;
 - ii. Provides benefits identical to or benefits the Director determines to be substantially equivalent to or in excess of those provided by the terminating coverage; and
 - iii. Has a premium calculated in a manner consistent with the requirements of subsection (E)(6).
 8. Notwithstanding any other provision of this Section, a converted policy that an insurer issues to an individual who at the time of conversion is covered by another long-term care insurance policy providing benefits on the basis of incurred expenses, may contain a provision that reduces benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100% of incurred expenses. An insurer may include this provision in the converted policy only if the converted policy also provides for a premium decrease or refund that reflects the reduction in payable benefits.
 9. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.
 10. Notwithstanding any other provision of this Section, an insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person, is entitled to continuation of coverage under the group policy if the qualifying relationship terminates by death or dissolution of marriage.
- F. Discontinuance and replacement.** If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:
1. Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and
 2. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.
- G. Premium Increases.**
1. An insurer shall not increase the premium charged to an insured because of:
 - a. The increasing age of the insured at ages beyond 65, or
 - b. The duration of coverage under the policy.
 2. Purchase of additional coverage is not considered a premium rate increase, however, for the calculation required under R20-6-1019, an insurer shall add to and consider the portion of the premium attributable to the additional coverage as part of the initial annual premium.
 3. A reduction in benefits is not considered a premium change, however, for the calculation required under R20-6-1019, an insurer shall base the initial annual premium on the reduced benefits.
- H. Electronic enrollment for group policies.**
1. For coverage offered to a group defined in A.R.S. § 20-1691(5)(a), any requirement that an insurer or insurance producer obtain an insured's signature is satisfied if:
 - a. The group policyholder or insurer obtains the insured's consent by telephonic or electronic enrollment, and provides the enrollee with verification of enrollment information within five business days of enrollment; and
 - b. The telephonic or electronic enrollment process has necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records, and the confidentiality of individually identifiable and privileged information.
 2. If the Director requests, the insurer shall make available records showing the insurer's ability to confirm enrollment and coverage amounts.
- I. Minimum standards for home health and community care benefits.**
1. If an insurer issues a long-term care insurance policy or certificate that provides benefits for home-health or community care, the policy or certificate shall not limit or exclude benefits by any of the following:
 - a. Requiring that the insured would need skilled care in a skilled nursing facility if home health services are not provided;
 - b. Requiring that the insured first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health services are covered;

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- c. Requiring that eligible services be provided by a registered nurse or licensed practical nurse;
 - d. Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of licensure or certification;
 - e. Requiring that the insured or claimant have an acute condition before home health services are covered;
 - f. Limiting benefits to services provided by Medicare-certified agencies or providers;
 - g. Excluding coverage for personal care services provided by a home health aide;
 - h. Requiring that home health care services be provided at a level of certification or licensure greater than that required by the eligible service; or
 - i. Excluding coverage for adult day care services.
2. If a long-term care insurance policy provides benefits for home health or community care services, it shall provide home health or community care coverage that equals a dollar amount equivalent to at least one-half of one year's missing home benefit coverage available at the time covered home health or community care services are being received. This requirement does not apply to policies or certificates issued to residents of continuing care retirement communities.
3. An insurer may apply home health care coverage to non-home health care benefits in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.
- J. Appeals. Policy shall include a clear description of the process for appealing and resolving benefit determinations.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1004 recodified from R4-14-1004 (Supp. 95-1).

Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1005. Unintentional Lapse

- A. An insured may designate in writing at least one person to receive notice of lapse or termination of a long-term care insurance policy for nonpayment of premium, in addition to the insured. Designation shall not constitute acceptance of any liability by the third-party notice recipient for services provided to the insured.
- B. An insurer shall not issue an individual long-term care insurance policy or certificate until the applicant has provided either a written designation of at least one person, in addition to the applicant, who shall receive notice of lapse or termination of the policy or certificate for nonpayment of premium, with the person's full name and home address, or the applicant's written waiver, dated and signed, indicating that the applicant chooses not to designate a notice recipient.
- C. The insurer shall use a form for written designation or waiver that provides space clearly delineated for the designation. The insurer shall include the following language on the form for waiver of the right to name a designated recipient: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that this notice will not be given until 30 days after a premium is due

and unpaid. I elect NOT to designate a person to receive this notice."

- D. At least once every two years, an insurer shall notify the insured of the right to change the person designated to receive notice in subsection (A). An insured may add, delete, or change a designated recipient or change a designated recipient at any time by notifying the insurer in writing, and providing the name and home address for the new designated recipient or the designated recipient to be deleted.
- E. If the insured pays premiums for the long-term care insurance policy or certificate through a payroll or pension deduction plan, the insurer is not required to comply with the requirements in subsections (A) through (D) until 60 days after the insured is no longer on the payment plan.
- F. An individual long-term care insurance policy shall not lapse or be terminated for nonpayment of premium unless the insurer gives the insured and any recipient designated under subsections (A) through (D) written notice at least 30 days before the effective date of termination or lapse, by first class mail, postage prepaid, at the address provided by the insured for purposes of receiving notice of lapse or termination. An insurer shall not give notice until 30 days after the date on which a premium is due and unpaid. Notice is deemed given five days after the date of mailing.
- G. Reinstatement. In addition to the requirement in subsections (A) through (D), a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage in the event of a lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy or certificate. Reinstatement after termination for other than unintentional lapse shall be governed by A.R.S. § 20-1348.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1005 recodified from R4-14-1005 (Supp. 95-1). Section

R20-6-1005 renumbered to R20-6-1006; new Section R20-6-1005 made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1006. Inflation Protection

- A. An insurer shall not offer a long-term care insurance policy unless the insurer offers to the policyholder, at the time of purchase, in addition to any other inflation protection, the option to purchase a policy with an inflation protection provision that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. The terms of the required provision shall be no less favorable than one of the following:
 - 1. A provision that provides for annual increases in benefit levels compounding annually at a rate of not less than 5%;
 - 2. A provision that guarantees an insured the right to periodically increase benefit levels without providing evidence

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of insurability or health status, if the insured did not decline the option for the previous period. The increased benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning from the purchase of the existing benefit and extending until the year in which the offer is made; or

3. A provision for coverage of a specified percentage of actual or reasonable charges that is not subject to a maximum specified indemnity amount or limit.
- B. If the policy is issued to a group, the insurer shall extend the offer required by subsection (A) to the group policyholder; except, if the policy is issued under A.R.S. § 20-1691.04(C) to a group, other than to a continuing care retirement community, the insurer shall make the offer to each proposed certificate-holder.
- C. An insurer is not required to make the offer in subsection (A) for life insurance policies or riders with accelerated long-term care benefits.
- D. An insurer shall include the information listed in this subsection in or with the outline of coverage.
 1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.
 2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall provide a revised schedule of attained-age premiums. An insurer may use a reasonable hypothetical or a graphic demonstration for this disclosure.
- E. Inflation-protection benefit increases shall continue without regard to an insured's age, claim status, claim history, or length of time the person has been insured under the policy.
- F. An insurer's offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that the insurer expects to remain constant. The insurer shall disclose in the offer in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.
- G. An insurer shall include in a long-term care insurance policy inflation protection as provided in subsection (A)(1) unless the insurer obtains a rejection of inflation protection signed by the insured as required in subsection (H). The rejection may be either on the application form or on a separate form.
- H. A rejection of inflation protection is deemed part of an application and shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I reviewed Plans [insert description of plans], and I reject inflation protection."

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1006 recodified from R4-14-1006 (Supp. 95-1). R20-6-1006 renumbered to R20-6-1007; new Section R20-5-1006 renumbered from R20-6-1005 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1007. Required Disclosure Provisions

- A. Riders and endorsements. Except for riders or endorsements by which an insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, if an insurer adds a rider or endorsement to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduces or eliminates benefits or coverage in the policy, the insurer shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall require the signed written agreement of the insured unless the increased benefits or coverage are required by law. If the insurer charges a separate additional premium for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement.
- B. Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall define the terms and explain them in its accompanying outline of coverage.
- C. Disclosure of tax consequences. For life insurance policies that provide an accelerated benefit for long-term care, an insurer shall provide a disclosure statement at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted, that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax adviser. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.
- D. Benefit triggers. A long-term care insurance policy shall use activities of daily living and cognitive impairment to measure an insured's need for long-term care. The long-term care insurance policy shall describe these terms and provisions in a separate paragraph in the policy labeled "Eligibility for the Payment of Benefits" that includes and explains:
 1. Any additional benefit triggers,
 2. Benefit triggers that result in payment of different benefit levels, and
 3. Any requirement that an attending physician or other specified person certify a certain level of functional dependency for the insured to be eligible for benefits.
- E. A long-term care insurance contract shall contain a disclosure statement in the policy and in the outline of coverage indicating whether it is intended to be a qualified long-term care insurance contract as specified in the outline of coverage in Appendix J, paragraph 3. The contract shall also include a Specification Page which shall include the benefits, amounts, durations, the premium rate including all optional benefits selected by the insured, and any other benefit data applicable to the insured.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1007 recodified from R4-14-1007 (Supp. 95-1). Former Section R20-6-1007 renumbered to R20-6-1010; new Section R20-6-1007 renumbered from R20-6-1006 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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R20-6-1008. Required Disclosure of Rating Practices to Consumers

- A.** This Section applies as follows:
1. Except as provided in subsection (A)(2), this Section applies to any long-term care policy or certificate issued in this state on or after May 10, 2005.
 2. For certificates issued under an in-force, long-term care insurance policy issued to a group as defined in A.R.S. § 20-1691(5)(a), the provisions of this Section apply on the first policy anniversary that occurs on or after November 10, 2005.
- B.** Unless a policy is one for which an insurer cannot increase the applicable premium rate or rate schedule, the insurer shall provide the information listed in this subsection to the applicant at the time of application or enrollment. If the method of application does not allow for delivery at that time, the insurer shall provide the information to the applicant no later than at the time of delivery of the policy or certificate.
1. A statement that the policy may be subject to rate increases in the future.
 2. An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option if a premium rate revision occurs.
 3. The premium rate or rate schedules applicable to the applicant that will be in effect until the insurer makes a request for an increase.
 4. A general explanation for applying premium rate or rate schedule adjustments that includes:
 - a. A description of when premium rate or rate-schedule adjustments will be effective (e.g., next anniversary date, next billing date); and
 - b. The insurer's right to a revised premium rate or rate schedule as provided in subsection (B)(3) if the premium rate or rate schedule is changed.
 5. Information regarding each premium rate increase on this policy form or similar policy form over the past 10 years for this state or any other state that, at a minimum, identifies:
 - a. The policy forms for which premium rates have been increased;
 - b. The calendar years when the form was available for purchase; and
 - c. The amount or percent of each increase, which may be expressed as a percentage of the premium rate before the increase, or as minimum and maximum percentages if the rate increase is variable by rating characteristics.
 6. The insurer may, in a fair manner, provide explanatory information related to the rate increases in addition to the information required under subsection (B)(5).
- C.** An insurer may exclude from the disclosure required under subsection (B)(5), premium rate increases applicable to:
1. Blocks of business acquired from other nonaffiliated insurers, and
 2. Policies acquired from other nonaffiliated insurers if the increases occurred before the acquisition.
- D.** If an acquiring insurer files for a rate increase on a long-term care insurance policy form or a block of policy forms acquired from a nonaffiliated insurer on or before the later of the January 10, 2005, or the end of a 24-month period following the acquisition of the policies or block of policies, the acquiring insurer may exclude that rate increase from the disclosure required under subsection (B)(5). However, the nonaffiliated insurer that sells the policy form or a block of policy forms

- shall include that rate increase in the disclosure required under subsection (B)(5). If the acquiring insurer files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from a nonaffiliated insurer or block of policy forms acquired from nonaffiliated insurers, the acquiring insurer shall make all disclosures required by subsection (B)(5), including disclosure of the earlier rate increase.
- E.** Unless the method of application does not allow an insured to sign an acknowledgement that the insurer made the disclosures required under subsection (B) at the time of application, the applicant shall sign an acknowledgement of disclosure at that time. Otherwise, the applicant shall sign a disclosure acknowledgement no later than at the time of delivery of the policy or certificate.
- F.** An insurer shall use the forms in Appendix A and Appendix B to comply with the requirements of subsections (B) through (E). The text and format of an insurer's forms shall be substantially similar to the text and format of Appendices A and B.
- G.** An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days before the effective date of the increase. The notice shall include the information required by subsection (B).

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1008 recodified from R4-14-1008 (Supp. 95-1). Former Section R20-6-1008 renumbered to R20-6-1011; new Section R20-6-1008 made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1009. Initial Filing Requirements

- A.** This Section applies to any long-term care policy issued in this state on or after May 10, 2005.
- B.** At the time of making a filing under A.R.S. § 20-1691.08, an insurer shall provide to the Director a copy of the disclosure documents required under R20-6-1008 and an actuarial certification that includes the following:
1. The initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
 2. The policy design and coverage provided have been reviewed and taken into consideration;
 3. The underwriting and claims adjudication processes have been reviewed and taken into consideration;
 4. The premiums contain at least the minimum margin for moderately adverse experience as defined in subsection (4)(a) or the specification of and justification for a lower margin as required by subsection (4)(b).
 - a. A composite margin shall not be less than 10% of lifetime claims.
 - b. A composite margin that is less than 10% may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted.
 - c. A composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract.

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Such lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.

- d. A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.
5. A statement that the premium rate schedule:
 - a. Is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits, or
 - b. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences; and
6. A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:
 - a. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and
 - b. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.
- C. An actuarial memorandum shall be included that is signed by a member of the Academy of Actuaries and that addresses and supports each specific item required as part of the actuarial certification and provides at least the following:
 1. An explanation of the review performed by the actuary prior to making the statements in subsections (B)(2) and (B)(3);
 2. A complete description of pricing assumptions;
 3. Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in subsection (B)(1) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. The actuary shall clearly describe deviations in margins between ages, sexes, plans or states. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales; and
 4. A demonstration that the gross premiums include the minimum composite margin specified in subsection (B)(4).
- D. In any review of the actuarial certification and actuarial memorandum, the Director may request review by an actuary with experience in long-term care pricing who is independent of the insurer. In the event the Director asks for additional information as a result of any review, the period in A.R.S. § 20-1691.08 does not include the period during which the insurer is preparing the requested information.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1009 recodified from R4-14-1009 (Supp. 95-1). Section R20-6-1009 renumbered to R20-6-1012; new Section R20-6-1009 made by final rulemaking at 10 A.A.R. 4661,

effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1010. Requirements for Application Forms and Replacement Coverage; Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates; Reporting Requirements

- A. An insurer's application form for a long-term care insurance policy shall include the questions listed in this Section to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other health or long-term care policy or certificate presently in force. An insurer may include the questions in a supplementary application or other form to be signed by the applicant and insurance producer, except where the coverage is sold without an insurance producer. For a replacement policy issued to a group as defined in A.R.S. § 20-1691(5)(a), the insurer may modify the questions only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced if the certificateholder has been notified of the replacement.
 1. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?
 2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?
 - a. If so, with which company?
 - b. If that policy lapsed, when did it lapse?
 3. Are you covered by Medicaid?
 4. Do you intend to replace any of your medical or health insurance coverage with this policy or certificate?
- B. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan the applicant selects.
- C. An insurance producer shall list any other health insurance policies the insurance producer has sold to the applicant, including:
 1. Policies that are still in force, and
 2. Policies sold in the past five years that are no longer in force.
- D. Solicitations Other than Direct Response. On determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its insurance producer; shall furnish the applicant, before issuing or delivering the individual long-term care insurance policy, a notice that substantially conforms to the form prescribed in Appendix C or D regarding replacement of health or long-term care coverage. The insurer shall:
 1. Give one copy of the notice to the applicant, and
 2. Keep an additional copy signed by the applicant.
- E. Direct Response Solicitations. Insurers using direct response solicitation methods as defined in A.R.S. § 20-1661 shall deliver a notice that substantially conforms to the form prescribed in Appendix C or D regarding replacement of health or long-term care coverage to the applicant upon issuance of the policy.
- F. If replacement is intended, the replacing insurer shall send the existing insurer written notice of the proposed replacement within five working days from the date the replacing insurer receives the application or issues the policy, whichever is sooner. The notice shall identify the existing policy by name of

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the insurer and the insured, and policy number or insured's address including zip code.

- G. A life insurance policy that accelerate benefits for long-term care shall comply with this Section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of Title 20, Chapter 6, Article 1.1. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with the requirements of this Section and with A.R.S. Title 20, Chapter 6, Article 1.1.
- H. Prohibition against preexisting conditions and probationary periods in replacement policies or certificates. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits if similar exclusions are satisfied under the original policy.
- I. Reporting requirements.
 - 1. An insurer shall maintain the following records for each insurance producer:
 - a. The amount of the insurance producer's replacement sales as a percent of the insurance producer's total annual sales, and
 - b. The amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales.
 - 2. No later than June 30 of each year, on the forms specified in Appendix E and Appendix F, an insurer shall report the following information for the preceding calendar year to the Department:
 - a. The 10% of its insurance producers licensed in Arizona with the greatest percentages of lapses and replacements as measured by subsection (I)(1);
 - b. The number of lapsed policies as a percent of the total annual sales and as a percent of the insurer's total number of policies in force as of the end of the preceding calendar year;
 - c. The number of replacement policies sold as a percent of the insurer's total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year; and
 - d. For qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied.
- J. In subsection (I):
 - 1. "Claim" means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.
 - 2. "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.
 - 3. "Policy" means only long-term care insurance.
 - 4. "Report" means on a statewide basis.
- K. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance. Reports required under this Section shall be filed with the Director.

- L. Annual rate certification requirements. This subsection applies to any long-term care policy issued in Arizona on or after November 10, 2017. The following annual submission requirements apply subsequent to initial rate filings for individual long-term care insurance policies made under this Section:
 - 1. An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries which contains a statement of the sufficiency of the current premium rate schedule, including:
 - a. For the rate schedules currently marketed, that the premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated or a statement that margins for moderately adverse experience may no longer be sufficient. For a statement that margins for moderately adverse experience may no longer be sufficient, the insurer shall provide to the Director, within 60 days of the date the actuarial certification is submitted to the Director, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the Director within 60 days or to comply with the time frame stated in the plan of action constitutes grounds for the Director to withdraw or modify approval of the form for future sales pursuant to A.R.S. § 20-1691.08.
 - b. For the rate schedules that are no longer marketed, that the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions or that the premium rate schedule may no longer be sufficient. If the premium rate schedule is no longer sufficient, the insurer shall provide to the Director, within 60 days of the date the actuarial certification is submitted to the Director, a plan of action, including time frame, for the re-establishment of adequate margins for moderately adverse experience;
 - 2. A description of the review performed that led to the statement; and
 - 3. An actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:
 - a. A detailed explanation of the data sources and review performed by the actuary prior to making the statement in subsection (L)(1),
 - b. A complete description of experience assumptions and their relationship to the initial pricing assumptions,
 - c. A description of the credibility of the experience data, and
 - d. An explanation of the analysis and testing performed in determining the current presence of margins.
 - 4. The actuarial certification required pursuant to subsection (L)(1) must be based on calendar year data and submitted annually starting in the second year following the year in which the initial rate schedules are first used. The actuar-

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ial memorandum required pursuant to subsection (L)(3) must be submitted at least once every three years with the certification.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1010 recodified from R4-14-1010 (Supp. 95-1). R20-6-1010 renumbered to R20-6-1013; new Section R20-6-1010 renumbered from R20-6-1007 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1011. Prohibition Against Post-claims Underwriting

A. An application for a long-term care insurance policy or certificate that is not guaranteed issue shall meet the requirements of this Section.

1. The application shall contain clear and unambiguous questions designed to ascertain the applicant's health condition.
 - a. If the application has a question asking whether the applicant has had medication prescribed by a physician, the application shall also ask the applicant to list the prescribed medication.
 - b. If the insurer knew or reasonably should have known that the medications listed in the application are related to a medical condition for which coverage would otherwise be denied, the insurer shall not rescind the policy or certificate for that condition.
2. The application shall include the following language which shall be set out conspicuously and in close conjunction with the applicant's signature block: **"Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."**
3. The policy or certificate shall contain, at the time of delivery, the following language, or language substantially similar to the following, set out conspicuously: **"Caution: The issuance of this long-term care insurance [policy] [certificate] is based on your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]."**

B. Before issuing a long-term care insurance policy or certificate that is not guaranteed issue to an applicant age 80 or older, the insurer shall obtain one of the following:

1. A report of a physical examination,
2. An assessment of functional capacity,
3. An attending physician's statement, or
4. Copies of medical records.

C. The insurer or its insurance producer shall deliver a copy of the completed application or enrollment form, as applicable, to the insured no later than at the time of delivery of the policy or certificate unless the insurer gave a copy to the applicant it at the time of application.

D. An insurer selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and country-wide, except those which the insured voluntarily effectuated.

E. On or before March 31 of each year, an insurer shall report the following information to the Director for the preceding calendar year, using the form prescribed in Appendix G:

1. Insurer name, address, phone number;
2. As to each rescission except those voluntarily effectuated by the insured:
 - a. Policy form number,
 - b. Policy and certificate number,
 - c. Name of the insured,
 - d. Date of policy issuance,
 - e. Date claim submitted,
 - f. Date of rescission, and
 - g. Detailed reason for rescission; and
3. Signature, name and title of the preparer, and date prepared.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1011 recodified from R4-14-1011 (Supp. 95-1). R20-6-1011 renumbered to R20-6-1014; new Section R20-6-1011 renumbered from R20-6-1008 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1012. Reserve Standards

A. If long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders, an insurer shall determine policy reserves for long-term care benefits under A.R.S. § 20-510. An insurer shall also establish claim reserves for a policy or rider in claim status.

B. An insurer shall base reserves for policies and riders under subsection (A) on the multiple decrement model using all relevant decrements except for voluntary termination rates. An insurer may use single decrement approximations if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The insurer, when calculating reserves, may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. The insurer shall not set the reserves for the long-term care benefit and the life insurance benefit to be less than the reserves for the life insurance benefit assuming no long-term care benefit.

C. In the development and calculation of reserves for policies and riders subject to this Section, an insurer shall give due regard to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which impact projected claim costs including the following:

1. Definition of insured events,
2. Covered long-term care facilities,
3. Existence of home convalescence care coverage,
4. Definition of facilities,
5. Existence or absence of barriers to eligibility,
6. Premium waiver provision,
7. Renewability,
8. Ability to raise premiums,
9. Marketing method,
10. Underwriting procedures,
11. Claims adjustment procedures,
12. Waiting period,
13. Maximum benefit,
14. Availability of eligible facilities,
15. Margins in claim costs,
16. Optional nature of benefit,
17. Delay in eligibility for benefit,

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- 18. Inflation protection provisions,
- 19. Guaranteed insurability option, and
- 20. Other similar or comparable factors affecting risk.
- D.** A member of the American Academy of Actuaries shall certify an insurer's use of any applicable valuation morbidity table as appropriate as a statutory valuation table.
- E.** When long-term care benefits are provided other than as described in subsection (A), an insurer shall determine reserves under A.R.S. § 20-508.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1012 recodified from R4-14-1012 (Supp. 95-1). R20-6-1012 renumbered to R20-6-1016; new Section R20-6-1012 renumbered from R20-6-1009 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section repealed; new Section renumbered from R20-6-1013 and amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1013. Loss Ratio

- A.** This Section applies to policies and certificates issued any time prior to May 10, 2005.
- B.** Benefits under an individual long-term care insurance policy are deemed reasonable in relation to premiums if the expected loss ratio is at least 60% calculated in a manner that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, the director shall consider all relevant factors, including:
 - 1. Statistical credibility of incurred claims experience and earned premiums;
 - 2. The period for which rates are computed to provide coverage;
 - 3. Experienced and projected trends;
 - 4. Concentration of experience within early policy duration;
 - 5. Expected claim fluctuation;
 - 6. Experience refunds, adjustments, or dividends;
 - 7. Renewability features;
 - 8. All appropriate expense factors;
 - 9. Interest;
 - 10. Experimental nature of the coverage;
 - 11. Policy reserves;
 - 12. Mix of business by risk classification; and
 - 13. Product features such as long elimination periods, high deductibles, and high maximum limits.
- C.** A premium rate schedule or proposed revision to a premium rate schedule that is expected to produce, over the lifetime of the long-term care insurance policy, benefits that are less than 60% of the proposed premium rate schedule is deemed to be unreasonable.
- D.** Subsections (B) and (C) do not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is deemed to provide reasonable benefits in relation to premiums paid if the policy complies with all of the following:
 - 1. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
 - 2. The portion of the policy that provides life insurance benefits complies with the nonforfeiture requirements of A.R.S. § 20-1231;

- 3. The policy complies with the disclosure requirements of A.R.S. § 20-1691.06(A) through (E);
- 4. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes the following information:
 - a. A description of the basis on which the long-term care rates were determined;
 - b. A description of the basis for the reserves;
 - c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
 - d. A description and a table of each actuarial assumption used; for expenses, an insurer shall include percent of premium dollars per policy and dollars per unit of benefits, if any;
 - e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - f. The estimated average annual premium per policy and the average issue age;
 - g. A statement as to whether underwriting is performed, including:
 - i. Time of underwriting;
 - ii. A description of the type of underwriting used, such as medical underwriting or functional assessment underwriting; and
 - iii. For a group policy, whether an enrollee's dependents are subject to underwriting; and
 - h. A description of the effect of the long-term care policy provisions on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1013 recodified from R4-14-1013 (Supp. 95-1). Section R20-6-1013 renumbered to R20-6-1017; new Section R20-6-1013 renumbered from R20-6-1010 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section R20-6-1013 renumbered to R20-6-1012; new Section R20-6-1013 renumbered from R20-6-1014 and amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1014. Premium Rate Schedule Increase

- A.** This Section applies to any long-term care policy or certificate issued in this state on or after May 10, 2005 and prior to November 10, 2017.
- B.** An insurer shall notify the Director of a proposed premium rate schedule increase, including an exceptional increase, at least 60 days before issuing notice to its policyholders. The notice to the Director shall include:
 - 1. Information required by R20-6-1008;
 - 2. Certification by a qualified actuary that:
 - a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
 - b. The premium rate filing complies with the provisions of this Section; and
 - c. The insurer may request a premium rate schedule increase less than what is required under this Section

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- and the Director may approve the premium rate schedule increase, without submission of the certification required by subsection (B)(2)(a), if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required by subsection (B)(2)(a), the premium rate schedule increase filing satisfies all other requirements of this Section, and is, in the opinion of the Director, in the best interest of the policyholders.
3. An actuarial memorandum justifying the rate schedule change request that includes:
 - a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including the following:
 - i. Any assumptions that deviate from those used for pricing other forms currently available for sale;
 - ii. Annual values for the five years preceding and the three years following the valuation date, provided separately;
 - iii. Development of the lifetime loss ratio, unless the rate increase is an exceptional increase; and
 - iv. A demonstration of compliance with subsection (C).
 - b. For exceptional increases, the actuarial memorandum shall also include:
 - i. The projected experience that is limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
 - ii. If the Director determines under Section R20-6-1002(B)(3) that offsets may exist, the insurer shall use appropriate net projected experience;
 - c. Disclosure of how reserves have been incorporated in this rate increase when the rate increase will trigger contingent benefit upon lapse;
 - d. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and any other actions of the insurer on which the actuary has relied;
 - e. A statement that the actuary has considered policy design, underwriting, and claims adjudication practices;
 - f. Composite rates reflecting projections of new certificates in the event it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase; and
 - g. A demonstration that actual and projected costs exceed costs anticipated at the time of the initial pricing under moderately adverse experience and that the composite margin specified in R20-6-1009(B)(4) is projected to be exhausted;
 4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless the insurer provides the Director with documentation justifying the greater rate; and
 5. Upon the Director's request, other similar and related information the Director may require to evaluate the premium rate schedule increase.
- C. All premium rate schedule increases shall be determined in accordance with the following requirements:
 1. The insurer shall return 70% of the present value of projected additional premiums from an exceptional increase to policyholders in benefits;
 2. The sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, shall not be less than the sum of the following:
 - a. The accumulated value of the initial earned premium times 58%;
 - b. 85% of the accumulated value of prior premium rate schedule increases on an earned basis;
 - c. The present value of future projected initial earned premiums times 58%; and
 - d. 85% of the present value of future projected premiums not in subsection (C)(2)(c) on an earned basis;
 3. If a policy form has both exceptional and other increases, the values in subsections (C)(2)(b) and (C)(2)(d) shall also include 70% for exceptional rate increase amounts; and
 4. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the NAIC Accounting Practices and Procedures Manual to which insurers are subject under A.R.S. § 20-223. The actuary shall disclose the use of any appropriate averages in the actuarial memorandum required under subsection (B)(3).
 - D. For each rate increase that is implemented, the insurer shall file for approval by the Director updated projections, as defined in subsection (B)(3)(a), annually for the next three years and shall include a comparison of actual results to projected values. The Director may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (M), the insurer shall provide the projections required by this subsection to the policyholder in lieu of filing with the Director.
 - E. If any premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, the insurer shall file lifetime projections, as defined in subsection (B)(3)(a), for the Director's approval every five years following the end of the required period in subsection (D). For group insurance policies that meet the conditions in subsection (M), the insurer shall provide the projections required by this subsection to the policyholder instead of filing with the Director.
 - F. If the Director finds that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (C), the Director may require the insurer to implement premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience matches the projected experience, the Director shall consider subsection (B)(3)(f), if applicable.
 - G. If the majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse, the insurer shall file:
 1. A plan, subject to Director approval, for improved administration or claims processing designed to eliminate the

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potential for further deterioration of the policy form experience requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Director may impose the conditions in subsections (H) through (J); and

2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (C) had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in subsections (C)(2)(a) and (C)(2)(c).
- H.** For a rate increase filing that meets the criteria listed in this subsection, the Director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if lapsation in excess of projected lapsation has occurred or is anticipated:
1. The rate increase is not the first rate increase requested for the specific policy form or forms,
 2. The rate increase is not an exceptional increase, and
 3. The majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse.
- I.** If the Director finds excess lapsation under subsection (H) has occurred, is anticipated in the filing or is evidenced in the actual results as presenting in the updated projections provided by the insurer following the requested rate increase, the Director may find that a rate spiral exists and may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The information communicating the offer is subject to the Director's approval. The offer shall:
1. Be based on actuarially sound principles, but not on attained age;
 2. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy; and
 3. Allow the insured the option of retaining the existing coverage.
- J.** The insurer shall maintain the experience of the insureds whose coverage was replaced under subsection (I) separate from the experience of insureds originally issued the policy forms. If the insurer requests a rate increase on the policy form, the rate increase shall be limited to the lesser of:
1. The maximum rate increase determined based on the combined experience; and
 2. The maximum rate increase determined based only on the experience of the insureds originally issued the form, plus 10%.
- K.** If the Director finds that an insurer has exhibited a history or pattern of filing inadequate initial premium rates for long-term care insurance, after considering the total number of policies filed over a period of time and the percentage of policies with inadequate rates, the Director may, in addition to remedies available under subsections (H) through (J), prohibit the insurer from the following:
1. Filing and marketing comparable coverage for a period of up to five years, and
 2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.
- L.** Subsections (A) through (K) shall not apply to a policy for which long-term care benefits provided by the policy are incidental, as defined under R20-6-1002(C), if the policy complies with all of the following provisions:
1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
 2. The portion of the policy that provides insurance benefits other than long-term care coverage meets the applicable nonforfeiture requirements under state law, including A.R.S. §§ 20-1231, 20-1232 and 20-2636;
 3. The policy meets the disclosure requirements of A.R.S. § 20-1691.06;
 4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the disclosure requirements as applicable in the following:
 - a. A.R.S. Title 20, Chapter 6, Article 1.2; and
 - b. A.R.S. Title 20, Chapter 16, Article 2;
 5. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes:
 - a. Description of the bases on which the actuary determined the long-term care rates and the reserves;
 - b. A summary of the type of policy, benefits, renewability provisions, general marketing method, and limits on ages of issuance;
 - c. A description and a table of each actuarial assumption used, with the percent of premium dollars per policy and dollars per unit of benefits, if any, for expenses;
 - d. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - e. The estimated average annual premium per policy and the average issue age;
 - f. A statement as to whether the insurer performs underwriting at the time of application with an explanation of the following:
 - i. Whether underwriting is used, and if used, a description of the type of underwriting, such as medical underwriting or functional assessment underwriting; and
 - ii. For a group policy, whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
 - g. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.
- M.** Subsections (F) and (H) through (J) shall not apply to group insurance as defined in A.R.S. § 20-1691(6) where:
1. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
 2. The policyholder, and not the certificateholder, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1014 recodified from R4-14-1014 (Supp. 95-1). Section repealed; R20-6-1014 renumbered from R20-6-1011 and

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amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section R20-6-1014 renumbered to R20-6-1013; new Section R20-6-1014 renumbered from R20-6-1015 and amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1015. Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings

- A. This Section applies to any long-term care policy or certificate issued in this state on or after November 10, 2017.
- B. An insurer shall notify the Director of a proposed premium rate schedule increase, including an exceptional increase, at least 60 days before issuing notice to its policyholders. The notice to the Director shall include:
 1. Information required by R20-6-1008;
 2. Certification by a qualified actuary that:
 - a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
 - b. The premium rate filing complies with the provisions of this Section; and
 - c. The insurer may request a premium rate schedule increase less than what is required under this Section and the Director may approve the premium rate schedule increase, without submission of the certification required by subsection (B)(2)(a), if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required by subsection (B)(2)(a), the premium rate schedule increase filing satisfies all other requirements of this Section, and is, in the opinion of the Director, in the best interest of the policyholders.
 3. An actuarial memorandum justifying the rate schedule change request that includes:
 - a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including the following:
 - i. Any assumptions that deviate from those used for pricing other forms currently available for sale;
 - ii. Annual values for the five years preceding and the three years following the valuation date, provided separately;
 - iii. Development of the lifetime loss ratio, unless the rate increase is an exceptional increase; and
 - iv. A demonstration of compliance with subsection (C).
 - b. For exceptional increases, the actuarial memorandum shall also include:
 - i. The projected experience that is limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
 - ii. If the Director determines under Section R20-6-1002(B)(3) that offsets may exist, the insurer shall use appropriate net projected experience;
 - c. Disclosure of how reserves have been incorporated in this rate increase when the rate increase will trigger contingent benefit upon lapse;
- C. All premium rate schedule increases shall be determined in accordance with the following requirements:
 1. Exceptional increases shall provide that 70% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;
 2. The insurer shall calculate premium rate increases such that the sum of the lesser of either the accumulated value of the actual incurred claims (without the inclusion of active life reserves) or the accumulated value of historic expected claims (without the inclusion of active life reserves) plus the present value of the future expected incurred claims (projected without the inclusion of active life reserves) will not be less than the sum of the following:
 - a. The accumulated value of the initial earned premium times the greater of 58% or the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience;
 - b. 85% of the accumulated value of prior premium rate schedule increases on an earned basis;
 - c. The present value of future projected initial earned premiums times the greater of 58% or the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and
 - d. 85% of the present value of future projected premiums not in subsection (C)(2)(c) on an earned basis;
 3. Historic expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Historic expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Historic expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in any rate increase filing;
 4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless the insurer provides the Director with documentation justifying the greater rate; and
 5. Upon the Director's request, other similar and related information the Director may require to evaluate the premium rate schedule increase.

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4. In the event that a policy form has both exceptional and other increases, the values in subsections (C)(2)(b) and (C)(2)(d) will also include 70% for exceptional rate increase amounts; and
 5. All present and accumulated values used to determine rate increases, including the lifetime loss ratio consistent with the original filing reflecting margins for moderately adverse experience, shall use the maximum valuation interest rate for contract reserves as specified in A.R.S. § 20-508. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.
- D.** For each rate increase that is implemented, the insurer shall file for approval by the Director updated projections, as defined in subsection (B)(3)(a), annually for the next three years and shall include a comparison of actual results to projected values. The Director may extend the reporting period beyond three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (M), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Director.
- E.** If any premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, the insurer shall file lifetime projections, as defined in subsection (B)(3)(a), for the Director's approval every five years following the end of the required period in subsection (D). For group insurance policies that meet the conditions in subsection (M), the insurer shall provide the projections required by this subsection to the policyholder instead of filing with the Director.
- F.** If the Director finds that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (C), the Director may require the insurer to implement premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience matches the projected experience, the Director shall consider subsection (B)(3)(f), if applicable.
- G.** If the majority of policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file a plan, subject to approval by the Director, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form experience requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect. Otherwise, the Director may impose the conditions in subsections (H) through (J).
- H.** For a rate increase filing that meets the criteria listed in this subsection, the Director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if lapsation in excess of projected lapsation has occurred or is anticipated:
1. The rate increase is not the first rate increase requested for the specific policy form or forms;
 2. The rate increase is not an exceptional increase; and
 3. The majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse.
- I.** If the Director finds excess lapsation under subsection (H) has occurred, is anticipated in the filing or is evidenced in the actual results as presenting in the updated projections provided by the insurer following the requested rate increase, the Director may find that a rate spiral exists and may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The information communicating the offer is subject to the Director's approval. The offer shall:
1. Be based on actuarially sound principles, but not on attained age; and
 2. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy; and
 3. Allow the insured the option of retaining the existing coverage.
- J.** The insurer shall maintain the experience of the insureds whose coverage was replaced under subsection (I) separate from the experience of insureds originally issued the policy forms. If the insurer requests a rate increase on the policy form, the rate increase shall be limited to the lesser of:
1. The maximum rate increase determined based on the combined experience; and
 2. The maximum rate increase determined based only on the experience of the insureds originally issued the form, plus 10%.
- K.** If the Director finds that an insurer has exhibited a history or pattern of filing inadequate initial premium rates for long-term care insurance, after considering the total number of policies filed over a period of time and the percentage of policies with inadequate rates, the Director may, in addition to remedies available under subsections (H) through (J), prohibit the insurer from the following:
1. Filing and marketing comparable coverage for a period of up to five years; and
 2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.
- L.** Subsections (A) through (K) shall not apply to a policy for which long-term care benefits provided by the policy are incidental, as defined under R20-6-1002(C), if the policy complies with all of the following provisions:
1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
 2. The portion of the policy that provides insurance benefits other than long-term care coverage meets the applicable nonforfeiture requirements under state law, including A.R.S. §§ 20-1231, 20-1232 and 20-2636;
 3. The policy meets the disclosure requirements of A.R.S. § 20-1691.06;
 4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the disclosure requirements as applicable in the following:
 - a. A.R.S. Title 20, Chapter 6, Article 1.2; and
 - b. A.R.S. Title 20, Chapter 16, Article 2.
 5. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes:
 - a. Description of the bases on which the actuary determined the long-term care rates and the reserves;

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- b. A summary of the type of policy, benefits, renewability provisions, general marketing method, and limits on ages of issuance;
- c. A description and a table of each actuarial assumption used, with the percent of premium dollars per policy and dollars per unit of benefits, if any, for expenses;
- d. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
- e. The estimated average annual premium per policy and the average issue age;
- f. A statement as to whether the insurer performs underwriting at the time of application with an explanation of the following:
 - i. Whether underwriting is used, and if used, a description of the type of underwriting, such as medical underwriting or functional assessment underwriting; and
 - ii. For a group policy, whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
- g. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

M. Subsections (F) and (H) through (J) shall not apply to group insurance as defined in A.R.S. § 20-1691(6) where:

- 1. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
- 2. The policyholder, and not the certificateholder, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1015 recodified from R4-14-1015 (Supp. 95-1). Section R20-6-1015 renumbered to R20-6-1022; new Section R20-6-1015 made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section R20-6-1015 renumbered to R20-6-1014; new Section R20-6-1015 made by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1016. Filing Requirements for Group Policies

- A.** Out-of-State Policies. Before an insurer or similar organization may offer group long-term care insurance to a resident of this state under A.R.S. § 20-1691.02(D), the insurer or organization shall file with the Director evidence that a state with statutory or regulatory long-term care insurance requirements substantially similar to those of this state has approved the group policy or certificate for use in that state.
- B.** Associations. For long-term policies marketed or issued to associations, the insurer or organization shall file with the insurance department the policy, certificate, and corresponding outline of coverage.

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1016 recodified from R4-14-1016 (Supp. 95-1). Section R20-6-1016 renumbered to R20-6-1023; new Section R20-6-1016 renumbered from R20-6-1012 and amended

by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1017. Standards for Marketing

- A.** Every insurer marketing long-term care insurance coverage in this state, directly or through an insurance producer shall:
 - 1. Establish marketing procedures to assure that any comparison of policies by its insurance producers is fair and accurate, and that excessive insurance is not sold or issued;
 - 2. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy, the following language: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations;"
 - 3. Provide the applicant with copies of the disclosure forms in Appendices A and B;
 - 4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has health or long-term care insurance and the types and amounts of any such insurance;
 - 5. Provide an explanation of contingent benefit upon lapse as provided for in R20-6-1019(D)(3);
 - 6. Provide written notice to an applicant or prospective policyholder or certificateholder advising of this state's senior insurance counseling program (SHIP), and the name, address, and phone number for the SHIP, at the time of solicitation; and
 - 7. Establish auditable procedures for verifying compliance with this subsection (A).
- B.** In addition to the practices prohibited in A.R.S. § 20-441 et seq., the following acts and practices are prohibited:
 - 1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
 - 2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
 - 3. Cold lead advertising. Making use directly or indirectly or any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.
 - 4. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.
- C.** An insurer shall not market or issue a long-term care policy or certificate to an association unless the insurer files the information required under R20-6-1016(B) and annually certifies that the association has complied with the requirements of this Section.

Historical Note

New Section R20-5-1017 renumbered from R20-6-1013 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final

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exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1018. Suitability

- A.** This Section does not apply to life insurance policies that accelerate benefits for long-term care.
- B.** Every insurer or other person marketing long-term care insurance, including an insurance producer or managing general agent, (the “issuer”) shall:
 1. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant,
 2. Train its insurance producers in the use of its suitability standards, and
 3. Maintain a copy of its suitability standards and make them available for inspection upon the Director’s request.
- C.** To determine whether an applicant meets an issuer’s suitability standards, the insurance producer and issuer shall develop procedures that take the following into consideration:
 1. The applicant’s ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
 2. The applicant’s goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
 3. The values, benefits, and costs of the applicant’s existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.
- D.** The issuer shall make reasonable efforts to obtain the information set out in subsection (C), including giving the applicant the “Long-Term Care Insurance Personal Worksheet” prescribed in Appendix A, to complete before or at the time of application. The issuer shall use a personal worksheet that contains, at a minimum, the information contained in Appendix A, in substantially the same text and format, in not less than 12 point type. The issuer may ask the applicant to provide additional information to comply with its suitability standards. An issuer shall file a copy of its personal worksheet with the Director.
- E.** An issuer shall not consider an applicant for coverage until the issuer has received the applicant’s completed personal worksheet, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.
- F.** No one shall sell or disseminate information obtained through the personal worksheet outside the issuer that obtains the worksheet.
- G.** The issuer shall use its suitability standards to determine whether issuance of long-term care insurance coverage to a particular applicant is appropriate.
- H.** An insurance producer shall use the suitability standards developed by the issuer in marketing long-term care insurance.
- I.** When giving an applicant a personal worksheet, the issuer shall also provide the applicant with a disclosure form entitled “Things You Should Know Before You Buy Long-Term Care Insurance.” The form shall be in substantially the same format and text contained in Appendix H, in not less than 12 point type.
- J.** If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter that is substantially similar to Appendix I. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant’s

intent to purchase the long-term care policy. The issuer shall have either the applicant’s returned Appendix I letter or a record of the alternative method of verification as part of the applicant’s file.

- K.** The issuer shall report annually to the Director the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter as prescribed in subsection (J).

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1019. Nonforfeiture Benefit Requirement

- A.** This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- B.** To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of A.R.S. § 20-1691.11, an insurer shall meet the following requirements:
 1. A policy or certificate offered with nonforfeiture benefits shall have the same coverage elements, eligibility, benefit triggers and benefit length as a policy or certificate issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection (E); and
 2. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.
- C.** If the offer required to be made under A.R.S. § 20-1691.11 is rejected, the insurer shall provide the contingent benefit upon lapse described in this Section. Even if the non-forfeiture benefit offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in subsection (D)(4) shall still apply.
- D.** Contingent Benefit Upon Lapse.
 1. If a prospective policyholder rejects the offer of a nonforfeiture benefit, the insurer shall provide the contingent benefit upon lapse described in this Section for individual and group policies without the nonforfeiture benefit, issued after January 10, 2005.
 2. If a group policyholder elects to make the nonforfeiture benefit an option to a certificateholder, the certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.
 3. The contingent benefit on lapse is triggered when:
 - a. An insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured’s initial annual premium set forth in the chart below, based on the insured’s issue age; and
 - b. The policy or certificate lapses within 120 days of the due date of the increased premium.
 - c. Unless otherwise required, an insurer shall notify policyholders at least 30 days before the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
29 and under	200%

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30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

4. A contingent benefit on lapse is also triggered for policies with a fixed or limited premium paying period when:
- An insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the chart below, based on the insured's issue age; and
 - The policy or certificate lapses within 120 days of the due date of the increased premium; and
 - The ratio in subsection (D)(6)(b) is 40% or more.
 - Unless otherwise required, an insurer shall notify policyholders at least 30 days before the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase on policies with a fixed or limited premium paying period

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

- This provision shall be in addition to the contingent benefit provided by subsection (D)(3) and where both are triggered, the benefit provided shall be at the option of the insured.
5. On or before the effective date of a substantial premium increase as defined in subsection (D)(3), an insurer shall:
- Offer the insured the option of reducing policy benefits under the current coverage consistent with the requirements of R20-6-1025 so that required premium payments are not increased;
 - Offer to convert the coverage to a paid-up status with a shortened benefit period according to the terms of subsection (E), which the insured may elect at any time during the 120-day period referenced in subsection (D)(3); and
 - Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection (D)(3) is deemed to be the election of the offer to convert under subsection (5)(b) unless the automatic option in subsection (D)(6)(c) applies.
6. On or before the effective date of a substantial premium increase on policies with a fixed or limited premium paying period as defined in subsection (D)(4), an insurer shall:
- Offer the insured the option of reducing policy benefits under the current coverage consistent with the requirements of R20-6-1025 so that required premium payments are not increased;
 - Offer to convert the coverage to paid-up status where the amount payable for each benefit is 90% of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. The insured may elect this option at any time during the 120-day period referenced in subsection (D)(4); and
 - Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection (D)(4) is deemed to be the election of the offer to convert under subsection (D)(6)(b) if the ratio is 40% or more.
7. For any long-term care policy issued on or after November 10, 2017, that an insurer issued at least 20 years prior to the effective date of a substantial premium increase, the insurer shall use a rate increase value of 0% in place of all values in the above tables.
- E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subsection (D)(3) but not subsection (D)(4), mean any of the following:
- Attained age rating is defined as a schedule of premiums starting from the issue date that increases age at least 1% per year before age 50, and at least 3% per year beyond age 50.
 - For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of

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lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subsection (E)(3).

3. The standard nonforfeiture credit equals 100% of the sum of all premiums paid, including the premiums paid before any change in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. The minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (F).
4. When the nonforfeiture benefit begins.
 - a. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years, and thereafter.
 - b. Notwithstanding subsection (E)(4)(a), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:
 - i. The end of the tenth year following the policy or certificate issue date, or
 - ii. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.
5. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.
- F. All benefits paid by the insurer while the policy or certificate is in premium-paying status and in the paid-up status shall not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium-paying status.
- G. There shall be no difference in the minimum nonforfeiture benefits for group and individual policies.
- H. The requirements in this Section are effective on or after November 10, 2005 and shall apply as follows:
 1. Except as provided in subsection (H)(2) and (H)(3), this Section applies to any long-term care policy issued in this state on or after January 10, 2005.
 2. The provisions of this Section do not apply to certificates issued on or after January 10, 2005, under a group long-term care insurance policy as defined in A.R.S. § 20-1691(5)(a), that was in force on January 10, 2005.
 3. The provisions of this Section that apply to fixed or limited premium paying period policies shall only apply to policies issued on or after November 10, 2017.
- I. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of R20-6-1013, R20-6-1014 or R20-6-1015, whichever is applicable, treating the policy as a whole.
- J. To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (D)(3) or (D)(4), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium the insured paid when first buying the policy from the original insurer.

K. An insurer shall offer a nonforfeiture benefit for a qualified long-term care insurance contract that is a level premium contract and the benefit shall meet the following requirements:

1. The nonforfeiture provision shall be separately captioned using the term "nonforfeiture benefit" or a substantially similar caption;
2. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the insurer may adjust the amount of the benefit initially granted only as needed to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the Director under to A.R.S. § 20-1691.08 for the same contract form; and
3. The nonforfeiture provision shall provide at least one of the following:
 - a. Reduced paid-up premiums,
 - b. Extended term insurance,
 - c. Shortened benefit period, or
 - d. Other similar offerings that the Director has approved.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1020. Standards for Benefit Triggers

- A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Except as otherwise provided in R20-6-1021, eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.
- B. Activities of daily living shall include at least the following as defined in R20-6-1003(A)(1) and in the policy:
 1. Bathing,
 2. Continence,
 3. Dressing,
 4. Eating,
 5. Toileting, and
 6. Transferring.
- C. An insurer may use additional activities of daily living to trigger covered benefits if the activities are defined in the policy.
- D. An insurer may use additional provisions to determine when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements in subsections (A), (B) and (C).
- E. For purposes of this Section the determination of a deficiency shall not be more restrictive than:
 1. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
 2. If the deficiency is due to the presence of a cognitive impairment, requiring supervision or verbal cueing by another person to protect the insured or others.
- F. Licensed or certified professionals, such as physicians, nurses or social workers, shall perform assessments of activities of daily living and cognitive impairment.
- G. The requirements in this Section are effective on and after November 10, 2005 and shall apply as follows:

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1. Except as provided in subsection (G)(2), the provisions of this Section apply to a long-term care policy issued in this state on or after January 10, 2005.
2. The provisions of this Section do not apply to certificates issued on or after January 10, 2005, under a long-term care insurance policy issued to a group as defined in A.R.S. § 20-1691(5)(a), which policy was in force on January 10, 2005.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1021. Additional Standards for Benefit Triggers for Qualified Long-term Care Insurance Contracts

- A. A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided under a plan of care prescribed by a licensed health care practitioner, which is not subject to approval or modification by the insurer.
- B. A qualified long-term care insurance contract shall condition the payment of benefits on a certified determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.
- C. Licensed health care practitioners shall perform the certified determinations regarding activities of daily living and cognitive impairment required under subsection (B).
- D. Certified determinations required under subsection (B) may be performed at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certified determination may not be rescinded and additional certified determinations may not be performed until after the expiration of the 90-day period.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1022. Standard Format Outline of Coverage

- A. The outline of coverage prescribed in A.R.S. § 20-1691.06 shall be a free-standing document, using no smaller than 10 point type, and shall contain no advertising or promotional material.
- B. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that give prominence equivalent to capitalization or underscoring.
- C. An insurer shall use the text and sequence of text in the standard format outline of coverage prescribed in Appendix J, unless otherwise specifically indicated.

Historical Note

New Section R20-6-1022 renumbered from R20-6-1015 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

R20-6-1023. Requirement to Deliver Shopper's Guide

- A. All prospective applicants of a long-term care insurance policy or certificate shall receive a long-term care insurance shop-

per's guide approved by the Director. This requirement may be satisfied by delivery of the current edition of the long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners.

1. In the case of insurance producer solicitation, an insurance producer shall deliver the shopper's guide before presenting an application or enrollment form.
2. In the case of direct response solicitations, the insurer shall provide the shopper's guide with any application or enrollment form.

- B. A prospective applicant for a life insurance policy or rider containing accelerated long-term care benefits is not required to receive the guide described in subsection (A), but shall receive the policy summary required under A.R.S. § 20-1691.06.

Historical Note

New Section R20-6-1023 renumbered from R20-6-1016 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1024. Availability of New Health Care Services or Providers

- A. An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or health care providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within 12 months of the date the new policy series is made available for sale in this state.
- B. Notwithstanding subsection (A), notification is not required for any policy issued prior to the effective date of this Section or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.
- C. The insurer shall make the new coverage available in one of the following ways:
 1. By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;
 2. By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;
 3. By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or
 4. By an alternative program developed by the insurer that meets the intent of this Section if the program is filed with and approved by the Director.
- D. An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited dis-

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tribution channel. For purposes of this subsection, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders who purchased such a new proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

- E. Policies issued pursuant to this Section shall be considered exchanges and not replacements. These exchanges shall not be subject to R20-6-1010(A), (C) through (G) and R20-6-1018 and are not subject to the reporting requirements of R20-6-1010(I)(1), (I)(2)(a) through (I)(2)(c).
- F. Where an employer, labor organization, professional, trade or occupational association offers the policy, the required notification in subsection (A) shall be made to the offering entity. However, if the policy is issued to a group defined in A.R.S. § 20-1691(5), the notification shall be to each certificateholder.
- G. Nothing in this Section shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request, any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium, to add such new services or providers.
- H. This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- I. This Section shall become effective on or after November 10, 2017.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section R20-6-1024 renumbered to R20-6-1026; new Section R20-6-1024 made by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1025. Right to Reduce Coverage and Lower Premiums

- A. Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:
 1. Reducing the maximum benefit; or
 2. Reducing the daily, weekly or monthly benefit amount.
- B. The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.
- C. In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer

shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.

- D. The provision in subsection (A) shall include a description of the process for requesting and implementing a reduction in coverage.
- E. The premium for the reduced coverage shall:
 1. Be based on the same age and underwriting class used to determine the premium for the coverage currently in force, and
 2. Be consistent with the approved rate table.
- F. The issuer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.
- G. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by R20-6-1005(F).
- H. This Section does not apply to life insurance policies or riders containing accelerated long-term benefits.
- I. The requirements of subsections (A) through (H) shall apply to any long-term care policy issued in this state on or after November 10, 2017.
- J. A premium increase notice required by R20-6-1008(G) shall include:
 1. An offer to reduce policy benefits provided by the current coverage consistent with the requirements of this Section;
 2. A disclosure stating that all options available to the policyholder may not be of equal value; and
 3. In the case of a partnership policy, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections.
- K. The requirements of subsection (J) shall apply to any rate increase implemented in this state on or after November 10, 2017.

Historical Note

New Section R20-6-1025 made by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

R20-6-1026. Instructions for Appendices

Information that is designated as a "Drafting Instruction" in a form appended to this Article is not required to be included as part of the form. Any person using the form shall abide by the instructions when drafting, preparing, or completing the form.

Historical Note

New Section R20-6-1026 renumbered from R20-6-1024 by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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Appendix A. Long-term Care Insurance Personal Worksheet

Long-term Care Insurance
Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [\$_____ per month, or \$_____ per year,] [a one-time single premium of \$_____.]

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums:

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

(Drafting Instruction: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.)

Questions Related to Your Income

How will you pay each year's premium?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

[☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 50%?]

(Drafting Instruction: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.)

What is your annual income? (check one) ☐ Under \$10,000 ☐ \$[10-20,000] ☐ \$[20-30,000] ☐ \$[30-50,000] ☐ Over \$50,000

(Drafting Instruction: The issuer may choose the numbers to put in the brackets to fit its suitability standards.)

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.

(Drafting Instruction: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.)

What elimination period are you considering? Number of days _____ Approximate cost \$_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

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☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under \$20,000 ☐ \$20,000-\$30,000 ☐ \$30,000-\$50,000 ☐ Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐ The answers to the questions above describe my financial situation.
or
☐ I choose not to complete this information.
(Check one.)

☐ I acknowledge that the carrier and/or its insurance provider (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] **I understand the above disclosures. I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed: _____

(Applicant)

(Date)

☐ I explained to the applicant the importance of completing this information.

Signed: _____

(Insurance Producer)

(Date)

Insurance Producer's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My insurance provider has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.]

Signed: _____

(Applicant)

(Date)

(Drafting Instruction: Choose the appropriate sentences depending on whether this is a direct mail or insurance producer sale.)
The company may contact you to verify your answers.

(Drafting Instruction: When the Long-term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the document may be removed.)

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). Former Appendix A renumbered to Appendix C; new Appendix A made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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Appendix B. Long-term Care Insurance Potential Rate Increase Disclosure Form**Instructions:**

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

**Long-term Care Insurance
Potential Rate Increase Disclosure Form**

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [approved] for an increase [is][are] [on the application] [\$_____]
2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**
3. **Rate Schedule Adjustments:**
The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.
4. **Potential Rate Revisions:**
This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- ☐ Pay the increased premium and continue your policy in force as is.
- ☐ Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- ☐ Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- ☐ Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That qualifies for Contingent Nonforfeiture	
(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)	
Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%

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61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). Former Appendix B renumbered to Appendix D; new Appendix B made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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Appendix C. Notice to Applicant Regarding Replacement of Individual Health or Long-term Care Insurance

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL HEALTH OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing health or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all health or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY [INSURANCE PRODUCER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under your new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all of the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Insurance Producer or Other Representative)

(Typed Name and Address of Insurance Producer)

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

Historical Note

Adopted effective August 10, 1992 (Supp. 92-3). New Appendix C renumbered from Appendix A and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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Appendix D. Notice to Applicant Regarding Replacement of Health or Long-term Care Insurance**NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH OR LONG-TERM CARE INSURANCE****[Insurance company's name and address]****SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE**

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing health or long-term care insurance and replace it with the long-term care insurance policy being delivered and issued by [company name] Insurance Company. Your new policy gives you thirty (30) days to decide, without cost, whether you want to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all health or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, even though a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its insurance producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

Historical Note

New Appendix D renumbered from Appendix B and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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Appendix E. Long-Term Care Insurance Replacement and Lapse Reporting Form

Long-term Care Insurance
Replacement and Lapse Reporting FormFor the State of _____
For the Reporting Year of _____Company Name: _____ Due: June 30 annually
Company Address: _____ Company NAIC Number: _____
Contact Person: _____ Phone Number: (____) _____**Instructions**

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Every insurer shall maintain the following records for each insurance producer: (1) the amount of long-term care insurance replacement sales as a percent of the insurance producer's total annual sales and (2) the amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales. The tables below should be used to report the 10% of the insurer's insurance producers with the greatest percentages of replacements and lapses.

Listing of the 10% of Insurance Producers with the Greatest Percentage of Replacements

Insurance Producer's Name	Number of Policies Sold By This Insurance Producer	Number of Policies Replaced By This Insurance Producer	Number of Replacements as % of Number of Policies Sold By This Insurance Producer

Listing of the 10% of Insurance Producers with the Greatest Percentage of Lapses

Insurance Producer's Name	Number of Policies Sold By This Insurance Producer	Number of Policies Lapsed By This Insurance Producer	Number of Lapses As % of Number Sold By This Insurance Producer

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales _____ %
 Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) _____ %
 Percentage of Lapsed Policies to Total Annual Sales _____ %
 Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____ %

Historical Note

New Appendix E made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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Appendix F. Long-term Care Insurance Claims Denial Reporting Form

Long-term Care Insurance
Claims Denial Reporting FormFor the State of _____
For the Reporting Year of _____Company Name: _____ Due: June 30 annually
Company Address: _____Company NAIC Number: _____
Contact Person: _____ Phone Number: _____
Line of Business: Individual Group**Instructions**

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. Indicate the manner of reporting by checking one of the boxes below:

- ☐ Per Claimant - counts each individual who makes one or a series of claim requests
☐ Per Transaction - counts each claim payment request

“Denied” means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition. It does not include a request for payment that is in excess of the applicable contractual limits.

Inforce Data

	State Data	Nationwide Data ¹
Total Number of Inforce Policies [Certificates] as of December 31st		

Claims & Denial Data

	State Data	Nationwide Data ¹
1 Total Number of Long-Term Care Claims Reported		
2 Total Number of Long-Term Care Claims Denied/Not Paid		
3 Number of Claims Not Paid due to Preexisting Condition Exclusion		
4 Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5 Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6 Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7 Number of Long-Term Care Claim Denied due to:		
8 • Long-Term Care Services Not Covered under the Policy ²		
9 • Provider/Facility Not Qualified under the Policy ³		
10 • Benefit Eligibility Criteria Not Met ⁴		
11 • Other		

- The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
- Example—home health care claim filed under a nursing home only policy.
- Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
- Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

Historical Note

New Appendix F made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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Appendix G. Rescission Reporting Form for Long-term Policies

RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIESFOR THE STATE OF _____
FOR THE REPORTING YEAR _____

Company Name _____

Address: _____

Phone Number: _____

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission:

Signature_____
Name and Title (please type)_____
Date**Historical Note**

New Appendix G made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

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Appendix H. Things You Should Know Before You Buy Long-term Care Insurance

Things You Should Know Before You Buy
Long-term Care Insurance

Long-Term
Care
Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- **[WARNING! You should *not* buy this insurance policy unless you can afford to pay the premiums every year. You are making a multi-year financial commitment.]** [Remember that the company can increase premiums in the future.]

(Drafting Instruction: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.)

Medicare
Medicaid

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
- Medicare does **not** pay for most long-term care.
- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's
Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

Historical Note

New Appendix H made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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Appendix I. Long-term Care Insurance Suitability Letter**Long-term Care Insurance Suitability Letter**

Dear [Applicant]:

Your recent application for long-term care insurance included a “personal worksheet,” which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet “Shopper’s Guide to Long-Term Care Insurance” and the page titled “Things You Should Know Before Buying Long-Term Care Insurance.” Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

(Drafting Instruction: Choose the paragraph that applies.)

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

- ☐ **Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Instruction: Delete the phrase in brackets if the applicant did not answer the questions about income.

- ☐ **No**. I have decided not to buy a policy at this time.

APPLICANT’S SIGNATURE

DATE

Please return to [issuer] at [address] by [date].

Historical Note

New Appendix I made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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Appendix J. Long-term Care Insurance Outline of Coverage

[COMPANY NAME]
 [ADDRESS - CITY & STATE]
 [TELEPHONE NUMBER]
 LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE
 [Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, shall appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].
2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!**
3. **FEDERAL TAX CONSEQUENCES**
 This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED**
 - (a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:
 - (1) Policies and certificates that are guaranteed renewable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, **IT MAY INCREASE THE PREMIUM YOU PAY.**
 - (2) [Policies and certificates that are noncancellable shall contain the following statement:] **RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE.** This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.
 - (b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy:]
 - (c) [Describe waiver of premium provisions or state that there are not such provisions:]
5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.**
 [In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]
6. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.**
 - (a) [Provide a brief description of the right to return - "free look" provision of the policy.]
 - (b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]
7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.
 - (a) [For insurance producers] Neither [insert company name] nor its [agents or insurance producers] represent Medicare, the federal government or any state government.
 - (b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.
8. **LONG-TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute-care unit of a hospital, such as in a nursing home, in the community or in the home.
 This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]
9. **BENEFITS PROVIDED BY THIS POLICY.**
 - (a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]
 - (b) [Institutional benefits, by skill level.]

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(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be defined and described as part of the outline of coverage.]

[Any additional benefit triggers shall be explained in this Section. If these triggers differ for different benefits, explanation of the triggers shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and providers;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This Section shall provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in paragraph 6 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

Historical Note

New Appendix J renumbered from Appendix C and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

R20-6-1101. Incorporation by Reference and Modifications

A. The Department incorporates by reference the Model Regulation to Implement the National Association of Insurance Commissioners (NAIC) Medicare Supplement Insurance Minimum Standards Model Act, August 2016 (Model Regulation), and no future editions or amendments, which is on file with the Department of Insurance, 100 N. 15th Ave., Suite 102, Phoenix, AZ 85007-2624 and available from the National Association of Insurance Commissioners, Publications Department, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197.

B. The Model Regulation is modified as follows:

1. In addition to the terms defined in the Model Regulation, the following definitions apply:

a. "Agent" means an insurance producer as defined in A.R.S. § 20-281(5).

b. "Commissioner" means the Director of the Arizona Department of Insurance.

c. "HMO" and "health maintenance organization" mean a health care services organization as defined in A.R.S. § 20-1051(7).

d. "Regulation" means Article.

2. Section 3(A)(2) reads:

(2) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state including association plans.

3. Section 8(A)(7)(c) reads:

c. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss of the group health plan and pays the premium attributable to the supplemental policy period, effective as of the date of termination of enrollment in the group health plan.

4. Section 8.1 is revised to insert the citation to A.R.S. § 20-1133 as follows:

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The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any [1990 Standardized Medicare supplement benefit plan] for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of A.R.S. § 20-1133.

5. Section 8.1(A)(7)(c) is revised to read as follows:
Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.
6. Section 9.1 is revised to insert the citation to A.R.S. § 20-1133 as follows:
The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of A.R.S. § 20-1133.
7. Section 9.2 is revised to insert the citation to A.R.S. § 20-1133 as follows:
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of A.R.S. § 20-1133.
8. Section 15(G) is revised as follows:
An insurer shall not file or request approval of a rate structure for its Medicare supplement policies or certificates based upon attained-age rating as a structure or methodology.
9. Section 23 is revised as follows:

- A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.
- B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

Historical Note

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1101 recodified from R4-14-1101 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed; new Section made by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 15 A.A.R. 996, effective June 2, 2009 (Supp. 09-2). Amended by final rulemaking at 25 A.A.R. 1923, effective September 8, 2019 (Supp. 19-3).

R20-6-1102. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted with changes effective May 28, 1992 (Supp. 92-2). R20-6-1102 recodified from R4-14-1102 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1102.01 Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1103. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective

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March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1103 recodified from R4-14-1103 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1104. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1104 recodified from R4-14-1104 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1105. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1105 recodified from R4-14-1105 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1106. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1106 recodified from R4-14-1106 (Supp. 95-1). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910 effective March 3, 1999 (Supp. 99-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1107. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted with changes effective May 28, 1992 (Supp. 92-2). R20-6-1107 recodified from R4-14-1107 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1108. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1108 recodified from R4-14-1108 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 5 A.A.R. 910 effective March 3, 1999 (Supp. 99-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1109. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1109 recodified from R4-14-1109 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1110. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1110 recodified from R4-14-1110 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1111. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1111 recodified from R4-14-1111 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1112. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1112 recodified from R4-14-1112 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

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R20-6-1113. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1113 recodified from R4-14-1113 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910 effective March 3, 1999 (Supp. 99-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1114. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1114 recodified from R4-14-1114 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1115. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1115 recodified from R4-14-1115 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1116. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1116 recodified from R4-14-1116 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1117. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1117 recodified from R4-14-1117 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1118. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1118 recodified from R4-14-1118 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1119. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1119 recodified from R4-14-1119 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1120. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1120 recodified from R4-14-1120 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

R20-6-1121. Repealed**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix A. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again and correction made to heading of form on last page of Appendix A effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Appendix A repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix B. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again and corrections made to Plan C (Medicare (Part B) - Medical Services - Per Calendar Year) and Plan J (Other Benefits)

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effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Appendix B repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix C. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Amended effective August 16, 1996 (Supp. 96-3). Appendix C repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix D. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Amended effective August 16, 1996 (Supp. 96-3). Appendix D repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix E. Repealed**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Appendix E repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

Appendix F. Repealed**Historical Note**

Appendix F adopted effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Appendix F repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

ARTICLE 12. HIV/AIDS: PROHIBITED AND REQUIRED PRACTICES**R20-6-1201. Definitions**

- A. "AIDS" means Acquired Immune Deficiency Syndrome.
- B. "Applicant" means an applicant for a life or disability insurance policy or coverage under a health care plan, as well as any potential certificate holder or dependent covered under such policy or plan.
- C. "Insurer" means life and disability insurers (including but not limited to health insurers), hospital and medical service corpo-

rations, and health care services organizations, including all employees, contractors, and agents thereof.

- D. "Person" means any individual, company, insurer, association, organization, society, reciprocal or inter-insurance exchange, partnership, syndicate, business trust, corporation, or entity.

Historical Note

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1201 recodified from R4-14-1201 (Supp. 95-1).

R20-6-1202. Applications for Insurance

- A. Insurers shall not use questions on applications for life or disability policies or health care plans that inquire directly or indirectly about:
 1. The sexual orientation of an applicant;
 2. An applicant's receipt of transfusions of blood or blood products; or
 3. Whether or not the applicant has had any HIV-related test, except as provided in subsection (B) of this rule.
- B. Insurers may include specific questions on applications for life or disability insurance policies or health care plans asking if the applicant has ever been diagnosed or treated for AIDS or AIDS-related conditions or tested positive for the presence of HIV antibodies, antigens, or the virus. No adverse underwriting decision shall be made on the basis of any prior positive HIV-related test or tests unless the insurer has verified that the prior test(s) consisted of both a positive screening test such as enzyme-linked immunoassay (ELISA) and a positive supplemental test such as a Western Blot. All such tests used shall be approved and licensed by the Food and Drug Administration and conducted in accordance with the manufacturer's directions for use, including but not limited to the manufacturers' specified interpretation of positivity.

Historical Note

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1202 recodified from R4-14-1202 (Supp. 95-1).

R20-6-1203. Testing for HIV; Consent Form

- A. An insurer may test for HIV infection in the same way that the insurer tests for other conditions that affect mortality and morbidity. No adverse underwriting decision shall be made on the basis of a positive result to an HIV-related test unless the result consists of both a positive screening test such as enzyme-linked immunoassay (ELISA) and a positive supplemental test such as a Western Blot. All such tests used shall be approved and licensed by the Food and Drug Administration and conducted in accordance with the manufacturers' directions for use, including but not limited to the manufacturers' specified interpretation of positivity.
- B. If an applicant is requested to take an HIV-related test in connection with an application for a life or disability insurance policy or a health care plan, the insurer shall reveal the use of such test to the applicant and shall obtain the written consent of the applicant prior to the administration of such test. The insurer shall allow the applicant up to 10 days within which to decide whether or not to sign the consent form, and no adverse underwriting decision may be made on the basis of the applicant's delay during this time period. Insurers need not provide pretest counseling to applicants but shall advise applicants of the availability of counseling in accordance with subsection (C) of this rule.
- C. The written consent form, which shall be approved by the Director in advance of its use, shall contain the following information:

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1. Purpose of the consent form. The form shall contain a clear disclosure that the test to be performed is a test for the presence of HIV antibodies, antigens, or the virus, and that underwriting decisions will be based on the results of such test. The form shall further provide notice of a period of not less than 10 days during which the applicant may decide whether or not to sign the form, along with a disclosure that the applicant's refusal to be tested may be used as a reason to deny coverage.
2. Information on HIV. The form shall provide clear, concise, and accurate information on how the disease is spread and what behavior places persons at risk of contracting the virus.
3. Pretest counseling considerations. The written consent form shall contain information advising the applicant that counseling is recommended by many public health organizations and that the applicant may obtain such counseling at the applicant's own expense. The form shall contain current information as provided by the Department regarding the availability in Arizona of free confidential or anonymous counseling through county health departments and through other governmental or government-funded agencies.
4. Disclosure of test results. The form shall advise the applicant that all test results shall be treated confidentially and that results shall be released only to the applicant and the named insurer or upon the applicant's written consent or as otherwise required or allowed by law, including but not limited to the release of information to the Department of Health Services as provided by law.
5. Meaning of positive test results. The form shall advise the applicant of the type of test (including but not limited to antibody, antigen, or viral culture) to be used, and that a positive test result indicates that the applicant has been infected with HIV but does not necessarily have AIDS. The form shall explain that a positive test result will adversely affect the application for insurance.
6. Consent. The consent form shall contain an attestation to be signed by the applicant or, if the applicant lacks legal capacity to consent, a person authorized pursuant to law to consent on behalf of the applicant, that he or she has read and understands the written consent form and voluntarily consents to the performance of a test for HIV and to the disclosure of the test results as described in the consent form. The applicant or the applicant's legal representative shall have the right to request and receive a copy of the written consent form. A photocopy of the form shall be as valid as the original.
7. Optional release of information to personal physician. In addition to the release of information to the insurer provided in the consent form, the applicant may, at the applicant's option, consent to the release of information to the applicant's personal physician. The form shall provide for such release to be separately signed and dated by the applicant, or if the applicant lacks legal capacity to consent, by a person authorized pursuant to law to consent on behalf of the applicant.
8. Time period during which release of information is effective. The consent form shall specify the time period during which any and all release provisions of the consent form shall be effective, but in no case shall such time period exceed 180 days from the date the consent form is signed by the applicant or the applicant's legal representative. No HIV-related information shall be released to

any person after the expiration of that time period unless the insurer obtains the express written consent, pursuant to R20-6-1204, of the applicant or, if the applicant lacks legal capacity to consent, by a person authorized by law to consent on behalf of the applicant.

Historical Note

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1203 recodified from R4-14-1203 (Supp. 95-1).

R20-6-1204. Release of Confidential HIV-related Information; Release Form

- A. Except as required by law or authorized pursuant to a written consent to be tested, an insurer shall not disclose confidential HIV-related information to any person unless a written release form is executed by the applicant or, if the applicant lacks legal capacity to consent to such release, by a person authorized by law to consent to the release of information on behalf of the applicant. The applicant or the applicant's legal representative shall be entitled to receive a copy of the release. A photocopy shall be as valid as the original.
- B. Such written release form shall contain the following information:
 1. The name and address of the person to whom the information shall be disclosed;
 2. The specific purpose for which disclosure is to be made; and
 3. The time period during which the written release is to be effective but in no case shall such time period exceed 180 days from the date the release is signed by the applicant or the applicant's legal representative;
 4. The signature of the applicant or of the person authorized by law to consent to such release, and the date the release form was signed.

Historical Note

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1204 recodified from R4-14-1204 (Supp. 95-1).

R20-6-1205. Benefits; Prohibited Practices

- A. Life and disability insurance policies or health care plans that provide benefits for prescription drugs shall provide benefits for any and all drugs and pharmaceutical forms of treatment for HIV and/or AIDS approved by the Food and Drug Administration pursuant to 21 U.S.C. Chapter 9 or licensed by the Food and Drug Administration pursuant to 42 U.S.C. Chapter 6A, including but not limited to Zidovudine, formerly Azidothymidine ("AZT"), Didanosine (ddI) and Zalcitabine (ddC), to the same extent as other prescription drugs and treatments.
- B. Insurers shall provide benefits for HIV, AIDS, and AIDS-related conditions in the same manner and to the same extent as those benefits provided for all other diseases.

Historical Note

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1205 recodified from R4-14-1205 (Supp. 95-1).

ARTICLE 13. MENTAL HEALTH PARITY**R20-6-1301. Definitions**

The definitions in A.R.S. § 20-3501 and the following definitions apply to this Article:

"Arizona Mental Health Parity Act" means the statutes found at A.R.S. §§ 20-3501 through 20-3505.

"Coverage unit" has the meaning prescribed at 45 CFR § 146.136(a) "Coverage unit."

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“Department of Insurance and Financial Institutions (Department)” has the meaning prescribed at A.R.S. § 20-101.

“CMS MHPAEA tool” means the Microsoft Excel Mental Health Parity tool maintained by the Center for Medicare and Medicaid Services.

“Financial requirements (FR)” has the meaning at 45 CFR § 146.136(a) “Financial requirements.”

“Health care insurer” has the meaning prescribed at A.R.S. § 20-3501(2).

“Health plan” has the meaning prescribed at A.R.S. § 20-3501(3).

“Inpatient, in-network benefits” are benefits furnished on an inpatient basis and within a network of contracted providers under a health plan.

“Inpatient, out-of-network benefits” are benefits furnished on an inpatient basis by providers without a contract under a health plan or for a health plan that has no network of providers.

“Large group health plan” is a health plan issued to an employer group that is not a small employer as defined at A.R.S. § 20-2301(A)(20).

“Medical/surgical (Med/Surg) benefits” has the meaning prescribed at 45 CFR § 146.136(a) “Medical/surgical benefits.”

“Mental (MH) health benefits” has the meaning prescribed at 45 CFR § 146.136(a) “Mental health benefits.”

“MHPAEA” means the Mental Health Parity and Addiction Equity Act prescribed in A.R.S. § 20-3501(4).

“Nonquantitative treatment limitation (NQTL)” is a limitation that restricts the scope or duration of benefits for treatment under a health plan or coverage. Illustrations of NQTLs include: medical management standards limiting or excluding benefits based on medical necessity or appropriateness or based on whether the treatment is experimental or investigative as identified under 45 CFR 146.136(c)(4)(ii)(A); formulary design for prescription drugs as identified under 45 CFR 146.136(c)(4)(ii)(B); network tier design (for health plans with multiple network tiers such as preferred providers and participating providers) as identified under 45 CFR 146.136(c)(4)(ii)(C); standards for provider admission to participate in a network, including reimbursement rates as identified under 45 CFR 146.136(c)(4)(ii)(D); methods for determining usual, customary, and reasonable charges as identified under 45 CFR 146.136(c)(4)(ii)(E); refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as “fail-first policies” or “step therapy protocols”) as identified under 45 CFR 146.136(c)(4)(ii)(F); exclusions based on failure to complete a course of treatment; and restrictions based on geographic location as identified under 45 CFR 146.136(c)(4)(ii)(G), facility type, provider specialty, and other criteria than limit the scope or duration of benefits for services provided under the health plan or coverage as identified under 45 CFR 146.136(c)(4)(ii)(H).

“Outpatient, in-network benefits” are benefits furnished on an outpatient basis and within a network of providers established or recognized under a health plan.

“Outpatient, out-of-network benefits” are benefits furnished on an outpatient basis and outside any network of providers

established or recognized under a health plan or under a health plan that has no network of providers.

“Predominant test” means that if a type of FR or QTL applies to substantially all of the Med/Surg benefits in a classification, the predominant level of the FR or QTL is the level that applies to more than 1/2 of the Med/Surg benefits in that classification subject to the FR or QTL. If no single level can be determined, the health plan (or health insurance issuer) may combine levels until the combination of levels applies to more than 1/2 of Med/Surg benefits subject to the FR or QTL in the classification. The least restrictive level within the combination is considered the predominant level of that type of classification. For this purpose, a health plan may combine the most restrictive levels first with each less restrictive level added to the combination until the combination applies to more than 1/2 of the benefits subject to the FR or QTL.

“Quantitative treatment limitation (QTL)” is a limitation on the scope or duration of a benefit that can be expressed numerically that includes day or visit limits such as “50 outpatient visits per year.” QTLs include annual, episode, and lifetime day and visit limits such as number of treatments, number of visits, or days of coverage.

“Substance use disorder (SUD) benefits” has the meaning prescribed at 45 CFR § 146.136(a) “Substance use disorder benefits.”

“Substantially all test” means that a FR or QTL applies to at least 2/3 of all Med/Surg benefits in a classification of benefits for a coverage unit. (For this purpose, benefits expressed as subject to a zero level of a type of FR are treated as not subject to that type of FR. In addition, benefits expressed as subject to an unlimited QTL are treated as not subject to that type of QTL.) If a type of FR or QTL does not apply to at least 2/3 of all Med/Surg benefits in a classification, then that type of FR or QTL cannot be applied to MH or SUD benefits in that classification.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 1824 (July 29, 2022), effective September 4, 2022 (Supp. 22-3).

R20-6-1302. Medical Necessity Criteria and NQTL Reporting

- A. Health care insurers subject to the reporting requirement. A health care insurer that issues health plans in Arizona is required to file the reports required by this Section with the Department.
- B. Health plans subject to reporting. A health care insurer shall submit a report for all health plans it offers in this state (including grandfathered and non-grandfathered health plans) that meet all of the criteria listed in subsections (B)(1) through (4). If a health care insurer determines that the information to be reported varies by network plan, or varies in the individual, small group, or large group market, the health care insurer must submit a separate report for each variation.
 1. The health plan offers MH and/or SUD benefits in addition to Med/Surg benefits.
 2. The health plan offers MH and/or SUD benefits in at least one of the following classifications:
 - a. Inpatient, in-network;
 - b. Inpatient, out-of-network;
 - c. Outpatient, in-network;
 - d. Outpatient, out-of-network;
 - e. Emergency care; or

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- f. Prescription drugs.
- 3. The health plan is offered on a group (large or small) or individual basis.
- 4. The health plan has not received and notified the Department of an increased cost exemption pursuant to 45 CFR 146.136(g).
- C. Health plans exempt from reporting. A health plan that meets the criteria of subsection (B) is exempt from reporting under this Article if it is one of the following types of health plans:
 - 1. A small group grandfathered health plan;
 - 2. A small group non-grandfathered health plan subject to the HHS transitional policy; or
 - 3. A health plan that meets the definition of excepted benefit provided in 45 CFR 146.145(b) or 45 C.F.R. 148.220.
- D. Required reports. A health care insurer shall file a separate report for each fully insured product network type the health care insurer issues in Arizona. If the information to be reported varies by network or health plan, or varies in the individual, small group or large group market, the health care insurer must file a separate report for each variation.
- E. Triennial Reports.
 - 1. Existing health care insurers. Beginning on March 15, 2023 and every third year thereafter, a health care insurer issuing health plans and collecting premium in Arizona as of January 1, 2022 shall file a triennial report with the Department for each health plan subject to reporting.
 - 2. Entering or re-entering health care insurers. On or before March 15 of the second year an entering or re-entering health care insurer issues health plans and collects premiums in Arizona, the health care insurer shall file an original triennial report with the Department for each health plan subject to reporting. Following the filing of the original triennial report, the health care insurer shall submit subsequent triennial reports on the schedule described in subsection (E)(1).
 - 3. Due date for triennial reports. Triennial reports are due on or before March 15 of each reporting year.
 - 4. Content of the original triennial report. Health care insurers shall file an original triennial report with the Department under A.R.S. § 20-3502(B) that provides the required information in Exhibit A.
 - 5. Subsequent triennial reports.
 - a. A health care insurer must file an updated triennial report, including the information required in Exhibit A, unless the health care insurer can attest that it has made no changes since the previously filed triennial report.
 - b. As required by A.R.S. § 20-3502(E), a health care insurer shall file the following with the Department for each health plan subject to reporting:
 - i. An updated triennial report, including the information required in Exhibit A; or
 - ii. The last triennial report filed with the Department and a written attestation that the health care insurer has made no changes since it filed the previous triennial report.
- F. Annual Reports. Pursuant to A.R.S. § 20-3502(E), on or before March 15 of each intervening year between the filing of a triennial report, a health care insurer shall file:
 - 1. A report that summarizes any changes made to its medical necessity criteria and NQTLs (Exhibit A, Parts I, II, and III);
 - 2. A written attestation by an officer or director of the health care insurer that the health care insurer is in compliance with MHPAEA; and
 - 3. If requested by the Department, any additional data required by the Department including Exhibit A, Part IV.
- G. Additional information. At any time after a health care insurer files a report under this Section, the Department may request additional information, including an updated triennial or annual report, by contacting the health care insurer and making the request in writing. The health care insurer shall provide contact information to the Department when it files any of the reports required by this Section. The Department may set a deadline for a health care insurer to respond to its request and specify the format for the response.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 1824 (July 29, 2022), effective September 4, 2022 (Supp. 22-3).

R20-6-1303. FR and QTL Reporting

- A. Method of reporting. A health care insurer that issues health plans in Arizona and whose policy forms are not exempt from the form filing requirement shall demonstrate its compliance with the FR and QTL parity requirements of MHPAEA through its form and rate filings with the Department.
- B. Department's authority to require additional data. In addition to the forms filed by a health care insurer, the Department may require a health care insurer to submit additional data relating to its methods for meeting the MHPAEA FR and QTL standards. The Department may utilize the CMS MHPAEA tool and may request samples of a health care insurer's internal testing to demonstrate compliance with the substantially all and predominant tests within each classification of benefits for a health plan.
- C. Separate consolidated report for large group health plans. The Department may require a health care insurer that issues large group health plans to file a consolidated report that demonstrates compliance with the substantially all and predominant tests within each classification of benefits for a sample of large group health plans with similar benefit structures.
- D. Special rule for FRs - Prescription Drug Classification. The multi-tiered prescription drug benefits exception of A.R.S. § 20-3502(D)(1) applies to the FRs for the prescription drug classification. For example, a health plan applies 4 tiers as follows: Tier 1: Generic Drugs for which the health plan pays 90%; Tier 2: Preferred Brand-name Drugs for which the health plan pays 80%; Tier 3: Non-preferred Brand-name Drugs for which the health plan pays 60%; and Tier 4: Specialty Drugs for which the health plan pays 50%. These FRs are applied without regard to whether a drug is prescribed for Med/Surg or MH/SUD benefits. In addition, the process for certifying a particular drug within a tier complies with the rules for NQTLs. Therefore, the FRs applied to prescription drug benefits meet the parity requirements under MHPAEA.
- E. Special rules for FRs and QTLs.
 - 1. In-network Classifications. The multiple network tiers exception of A.R.S. § 20-3502(D)(2) applies to the FRs and QTLs for the in-network classifications. For example, a health plan has two tiers of in-network providers: Tier 1: Preferred provider; and Tier 2: Participating provider. Placement of a provider into a tier complies with the rules for NQTLs and is determined without regard to whether the provider specializes in the treatment of Med/Surg conditions or MH/SUD disorders. The in-network

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classifications are divided into two subclassifications: 1. In-network preferred; and 2. In-network participating. The health plan does not impose any FR or QTL on MH/SUD benefits in either subclassification that is more restrictive than the predominant FR or QTL that applies to all Med/Surg benefits in each subclassification. Therefore, the FRs or QTLs applied to the in-network subclassifications that reflect the provider tiers meet the parity requirements under MHPAEA.

2. Outpatient Classifications. The subclassification permitted for the office visits exception of A.R.S. § 20-3502(D)(3) applies to the FRs and QTLs for the outpatient classifications. For example, a health plan divides the outpatient, in-network classification into two subclassifications: 1. In-network office visits; and 2. All other outpatient, in-network items and services. The health plan does not impose any FR or QTL on MH/SUD benefits in either subclassification that is more restrictive than the predominant FR or QTL that applies to Med/Surg benefits in each subclassification. Therefore, the FRs or QTLs applied to the outpatient subclassifications for office visits and all other outpatient items and services meet the parity requirements under MHPAEA.
3. The health plan cannot use a subclassification for generalists and specialists. The only subclassifications permitted for the in-network classifications are: 1. Office visits (such as physician visits); and 2. All other outpatient items and services (such as outpatient surgery, facility

charges for day treatment centers, laboratory charges, or other medical items).

Historical Note

New Section made by final rulemaking at 28 A.A.R. 1824 (July 29, 2022), effective September 4, 2022 (Supp. 22-3).

R20-6-1304. Additional Information or Data

According to A.R.S. § 20-3502(F), the Department is not prohibited from otherwise requesting information or data that is necessary to verify compliance with MHPAEA and the Arizona Mental Health Parity Act.

Historical Note

New Section made by final rulemaking at 28 A.A.R. 1824 (July 29, 2022), effective September 4, 2022 (Supp. 22-3).

R20-6-1305. Confidentiality of Information

According to A.R.S. § 20-3502(G), all documents, reports, or other materials provided to the Department under this Article are confidential and are not subject to disclosure and are subject to the restrictions of A.R.S. § 20-157.01(B).

Historical Note

New Section made by final rulemaking at 28 A.A.R. 1824 (July 29, 2022), effective September 4, 2022 (Supp. 22-3).

Exhibit A. Medical Necessity Criteria and NQTL Reports

Exhibit A
Medical Necessity Criteria and NQTL Reports

Instructions for Exhibit A:

Submit an Exhibit A for each fully insured, major medical health plan subject to reporting under Section R20-6-1302(B). Please submit the information in a word-searchable PDF file which is organized and identified by the numbered sections that appear below.

Part I: Identify Plan and Reporting Year.**Instructions for Part I:**

The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit A.

Reporting Year:		
Health Care Insurer Name:		
Health Care Insurer NAIC Company Code:		
Network Name(s):		
Service Area: (List all counties in the service area for these networks)		
Covered Lives: (List the number of covered lives enrolled in plans in these networks in the reporting year)		
Plan Types: (Check all that apply)	<input type="checkbox"/> Individual ACA-Compliant	<input type="checkbox"/> Small Group ACA-Compliant
	<input type="checkbox"/> Individual Transitional, plans include MH/SUD benefits	<input type="checkbox"/> Small Group Transitional, plans include MH/SUD benefits
	<input type="checkbox"/> Individual Grandfathered, plans include MH/SUD benefits	<input type="checkbox"/> Large Group Fully Insured, plans include MH/SUD benefits
	<input type="checkbox"/> PPO	<input type="checkbox"/> HMO (HCSO)
Product Types: (Check all that apply)	<input type="checkbox"/> POS	<input type="checkbox"/> Indemnity

Part II: Medical necessity criteria.**Instructions for Part II:**

To comply with A.R.S. § 20-3502(B)(1), describe the process that is used to develop or select medical necessity criteria for the plan and reporting year identified in Part I. When the plan describes the process used to develop or select criteria for MH/SUD benefits, then it must also describe the process used to develop or select criteria for Med/Surg benefits.

To comply with A.R.S. § 20-3502(B)(1), report:

- A. Describe the process used to develop or select medical necessity criteria for MH/SUD benefits.
- B. Describe the process used to develop or select medical necessity criteria for Med/Surg benefits.

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Part III: Identify all NQTLs.**Instructions for Part III:**

To comply with A.R.S. § 20-3502(B)(2), identify all NQTLs that are applied to MH/SUD benefits and all NQTLs that are applied to Med/Surg benefits for the plan and reporting year identified in Part I. NQTLs shall be identified within each classification of benefits.

- A. Identify and report all NQTLs applied to MH/SUD benefits:**
 - 1. All NQTLs applied to In-Patient, In-Network Classification.
 - 2. All NQTLs applied to In-Patient, Out-of-Network Classification.
 - 3. All NQTLs applied to Out-Patient, In-Network Classification.
 - 4. All NQTLs applied to Out-Patient, Out-of-Network Classification.
 - 5. All NQTLs applied to Emergency Care.
 - 6. All NQTLs applied to Prescription Benefits.
- B. Identify and report all NQTLs applied to Med/Surg benefits:**
 - 1. All NQTLs applied to In-Patient, In-Network Classification.
 - 2. All NQTLs applied to In-Patient, Out-of-Network Classification.
 - 3. All NQTLs applied to Out-Patient, In-Network Classification.
 - 4. All NQTLs applied to Out-Patient, Out-of-Network Classification.
 - 5. All NQTLs applied to Emergency Care.
 - 6. All NQTLs applied to Prescription Benefits.

Part IV: Demonstrate parity through analysis.**Instructions for Part IV:**

To comply with A.R.S. § 20-3502(B)(3), for each NQTL listed in Part III, demonstrate through analysis that the process, strategy, evidentiary standard, and other factor of applying the NQTL to MH/SUD benefits in a classification of benefits, as written and in operation, is comparable to, and applied not more stringently than, any process, strategy, evidentiary standard or other factor used in applying the NQTL to Med/Surg benefits in the same classification. The report should define each "Other Factor" and include qualitative and quantitative statistical data to support and explain the analysis.

Identify and report on the NQTLs reported in Part III as follows:

- A. Classification - Inpatient, in-network**
 - 1. Process
 - a. Process applying NQTL to MH/SUD benefit.
 - b. Process applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
 - 2. Strategy
 - a. Strategy applying NQTL to MH/SUD benefit.
 - b. Strategy applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
 - 3. Evidentiary Standard
 - a. Evidentiary standard applying NQTL to MH/SUD benefit.
 - b. Evidentiary standard applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
 - 4. Other Factor
 - a. Other factor applying NQTL to MH/SUD benefit.
 - b. Other factor applying NQTL to Med/Surg benefit.
 - c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.
- B. Classification - Inpatient, out-of-network**
 - 1. Process
 - a. Process applying NQTL to MH/SUD benefit.
 - b. Process applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.

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2. Strategy
 - a. Strategy applying NQTL to MH/SUD benefit.
 - b. Strategy applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
 3. Evidentiary Standard
 - a. Evidentiary standard applying NQTL to MH/SUD benefit.
 - b. Evidentiary standard applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
 4. Other Factor
 - a. Other factor applying NQTL to MH/SUD benefit.
 - b. Other factor applying NQTL to Med/Surg benefit.
 - c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.
- C. Classification - Outpatient, in-network
1. Process
 - a. Process applying NQTL to MH/SUD benefit.
 - b. Process applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
 2. Strategy
 - a. Strategy applying NQTL to MH/SUD benefit.
 - b. Strategy applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
 3. Evidentiary Standard
 - a. Evidentiary standard applying NQTL to MH/SUD benefit.
 - b. Evidentiary standard applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
 4. Other Factor
 - a. Other factor applying NQTL to MH/SUD benefit.
 - b. Other factor applying NQTL to Med/Surg benefit.
 - c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.
- D. Classification - Outpatient, out-of-network
1. Process
 - a. Process applying NQTL to MH/SUD benefit.
 - b. Process applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
 2. Strategy
 - a. Strategy applying NQTL to MH/SUD benefit.
 - b. Strategy applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.

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- d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
- 3. Evidentiary Standard
 - a. Evidentiary standard applying NQTL to MH/SUD benefit.
 - b. Evidentiary standard applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
- 4. Other Factor
 - a. Other factor applying NQTL to MH/SUD benefit.
 - b. Other factor applying NQTL to Med/Surg benefit.
 - c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.
- E. Classification - Emergency care
 - 1. Process
 - a. Process applying NQTL to MH/SUD benefit.
 - b. Process applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
 - 2. Strategy
 - a. Strategy applying NQTL to MH/SUD benefit.
 - b. Strategy applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
 - 3. Evidentiary Standard
 - a. Evidentiary standard applying NQTL to MH/SUD benefit.
 - b. Evidentiary standard applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
 - 4. Other Factor
 - a. Other factor applying NQTL to MH/SUD benefit.
 - b. Other factor applying NQTL to Med/Surg benefit.
 - c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.
- F. Classification - Prescription benefits
 - 1. Process
 - a. Process applying NQTL to MH/SUD benefit.
 - b. Process applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
 - 2. Strategy
 - a. Strategy applying NQTL to MH/SUD benefit.
 - b. Strategy applying NQTL to Med/Surg benefit.
 - c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
 - 3. Evidentiary Standard
 - a. Evidentiary standard applying NQTL to MH/SUD benefit.
 - b. Evidentiary standard applying NQTL to Med/Surg benefit.

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- c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
- d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
- 4. Other Factor
 - a. Other factor applying NQTL to MH/SUD benefit.
 - b. Other factor applying NQTL to Med/Surg benefit.
 - c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
 - d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.

Historical Note

New Exhibit A made by final rulemaking at 28 A.A.R. 1824 (July 29, 2022), effective September 4, 2022 (Supp. 22-3).

ARTICLE 14. INSURANCE HOLDING COMPANY**R20-6-1401. Definitions**

- A. "The Act" means the Insurance Holding Company Systems Act, A.R.S. §§ 20-481 through 20-481.32.
- B. "Executive officer" means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.
- C. "Ultimate controlling person" means that person which is not controlled by any other person.
- D. Unless the context otherwise requires, other terms found in these regulations and in A.R.S. § 20-481 are used as defined in the Act. Other nomenclature or terminology is according to Title 20, A.R.S. or industry usage if not defined by Title 20, A.R.S.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1401 recodified from R4-14-1401 (Supp. 95-1).
Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

R20-6-1402. Acquisition of Control – Statement Filing

- A. A person required to file a statement pursuant to A.R.S. § 20-481.02 shall furnish the required information on Form A, attached hereto as Appendix A and on Form E, attached hereto as Appendix E, and described in subsections (D) and (E) of this Section.
- B. The applicant shall promptly advise the Director of any changes in the information furnished on Form A arising subsequent to the date upon which the information was furnished but prior to the Director's disposition of the application.
- C. If the person being acquired is deemed to be a "domestic insurer" solely because of the provisions of A.R.S. § 20-481.02(G), the name of the domestic insurer on the cover page should be indicated as follows: "[ABC Insurance Company), a subsidiary of [XYZ Holding Company]." Where a A.R.S. § 20-481.02(G) insurer is being acquired, references to "the insurer" contained in Form A shall refer to both the domestic subsidiary insurer and the person being acquired.
- D. If a domestic insurer, including any person controlling a domestic insurer, is proposing a merger or acquisition pursuant to A.R.S. § 20-481.02(A), that person shall file a pre-acquisition notification form, Form E, which was developed pursuant to A.R.S. § 20-481.25(C).
- E. Additionally, if a non-domiciliary insurer licensed to do business in this state is proposing a merger or acquisition pursuant to A.R.S. § 20-481.25, that person shall file a pre-acquisition notification form, Form E. No pre-acquisition notification

form need be filed if the acquisition is beyond the scope of A.R.S. § 20-481.25 as set forth in A.R.S. § 20-481.25(B).

- F. In addition to the information required by Form E, the Director may wish to require an expert opinion as to the competitive impact of the proposed acquisition.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1402 recodified from R4-14-1402 (Supp. 95-1).
Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

R20-6-1403. Annual Registration of Insurers – Statement Filing

- A. An insurer required to file an annual registration statement pursuant to A.R.S. § 20-481.09 shall furnish the required information on Form B, attached hereto as Appendix B, in accordance with the instructions contained in Appendix G.
- B. Amendments to Form B shall be filed in the Form B format with only those items which are being amended reported. Each such amendment shall include at the top of the cover page "Amendment No. (insert number) to Form B for (insert year)" and shall indicate the date of the amendment and not the date of the original filings.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1403 recodified from R4-14-1403 (Supp. 95-1).
Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

R20-6-1404. Summary of Registration – Statement Filing

An insurer required to file an annual registration statement pursuant to A.R.S. § 20-481.09 is also required to furnish information required on Form C, attached hereto as Appendix C.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1404 recodified from R4-14-1404 (Supp. 95-1).
Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

R20-6-1405. Alternative and Consolidated Registrations

- A. Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under A.R.S. § 20-481.09. A registration statement may include information not required by the Act regarding any insurer in the insurance holding company system even if such insurer is not authorized to do business in this state. In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its state of domicile, provided:

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1. The statement or report contains substantially similar information required to be furnished on Form B; and
2. The filing insurer is the principal insurance company in the insurance holding company system.
- B.** The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer, shall set forth a brief statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding company system.
- C.** With the prior approval of the Director, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under subsection (A) above.
- D.** Any insurer may take advantage of the provisions of A.R.S. §§ 20-481.15 or 20-481.16 without obtaining the prior approval of the Director. The Director, however, reserves the right to require individual filings if he or she deems such filings necessary in the interest of clarity, ease of administration or the public good.
2. Set forth the methods to allocate costs;
3. Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;
4. Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;
5. State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;
6. Define books and records of the insurer to include all books and records developed or maintained under or related to the agreement;
7. Specify that all books and records of the insurer are and remain the property of the insurer and are subject to control of the insurer;
8. State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;
9. Include standards for termination of the agreement with and without cause;
10. Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services;
11. Specify that, if the insurer is placed in receivership or seized by the Director under the Arizona Receivership Act:
 - a. All of the rights of the insurer under the agreement extend to the receiver or Director; and,
 - b. All books and records will immediately be made available to the receiver or the Director, and shall be turned over to the receiver or Director immediately upon the receiver or Director's request;
12. Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership pursuant to the Arizona Receivership Act; and
13. Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding a seizure by the Director under the Arizona Receivership Act, and will make them available to the receiver, for so long as the affiliate continues to receive timely payment for services rendered.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1405 recodified from R4-14-1405 (Supp. 95-1).

Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

R20-6-1406. Disclaimers and Termination of Registration

- A.** A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person, hereinafter referred to in this rule as the "subject," shall contain the following information:
 1. The number of authorized, issued and outstanding voting securities of the subject;
 2. With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned, and the number of shares concerning which there is a right to acquire, directly or indirectly;
 3. All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person;
 4. A statement explaining why the person should not be considered to control the subject.
- B.** A request for termination of registration shall be deemed to have been granted unless the director, within 30 days after receipt of the request, notifies the registrant otherwise.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1406 recodified from R4-14-1406 (Supp. 95-1).

Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

R20-6-1407. Transactions Subject to Prior Notice - Notice Filing

- A.** An insurer required to give notice of a proposed transaction pursuant to A.R.S. § 20-481.12 shall furnish the required information on Form D, attached hereto as Appendix D, in accordance with the instructions in Appendix G.
- B.** Agreements for cost sharing services and management services shall at a minimum and as applicable:
 1. Identify the person providing services and the nature of such services;

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1407 recodified from R4-14-1407 (Supp. 95-1).

Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

R20-6-1408. Enterprise Risk Report

The ultimate controlling person of an insurer required to file an enterprise risk report pursuant to A.R.S. § 481.10(D) shall furnish the required information on Form F, attached hereto as Appendix F.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1408 recodified from R4-14-1408 (Supp. 95-1). R20-6-1408 repealed; new Section R20-6-1408 made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

R20-6-1409. Extraordinary Dividends and Other Distributions

- A.** Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:
 1. The amount of the proposed dividend;

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2. The date established for payment of the dividend;
 3. A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof, its cost, and its fair market value together with an explanation of the basis for valuation;
 4. A copy of the calculations determining that the proposed dividend is extraordinary. The work paper shall include the following information:
 - a. The amounts, dates and form of payment of all dividends or distributions, including regular dividends but excluding distributions of the insurer's own securities, paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;
 - b. Surplus as regards policyholders, total capital and surplus, as of the 31st day of December next preceding;
 - c. If the insurer is a life insurer, the net gain from operations for the 12-month period ending the 31st day of December next preceding;
 - d. If the insurer is not a life insurer, the net income, net realized capital gains for the 12-month period ending the 31st day of December next preceding and the two preceding 12-months periods; and
 - e. If the insurer is not a life insurer, the dividends paid to stockholders excluding distributions of the insurer's own securities in the preceding two calendar years.
 5. A balance sheet and statement of income for the period intervening from the last annual statement filed with the Director and the end of the month preceding the month in which the request for dividend approval is submitted; and
 6. A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.
- B.** Subject to A.R.S. § 20-481.19, each registered insurer shall report to the Director all dividends and other distributions to shareholders within 5 business days following the declaration thereof and at least 10 business days before payment of the dividend or distribution, including the same information required by subsection (A)(4)(a) through (e) of this rule.

Historical Note

New Section made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4). Amended by final rulemaking at 23 A.A.R. 3311, effective January 16, 2018 (Supp. 17-4).

R20-6-1410. Adequacy of Surplus

The factors set for in A.R.S. §§ 20-481.01(F) and 20-481.24 are not intended to be an exhaustive list. In determining the adequacy and reasonableness of an insurer's surplus no single factor is necessarily controlling. The Director instead will consider the net effect of all of these factors plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the Director will consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the Director will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

Historical Note

New Section made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

Appendix A. Form A - Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer

**STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER
WITH A DOMESTIC INSURER**

[Name of Domestic Insurer]

By

[Name of Acquiring Person (Applicant)]

Filed with the Arizona Department of Insurance

Dated: _____, 20 ____

Name, Title, address and telephone number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

ITEM 1. METHOD OF ACQUISITION

[State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired. State the federal identification number and the NAIC number of the domestic insurer.]

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT

[(a) State the name and address of the applicant seeking to acquire control over the insurer.]

[(b) If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.]

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- [(c) Furnish a chart or listing clearly presenting the identities of the inter-relationships among the applicant and all affiliates of the applicant, including NAIC numbers for all insurers. No affiliate need be identified if its total assets are equal to less than 1/2 of 1% of the total assets of the ultimate controlling person affiliated with the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g. corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.]

ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT

[On the biographical affidavit, include a third party background check, and state the following with respect to (1) the applicant if (s)he is an individual, or (2) all persons who are directors, executive officers or owners of 10% or more of the voting securities of the applicant if the applicant is not an individual.

- (a) Name and business address;
- (b) Present principal business activity, occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on;
- (c) Material occupations, positions, officer or employment during the last 5 years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on: if any such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith;
- (d) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last 10 years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case;

Such persons may also submit fingerprints and the fingerprint processing fee in accordance with A.R.S. § 20-481.03(B).]

ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION

- [(a) Describe the nature, source and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating thereto.]
- [(b) Explain the criteria used in determining the nature and amount of such consideration.]
- [(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity of the lender to remain confidential, he must specifically request that the identity be kept confidential.)

ITEM 5. FUTURE PLANS OF INSURER

[Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.]

ITEM 6. VOTING SECURITIES TO BE ACQUIRED

[State the number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.]

ITEM 7. OWNERSHIP OF VOTING SECURITIES

[State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3.]

ITEM 8. CONTRACTS, ARRANGEMENTS, OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER

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[Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any person listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom the contracts, arrangements or understandings have been entered into.]

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES

[Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement. Include in the description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any such shares so purchased are hypothecated.]

ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE

[Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement.]

ITEM 11. AGREEMENTS WITH BROKER-DEALERS

[Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.]

ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS

[(a) Financial statements, exhibits, and three-year financial projections of the insurer(s) shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.]

[(b) The financial statements shall include the annual financial statements of the persons identified in Item 2(c) for the preceding five fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if such information is available. The statements may be prepared on either an individual basis, or, unless the Director otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of the person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of the state.]

[(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A or Appendix G.)

ITEM 13. AGREEMENT REQUIREMENTS FOR ENTERPRISE RISK MANAGEMENT

Applicant agrees to provide, to the best of its knowledge and belief, the information required by Form F within fifteen (15) days after the end of the month in which the acquisition of control occurs.

ITEM 14. SIGNATURE AND CERTIFICATION

[Signature and certification required as follows:]

SIGNATURE

Pursuant to the requirements of A.R.S. § 20-481.02 _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 20____.

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(SEAL)

Name of Applicant

BY _____
(Name)

(Title)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 20____, for and on behalf of _____; that (s)he is the _____

(Name of Applicant)

(Title of Officer)

of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)

(Type or print name beneath)

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

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Appendix B. Form B - Insurance Holding Company System Annual Registration Statement
INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of Arizona

By

[Name of Registrant]

On Behalf of Following Insurance Companies

Name

Address

Date: _____, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning
 This Statement Should Be Addressed:

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

[Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"), the federal identification number and the NAIC number of each, the home office address and principal executive offices of each; the date on which each Registrant became part of the insurance holding company system; and the method(s) by which control of each Registrant was acquired and is maintained.]

ITEM 2. ORGANIZATIONAL CHART

[Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of control. As to each person specified in the chart or listing, indicate the type of organization (e.g., - corporation, trust, partnership) and the state or other jurisdiction of domicile.]

ITEM 3. THE ULTIMATE CONTROLLING PERSON

[As to the ultimate controlling person in the insurance holding company system furnish the following information:

- (a) Name;
- (b) Home office address;
- (c) Principal executive office address;
- (d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.;
- (e) The principal business of the person;
- (f) The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned; and
- (g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.]

ITEM 4. BIOGRAPHICAL INFORMATION

[If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes

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other than minor traffic violations. If the ultimate controlling person is an individual, furnish the individual's name and address, his or her principal occupation and all offices and positions held during the past 5 years, and any conviction of crimes other than minor traffic violations.]

ITEM 5. TRANSACTIONS AND AGREEMENTS

[Briefly describe the following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the Registrant and its affiliates:

- (a) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;
- (b) Purchases, sales or exchanges of assets;
- (c) Transactions not in the ordinary course of business;
- (d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the Registrant's business;
- (e) All management agreements, service contracts and all cost-sharing arrangements;
- (f) Reinsurance agreements;
- (g) Dividends and other distributions to shareholders;
- (h) Consolidated tax allocation agreements; and
- (i) Any pledge of the Registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

No information need be disclosed if such information is not material for purposes of A.R.S. § 20-481.09.

Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving 1/2 of 1% or less of the Registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the Director and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to the transaction, and relationship of the affiliated parties to the Registrant.]

ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

[A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which the litigation or proceeding is or was pending:

- (a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and
- (b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.]

ITEM 7.a. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

[The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.]

ITEM 7.b. STATEMENT REGARDING CORPORATE GOVERNANCE AND INTERNAL CONTROLS

[The insurer shall furnish a statement that the insurer's board of directors oversees corporate governance and internal controls of the insurer and that the insurer's officers or senior management have approved, implemented and maintain and monitor corporate governance and internal control procedures.]

ITEM 8. FINANCIAL STATEMENTS AND EXHIBITS

- [(a) Financial statements and exhibits shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

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- (b) If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, the financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis; or, unless the Director otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

Other than with respect to the foregoing, such financial statement shall be filed in a standard form and format adopted by the National Association of Insurance Commissioners, unless an alternative form is accepted by the Director. Documentation and financial statements filed with the Securities and Exchange Commission or audited GAAP financial statements shall be deemed to be an appropriate form and format.

Unless the Director otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that the statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of the insurer's domiciliary State and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of that state.

Any ultimate controlling person who is an individual may file personal financial statements that are reviewed rather than audited by an independent public accountant. The review shall be conducted in accordance with standards for review of personal financial statements published in the Personal Financial Statements Guide by the American Institute of Certified Public Accountants. Personal financial statements shall be accompanied by the independent public accountant's Standard Review Report stating that the accountant is not aware of any material modifications that should be made to the financial statements in order for the statements to be in conformity with generally accepted accounting principles.

- (c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Forms B and G.]

ITEM 9. FORM C REQUIRED

[A Form C, Summary of Registration Statement, must be prepared and filed with this Form B.]

ITEM 10. SIGNATURE AND CERTIFICATION

[Signature and certification required as follows:]

SIGNATURE

Pursuant to the requirements of A.R.S. § 20-481.09, Registrant _____ has caused this annual registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 20____.

(SEAL)

Name of Applicant

BY _____
(Name)

(Title)

Attest:

(Signature of Officer)

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(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 20____, for and on behalf of _____; that (s)he is the _____
(Name of Applicant) (Title of Officer)
of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)

(Type or print name beneath)

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

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Appendix C. Form C - Summary of Registration Statement

SUMMARY OF CHANGES TO REGISTRATION STATEMENT

Filed with the Insurance Department of the State of Arizona

By

[Name of Registrant]

On Behalf of Following Insurance Companies

Name Address

Dated: _____, 20 ____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

[Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the Director, and shall include specific references to Item numbers in the annual registration statement and to the terms contained therein.]

Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities held by each affiliate is concerned, need only be included where such changes are ones which result in ownership or holdings of 10% or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

Changes occurring under Item 4 of Form B need only be included where: an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.]

SIGNATURE AND CERTIFICATION

[Signature and certification required as follows:]

Pursuant to the requirements of A.R.S. § 20-481.09, Registrant _____ has caused this annual registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 20 ____.

(SEAL)

Name of Applicant

BY _____
(Name)_____
(Title)

Attest:

(Signature of Officer)_____
(Title)

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CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated _____, 20____, for and on behalf of _____; that (s)he is the _____

(Name of Applicant)

(Title of Officer)

of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature)

(Type or print name beneath)

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

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Appendix D. Form D - Prior Notice of a Transaction

PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Department of the State of Arizona

By

[Name of Registrant]

On Behalf of Following Insurance Companies

Name Address

Dated: _____, 20 ____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

ITEM 1. IDENTITY OF PARTIES TO TRANSACTION

[Furnish the following information for each of the parties to the transaction:

- (a) Name;
- (b) Home office address;
- (c) Principal executive office address;
- (d) The organizational structure, i.e. corporation, partnership, individual, trust, etc.;
- (e) A description of the nature of the parties' business operations;
- (f) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties;
- (g) Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.]

ITEM 2. DESCRIPTION OF THE TRANSACTION

[Furnish the following information for each transaction for which notice is being given:

- (a) A statement as to whether notice is being given under A.R.S. § 20-481.12(B);
- (b) A statement of the nature of the transaction;
- (c) If a notice for amendments or modifications, the reasons for the change and the financial impact on the domestic insurer;
- (d) A statement of how the transaction meets the "fair and reasonable" standard of A.R.S. § 20-481.12(A)(1); and
- (e) The proposed effective date of the transaction.]

ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES OR INVESTMENTS

[Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment, whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice, a description of the terms of any securities being received, if any, and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

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If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit or guarantee is less than (a) in the case of non-life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as regards policyholders, or (b) in the case of life insurers, 3% of the insurer's admitted assets, each as of the 31st day of December next preceding.]

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NON-AFFILIATE

[If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate. Describe the amount and source of funds, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of non-life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as regards policyholders or, with respect to life insurers, 3% of the insurer's admitted assets, each as of the 31st day of December next preceding.]

ITEM 5. REINSURANCE

[If the transaction is a reinsurance agreement or modification thereto, as described by A.R.S. § 20-481.12(B)(3)(b), or a reinsurance pooling agreement or modification thereto as described by A.R.S. § 20-481.12(B)(3)(a), furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given for reinsurance agreements or modifications thereto if the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or change in the insurer's liabilities in any of the next three years, in connection with the reinsurance agreement or modification thereto is less than 5% of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding. Notice shall be given for all reinsurance pooling agreements including modifications thereto.]

ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS AND COST-SHARING ARRANGEMENTS

[For management and service agreements, furnish:

- (a) A brief description of the managerial responsibilities, or services to be performed;
- (b) A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.]

[For cost-sharing arrangements, furnish:

- (a) A brief description of the purpose of the agreement;
- (b) A description of the period of time during which the agreement is to be in effect;
- (c) A brief description of each party's expenses or costs covered by the agreement;
- (d) A brief description of the accounting basis to be used in calculating each party's costs under the agreement;]
- (e) A brief statement as to the effect of the transaction upon the insurer's policyholder surplus;
- (f) A statement regarding the cost allocation methods that specifies whether proposed charges are based on "cost or market." If market based, rationale for using market instead of cost, including justification for the company's determination that amounts are fair and reasonable; and
- (g) A statement regarding compliance with the NAIC Accounting Practices and Procedure Manual regarding expense allocation.]

ITEM 7. SIGNATURE AND CERTIFICATION

[Signature and certification required as follows:]

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SIGNATURE

Pursuant to the requirements of A.R.S. § 20-481.09, _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 20____.

(SEAL)

By _____
Name of Applicant

(Title)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 20____, for and on behalf of _____; that (s)he is the _____
(Name of Applicant) (Title of Officer)

of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

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Appendix E. Form E - Pre-acquisition Notification Form Regarding the Potential Competitive Impact of a Proposed Merger or Acquisition by a Non-domiciliary Insurer Doing Business in this State or by a Domestic Insurer

**PRE-ACQUISITION NOTIFICATION FORM
REGARDING THE POTENTIAL COMPETITIVE IMPACT
OF A PROPOSED MERGER OR ACQUISITION BY A
NON-DOMICILIARY INSURER DOING BUSINESS IN THIS
STATE OR BY A DOMESTIC INSURER**

Name of Applicant

Name of Other Person Involved in Merger or Acquisition

Filed with the Arizona Department of Insurance

Dated: _____, 20____

Name, title, address and telephone number of person completing this statement:

ITEM 1. NAME AND ADDRESS

[State the name and addresses of the persons who hereby provide notice of their involvement in a pending acquisition or change in corporate control.]

ITEM 2. NAME AND ADDRESSES OF AFFILIATED COMPANIES

[State the names and addresses of the persons affiliated with those listed in Item 1. Describe their affiliations.]

ITEM 3. NATURE AND PURPOSE OF THE PROPOSED MERGER OR ACQUISITION

[State the nature and purpose of the proposed merger or acquisition.]

ITEM 4. NATURE OF BUSINESS

[State the nature of the business performed by each of the persons identified in response to Item 1 and Item 2.]

ITEM 5. MARKET AND MARKET SHARE

[State specifically what market and market share in each relevant insurance market the persons identified in Item 1 and Item 2 currently enjoy in this state. Provide historical market and market share data for each person identified in Item 1 and Item 2 for the past five years and identify the source of such data. Provide a determination as to whether the proposed acquisition or merger, if consummated, would violate the competitive standards of the state as stated in A.R.S. § 20-481.25(D). If the proposed acquisition or merger would violate competitive standards, provide justification of why the acquisition or merger would not substantially lessen competition or create a monopoly in the state.]

For purposes of this question, market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). Appendix E. *Instructions on Forms*, renumbered to Appendix G; new Appendix E. Form E made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

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Appendix F. Form F - Enterprise Risk Report

ENTERPRISE RISK REPORT

Filed with the Arizona Department of Insurance

Name of Registrant/Applicant

On Behalf of/Related to Following Insurance Companies

Name Address

Dated: _____, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should be Addressed:

_____**ITEM 1. ENTERPRISE RISK**

[The Registrant/Applicant, to the best of its knowledge and belief, shall provide information regarding the following areas that could produce enterprise risk as defined in A.R.S. § 20-481(4), provided such information is not disclosed in the Insurance Holding Company System Annual Registration Statement filed on behalf of itself or another insurer for which it is the ultimate controlling person:

Any material developments regarding strategy, internal audit findings, compliance or risk management affecting the insurance holding company system;

Acquisition or disposal of insurance entities and reallocating of existing financial or insurance entities with the insurance holding company system;

Any changes of shareholders of the insurance holding company system exceeding ten percent (10%) or more of voting securities;

Developments in various investigations, regulatory activities or litigation that may have a significant bearing or impact on the insurance holding company system'

Business plan of the insurance holding company system and summarized strategies for next 12 months;

Identification of material concerns of the insurance holding company system raised by supervisory college, if any, in last year;

Identification of insurance holding company system capital resources and material distribution patterns;

Identification of any negative movement, or discussions with rating agencies which may have caused, or may cause, potential negative movement in the credit ratings and individual insurer financial strength ratings assessment of the insurance holding company system (include both the rating score and outlook);

Information on corporate or parental guarantees throughout the holding company and the expected source of liquidity should such guarantees be called upon; and

Identification of any material activity or development of the insurance holding company system that, in the opinion of senior management, could adversely affect the insurance holding company system.

[The Registrant/Applicant may attach the appropriate form most recently filed with the U.S. Securities and Exchange Commission, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the form provides responsive information. If the Registrant/Applicant is not domiciled in the U.S., it may attach its most recent public audited financial statement filed in its country of domicile, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the financial statement provides responsive information.]

ITEM 2. OBLIGATION TO REPORT

[If the Registrant/Applicant has not disclosed any information pursuant to Item 1, the Registrant/Applicant shall include a statement affirming that, to the best of its knowledge and belief, it has not identified enterprise risk subject to disclosure pursuant to Item 1.]

Historical Note

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Appendix F, Form F made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

Appendix G. Instructions on Forms A, B, C, D, E and F**INSTRUCTIONS ON FORMS A, B, C, D, E AND F****FORMS - GENERAL REQUIREMENTS**

Forms A, B, C, D, E and F are intended to be guides in the preparation of the statements required by A.R.S. §§ 20-481.02, 20-481.09, 20-481.12 and 20-481.25. They are not intended to be blank forms which are to be filled in. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

One original paper statement excluding exhibits, and all other papers and documents shall be filed with the Director. The statement shall be signed in the manner prescribed on the form. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of such power of attorney or other authority shall also be filed with the statement. All paper filings shall be by personal delivery or mail addressed to: Arizona Department of Insurance, Financial Affairs Division.

In addition to the filed paper statement, a copy of the statement, including exhibits, and all other papers and documents filed as a part thereof, shall be filed electronically.

All filed documents shall be easily readable and suitable for review and reproduction. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into United States currency.

If an applicant requests a hearing on a consolidated basis under A.R.S. § 20-481.07, in addition to filing the Form A with the Director, the applicant shall file a copy of Form A with the National Association of Insurance Commissioners (NAIC) in electronic form.

FORMS - INCORPORATION BY REFERENCE, SUMMARIES AND OMISSIONS

Information required by any item of Form A, Form B, Form D, Form E or Form F may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A, Form B, Form D, Form E or Form F provided the document is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents currently on file with the Director which were filed within three years need not be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Matter shall not be incorporated by reference in any case where such incorporation would render the statement incomplete, unclear or confusing.

Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to the statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with the Director which was filed within three years and may be qualified in its entirety by such reference. In any case where two or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution, or other details, a copy of only one of the documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which the documents differ from the documents, a copy of which is filed.

FORMS - INFORMATION UNKNOWN OR UNAVAILABLE AND EXTENSION OF TIME TO FURNISH

If it is impractical to furnish any required information, document or report at the time it is required to be filed, there may be filed with the Director as a separate document:

- (1) Identifying the information, document or report in question;
- (2) Stating why the filing thereof at the time required is impractical; and
- (3) Requesting an extension of time for filing the information, document or report to a specified date. The request for extension shall be deemed granted unless the Director within 60 days after receipt thereof enters an order denying the request.

FORMS - ADDITIONAL INFORMATION AND EXHIBITS

In addition to the information expressly required to be included in Form A, Form B, Form C, Form D, Form E and Form F, the Director may request such further information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the forms. The

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exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Forms A, B, C, D, E or F shall include on the top of the cover page the phrase: "Change No. (insert number) to" and shall indicate the date of the change and not the date of the original filing.

Historical Note

Appendix G. *Instructions on Forms*, renumbered from Appendix E. *Instructions on Forms*, with heading amended to include new Appendix F, by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

ARTICLE 15. RESERVED**ARTICLE 16. CREDIT FOR REINSURANCE****R20-6-1601. Renumbered****Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1601 recodified from R4-14-1601 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1601 renumbered to R20-6-A1601 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

R20-6-1602. Renumbered**Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1602 recodified from R4-14-1602 (Supp. 95-1). R20-6-1602 renumbered to R20-6-1607; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1602 renumbered to R20-6-A1602 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

R20-6-1603. Renumbered**Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1603 recodified from R4-14-1603 (Supp. 95-1). R20-6-1603 renumbered to R20-6-1608; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1603 renumbered to R20-6-A1603 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

R20-6-1604. Renumbered**Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1604 recodified from R4-14-1604 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). R20-6-1604 renumbered to R20-6-1609; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1604 renumbered to R20-6-A1604 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

R20-6-1605. Renumbered**Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1605 recodified from R4-14-1605 (Supp. 95-1). R20-6-1605 renumbered to R20-6-1610; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1605

renumbered to R20-6-A1605 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

R20-6-1606. Renumbered**Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1606 recodified from R4-14-1606 (Supp. 95-1). R20-6-1606 renumbered to R20-6-1611; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1606 renumbered to R20-6-A1606 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

R20-6-1607. Renumbered**Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1607 recodified from R4-14-1607 (Supp. 95-1). Section R20-6-1607 renumbered to R20-6-1612; new Section R20-6-1607 renumbered from R20-6-1602 and amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1607 renumbered to R20-6-A1607 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

R20-6-1608. Renumbered**Historical Note**

New Section R20-6-1608 renumbered from R20-6-1603 and amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1608 renumbered to R20-6-A1608 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

R20-6-1609. Repealed**Historical Note**

New Section R20-6-1609 renumbered from R20-6-1604 and amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). Repealed by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

R20-6-1610. Renumbered**Historical Note**

New Section R20-6-1610 renumbered from R20-6-1605 by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1610 renumbered to R20-6-B1601 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

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R20-6-1611. Renumbered**Historical Note**

New Section R20-6-1611 renumbered from R20-6-1606 and amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1611 renumbered to R20-6-B1602 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

R20-6-1612. Renumbered**Historical Note**

New Section R20-6-1612 renumbered from R20-6-1607 and amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1612 renumbered to R20-6-B1603 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

PART A. CREDIT FOR REINSURANCE**R20-6-A1601. Credit for Reinsurance – Reinsurer Licensed in Arizona**

Pursuant to A.R.S. § 20-3602(C) the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that was licensed in Arizona as of any date on which statutory financial statement credit for reinsurance is claimed.

Historical Note

New Section R20-6-A1601 renumbered from R20-6-1601 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

R20-6-A1602. Credit for Reinsurance – Accredited Reinsurers

A. Pursuant to A.R.S. § 20-3602(D) the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is accredited as a reinsurer in Arizona as of the date on which statutory financial statement credit for reinsurance is claimed.

B. An accredited reinsurer must:

1. File a properly executed Form AR-1, attached as Exhibit A to this Part, as evidence of its submission to the Director's jurisdiction and to the Director's authority to examine its books and records;
2. File with the Director a certified copy of a certificate of authority or other acceptable evidence that it is licensed to transact insurance or reinsurance in at least one state, or, in the case of a U.S. branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;
3. File annually with the Director a copy of its annual statement filed with the insurance department of its state of domicile or, in the case of an alien assuming insurer, with the state through which it is entered and in which it is licensed to transact insurance or reinsurance, and a copy of its most recent audited financial statement; and
4. Maintain a surplus as regards policyholders in an amount not less than \$20 million, or obtain the affirmative approval of the Director upon a finding that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers.

C. If the Director determines that the assuming insurer has failed to meet or maintain any of these qualifications, the Director may upon written notice and opportunity for hearing, suspend or revoke the accreditation. Credit shall not be allowed a domestic ceding insurer under this Section if the assuming

insurer's accreditation has been revoked by the Director, or if the reinsurance was ceded while the assuming insurer's accreditation was under suspension by the Director.

Historical Note

New Section R20-6-A1602 renumbered from R20-6-1602 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; clerical error under subsection (B)(1) referencing Form AR-1 as an Appendix A corrected to Exhibit A (Supp. 22-1).

R20-6-A1603. Credit for Reinsurance – Reinsurer Domiciled in Another State

A. Pursuant to A.R.S. § 20-3602(E) the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that as of any date on which statutory financial credit for reinsurance is claimed:

1. Is domiciled in (or, in the case of a U.S. branch of an alien assuming insurer, is entered through) a state that employs standards regarding credit for reinsurance substantially similar to those applicable under A.R.S. Title 20, Chapter 30 and this Part;
2. Maintains a surplus as regards policyholders in an amount not less than \$20 million; and
3. Files a properly executed Form AR-1 (Exhibit A) with the Director as evidence of the submission to the Director's authority to examine its books and records.

B. The provisions of this Section relating to surplus as regards policyholders shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system. As used in this Section, "substantially similar" standards means credit for reinsurance standards that the Director determines equal or exceed the standards of A.R.S. Title 20, Chapter 30 and this Part.

Historical Note

New Section R20-6-A1603 renumbered from R20-6-1603 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

R20-6-A1604. Credit for Reinsurance – Reinsurers Maintaining Trust Funds

A. Pursuant to A.R.S. § 20-3602(F) and (F)(1), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of any date on which statutory financial statement credit for reinsurance is claimed, and thereafter for so long as credit for reinsurance is claimed, maintains a trust fund in an amount prescribed below in a qualified U.S. financial institution as defined in A.R.S. § 20-3601 for the payment of the valid claims of its U.S. domiciled ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the Director substantially the same information as that required to be reported on the National Association of Insurance Commissioners (NAIC) annual statement form by licensed insurers, to enable the Director to determine the sufficiency of the trust fund.

B. The following requirements apply to the following categories of assuming insurer:

1. The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by U.S. domiciled insurers, and in addition, the assuming insurer shall maintain a trustee surplus of not less than \$20 million, except as provided in subsection (B)(2).
2. At any time after the assuming insurer has permanently discontinued underwriting new business secured by the

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trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trustee surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of U.S. ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trustee surplus may not be reduced to an amount less than 30% of the assuming insurer's liabilities, attributable to reinsurance ceded by U.S. ceding insurers covered by the trust.

3. The trust fund for a group including incorporated and individual unincorporated underwriters:
 - a. Shall consist of:
 - i. For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, funds in trust in an amount not less than the respective underwriters' several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any underwriter of the group;
 - ii. For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of this Part, funds in trust in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and
 - iii. In addition to these trusts, the group shall maintain a trustee surplus of which \$100 million shall be held jointly for the benefit of the U.S. domiciled ceding insurers of any member of the group for all the years of account.
 - b. The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members. The group shall, within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, provide to the Director:
 - i. An annual certification by the group's domiciliary regulator of the solvency of each underwriter member of the group; or
 - ii. If a certification is unavailable, a financial statement, prepared by independent public accountants, of each underwriter member of the group.
4. The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholders surplus of \$10 billion (calculated and reported in substantially the same manner as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the NAIC) and which has continuously transacted an insurance business

outside the United States for at least three years immediately prior to making application for accreditation, shall:

- a. Consist of funds in trust in an amount no less than the assuming insurers' several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group;
 - b. Maintain a joint trustee surplus of which \$100 million shall be held jointly for the benefit of U.S. domiciled ceding insurers of any member of the group; and
 - c. File a properly executed Form AR-1 (Exhibit A) as evidence of the submission to the Director's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination.
 - d. Within 90 days after the statements are due to be filed with the group's domiciliary regulator, the group shall file with the Director an annual certification of each underwriter member's solvency by the member's domiciliary regulators, and financial statements, prepared by independent public accountants, of each underwriter member of the group.
- C. Credit for reinsurance shall not be granted unless the form of the trust and any amendments to the trust have been approved by either the commissioner of the state where the trust is domiciled or the commissioner of another state who, pursuant to the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust. The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled.
1. The trust instrument shall provide that:
 - a. Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied 30 days after entry of the final order of any court of competent jurisdiction in the United States;
 - b. Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's U.S. ceding insurers, their assigns and successors in interest;
 - c. The trust shall be subject to examination as determined by the commissioner;
 - d. The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under reinsurance agreements subject to the trust; and
 - e. No later than February 28 of each year the trustee of the trust shall report to the commissioner in writing setting forth the balance in the trust and listing the trust's investments at the preceding year-end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the following December 31.
 2. Notwithstanding any other provisions in the trust instrument;
 - a. If the trust fund is inadequate because it contains an amount less than the amount required by this Section or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of

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competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight over the trust or other designated receiver all of the assets of the trust fund.

- b. The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight over the trust in accordance with the laws of the state in which the trust is domiciled applicable to the liquidation of domestic insurance companies.
 - c. If the commissioner with regulatory oversight over the trust determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the U.S. beneficiaries of the trust, the commissioner with regulatory oversight over the trust shall return the assets, or any part thereof, to the trustee for distribution in accordance with the trust agreement.
 - d. The grantor shall waive any right otherwise available to it under U.S. law that is inconsistent with this provision.
- D.** For purposes of this Section, the term “liabilities” shall mean the assuming insurer’s gross liabilities attributable to reinsurance ceded by U.S. domiciled insurers excluding liabilities that are otherwise secured by acceptable means, and, shall include:
- 1. For business ceded by domestic insurers authorized to write accident and health, and property and casualty insurance:
 - a. Losses and allocated loss expenses paid by the ceding insurer, recoverable from the assuming insurer;
 - b. Reserves for losses reported and outstanding;
 - c. Reserves for losses incurred but not reported;
 - d. Reserves for allocated loss expenses; and
 - e. Unearned premiums.
 - 2. For business ceded by domestic insurers authorized to write life, health and annuity insurance:
 - a. Aggregate reserves for life policies and contracts net of policy loans and net due, and deferred premiums;
 - b. Aggregate reserves for accident and health policies;
 - c. Deposit funds and other liabilities without life or disability contingencies; and
 - d. Liabilities for policy and contract claims.
- E.** Assets deposited in trusts established pursuant to A.R.S. § 20-3602 and this Section shall be valued according to their current fair market value and shall consist only of cash in U.S. dollars, certificates of deposit issued by a U.S. financial institution as defined in A.R.S. § 20-3601, clean, irrevocable, unconditional, and “evergreen” letters of credit issued or confirmed by a qualified U.S. financial institution as defined in A.R.S. § 20-3601, and investments of the type specified in this subsection, but investments in or issued by an entity controlling, controlled by or under common control with either the grantor or beneficiary of the trust shall not exceed 5% of total investments. No more than 20% of the total of the investments in the trust may be foreign investments authorized under subsections (E)(1)(e), (E)(3), (E)(6)(b), or (E)(7), and no more than 10% of the total of the investments in the trust may be securities denominated in foreign currencies. For purposes of applying the preceding sentence, a depository receipt denominated in U.S. dollars and representing rights conferred by a foreign security shall be classified as a foreign investment denominated in a foreign currency. The assets of a trust established to satisfy the

requirements of A.R.S. § 20-3602 shall be invested only as follows:

- 1. Government obligations that are not in default as to principal or interest that are valid and legally authorized and that are issued, assumed, or guaranteed by:
 - a. The United States or by any agency or instrumentality of the United States;
 - b. A state of the United States;
 - c. A territory, possession, or other governmental unit of the United States;
 - d. An agency or instrumentality of a governmental unit referred to in subsections (E)(1)(b) and (E)(1)(c) if the obligations shall be by law (statutory or otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for making these payments, but shall not be obligations eligible for investment under this subsection (E)(1)(d) if payable solely out of special assessments on properties benefited by local improvements; or
 - e. The government of any other country that is a member of the Organization for Economic Cooperation and Development and whose government obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;
- 2. Obligations that are issued in the United States, or that are dollar denominated and issued in a non-U.S. market, by a solvent U.S. institution (other than an insurance company) or that are assumed or guaranteed by a solvent U.S. institution (other than an insurance company) and that are not in default as to principal or interest if the obligations:
 - a. Are rated A or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC, or if not so rated, are similar in structure and other material respects to other obligations of the same institution that are so rated;
 - b. Are insured by at least one authorized insurer (other than the investing insurer or a parent, subsidiary or affiliate of the investing insurer) licensed to insure obligations in Arizona and, after considering the insurance, are rated AAA (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC; or
 - c. Have been designated as Class One or Class Two by the Securities Valuation Office of the NAIC;
- 3. Obligations issued, assumed or guaranteed by a solvent non-U.S. institution chartered in a country that is a member of the Organization for Economic Cooperation and Development or obligations of U.S. corporations issued in a non-U.S. currency, provided that in either case the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;
- 4. An investment made pursuant to the provisions of subsections (E)(1), (E)(2), or (E)(3) shall be subject to the following additional limitations:
 - a. An investment in or loan upon the obligations of an institution other than an institution that issues mortgage-related securities shall not exceed 5% of the assets of the trust;

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- b. An investment in any one mortgage-related security shall not exceed 5% of the assets of the trust;
 - c. The aggregate total investment in mortgage-related securities shall not exceed 25% of the assets of the trust; and
 - d. Preferred or guaranteed shares issued or guaranteed by a solvent U.S. institution are permissible investments if all of the institution's obligations are eligible as investments under subsections (E)(2)(a) and (E)(2)(c), but shall not exceed 2% of the assets of the trust.
5. As used in this Section:
- a. "Mortgage-related security" means an obligation that is rated AA or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC and that either:
 - i. Represents ownership of one or more promissory notes or certificates of interest or participation in the notes (including any rights designed to assure servicing of, or the receipt or timeliness of receipt by the holders of the notes, certificates, or participation of amounts payable under, the notes, certificates or participation), that: (1) Are directly secured by a first lien on a single parcel of real estate, including stock allocated to a dwelling unit in a residential cooperative housing corporation, upon which is located a dwelling or mixed residential and commercial structure, or on a residential manufactured home as defined in 42 U.S.C.A. 5402(6), whether the manufactured home is considered real or personal property under the laws of the state in which it is located; and (2) Were originated by a savings and loan association, savings bank, commercial bank, credit union, insurance company, or similar institution that is supervised and examined by a federal or state housing authority, or by a mortgagee approved by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.A. 1709 and 1715-b, or, where the notes involve a lien on the manufactured home, by an institution or by a financial institution approved for insurance by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.A. 1703; or
 - ii. Is secured by one or more promissory notes or certificates of deposit or participations in the notes (with or without recourse to the insurer of the notes) and, by its terms, provides for payments of principal in relation to payments, or reasonable projections of payments, or notes meeting the requirements of subsection (E)(5)(a)(i);
 - b. "Promissory note," when used in connection with a manufactured home, shall also include a loan, advance, or credit sale as evidenced by a retail installment sales contract or other instrument.
6. Equity interests.
- a. Investments in common shares or partnership interests of a solvent U.S. institution are permissible if:
 - i. Its obligations and preferred shares, if any, are eligible as investments under this Section; and
 - ii. The equity interests of the institution (except an insurance company) are registered on a national securities exchange as provided in the Securities Exchange Act of 1934, 15 U.S.C. 78a - 78kk or otherwise registered pursuant to that Act, and if otherwise registered, price quotations for them are furnished through a nationwide automated quotations system approved by the Financial Industry Regulatory Authority, or successor organization. A trust shall not invest in equity interests under this Section an amount exceeding 1% of the assets of the trust even though the equity interests are not so registered and are not issued by an insurance company;
 - b. Investments in common shares of a solvent institution organized under the laws of a country that is a member of the Organization for Economic Cooperation and Development, if:
 - i. All its obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC; and
 - ii. The equity interests of the institution are registered on a securities exchange regulated by the government of a country that is a member of the Organization for Economic Cooperation and Development;
 - c. An investment in or loan upon any one institution's outstanding equity interests shall not exceed 1% of the assets of the trust. The cost of an investment in equity interests made pursuant to this subsection (E)(6), when added to the aggregate cost of other investments in equity interests then held pursuant to this subsection (E)(6), shall not exceed 10% of the assets in the trust;
7. Obligations issued, assumed or guaranteed by a multinational development bank, provided the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC.
8. Investment companies.
- a. Securities of an investment company registered pursuant to the Investment Company Act of 1940, 15 U.S.C. 80a, are permissible investments if the investment company:
 - i. Invests at least 90% of its assets in the types of securities that qualify as an investment under subsection (E)(1), (E)(2), or (E)(3) or invests in securities that are determined by the Director to be substantively similar to the types of securities set forth in subsection (E)(1), (E)(2), or (E)(3); or
 - ii. Invests at least 90% of its assets in the types of equity interests that qualify as an investment under subsection (E)(6)(a);
 - b. Investments made by a trust in investment companies under this subsection (E)(8) shall not exceed the following limitations:
 - i. An investment in an investment company qualifying under subsection (E)(8)(a)(i) shall not exceed 10% of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall not exceed 25% of the assets in the trust, and

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- ii. Investments in an investment company qualifying under subsection (E)(8)(a)(ii) shall not exceed 5% of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall be included when calculating the permissible aggregate value of equity interests pursuant to subsection (E)(6)(a).
- 9. Letters of Credit.
 - a. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the Director) to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.
 - b. The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct, or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct.

F. A specific security provided to a ceding insurer by an assuming insurer pursuant to Section R20-6-A1607 shall be applied, until exhausted, to the payment of liabilities of the assuming insurer to the ceding insurer holding the specific security prior to, and as a condition precedent for, presentation of a claim by the ceding insurer for payment by a trustee of a trust established by the assuming insurer pursuant to this Section.

Historical Note

New Section R20-6-A1604 renumbered from R20-6-1604 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant phrase “of this Section” was removed when followed by a subsection reference (Supp. 22-1).

R20-6-A1605. Credit for Reinsurance – Certified Reinsurers

- A. Pursuant to A.R.S. §§ 20-3602(G), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that has been certified as a reinsurer in Arizona at all times for which statutory financial statement credit for reinsurance is claimed under this Section. The credit allowed shall be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the Director. The security shall be in a form consistent with the provisions of A.R.S. §§ 20-3602(G), and 20-3603 and R20-6-A1608 or R20-6-A1609(A). The amount of security required in order for full credit to be allowed shall correspond with the following requirements:
 - 1.

Ratings	Security Required
a. Secure-1	0%
b. Secure-2	10%
c. Secure-3	20%
d. Secure-4	50%
e. Secure-5	75%
f. Vulnerable-6	100%
 - 2. Affiliated reinsurance transactions shall receive the same opportunity for reduced security requirements as all other reinsurance transactions.
 - 3. The Director shall require the certified reinsurer to post 100%, for the benefit of the ceding insurer or its estate, security upon the entry of an order of rehabilitation, liquidation, or conservation against the ceding insurer.

- 4. In order to facilitate the prompt payment of claims, a certified reinsurer shall not be required to post security for catastrophe recoverables for a period of one year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the Director. The one year deferral period is contingent upon the certified reinsurer continuing to pay claims in a timely manner. Reinsurance recoverables for only the following lines of business as reported on the NAIC annual financial statement related specifically to the catastrophic occurrence will be included in the deferral:
 - a. Line 1: Fire
 - b. Line 2: Allied Lines
 - c. Line 3: Farmowners multiple peril
 - d. Line 4: Homeowners multiple peril
 - e. Line 5: Commercial multiple peril
 - f. Line 9: Inland Marine
 - g. Line 12: Earthquake
 - h. Line 21: Auto physical damage
- 5. Credit for reinsurance under this Section shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. Any reinsurance contract entered into prior to the effective date of the certification of the assuming insurer that is subsequently amended after the effective date of the certification of the assuming insurer, or a new reinsurance contract covering any risk for which collateral was provided previously, shall only be subject to this Section with respect to losses incurred and reserves reported from and after the effective date of the amendment or new contract.
- 6. Nothing in this Section shall prohibit the parties to a reinsurance agreement from agreeing to provisions establishing security requirements that exceed the minimum security requirements established for certified reinsurers under this Section.

B. Certification Procedure.

- 1. The Director shall post notice on the insurance department's website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The Director may not take final action on the application until at least 30 days after posting the notice required by this subsection (B)(1).
- 2. The Director shall issue written notice to an assuming insurer that has made application and been approved as a certified reinsurer. Included in such notice shall be the rating assigned the certified reinsurer in accordance with subsection (A). The Director shall publish a list of all certified reinsurers and their ratings.
- 3. In order to be eligible for certification, the assuming insurer shall meet the following requirements:
 - a. The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction, as determined by the Director pursuant to subsection (C).
 - b. The assuming insurer must maintain capital and surplus, or its equivalent, of no less than \$250 million calculated in accordance with subsection (B)(4)(h). This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least

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- \$250 million and a central fund containing a balance of at least \$250 million.
- c. The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the Director. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. These financial strength ratings will be one factor used by the Director in determining the rating that is assigned to the assuming insurer. Acceptable rating agencies include the following:
 - i. Standard & Poor's;
 - ii. Moody's Investors Service;
 - iii. Fitch Ratings;
 - iv. A.M. Best Company; or
 - v. Any other Nationally Recognized Statistical Rating Organization.
 - d. The certified reinsurer must comply with any other requirements reasonably imposed by the Director.
4. Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, the following:
 - a. The certified reinsurer's financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as outlined in the Table 1. The Director shall use the lowest financial strength rating received from an approved rating agency in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least two financial strength ratings from acceptable rating agencies will result in loss of eligibility for certification as outlined in Table 1.
 - b. The business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations;
 - c. For certified reinsurers domiciled in the U.S., a review of the most recent applicable NAIC Annual Statement Blank, either Schedule F (for property/casualty reinsurers) or Schedule S (for life and health reinsurers);
 - d. For certified reinsurers not domiciled in the U.S., a review annually of Form CR-F (instructions attached as Exhibit C) for property/casualty reinsurers or Form CR-S (instructions attached as Exhibit D) for life and health reinsurers;
 - e. The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers' Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than 90 days past due or are in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership;
 - f. Regulatory actions against the certified reinsurer;
 - g. The report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in subsection (B)(4)(h);
 - h. For certified reinsurers not domiciled in the U.S., audited financial statements, regulatory filings, and actuarial opinion (as filed with the non-U.S. jurisdiction supervisor, with a translation into English). Upon the initial application for certification, the Director will consider audited financial statements for the last two years filed with its non-U.S. jurisdiction supervisor;
 - i. The liquidation priority of obligations to a ceding insurer in the certified reinsurer's domiciliary jurisdiction in the context of an insolvency proceeding;
 - j. A certified reinsurer's participation in any solvent scheme of arrangement, or similar procedure, which involves U.S. ceding insurers. The Director shall receive prior notice from a certified reinsurer that proposes participation by the certified reinsurer in a solvent scheme of arrangement; and
 - k. Any other information deemed relevant by the Director.
 5. Based on the analysis conducted under subsection (B)(4)(e) of a certified reinsurer's reputation for prompt payment of claims, the Director may make appropriate adjustments in the security the certified reinsurer is required to post to protect its liabilities to U.S. ceding insurers, provided that the Director shall, at a minimum, increase the security the certified reinsurer is required to post by one rating level under subsection (B)(4)(a) if the Director finds that:
 - a. More than 15% of the certified reinsurer's ceding insurance clients have overdue reinsurance recoverables on paid losses of 90 days or more which are not in dispute and which exceed \$100 thousand for each cedent; or
 - b. The aggregate amount of reinsurance recoverables on paid losses which are not in dispute that are overdue by 90 days or more exceeds \$50 million.
 6. The assuming insurer must submit a properly executed Form CR-1 (attached as Exhibit B) as evidence of its submission to the jurisdiction of Arizona, appointment of the Director as an agent for service of process in Arizona, and agreement to provide security for 100% of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers if it resists enforcement of a final U.S. judgment. The Director shall not certify any assuming insurer that is domiciled in a jurisdiction that the Director has determined does not adequately and promptly enforce final U.S. judgments or arbitration awards.
 7. The certified reinsurer must agree to meet applicable information filing requirements as determined by the Director, both with respect to an initial application for certification and on an ongoing basis. All information submitted by certified reinsurers which are not otherwise public information subject to disclosure shall be exempted from disclosure under A.R.S. § 20-158 and shall be withheld from public disclosure. The applicable information filing requirements are, as follows:
 - a. Notification within ten days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license or any change in rating by an approved rating agency,

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- including a statement describing such changes and the reasons therefore;
- b. Annually, Form CR-F or CR-S, as applicable;
 - c. Annually, the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in subsection (B)(7)(d);
 - d. Annually, the most recent audited financial statements, regulatory filings, and actuarial opinion (as filed with the certified reinsurer's supervisor, with a translation into English). Upon the initial certification, audited financial statements for the last two years filed with the certified reinsurer's supervisor;
 - e. At least annually, an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers;
 - f. A certification from the certified reinsurer's domestic regulator that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level; and
 - g. Any other information that the Director may reasonably require.
8. Change in Rating or Revocation of Certification.
 - a. In the case of a downgrade by a rating agency or other disqualifying circumstance, the Director shall upon written notice assign a new rating to the certified reinsurer in accordance with the requirements of subsection (B)(4)(a).
 - b. The Director shall have the authority to suspend, revoke, or otherwise modify a certified reinsurer's certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this Section, or if other financial or operating results of the certified reinsurer, or documented significant delays in payment by the certified reinsurer, lead the Director to reconsider the certified reinsurer's ability or willingness to meet its contractual obligations.
 - c. If the rating of a certified reinsurer is upgraded by the Director, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the Director shall require the certified reinsurer to post security under the previously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the Director, the Director shall require the certified reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer.
 - d. Upon revocation of the certification of a certified reinsurer by the Director, the assuming insurer shall be required to post security in accordance with R20-6-A1607 in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust in accordance with R20-6-A1604, the Director may allow additional credit equal to the ceding insurer's pro rata share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer's rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of three months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the Director to be at high risk of uncollectibility.
 - C. Qualified Jurisdictions.
 1. If, upon conducting an evaluation under this Section with respect to the reinsurance supervisory system of any non-U.S. assuming insurer, the Director determines that the jurisdiction qualifies to be recognized as a qualified jurisdiction, the Director shall publish notice and evidence of such recognition in an appropriate manner. The Director may establish a procedure to withdraw recognition of those jurisdictions that are no longer qualified.
 2. In order to determine whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the Director shall evaluate the reinsurance supervisory system of the non-U.S. jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. jurisdiction to reinsurers licensed and domiciled in the U.S. The Director shall determine the appropriate approach for evaluating the qualifications of such jurisdictions, and create and publish a list of jurisdictions whose reinsurers may be approved by the Director as eligible for certification. A qualified jurisdiction must agree to share information and cooperate with the Director with respect to all certified reinsurers domiciled within that jurisdiction. Additional factors to be considered in determining whether to recognize a qualified jurisdiction, in the discretion of the Director, include but are not limited to the following:
 - a. The framework under which the assuming insurer is regulated.
 - b. The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and financial surveillance.
 - c. The substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction.
 - d. The form and substance of financial reports required to be filed or made publicly available by reinsurers in the domiciliary jurisdiction and the accounting principles used.
 - e. The domiciliary regulator's willingness to cooperate with U.S. regulators in general and the Director in particular.
 - f. The history of performance by assuming insurers in the domiciliary jurisdiction.
 - g. Any documented evidence of substantial problems with the enforcement of final U.S. judgments in the domiciliary jurisdiction. A jurisdiction will not be considered to be a qualified jurisdiction if the Director has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.
 - h. Any relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the International Association of Insurance Supervisors or successor organization.
 - i. Any other matters deemed relevant by the Director.
 3. A list of qualified jurisdictions shall be published through the NAIC Committee Process. The Director shall consider this list in determining qualified jurisdictions. If the Director approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the Director shall provide thoroughly documented justification with

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respect to the criteria provided under subsections (C)(2)(a) through (C)(2)(i).

4. U.S. jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.
- D. Recognition of Certification Issued by an NAIC Accredited Jurisdiction.**
1. If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the Director has the discretion to defer to that jurisdiction's certification, and to defer to the rating assigned by that jurisdiction, if the assuming insurer submits a properly executed Form CR-1 (Exhibit B) and such additional information as the Director requires. The assuming insurer shall be considered to be a certified reinsurer in Arizona.
 2. Any change in the certified reinsurer's status or rating in the other jurisdiction shall apply automatically in Arizona as of the date it takes effect in the other jurisdiction. The certified reinsurer shall notify the Director of any change in its status or rating within ten days after receiving notice of the change.
 3. The Director may withdraw recognition of the other jurisdiction's rating at any time and assign a new rating in accordance with subsection (B)(8).

4. The Director may withdraw recognition of the other jurisdiction's certification at any time with written notice to the certified reinsurer. Unless the Director suspends or revokes the certified reinsurer's certification in accordance with subsection (B)(8), the certified reinsurer's certification shall remain in good standing in this State for a period of three months, which shall be extended if additional time is necessary to consider the assuming insurer's application for certification in Arizona.

- E. Mandatory Funding Clause.** In addition to the clauses required under R20-6-A1609(B), reinsurance contracts entered into or renewed under this Section shall include a proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this Section for reinsurance ceded to the certified reinsurer.
- F.** The Director shall comply with all reporting and notification requirements that may be established by the NAIC with respect to certified reinsurers and qualified jurisdictions.

Historical Note

New Section R20-6-A1605 renumbered from R20-6-1605 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant phrase "of this Section" and word "below" were removed when by followed a subsection reference (Supp. 22-1).

Table 1. Financial Strength Ratings

Ratings	Best	S&P	Moody's	Fitch
Secure – 1	A++	AAA	Aaa	AAA
Secure – 2	A+	AA+, AA, AA-	Aa1, Aa2, Aa3	AA+, AA, AA-
Secure – 3	A	A+, A	A1, A2	A+, A
Secure – 4	A-	A-	A3	A-
Secure – 5	B++, B+	BBB+, BBB, BBB-	Baa1, Baa2, Baa3	BBB+, BBB, BBB-
Vulnerable – 6	B, B-C++, C+, C, C-, D, E, F	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C	BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, DD

Historical Note

Table 1 renumbered from R20-6-1605 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

R20-6-A1606. Credit for Reinsurance - Reciprocal Jurisdictions; Credit for Reinsurance Required by Law

- A.** Credit for reinsurance to a reciprocal jurisdiction assuming insurer. Pursuant to A.R.S. § 20-3602(H), (I), (J), (K), (L), and (R), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is licensed to write reinsurance by, and has its head office or is domiciled in, a reciprocal jurisdiction, and which meets the other requirements of this Part.
- B.** A "reciprocal jurisdiction" is a jurisdiction, as designated by the Director pursuant to subsection (D) that meets one of the following:
1. A non-U.S. jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member state of the European Union. For purposes of this subsection, a "covered agreement" is an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a con-

dition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

2. A U.S. jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or
3. A qualified jurisdiction, as determined by the Director pursuant to A.R.S. § 20-3602(G)(3) and Section R20-6-A1605(C), which is not otherwise described in subsections (B)(1) or (B)(2) and which the Director determines meets all of the following additional requirements:
 - a. Provides that an insurer who has its head office or is domiciled in such qualified jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance is received for reinsurance assumed by insurers domiciled in such qualified jurisdiction;
 - b. Does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by the non-U.S. jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

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- c. Recognizes the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by a competent regulatory authority, in such qualified jurisdiction, that insurers and insurance groups who are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the Director or the commissioner of the domiciliary state and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the qualified jurisdiction; and
 - d. Provides written confirmation by a competent regulatory authority in such qualified jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the Director in accordance with a memorandum of understanding or similar document between the Director and such qualified jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.
- C. Credit shall be allowed when the reinsurance is ceded from an insurer domiciled in this state to a reciprocal jurisdiction assuming insurer meeting each of these conditions:
 - 1. The assuming insurer must be licensed to transact insurance by, and have its head office or be domiciled in, a reciprocal jurisdiction;
 - 2. The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, and confirmed as set forth in subsection (C)(7) according to the methodology of its domiciliary jurisdiction, in the following amounts:
 - a. No less than \$250 million; or
 - b. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters:
 - i. Minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least \$250 million; and
 - ii. A central fund containing a balance of the equivalent of at least \$250 million.
 - 3. The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, as follows:
 - a. If the assuming insurer has its head office or is domiciled in a reciprocal jurisdiction as defined in subsection (B)(1), the ratio specified in the applicable covered agreement;
 - b. If the assuming insurer is domiciled in a reciprocal jurisdiction as defined in subsection (B)(2), a risk-based capital (RBC) ratio of 300% of the authorized control level, calculated in accordance with the formula developed by the NAIC; or
 - c. If the assuming insurer is domiciled in a reciprocal jurisdiction as defined in subsection (B), after consultation with the reciprocal jurisdiction and considering any recommendations published through the NAIC Committee Process, such solvency or capital ratio as the Director determines to be an effective measure of solvency.
- 4. The assuming insurer must agree to and provide adequate assurance, in the form of a properly executed Form RJ-1 (Exhibit E), of its agreement to the following:
 - a. The assuming insurer must agree to provide prompt written notice and explanation to the Director if it falls below the minimum requirements set forth in subsections (C)(2) or (C)(3), or if any regulatory action is taken against it for serious noncompliance with applicable law;
 - b. The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the Director as agent for service of process.
 - i. The Director may also require that such consent be provided and included in each reinsurance agreement under the Director's jurisdiction.
 - ii. Nothing in this provision shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;
 - c. The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained;
 - d. Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its estate, if applicable;
 - e. The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement, which involved this state's ceding insurers, and agrees to notify the ceding insurer and the Director and to provide 100% security to the ceding insurer consistent with the terms of the scheme, should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of A.R.S. §§ 20-3602(G) and 20-3603, R20-6-A1608, or R20-6-A1609(A). For purposes of this Section, the term "solvent scheme of arrangement" means a foreign or alien statutory or regulatory compromise procedure subject to requisite majority creditor approval and judicial sanction in the assuming insurer's home jurisdiction either to finally commute liabilities of duly noticed class members or creditors of a solvent debtor, or to reorganize or restructure the debts and obligations of a solvent debtor on a final basis, and which may be subject to judicial recognition and enforcement of the arrangement by a

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governing authority outside the ceding insurer's home jurisdiction; and

- f. The assuming insurer must agree in writing to meet the applicable information filing requirements as set forth in subsection (C)(5).
5. The assuming insurer or its legal successor must provide, if requested by the Director, on behalf of itself and any legal predecessors, the following documentation to the Director:
 - a. For the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, the assuming insurer's annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report;
 - b. For the two years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer's supervisor;
 - c. Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States; and
 - d. Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, information regarding the assuming insurer's assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer to allow for the evaluation of the criteria set forth in subsection (C)(6).
6. The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met:
 - a. More than 15% of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported by the Director;
 - b. More than 15% of the assuming insurer's ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer \$100 thousand, or as otherwise specified in a covered agreement; or
 - c. The aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds \$50 million, or as otherwise specified in a covered agreement.
7. The assuming insurer's supervisory authority must confirm to the Director on an annual basis that the assuming insurer complies with the requirements set forth in subsections (C)(2) and (C)(3).
8. Nothing in this provision precludes an assuming insurer from providing the Director with information on a voluntary basis.
- D.** The Director shall timely create and publish a list of reciprocal jurisdictions.
 1. A list of reciprocal jurisdictions is published through the NAIC committee process. The Director's list shall include any reciprocal jurisdiction as defined under subsections (B)(1) and (B)(2), and shall consider any other reciprocal jurisdiction included on the NAIC list. The Director may approve a jurisdiction that does not appear on the NAIC list of reciprocal jurisdictions as provided by applicable law, regulation, or in accordance with criteria published through the NAIC committee process.
 2. The Director may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets one or more of the requirements of a reciprocal jurisdiction, as provided by applicable law, regulation, or in accordance with a process published through the NAIC committee process, except that the Director shall not remove from the list a reciprocal jurisdiction as defined under subsections (B)(1) and (B)(2). Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an assuming insurer domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to A.R.S. Title 20, Chapter 30 and this Part.
- E.** The Director shall timely create and publish a list of reciprocal jurisdiction assuming insurers that have satisfied the conditions set forth in this Section and to which cessions shall be granted credit in accordance with this subsection.
 1. If an NAIC accredited jurisdiction has determined that the conditions set forth in subsection (C) have been met, the Director has the discretion to defer to that jurisdiction's determination, and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit in accordance with this subsection. The Director may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirement of subsection (C).
 2. When requesting that the Director defer to another NAIC accredited jurisdiction's determination, an assuming insurer must submit a properly executed Form RJ-1 (Appendix E) and additional information as the Director may require. A state that has received such a request will notify other states through the NAIC committee process and provide relevant information with respect to the determination of eligibility.
- F.** If the Director determines that a reciprocal jurisdiction assuming insurer no longer meets one or more of the requirements under this Section, the Director may revoke or suspend the eligibility of the reciprocal jurisdiction assuming insurer for recognition under this Section.
 1. While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with R20-6-A1607.
 2. If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the Director and consistent with the provisions of R20-6-A1607.
- G.** Before denying statement credit or imposing a requirement to post security with respect to subsection (F) or adopting any similar requirement that will have substantially the same regulatory impact as security, the Director shall:

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1. Communicate with the ceding insurer, the assuming insurer, and the assuming insurer's supervisory authority that the assuming insurer no longer satisfies one of the conditions listed in subsection (C);
 2. Provide the assuming insurer with 30 days from the initial communication to submit a plan to remedy the defect, and 90 days from the initial communication to remedy the defect, except in exceptional circumstances in which a shorter period is necessary for policyholder and other consumer protection;
 3. After the expiration of 90 days or less, as set out in subsection (G)(2), if the Director determines that no or insufficient action was taken by the assuming insurer, the Director may impose any of the requirements as set out in this subsection (G); and
 4. Provide a written explanation to the assuming insurer of any of the requirements set out in this subsection (G).
- H.** If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring the reciprocal jurisdiction assuming insurer to post security for all outstanding liabilities.
- I.** Credit for reinsurance required by law. Pursuant to A.R.S. § 20-3602(M), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of A.R.S. §§ 20-3602(C) through (G) but only as to the insurance of risks located in jurisdictions where the reinsurance is required by the applicable law or regulation of that jurisdiction. As used in this Section, "jurisdiction" means state, district, or territory of the United States and any lawful national government.

Historical Note

New Section R20-6-A1606 renumbered from R20-6-1606 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant phrase "of this Section" and word "above" were removed when followed by a subsection reference (Supp. 22-1).

R20-6-A1607. Asset or Reduction from Liability for Reinsurance Ceded to an Unauthorized Assuming Insurer not Meeting the Requirements of R20-6-A1601 through R20-6-A1606

- A.** Pursuant to A.R.S. § 20-3603, the Director shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of A.R.S. § 20-3602 in an amount not exceeding the liabilities carried by the ceding insurer. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations under the reinsurance contract. The security shall be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution as defined in A.R.S. § 20-3601. This security may be in the form of any of the following:
1. Cash;
 2. Securities listed by the Securities Valuation Office of the NAIC, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;
 3. Clean, irrevocable, unconditional, and "evergreen" letters of credit issued or confirmed by a qualified United States institution, as defined in A.R.S. § 20-3601, effective no later than December 31 of the year for which filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or
 4. Any other form of security acceptable to the Director.
- B.** An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to this Section shall be allowed only when the requirements of R20-6-A1609(B) and the applicable portions of R20-6-A1608 or R20-6-A1609(A) have been satisfied.

Historical Note

New Section R20-6-A1606 renumbered from R20-6-1606 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant word "Section" was removed before a Chapter Section number (Supp. 22-1).

R20-6-A1608. Trust Agreements Qualified under R20-6-A1607; Letters of Credit Qualified under R20-6-A1607

- A.** Trust agreements - definitions. As used in subsections (B) through (G):
1. "Beneficiary" includes any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver, or conservator.
 2. "Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.
 3. "Obligations," as used in subsection (B)(11), means:
 - a. Reinsured losses and allocated loss expenses paid by the ceding company but not recovered from the assuming insurer;
 - b. Reserves for reinsured losses reported and outstanding;
 - c. Reserves for reinsured losses incurred but not reported; and
 - d. Reserves for allocated reinsured loss expenses and unearned premiums.
- B.** Trust agreements - required conditions.
1. The trust agreement shall be entered into between the beneficiary, the grantor, and a trustee which shall be a qualified United States financial institution as defined in A.R.S. § 20-3601.
 2. The trust agreement shall create a trust account into which assets shall be deposited.
 3. All assets in the trust account shall be held by the trustee at the trustee's office in the United States.
 4. The trust agreement shall provide that:
 - a. The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;
 - b. No other statement or document is required to be presented in order to withdraw assets, except that the

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- beneficiary may be required to acknowledge receipt of withdrawn assets;
- c. It is not subject to any conditions or qualifications outside of the trust agreement; and
 - d. It shall not contain references to any other agreements or documents except as provided for in subsections (B)(11) and (B)(12).
5. The trust agreement shall be established for the sole benefit of the beneficiary.
 6. The trust agreement shall require the trustee to:
 - a. Receive assets and hold all assets in a safe place;
 - b. Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;
 - c. Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;
 - d. Notify the grantor and the beneficiary within ten days, of any deposits to or withdrawals from the trust account;
 - e. Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title, and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and
 - f. Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.
 7. The trust agreement shall provide that at least 30 days, but not more than 45 days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.
 8. The trust agreement shall be made subject to and governed by the laws of the state in which the trust is domiciled.
 9. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying commission to, or reimbursing the expenses of, the trustee. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the Director), to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.
 10. The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct, or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct.
 11. Notwithstanding other provisions of subsections (A) through (G), when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities, and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:
 - a. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;
 - b. To make payment to the assuming insurer of any amounts held in the trust account that exceed 102% of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or
 - c. Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution as defined in A.R.S. § 20-3601 apart from its general assets, in trust for such uses and purposes specified in subsections (11)(a) and (11)(b) as may remain executory after such withdrawal and for any period after the termination date.
 12. Notwithstanding other provisions of subsections (A) through (G), when a trust agreement is established to meet the requirements of R20-6-A1607 in conjunction with a reinsurance agreement covering life, annuities, or accident and health risks, where it is customary to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:
 - a. To pay or reimburse the ceding insurer for:
 - i. The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of the policies; and
 - ii. The assuming insurer's share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurer, under the terms and provision of the policies reinsured under the reinsurance agreement.
 - b. To pay to the assuming insurer amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer, or
 - c. Where the ceding insurer has received notification of termination of the trust and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten days prior to the termination date, to

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withdraw amounts equal to the assuming insurer's share of liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer, and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U.S. financial institution apart from its general assets, in trust for the uses and purposes specified in subsections (12)(a) and (12)(b) as may remain executory after withdrawal and for any period after the termination date.

13. Either the reinsurance agreement or the trust agreement must stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash in United States dollars, certificates of deposit issued by a United States bank and payable in United States dollars, and investments permitted by the Insurance Code, or any combination of the above, provided investments in or issued by an entity controlling, controlled by, or under common control with either the grantor or the beneficiary of the trust shall not exceed 5% of total investments. The agreement may further specify the types of investments to be deposited. If the reinsurance agreement covers life, annuities, or accident and health risks, then the provisions required by this subsection must be included in the reinsurance agreement.

C. Trust agreements - permitted conditions.

1. The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than 90 days after the beneficiary and grantor receive the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after the trustee and the beneficiary receive the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.
2. The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.
3. The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions that the trustee determines are at least equal in current fair market value to the assets withdrawn and that are consistent with the restrictions in subsection (D)(1)(b).
4. The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.
5. The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn

by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

D. Trust agreements - additional conditions applicable to reinsurance agreements:

1. A reinsurance agreement may contain provisions that:
 - a. Require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what the agreement is to cover;
 - b. Require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations, or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity;
 - c. Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and
 - d. Stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver, or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:
 - i. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies; and
 - ii. To pay or reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement; and
 - iii. To pay or reimburse the ceding insurer for any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding reinsurer; or
 - iv. To make payment to the assuming insurer of amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.
2. The reinsurance agreement also may contain provisions that:
 - a. Give the assuming insurer the right to seek approval from the ceding insurer, which shall not be unreasonably or arbitrarily withheld, to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:

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- i. The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a current fair market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount, or
 - ii. After withdrawal and transfer, the current fair market value of the trust account is no less than 102% of the required amount.
 - b. Provide for the return of any amount withdrawn in excess of the actual amounts required for subsection (D)(1)(d), and for interest payments at a rate not in excess of the prime rate of interest on such amounts;
 - c. Permit the award by any arbitration panel or court of competent jurisdiction of:
 - i. Interest at a rate different from that provided in subsection (D)(2)(b);
 - ii. Court or arbitration costs;
 - iii. Attorney's fees; and
 - iv. Any other reasonable expenses.
- E. Trust agreements - financial reporting. A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with the Director in compliance with the provisions of this Part when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.
- F. Trust agreements - existing agreements. Notwithstanding the effective date of this Part, any trust agreement or underlying reinsurance agreement in existence and approved by the Director prior to the effective date of this Part will continue to be acceptable until December 31, 2016, at which time the agreements will have to fully comply with subsections (A) through (G) for the trust agreement to be acceptable.
- G. Trust agreements - failure to identify beneficiary. The failure of any trust agreement to specifically identify the beneficiary as defined in subsection (A)(1) shall not be construed to affect any actions or rights that the Director may take or possess pursuant to the provisions of the laws of Arizona.
- H. Letters of credit. The letter of credit must be clean, irrevocable, unconditional, and issued or confirmed by a qualified United States financial institution as defined A.R.S. § 20-3601. The letter of credit shall contain an issue date and expiration date and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit also shall indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in subsection (N)(1). As used in this Section, "beneficiary" includes any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver, or conservator. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator, or liquidator).
- I. Letters of credit - heading. The heading of the letter of credit may include a boxed section containing the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.
- J. Letters of credit - required statements and clauses.
 - 1. A letter of credit shall contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.
 - 2. The letter of credit shall state whether it is subject to and governed by the laws of Arizona or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98). All drafts of letters of credit drawn according to UCP 600 or ISP98 shall be presentable at an office in the United States of a qualified United States financial institution.
 - 3. The letter of credit shall contain an "evergreen clause" in compliance with subsection (K).
- K. Letters of credit - term of the letter of credit. The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause" that prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" shall provide for no less than 30 days' notice prior to expiration date or nonrenewal.
- L. Letters of credit made subject to UCP 600 or ISP98. If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), then the letter of credit shall specifically address and provide for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 36 of UCP 600 occur.
- M. Letters of credit - additional requirements. If the letter of credit is issued by a financial institution authorized to issue letters of credit, other than a qualified United States financial institution as described in subsection (H), then the following additional requirements shall be met:
 - 1. The issuing financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts; and
 - 2. The "evergreen clause" shall provide for 30 days' notice prior to expiration date or nonrenewal.
- N. Letters of credit - reinsurance agreement provisions.
 - 1. The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions that:
 - a. Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover;
 - b. Stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:
 - i. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific

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- reinsurance agreement of premiums returned, but not yet recovered from the assuming insurers, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;
- ii. To pay or reimburse the ceding insurer for the assuming insurer's share, under the specific reinsurance agreement, of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurers, under the terms and provisions of the policies reinsured under the reinsurance agreement; and
 - iii. To pay or reimburse the ceding insurer for any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer;
 - iv. Where the letter of credit will expire without renewal or be reduced or replaced by a letter of credit for a reduced amount and where the assuming insurer's entire obligations under the reinsurance agreement remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of the liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer and exceed the amount of any reduced or replacement letter of credit, and deposit those amounts in a separate account in the name of the ceding insurer in a qualified U.S. financial institution apart from its general assets, in trust for such uses and purposes specified in subsections (N)(1)(b)(i), (N)(1)(b)(ii), and (N)(1)(b)(iii) as may remain after withdrawal and for any period after the termination date.
- c. All of the provisions of subsections (N)(1)(a) and (N)(1)(b) shall be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.
2. Nothing contained in subsection (N)(1) shall preclude the ceding insurer and assuming insurer from providing for:
 - a. An interest payment, at a rate not in excess of the prime rate of interest on the amounts held pursuant to subsection (N)(1)(b); or
 - b. The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or any amounts that are subsequently determined not to be due.

Historical Note

New Section R20-6-A1608 renumbered from R20-6-1608 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant phrase "of this Section" was removed when followed by a subsection reference, and the word "Section" was removed before a Chapter Section number (Supp. 22-1).

R20-6-A1609. Other Security; Reinsurance Contract; Contracts Affected

- A. Other Security. A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control.
- B. Reinsurance Contract. Credit will not be granted, nor an asset or reduction from liability allowed, to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of R20-6-A1601 through R20-6-A1605 or R20-6-A1607 of this Article or otherwise in compliance with A.R.S. § 20-3602 after the adoption of this Part unless the reinsurance agreement:
 1. Includes a proper insolvency clause, which stipulates that reinsurance is payable directly to the liquidator or successor without diminution regardless of the status of the ceding company, pursuant to A.R.S. § 20-261(C);
 2. Includes a provision pursuant to A.R.S. § 20-3602 whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute-resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give the court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of the court or panel; and
 3. Includes a proper reinsurance intermediary clause, if applicable, which stipulates that the credit risk for the intermediary is carried by the assuming insurer.
- C. Contracts affected. All new and renewal reinsurance transactions entered into after the effective date of this Part shall conform to the requirements of A.R.S. Title 20, Chapter 30 and this Part if credit is to be given to the ceding insurer for such reinsurance.

Historical Note

New Section R20-6-A1609 renumbered from R20-6-1609 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant word "Section" was removed before a Chapter Section number (Supp. 22-1).

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FORM AR-1, CERTIFICATE OF ASSUMING INSURER

Adopted effective February 3, 1993 (Supp. 93-1). Exhibit A amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). Exhibit A amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

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Exhibit B. Form CR-1, Certificate of Certified Reinsurer**FORM CR-1, CERTIFICATE OF CERTIFIED REINSURER**

I, _____, _____
(name of officer) (title of officer)
of _____, the assuming insurer under
(name of assuming insurer)

a reinsurance agreement with one or more insurers domiciled in _____
(name of state)

in order to be considered for approval in this state, hereby certify that

(name of assuming insurer) ("Assuming Insurer");

1. Submits to the jurisdiction of any court of competent jurisdiction in _____ for the adjudication of any issue arising out of the (ceding insurer's state of domicile) reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement.
2. Designates the Insurance Commissioner of _____ (ceding insurer's state of domicile) as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.
3. Agrees to provide security in an amount equal to 100% of liabilities attributable to U.S. ceding insurers if it resists enforcement of a final U.S. judgment or properly enforceable arbitration award.
4. Agrees to provide notification within 10 days of any regulatory actions taken against it, any change in the provisions of its domiciliary license or any change in its rating by an approved rating agency, including a statement describing such changes and the reasons therefore.
5. Agrees to annually file information comparable to relevant provisions of the NAIC financial statement for use by insurance markets in accordance with this Article.
6. Agrees to annually file the report of the independent auditor on the financial statements of the insurance enterprise.
7. Agrees to annually file audited financial statements, regulatory filings, and actuarial opinion in accordance with this Article.
8. Agrees to annually file an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers.
9. Is in good standing as an insurer or reinsurer with the supervisor of its domiciliary jurisdiction.

Dated: _____

(name of assuming insurer)

BY: _____
(name of officer)

(title of officer)

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). Exhibit B repealed; new Exhibit B made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

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Exhibit C. Form CR-F Instructions**Form CR-F Instructions****Part 1 - Assumed Reinsurance as of December 31, Current Year (000 Omitted)**

Create a spreadsheet with the following columns (total each column 5 through 15):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Name of Reinsured
4. Domiciliary Jurisdiction
5. Assumed Premium
6. Reinsurance on Paid Losses and Loss Adjustment Expenses
7. Reinsurance on Known Case Losses and LAE
8. Cols. 6 + 7
9. Contingent Commissions Payable
10. Assumed Premium Receivable
11. Unearned Premium
12. Funds Held By or Deposited With Reinsured Companies
13. Letters of Credit Posted
14. Amount of Assets Pledged or Compensating Balances to Secure Letters of Credit
15. Amount of Assets Pledged or Collateral Held in Trust

Each row shall list each insurer for which reinsurance is assumed for the calendar year.

Part 2 - Ceded Reinsurance as of December 31, Current Year (000 Omitted)

Create a spreadsheet with the following columns (total each column 6 through 19):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Name of Reinsurer
4. Domiciliary Jurisdiction
5. Reinsurance Contracts Ceding 75% or More of Direct Premiums Written
6. Reinsurance Premiums Ceded
7. Reinsurance Recoverable on Paid Losses
8. Reinsurance Recoverable on Paid LAE
9. Reinsurance Recoverable on Known Case Loss Reserves
10. Reinsurance Recoverable on Known Case LAE Reserves
11. Reinsurance Recoverable on IBNR Loss Reserves
12. Reinsurance Recoverable on IBNR LAE Reserves
13. Reinsurance Recoverable on Unearned Premiums
14. Reinsurance Recoverable on Contingent Commissions
15. Cols. 7 through 14 Totals
16. Reinsurance Payable Ceded Balances Payable
17. Reinsurance Payable Other Amounts Due to Reinsurers
18. Net Amount Recoverable From Reinsurers, Cols. 15 – [16 + 17]
19. Funds Held by Company Under Reinsurance Treaties

Each row shall list each insurer to whom reinsurance was ceded for the calendar year.

Historical Note

Exhibit C made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

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Exhibit D. Form CR-S Instructions**Form CR-S Instructions**

Part 1 – Section 1. Reinsurance Assumed Life Insurance, Annuities, Deposit Funds and Other Liabilities Without Life or Disability Contingencies, and Related Benefits Listed by Reinsured Company as of December 31, Current Year

Create a spreadsheet with the following columns (total each column 7 through 12):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date
4. Name of Reinsured
5. Location
6. Type of Reinsurance Assumed
7. Amount of In Force at End of Year
8. Reserve
9. Premiums
10. Reinsurance Payable on Paid and Unpaid Losses
11. Modified Coinsurance Reserve
12. Funds Withheld Under Coinsurance

Each row shall list each insurer for which reinsurance was assumed (life insurance, annuities, deposit funds and other liabilities without life or disability contingencies, and related benefits) for the calendar year.

Part 1 – Section 2. Reinsurance Assumed Accident and Health Insurance Listed by Reinsured Company as of December 31, Current Year

Please create a spreadsheet with the following columns (total columns 7 through 12):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date
4. Name of Reinsured
5. Domiciliary Jurisdiction
6. Type of Reinsurance Assumed
7. Premiums
8. Unearned Premiums
9. Reserve Liability Other Than For Unearned Premiums
10. Reinsurance Payable on Paid and Unpaid Losses
11. Modified Coinsurance Reserve
12. Funds Withheld Under Coinsurance

Each row shall list each insurer for which reinsurance was assumed (accident and health insurance) for the calendar year.

Part 2. Reinsurance Recoverable on Paid and Unpaid Losses Listed by Reinsuring Company as of December 31, Current Year

Create a spreadsheet with the following columns (total each column 6 and 7):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date
4. Name of Company
5. Location
6. Paid Losses
7. Unpaid Losses

Each row shall list each insurer for which reinsurance on paid and unpaid losses is recoverable.

Part 3 – Section 1. Reinsurance Ceded Life Insurance, Annuities, Deposit Funds and Other Liabilities Without Life or Disability Contingencies, and Related Benefits Listed by Reinsuring Company as of December 31, Current Year

Create a spreadsheet with the following columns (total each column 7 through 14):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date
4. Name of Company
5. Location

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6. Type of Reinsurance Ceded
7. Amount in Force at End of Year
8. Reserve Credit Taken Current Year
9. Reserve Credit Taken Prior Year
10. Premiums
11. Outstanding Surplus Relief Current Year
12. Outstanding Surplus Relief Prior Year
13. Modified Coinsurance Reserve
14. Funds Withheld Under Coinsurance

Each row shall list each insurer for which reinsurance was ceded (life insurance, annuities, deposit funds and other liabilities without life or disability contingencies and related benefits).

Part 3 – Section 2. Reinsurance Ceded Accident and Health Insurance Listed by Reinsuring Company as of December 31, Current Year
Create a spreadsheet with the following columns (total each column 7 through 13):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date
4. Name of Company
5. Location
6. Type
7. Premiums
8. Unearned Premiums (Estimated)
9. Reserve Credit Taken other than for Unearned Premiums
10. Outstanding Surplus Relief Current Year
11. Outstanding Surplus Relief Prior Year
12. Modified Coinsurance Reserve
13. Funds Withheld Under Coinsurance

Each row shall list each insurer for which reinsurance was ceded (accident and health insurance).

Historical Note

Exhibit D made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

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- a. Policies that satisfy the criteria for exemption set forth in A.R.S. § 20-510 and which are issued before the later of:
 - i. The effective date of this Part B; and
 - ii. The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies' statutory reserves, but in no event later than January 1, 2020;
 - b. Portions of policies that satisfy the criteria for exemption set forth in A.R.S. § 20-510 and which are issued before the later of:
 - i. The effective date of this Part B; and
 - ii. The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies' statutory reserves, but in no event later than January 1, 2020;
 - c. Any universal life policy that meets all of the following requirements:
 - i. Secondary guarantee period, if any, if five years or less;
 - ii. Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the Director's Standard Ordinary (CSO) valuation tables and valuation interest rate applicable to the issue year of the policy; and
 - iii. The initial surrender charge is not less than 100% of the first year annualized specified premium for the secondary guarantee period;
 - d. Credit life insurance;
 - i. Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts; or
 - ii. Any group life insurance certificate unless the certificate provides for a stated and implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.
2. Reinsurance ceded to an assuming insurer that meets the applicable requirements of A.R.S. § 20-3602(F); or
 3. Reinsurance ceded to an assuming insurer that meets the applicable requirements of A.R.S. §§ 20-3602(C), (D), or (E), and that, in addition:
 - a. Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual, without any departures from NAIC statutory accounting practices and procedures pertaining to the admissibility or valuation of assets or liabilities that increase the assuming insurer's reported surplus and are material enough that they need to be disclosed in the financial statement of the assuming insurer pursuant to the Statement of Statutory Accounting Principles No. 1 ("SSAP 1"); and
 - b. Is not a Company Action Level Event, Regulatory Action Level Event, Authorized Control Level Event, or Mandatory Control Level Event as those terms are defined in A.R.S. § 20-488 when its Risk-Based Capital ("RBC") is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation; or holder to keep a policy in force over a secondary
 4. Reinsurance ceded to an assuming insurer that meets the applicable requirements of A.R.S. §§ 20-3602(C), (D), or (E), and that, in addition:
 - a. Is not an affiliate, as that term is defined in A.R.S. § 20-481, of:
 - i. The insurer ceding the business to the assuming insurer; or
 - ii. Any insurer that directly or indirectly ceded the business to that ceding insurer;
 - b. Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual;
 - c. Is both:
 - i. Licensed or accredited in at least ten states including its state of domicile; and
 - ii. Not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary, or any other similar licensing regime; and
 - d. Is not, or would not be, below 500% of the Authorized Control Level RBC as that term is defined in A.R.S. § 20-488 when its RBC is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation, and without recognition of any departures from NAIC statutory accounting practices and procedures pertaining to the admission or valuation of assets or liabilities that increase the assuming insurer's reported surplus; or
 5. Reinsurance ceded to an assuming insurer that meets the requirements of A.R.S. § 20-3604(D)(2); or
 6. Reinsurance not otherwise exempt under subsections (B)(1) through (B)(5) if the Director, after consulting with the NAIC Financial Analysis Working Group (FAWG) or other group of regulators designated by the NAIC, as applicable, determines under all the facts and circumstances that all of the following apply:
 - a. The risks are clearly outside of the intent and purpose of this Part B;
 - b. The risks are included within the scope of this regulation only as a technicality; and
 - c. The application of this Part B to those risks is not necessary to provide appropriate protection to policyholders. The Director shall publicly disclose any decision made pursuant to this subsection (B)(6) to exempt a reinsurance treaty from this Part B, as well as the general basis for the decision including a summary of the treaty.
- C. Part B Definitions:
1. "Actuarial Method" means the methodology used to determine the Required Level of Primary Security, as described in R20-6-B1602.
 2. "Covered Policies" means policies, other than Grandfathered Policies and policies that are not exempt under subsection (B), of the following policy types:
 - a. Life insurance policies with guaranteed nonlevel gross premiums and/or guaranteed nonlevel benefits, except for flexible premium universal life insurance policies; or
 - b. Flexible premium universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary

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3. "Grandfathered Policies" means Covered Policies that were:
 - a. Issued prior to January 1, 2015; and
 - b. Ceded, as of December 31, 2014, as part of a reinsurance treaty that would not have met one of the exemptions set forth in subsection (B).
4. "Non-Covered Policies" means any policy that does not meet the definition of Covered Policies, including Grandfathered Policies.
5. "Other Security" means any security acceptable to the Director other than security meeting the definition of Primary Security.
6. "Primary Security" means the following forms of security:
 - a. Cash meeting the requirements of A.R.S. § 20-3603(B)(1);
 - b. Securities listed by the Securities Valuation Office meeting the requirements of A.R.S. § 20-3603(B)(2), but excluding any synthetic letter of credit, contingent note, credit-linked note, or other similar security that operates in a manner similar to a letter of credit excluding any securities issued by the ceding insurer or any of its affiliates; and
 - c. For security held in connection with funds-withheld and modified coinsurance reinsurance treaties:
 - i. Commercial loans in good standing of CM3 quality and higher;
 - ii. Policy loans; and
 - iii. Derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty.
7. "Required Level of Primary Security" means the dollar amount determined by applying the Actuarial Method to the risks ceded with respect to Covered Policies, but not more than the total reserve ceded.
8. "Valuation Manual" means the Valuation Manual adopted by the NAIC as described in A.R.S. § 20-510, with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed.
9. "VM-20" means "Requirements for Principle-Based Reserves for Life Products" including all relevant definitions from the Valuation Manual.
- D. Severability. If any provision of this Part B is held invalid, the remainder shall not be affected.
- E. Prohibition against avoidance. No insurer that has Covered Policies to which this Part B applies, as set forth in subsection (A), shall take any action or series of actions or enter into any transaction or arrangement or series of transactions or arrangements if the purpose of the action, transaction, or arrangement or series is to avoid the requirements of this Part B or to circumvent its purpose and intent.

Historical Note

New Section R20-6-B1601 renumbered from R20-6-1610 and repealed; new Section R20-6-B1601 made by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant phrase "of this Section" was removed when followed by a subsection reference, and the word "Section" was removed before a Chapter Section number (Supp. 22-1).

R20-6-B1602. The Actuarial Method

- A. Actuarial Method. The Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this Part B shall be VM-20, applied on a treaty-by-treaty basis, including all relevant definitions, from the Valuation Manual then in effect, applied as follows:
 1. For Covered Policies described in R20-6-B1601(C)(2)(a), the Actuarial Method is the greater of the Deterministic Reserve or the Net Premium Reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the Covered Policies do not meet the requirements of the Stochastic Reserve exclusion test in the Valuation Manual, then the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR. In addition, if such Covered Policies are reinsured in a reinsurance treaty that also contains Covered Policies described in R20-6-B1601(C)(2)(b), the ceding insurer may elect to instead use subsection (A)(2) as the Actuarial Method for the entire reinsurance agreement. Whether subsection (A)(1) or (A)(2) is used, the Actuarial Method must comply with any requirements or restrictions that the Valuation Manual imposes when aggregating these policy types for purposes of principle-based reserve calculations.
 2. For Covered Policies described in R20-6-B1601(C)(2)(b), the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR regardless of whether the criteria for exemption testing can be met.
 3. Except as provided in subsection (A)(4), the Actuarial Method is to be applied on a gross basis to all risks with respect to the Covered Policies as originally issued or assumed by the ceding insurer.
 4. If the reinsurance treaty cedes less than 100% of the risk with respect to the Covered Policies, then the Required Level of Primary Security may be reduced as follows:
 - a. If a reinsurance treaty cedes only a quota share of some of all of the risks pertaining to the Covered Policies, the Required Level of Primary Security, as well as any adjustment under subsection (A)(4)(c), may be reduced to a pro rata portion in accordance with the percentage of the risk ceded;
 - b. If the reinsurance treaty in a non-exempt arrangement cedes only the risks pertaining to a secondary guarantee, the Required Level of Primary Security may be reduced by an amount determined by applying the Actuarial Method on a gross basis to all risks, other than risks related to the secondary guarantee, pertaining to the Covered Policies, except that for Covered Policies for which the ceding insurer did not elect to apply the provisions of VM-20 to establish statutory reserves, the Required Level of Primary Security may be reduced by the statutory reserve retained by the ceding insurer on those Covered Policies, where the retained reserve of those Covered Policies should be reflective of any reduction pursuant to the cessation of mortality risk on a yearly renewable term basis in an exempt arrangement;
 - c. If a portion of the covered policy risk is ceded to another reinsurer on a yearly renewable term basis in an exempt arrangement, the Required Level of Primary Security may be reduced by the amount resulting by applying the Actuarial Method including the

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reinsurance section of VM-20 to the portion of the covered policy risks ceded in the exempt arrangement, except that for Covered Policies issued prior to January 1, 2017, this adjustment is not to exceed $[cx / (2 * \text{number of reinsurance premiums per year})]$ where cx is calculated using the same mortality table used in calculating the Net Premium Reserve; and

- d. For any other treaty ceding a portion of risk to a different reinsurer, including but not limited to stop loss, excess of loss, and other non-proportional reinsurance treaties, there will be no reduction in the Required Level of Primary Security. It is possible for any combination of subsections (A)(4)(a), (A)(4)(b), (A)(4)(c), and (A)(4)(d) to apply. Such adjustments to the Required Level of Primary Security will be done in the sequence that accurately reflects the portion of the risk ceded via the treaty. The ceding insurer should document the rationale and steps taken to accomplish the adjustments to the Required Level of Primary Security due to the cession of less than 100% of the risk. The adjustments for other reinsurance will be made only with respect to reinsurance treaties entered into directly by the ceding insurer. The ceding insurer will make no adjustment as a result of a retrocession treaty entered into by the assuming insurers.

5. In no event will the Required Level of Primary Security resulting from application of the Actuarial Method exceed the amount of statutory reserves ceded.

6. If the ceding insurer cedes risk with respect to Covered Policies, including any riders, in more than one reinsurance treaty subject to this Part B, in no event will the aggregate Required Level of Primary Security for those reinsurance treaties be less than the Required Level of Primary Security calculated using the Actuarial Method as if all risks ceded in those treaties were ceded in a single treaty subject to this Part B.

7. If a reinsurance treaty subject to this Part B cedes risk on both Covered and Non-Covered Policies, credit for the ceded reserves shall be determined as follows:

- a. The Actuarial Method shall be used to determine the Required Level of Primary Security for the Covered Policies, and R20-6-B1603 shall be used to determine the reinsurance credit for the covered policy reserves; and
- b. Credit for the non-covered policy reserves shall be granted only to the extent that security, in addition to the security held to satisfy the requirements of subsection (A)(7)(a), is held by or on behalf of the ceding insurer in accordance with A.R.S. §§ 20-3602 and 20-3603. Any Primary Security used to meet the requirements of this subsection (A)(7)(b) may not be used to satisfy the Required Level of Primary Security for the Covered Policies.

- B. Valuation used for Purposes of Calculations. For the purposes of both calculating the Required Level of Primary Security pursuant to the Actuarial Method and determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, the following shall apply:

1. For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were

held in the ceding insurer's general account and without taking into consideration the effect of any prescribed or permitted practices; and

2. For all other assets, the valuations are to be those that were assigned to the assets for the purpose of determining the amount of reserve credit taken. In addition, the asset spread tables and asset default cost tables required by VM-20 shall be included in the Actuarial Method if adopted by the NAIC's Life Actuarial (A) Task Force no later than the December 31st on or immediately preceding the valuation date for which the Required Level of Primary Security is being calculated. The tables of asset spreads and asset default costs shall be incorporated into the Actuarial Method in the manner specified in VM-20.

Historical Note

New Section R20-6-B1602 renumbered from R20-6-1611 and repealed; new Section R20-6-B1602 made by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant phrase "of this Section" and word "below" were removed when followed by a subsection reference, and the word "Section" was removed before a Chapter Section number (Supp. 22-1).

R20-6-B1603. Requirements Applicable to Covered Policies to Obtain Credit for Reinsurance; Opportunity for Remediation

- A. Requirements. Subject to the exemptions described in R20-6-B1601(B) and the provisions of subsection (B), credit for reinsurance shall be allowed with respect to ceded liabilities pertaining to Covered Policies pursuant to A.R.S. §§ 20-3602 or 20-3603 if, and only if, in addition to all other requirements imposed by law or regulation, the following requirements are met on a treaty-by-treaty basis:

1. The ceding insurer's statutory policy reserves with respect to the Covered Policies are established in full and in accordance with the applicable requirements of A.R.S. § 20-510 and related regulations and actuarial guidelines, and credit claimed for any reinsurance treaty subject to this regulation does not exceed the proportionate share of those reserves ceded under the contract; and
2. The ceding insurer determines the Required Level of Primary Security with respect to each reinsurance treaty subject to this Part B and provides support for its calculation as determined to be acceptable to the Director; and
3. Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance treaty within the meaning of A.R.S. § 20-3603, on a funds withheld, trust, or modified coinsurance basis; and
4. Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to subsection (A)(3), are held by or on behalf of the ceding insurer as security under the reinsurance treaty within the meaning of A.R.S. § 20-3603; and
5. Any trust used to satisfy the requirements of this Section shall comply with all of the conditions and qualifications of R20-6-A1608(A) through (G), except that:
 - a. Funds consisting of Primary Security or Other Security held in trust, shall for the purposes identified in R20-6-B1602(B), be valued according to the valuation rules set forth in R20-6-B1602(B), as applicable; and

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- b. There are no affiliate investment limitations with respect to any security held in the trust if such security is not needed to satisfy the requirements of subsection (A)(3); and
 - c. The reinsurance treaty must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the Primary Security within the trust (when aggregated with Primary Security outside the trust that is held by or on behalf of the ceding insurer in the manner required by subsection (A)(3) 102% of the level required by subsection (A)(3) at the time of the withdrawal or substitution; and
 - d. The determination of reserve credit under R20-6-A1608(E) shall be determined according to the valuation rules set forth in R20-6-B1602(B), as applicable; and
6. The reinsurance treaty has been approved by the Director.
- B. Requirements at inception date and on an on-going basis; remediation:**
- 1. The requirements of subsection (A) must be satisfied as of the date that risks under Covered Policies are ceded (if such date is on or after the effective date of this Part B) and on an ongoing basis thereafter. Under no circumstances shall a ceding insurer take or consent to any action or series of actions that would result in a deficiency under subsections (A)(3) or (A)(4) with respect to any reinsurance treaty under which Covered Policies have been ceded, and in the event that a ceding insurer becomes aware at any time that such a deficiency exists, it shall use its best efforts to arrange for the deficiency to be eliminated as expeditiously as possible.
 - 2. Prior to the due date of each quarterly or annual statement, each life insurance company that has ceded reinsurance within the scope of subsection R20-6-B1601(A) shall perform an analysis, on a treaty-by-treaty basis, to determine, as to each reinsurance treaty under which Covered Policies have been ceded, whether as of the end of the immediately preceding calendar quarter (the valuation date) the requirements of subsections (A)(3) and (A)(4) were satisfied. The ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held pursuant to subsection (A)(3), unless either:
 - a. The requirements of subsections (A)(3) and (A)(4) were fully satisfied as of the valuation date as to the reinsurance treaty; or
 - b. Any deficiency has been eliminated before the due date of the quarterly or annual statement to which the valuation date relates through the addition of Primary Security and/or Other Security, as the case may be, in such amount and in such form as would have caused the requirements of subsections (A)(3) and (A)(4) to be fully satisfied as of the valuation date.
 - 3. Nothing in subsection (B)(2) shall be construed to allow a ceding company to maintain any deficiency under subsection (A)(3) or (A)(4) for any period of time longer than is reasonably necessary to eliminate it.

Historical Note

New Section R20-6-B1603 renumbered from R20-6-1612 and repealed; new Section R20-6-B1603 made by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant phrase “of this Section” and word “below” were removed when followed by

a subsection reference, and the word “Section” was removed before a Chapter Section number (Supp. 22-1).

ARTICLE 17. EXAMINATIONS**R20-6-1701. Definitions**

- A. “Company” means any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative, regulatory or taxing authority of the Director.
- B. “Examination” shall be defined for purposes of this Article to mean any examination relating to the financial condition of a company.
- C. “Examiner” means any individual or firm having been authorized by the Director to conduct an examination under this Article.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1701 recodified from R4-14-1701 (Supp. 95-1).

R20-6-1702. Authority, Scope, and Scheduling of Examinations

- A. The Director shall examine an insurer under A.R.S. § 20-156(A) at least once every five years.
- B. Instead of the examination under subsection (A), the Director may accept the most recent examination report prepared by the National Association of Insurance Commissioners insurance regulatory authority of another state on any foreign or alien insurer if:
 - 1. The insurance regulatory authority was accredited under the National Association of Insurance Commissioners’ Financial Regulation Standards and Accreditation Program at the time of the examination,
 - 2. A National Association of Insurance Commissioners accredited insurance regulatory authority supervised the examination, or
 - 3. At least one examiner employed or contracted by a National Association of Insurance Commissioners accredited insurance regulatory authority:
 - a. Participated in and reviewed the examination work papers and report, and
 - b. Signed an affidavit stating that the examination was performed in a manner consistent with the standards and procedures required by the National Association of Insurance Commissioners accredited insurance regulatory authority.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). Amended effective October 27, 1993 (Supp. 93-4). R20-6-1702 recodified from R4-14-1702 (Supp. 95-1). Amended by final rulemaking at 11 A.A.R. 2975, effective September 10, 2005 (Supp. 05-3).

R20-6-1703. Conduct of Examinations

- A. Upon determining that an examination should be conducted, the Director or the Director’s designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination.
- B. Nothing contained in this Article shall be construed to limit the Director’s authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state or to pursue such action concurrent with the examination.

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- C. The Director may disclose the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of any other state or country or to law enforcement officials of this or any other state or agency of the federal government at any time. Prior to making such disclosure, the Director may require such other department or office to agree in writing to hold as confidential the examination report, preliminary examination report or results or any matter relating thereto until such time as the examination report, preliminary examination report or results or matter relating thereto are made public by the Director.

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1703 recodified from R4-14-1703 (Supp. 95-1).

R20-6-1704. Examination Reports

- A. All examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the company, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find warranted from the facts.
- B. No later than 60 days following completion of the examination, the examiner in charge shall submit to the Department a verified written report of examination under oath. Upon receipt of the verified report, the Department shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not less than 10 days nor more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report.
- C. Within 30 days after the end of the period allowed for the receipt of written submissions or rebuttals, the Director shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers and shall:
1. File the examination report as submitted or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the Director, the Director may order the company to take any action necessary and appropriate to cure such violation; or
 2. Reject the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and resubmission pursuant to subsection (B).

Historical Note

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1704 recodified from R4-14-1704 (Supp. 95-1).

ARTICLE 18. PREPAID DENTAL PLAN ORGANIZATIONS**R20-6-1801. Definitions**

In this Article the following definitions apply:

"Appointment" means a first-available, initial, non-emergent, diagnostic visit to a dentist.

"Board certified" means a dentist who is recognized by the appropriate specialty board of the Commission on Accreditation of Dental Education of the American Dental Association.

"Board eligible" means a dentist who successfully completes an approved training program in a specialty field recognized by the American Dental Association.

"BODEX" means the Arizona State Board of Dental Examiners.

"Chief executive officer" means the person who has the authority and responsibility for the operation of an Organization according to applicable legal requirements and policies approved by the governing authority.

"Dental hygienist" means a person who is licensed to practice dental hygiene under A.R.S. § 32-1281 et seq.

"Dentist" means a person who is licensed to practice dentistry under A.R.S. § 32-1201 et seq.

"Department" means the Arizona Department of Insurance and Financial Institutions.

"Diagnostic service" means a dental service intended to identify a dental abnormality, and includes a radiograph and a clinical exam.

"Director" has the meaning prescribed at A.R.S. § 20-102.

"Emergency dental service" means a dental service intended to evaluate and stabilize a dental condition of recent onset, control bleeding, and relieve pain, and includes the provision of local anesthesia, and elimination of acute infection, but does not mean a medication that is prescribed by the dentist.

"General dentist" means a dentist whose practice is not limited to a specific area and who is not board certified.

"Governing authority" means the persons, including a board of trustees or board of directors, who have the ultimate authority and responsibility for the direction of a prepaid dental plan Organization.

"Organization" means a prepaid dental plan organization as defined in A.R.S. § 20-1001.

"Patient" means a person who is being attended by a dentist or dental hygienist to receive an examination, diagnosis, or dental treatment, or a combination of an examination, diagnosis, and dental treatment.

"Preventive service" means dental care intended to maintain dental health and prevent dental disease, including any combination of oral hygiene education, routine prophylaxis, and application of fluorides.

"Prophylaxis" means cleaning the teeth of a patient with healthy tissue using mild abrasives and dental instruments to remove plaque, calculus, and stains above the gum line.

"Provider directory" means an Organization's published listing of all contracted network dentists.

"Radiograph" means a picture produced on a sensitive surface by a form of radiation other than light, including x-ray.

"Restorative service" means the use of a metal or composite filling or crown.

"Specialist" means a dentist whose practice is limited to one of the nine specialty categories recognized by the American Dental Association: endodontics, oral and maxillofacial surgery, oral and maxillofacial radiology, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics, oral pathology, or dental public health.

"Treatment plan" means a statement of the services to be performed to eliminate or alleviate a patient's symptoms or dis-

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case, based on a dentist's assessment of the patient's dental history, the clinical examination, and the dentist's diagnosis.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

R20-6-1802. Application for Certificate of Authority

- A. A person who wishes to operate as prepaid dental plan organization in Arizona shall file an application for certificate of authority under A.R.S. § 20-1003 for the Director's review and approval under A.R.S. § 20-1004. The application shall contain all the information required in A.R.S. § 20-1003 and this Section.
- B. An authorized insurer shall issue the fidelity bond required under A.R.S. § 20-1004(A)(4).
- C. An Organization shall not commence operation of, or service under, a prepaid dental plan without approval of the Director under A.R.S. § 20-1004.
- D. An application is deemed filed with the Director when the Director receives it.
- E. An applicant not domiciled in this state shall file a power of attorney as required by A.R.S. § 20-1003(A)(11) on a Department-prescribed form, with the application.
- F. At the time it submits its application for certificate of authority, an Organization shall submit a written program of compliance with supporting documents that specify how the Organization will comply with the provisions of this Article. The written program of compliance shall contain the following:
 1. The responsibilities of and qualifications for the following positions:
 - a. The Organization's chief executive officer, and
 - b. The Organization's dental director;
 2. A plan for provision of basic dental services required under subsection R20-6-1806(A) and a copy of the schedule of benefits required under subsection R28-6-1806(B);
 3. A description of the system for delivery of services under Section R20-6-1807;
 4. A description of the geographic area designated under Section R20-6-1808;
 5. A plan for compliance with contract requirements under Section R20-6-1809 and a copy of a contract with a general dentist and a specialist;
 6. A plan for compliance with records requirements under Section R20-6-1810; and
 7. The Organization's quality improvement plan under Section R20-6-1811.
- G. An application shall include the following information:
 1. The proposed number of members, and
 2. A copy of a letter from each network dentist that documents the dentist's intent to contract with the Organization to provide services to patients under the Organization's prepaid dental plan.
- H. The Director may require that an applicant for a certificate of authority under A.R.S. § 20-1003(A)(14) submit information that discloses biographical, employment and business financial history, criminal activity, fingerprints, or any information that relates to the ability to operate a prepaid dental plan for principals, principal officers, controlling persons, and insurance producers of the applicant, if necessary for the protection of residents of this State.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

R20-6-1803. Chief Executive Officer

- A. The governing authority shall appoint a chief executive officer (CEO). The CEO shall have:
 1. The education and experience to manage the Organization, and
 2. Responsibility for the geographic area in Arizona that the Organization serves, including:
 - a. Implementing the policies of the governing authority, and
 - b. Maintaining adequate personnel to ensure compliance with applicable Arizona statutes and rules.
- B. The governing authority shall notify the Department within ten days after the effective date of a change in the appointment of the CEO.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1804. Dental Director

- A. The governing authority or CEO shall appoint as the Organization's dental director a dentist licensed to practice dentistry in any state or territory of the United States or the District of Columbia.
- B. The dental director shall perform at least the following functions for the Organization's geographic area in Arizona:
 1. Participate on the Organization's quality improvement committee required under Section R20-6-1811;
 2. Oversee the Organization's program and processes for:
 - a. Maintaining and improving clinical quality of care, including continuity of care;
 - b. Provider relations;
 - c. Facility and dental record reviews; and
 - d. Provider credentialing and recredentialing;
 3. Be knowledgeable about and participate in decisions regarding the Organization's operations;
 4. Comply with A.R.S. § 20-2510(B) and (C) when directly denying, on the basis of medical necessity, a health care provider's request for prior authorization; and
 5. Timely respond to matters within the Organization's Arizona geographic area that require personal onsite attention or ensure that a designee who meets the requirements specified in subsection (D) timely responds to those matters.
- C. Matters that require personal onsite attention include:
 1. Urgent patient care issues that require examination of dental records or X-rays;
 2. Prompt personal discussion with a provider of urgent concerns relating to credentialing, disciplinary problems, access to care, or quality of care.
- D. Any designee acting under subsection (B)(5) shall:
 1. Be a dentist licensed to practice dentistry in any state or territory of the United States or the District of Columbia;
 2. Have expedient access to the dental director, the CEO, and other organization management personnel as necessary to resolve any matter requiring personal onsite attention; and
 3. Have the education, experience, and Organizational knowledge required to address the matter requiring personal onsite attention.

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- E. The Organization shall notify the Department in writing within ten days after the effective date of a change in the appointment of the dental director or any designee.
- F. The requirements for a designee under subsections (B)(5), (D), and (E) shall not apply to an Organization with fewer than 2,000 members in Arizona.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

R20-6-1805. Required Reporting

- A. On or before March 1 of each year, an Organization shall submit the following information to the Department for the previous calendar year:
 1. Member satisfaction survey results and supporting data;
 2. A spreadsheet that lists the name, address, and telephone number of each provider and whether the provider: is accepting new members, is a general dentist or specialist, and has graduated from a specialty graduate program accredited by the American Dental Association;
 3. A list of all contracted network general dentists and specialists that have been added or deleted since the previous annual report;
 4. The total number of members and the number of members assigned to each general dentist's office;
 5. The average member wait time measured in weeks for an appointment for each network dentistry office; and
 6. A website link to its current provider directory.
- B. If a network dental office that is open to new members has an appointment wait time of longer than nine weeks for three consecutive calendar quarters, the Organization shall report to the Director who may require the Organization to close the office to new members until the wait time is less than nine weeks.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

R20-6-1806. Basic Dental Services

- A. A prepaid dental plan shall provide the basic dental services listed below:
 1. Emergency dental services on a 24-hour-per-day basis,
 2. Diagnostic services,
 3. Preventive services, and
 4. Restorative services.
- B. An Organization shall publish and make available to its members and purchasers a schedule of benefits that includes the dental plan's basic dental services and other available dental services and any associated copays.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1807. System for Delivery of Services

- A. An Organization shall have a system for delivery of services that includes:
 1. An adequate network of general dentists. To determine network adequacy, the Department shall consider the following:
 - a. Geographic distribution of network general dentists' offices,

- b. The number of dental offices accepting new members,
 - c. The percentage of all network members who are able to schedule an appointment within nine weeks,
 - d. The availability of trained clinical support staff in the Arizona geographic area,
 - e. The ratio of population growth to the increase or decrease in the number of dentists in the Arizona geographic area, and
 - f. Current availability for appointments in all general dentist practices in Arizona; and
- 2. Provision for using specialists for dental services that cannot be provided by the Organization's network of contracted specialists, if the services are covered benefits.
- B. If more than 15% of the network offices that are open to new members have an appointment wait time of longer than nine weeks, the Organization shall submit a plan to the Department under which the Organization will, within 90 days, reduce the wait time to less than nine weeks. If the Organization does not reduce the wait time to less than nine weeks within the 90 day period the Organization shall refer the members who are waiting for an appointment to another network general dentist or a non-network general dentist who can schedule the member for an appointment in less than nine weeks. The member may choose to continue dental care under the prepaid dental plan with the referred dentist for the remainder of the member's enrollment period. The Organization shall provide the non-network services to the referred member at a cost that is no greater than if the services are provided by the member's assigned network dentist.
- C. An Organization shall pay for emergency dental services provided to a member by a dentist licensed in the jurisdiction where the services are provided, subject to plan limitations disclosed in the dental care plan, including emergency dental services that occur:
 1. Within the geographic area served by the member's designated provider but the provider is unavailable, or
 2. Occurs outside of the member's designated geographic service area.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

R20-6-1808. Geographic Areas

- A. An Organization shall designate the geographic areas in Arizona in which the Organization intends to provide dental services that are reasonably convenient to the prospective members. The Organization shall provide a description of the geographic areas and locations of all facilities in which dental care will be provided under the prepaid dental plan. This information shall accompany or be included in any advertisements or sales materials provided to prospective employer groups and prospective members.
- B. An Organization shall define its geographic areas by local government jurisdictions, such as cities or counties.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

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R20-6-1809. Contract Requirements

- A.** An Organization shall have a written contract with each provider that documents the requirements for providing services under the prepaid dental plan and the terms of the agreements between the parties. The Organization shall ensure that the provider complies with all contract requirements.
- B.** In addition to the requirements in subsection (A), an Organization shall ensure that its contract with a provider includes the following provisions:
1. That the Organization has authority to review the provider's records,
 2. That the provider is responsible to implement and maintain a process to inform assigned members of the need to schedule periodic preventive dental services based on the member's oral health status, and
 3. That the provider is responsible to complete any procedure undertaken upon a member if the contract is terminated or expires.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1810. Records

- A.** Dental records are the property of the provider and shall not be removed from the provider's possession, except:
1. With the patient's permission, including for routing records to a dental or medical practitioner for consultation or evaluation; or
 2. When subpoenaed by a court or BODEX.
- B.** An Organization shall maintain at its principal office a copy of each issued or delivered advertising matter or sales material, letter of solicitation, evidence of coverage, provider directory, certificate, agreement, or contract. The Organization shall note the date each advertising matter or sales material is filed with the Department and the date of distribution to any person. The advertising matter or sales material shall be maintained for at least three years.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1811. Quality Improvement

- A.** An Organization shall have a governing authority.
- B.** The governing authority shall appoint a quality improvement committee that consists of the chief executive officer or designee, the dental director, the person who manages the Organization's quality improvement process, and at least one dental health professional. The committee may also include network allied health professionals and members of the plan.
- C.** The quality improvement committee shall:
1. Meet at least quarterly,
 2. Review and evaluate dental services delivered under the Organization's plan, and
 3. Establish procedures for recordkeeping and distribution of committee reports.
- D.** An Organization shall maintain a written quality improvement plan that contains procedures for each of the following:
1. Ensuring that a dentist licensed in any state or territory of the United States or District of Columbia reviews and evaluates dental care and services provided by each contracted general dentist at least once every three years;
 2. Allocation of the Organization's resources to analyze a problem or any identified deficiency;

3. Implementing a corrective action plan and methods for monitoring improvement;
4. Notifying a member in writing of the member's responsibility to cooperate with those providing dental care services and of the member's rights to:
 - a. Voice concerns about the Organization or care provided;
 - b. Be provided with information about the Organization, its services, providers, and member rights and responsibilities;
 - c. Participate in decisions about the member's dental care; and
 - d. Be treated with respect and have the right to privacy recognized;
5. Monitoring and improving membership satisfaction;
6. Maintaining an accurate provider directory that meets at least the following requirements:
 - a. Lists only credentialed providers who are currently scheduling members for diagnosis and treatment; and
 - b. Clearly designates providers who are not accepting new members;
7. Review by the dental director of the following for initial credentialing of network providers:
 - a. Query to the National Practitioner Data Bank;
 - b. Query to BODEX;
 - c. Valid United States Drug Enforcement Administration certificate, if applicable;
 - d. Evidence of current malpractice insurance; and
 - e. Documentation that each specialist has graduated from an accredited specialty graduate program as required by the Council on Dental Education and Licensure, American Dental Association; and
8. Recredentialing, at least every three years, that updates information obtained in subsections (D)(7)(b) through (d), for the dental director's review.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

R20-6-1812. Confidentiality of Records

An Organization shall not disclose information obtained pertaining to the diagnosis, treatment, or health of a member to any person except:

1. To the extent necessary to carry out this Article;
2. Upon the express written consent of the member, applicant, provider, or Organization, as appropriate; or
3. Under statute or court order for the production or discovery of evidence or as part of a civil or criminal investigation.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1813. Assignment of Members

- A.** Within 30 days of enrollment, an Organization shall assign a member to the provider the member chooses. The Organization, however, shall choose and assign a provider to a member within 30 days of any of the following:
1. Receipt of a member enrollment form that does not designate a provider, or receipt of a member enrollment form that designates a provider who is unavailable;

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2. The date of the notice that the member's assigned provider intends to cease providing services; or
 3. The date the member's assigned provider becomes unavailable, for any reason.
- B.** An Organization shall give each member the option of selecting a network provider other than the provider assigned by the Organization under subsection (A).
- C.** An Organization shall maintain a continuous assignment process in compliance with subsections (A) and (B), allowing no more than 4% of members to be unassigned at any time.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

ARTICLE 19. HEALTH CARE SERVICES ORGANIZATIONS OVERSIGHT**R20-6-1901. Applicability**

- A.** This Article applies to:
1. All proposed and existing health care services organizations (HCSOs), and
 2. Each product offered by an HCSO under the HCSO's certificate of authority.
- B.** The Department shall not issue a certificate of authority to an HCSO unless the HCSO meets the requirements of this Article.
- C.** The Department shall not require an existing HCSO to re-file information already on file with the Department, but the HCSO shall modify its operations and procedures as may be necessary to comply with this Article and file with the Department all additional information necessary to make statements complete and current.
- D.** This Article applies to inpatient emergency care, but does not apply to emergency services.
- E.** This Article applies only to covered services.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Amended by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1902. Definitions

In this Article, the following definitions apply:

"Access" or "accessibility" means the extent to which an enrollee can obtain timely covered services from a contracted provider at the appropriate level of care, and appropriate location.

"Adult" means an enrollee in the age group the HCSO has designated for an adult.

"Adult PCP" means a primary care provider practicing in any specialty the HCSO designates as adult primary care.

"Ancillary provider" means a provider of laboratory, radiology, pharmacy or rehabilitative services, physical therapy, occupational therapy, or speech therapy, home health services, dialysis, and durable medical equipment or medical supplies dispensed by order or prescription of a provider with the appropriate prescribing authority.

"Available" or "availability" means the extent to which the plan has contracted providers of the appropriate type and numbers at geographic locations to afford members access to timely covered services.

"Chief executive officer" or "CEO" means the person who has the authority and responsibility for the operation of the health care services organization according to applicable legal requirements and policies approved by the governing authority.

"Child" means an enrollee in the age group the HCSO has designated for children.

"Contracted" means a provider has a current written agreement or an employment arrangement with an HCSO to provide covered services to an enrollee, or a current written agreement or an employment arrangement with a contracted provider to provide covered services to an enrollee.

"Covered" or "covered services" means the health care services described as covered benefits in the HCSO's evidence of coverage.

"Day" means calendar day unless specified otherwise.

"Department" means the Department of Insurance.

"Effective process" means written policies and procedures that:

Outline the steps that the HCSO implements and consistently follows internally,

The HCSO subjects to internal quality improvement, and

The HCSO communicates to providers when established or changed.

"Emergency services" has the meaning in A.R.S. § 20-2801(3).

"Enrollee" means an individual who is enrolled in a health plan operated by an HCSO.

"Facility" means an institution that is licensed or authorized to furnish health care services in this state, including general hospitals, special hospitals, residential treatment centers, residential rehabilitation centers, skilled nursing facilities, urgent care centers, and ambulatory surgical treatment centers.

"Governing authority" means a person or body such as a board of trustees or board of directors in whom the ultimate authority and responsibility for the direction of the HCSO is vested.

"HCSO" means a health care services organization.

"Health care services" has the meaning in A.R.S. § 20-1051(6).

"High profile" means one of no fewer than four specialties designated by the HCSO, and does not include obstetrics-gynecology. An HCSO may designate a specialty as high profile on the basis of high volume or other basis the HCSO reasonably determines is directly related to providing covered services to a member.

"Hospital" means a facility that provides inpatient care, medical services, and continuous nursing services for the diagnosis and treatment of patients.

"Inpatient care" means the covered services that an enrollee who is admitted to a hospital receives for at least 24 consecutive hours.

"Inpatient emergency care" means covered services that would be emergency services if provided in a licensed hospital emergency facility.

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“License” means documented authorization issued by the appropriate state of Arizona agency to operate a facility in Arizona, or to practice a health care profession in Arizona.

“Medically necessary” has the meaning set forth in the HCSO’s evidence of coverage.

“Network” means the group of providers contracted with an HCSO to provide covered services to an enrollee covered under the HCSO’s health benefit plan.

“Network exception” means an enrollee receives covered services from a non-contracted provider either:

Because there is no contracted provider accessible or available that can provide the enrollee timely covered services, or

For any reason the HCSO determines it is in the enrollee’s best interests to receive care from a non-contracted provider.

“Non-contracted” means a provider that does not have a contract with an HCSO to provide services to an enrollee.

“Normal business hours” means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding state or national holidays.

“Outpatient care” means covered services that an enrollee who is not an inpatient receives.

“Pediatric primary care provider” means a physician or practitioner practicing in any specialty the HCSO designates as pediatric primary care.

“Physician” means a licensed doctor of allopathic, chiropractic, optometric, osteopathic, or podiatric medicine.

“Practitioner” means any individual other than a physician who is licensed to furnish health care services, including behavioral health care services, in this state.

“Preventive care” means health maintenance care the HCSO provides or arranges to prevent illness and to improve the general health of an enrollee, including:

Immunizations,

Health education,

Health evaluation and follow-up,

Early disease detection,

Screening tests appropriate for a person’s age and gender, and

Periodic health care examinations.

“Primary care” means any specialty the HCSO designates as primary care.

“Primary care physician” or “PCP” means a physician or practitioner practicing in a specialty the HCSO designates as primary care.

“Provider” means any physician, practitioner, ancillary provider, or facility.

“Quality improvement” means an HCSO’s system for assessing and improving the level of performance of key process and outcomes.

“Routine care” means covered primary care for an enrollee’s non-urgent, symptomatic condition.

“Rural” means a zip code area with fewer than 1,000 persons per square mile as calculated annually by a population data gathering service designated by the Director.

“Service area” means any geographic area designated by any HCSO and approved by the Director under A.R.S. § 20-1053(A)(11).

“Specialty care provider” or “SCP” means a physician or practitioner who has education, training, or qualifications in a specialty, other than primary care, beyond the education or qualifications required for the license.

“Specialty” or “specialty care” means a specific area of medicine practiced by a physician or practitioner who has education, training, or qualifications in that specific area of medicine in addition to the education or qualifications required for the physician’s or practitioner’s license.

“Special hospital” means a hospital that is licensed to provide hospital services within a specific area of medicine, or limits patient admission according to age, gender, type of disease, or medical condition.

“Suburban area” means any zip code area with 1,000-3,000 persons per square mile, as calculated annually by a population data gathering service designated by the Director.

“Telemedicine” means diagnostic, consultation, and treatment services that occur in the physical presence of an enrollee on a real-time basis through interactive audio, video, or data communication.

“Timely” means services are provided at the time when medically necessary.

“Travel expenses” has the meaning set forth in writing by an HCSO.

“Urban area” means a zip code with more than 3,000 persons per square mile as calculated annually by a population data gathering service designated by the Director.

“Urgent care” means unscheduled services for an enrollee’s condition that requires medical attention not amenable to scheduling in order to avoid a serious risk of harm.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Amended by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1903. Documentation

The CEO shall ensure that the HCSO’s policies, procedures, plans, class specifications, orders, reports, minutes of meetings, contracts, agreements, records, and duty schedules are in writing, compiled and indexed in one or more manuals, and readily available for inspection by the Director.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Amended by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1904. Health Care Plan

A. An HCSO shall submit a statement to the Department that describes the proposed health care plan.

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- B. The HCSO shall have an organized system for the delivery of health care services contained in subsection (D) that includes the following:
 1. Contracted providers that provide services under the plan;
 2. An effective process to promote a continuing relationship between an enrollee and the same PCP; and
 3. An effective process for referrals that ensures continuity of care to an enrollee.
- C. The HCSO shall list:
 1. The proposed or actual enrollment;
 2. The number and names of contracted, employed, or HCSO-owned providers that will serve the enrollees and the board eligibility or certification of each physician, if applicable; and
 3. The plan for providing covered services to enrollees as required under this Article.
- D. The HCSO's health care plan shall provide within the geographic area served the following basic health care services covered by the monthly charges in the evidence of coverage:
 1. Emergency care that includes emergency services and inpatient emergency care;
 2. Inpatient care;
 3. Specialty care, primary care, or ancillary care that includes diagnostic and therapeutic services;
 4. Outpatient care;
 5. Preventive care; and
 6. Emergency ambulance services under A.R.S. § 20-2801(2), and other ambulance services when approved by a plan physician.
- E. The HCSO shall provide appropriate coverage for out-of-area emergency care to an enrollee traveling outside the area served by the HCSO.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). R20-6-1904 repealed; new Section R20-6-1904 renumbered and amended from R20-6-1906 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1905. Geographic Area

- A. An applicant shall describe the proposed geographic area in at least one of the following ways:
 1. Legal description,
 2. Local governmental jurisdiction such as city or county,
 3. Census tracts,
 4. Street boundaries, or
 5. Area within a specified radius of a specified intersection or a specified primary care center.
- B. An applicant shall submit a map that shows the boundaries for the proposed geographic area.
- C. An applicant shall submit a description of the proposed network including the data required under R20-6-1913(A)(2) and (A)(3).
- D. All advertising matter and sales material provided a prospective enrollee shall include a description of the geographic area in terms readily understandable by the general public.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). R20-6-1905 repealed; new Section R20-6-1905 renumbered and amended from R20-6-1907 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1906. Chief Executive Officer

- A. The governing authority shall appoint a CEO who has appropriate education and experience to manage the HCSO. The governing authority shall define the authority and duties of the CEO in writing. The CEO is the appointed representative of the governing authority and is the executive officer of the HCSO.
- B. The CEO shall have at least the following duties and responsibilities:
 1. Manage the HCSO;
 2. Establish and implement policies, procedures, and effective processes of the HCSO;
 3. Act as liaison between the governing authority and the providers of healthcare and other services to the HCSO; and
 4. Establish a written plan of authority that will be in place in the CEO's absence.
- C. When there is a change of CEO, the governing authority shall notify Department within 10 days after the effective date of change.
- D. The HCSO shall ensure that all HCSO employees and contracted providers are knowledgeable about and qualified to perform the duties assigned to them through employment or by contract.
- E. The HCSO shall designate a central place of business within the major geographic area served at which the CEO shall be based and from which the HCSO shall direct administrative activities.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section R20-6-1906 renumbered to R20-6-1904; new Section R20-6-1906 renumbered and amended from R20-6-1908 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1907. Medical Director

- A. The HCSO shall designate a physician as medical director.
- B. The medical director shall be responsible for planning and implementing the method for the continuing review and evaluation of health care provided by the HCSO and the continuing education of its providers of health care services. The medical director may also serve as the CEO if the medical director has appropriate education and experience to manage the HCSO.
- C. The medical director responsibilities include:
 1. Supervising medical staff;
 2. Performance planning and evaluating medical staff;
 3. Coordinating medical staff activities; and
 4. Developing medical care policies.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section R20-6-1907 renumbered to R20-6-1905; new Section R20-6-1907 renumbered and amended from R20-6-1909 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1908. Quality Assurance

- A. The HCSO shall provide an effective process for a continuing review and evaluation of the covered services it provides to enrollees to ensure that:
 1. Treatment and level of covered services are appropriate and adequate and

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2. The quality of covered services is acceptable to the HCSO.
- B. The HCSO shall have a quality assurance committee that includes at least the CEO or designee, the medical director, and representative network providers. The quality assurance committee shall:
 1. Arrange for physicians or practitioners to review and evaluate covered services provided by others physicians or practitioners within the respective disciplines.
 2. Adopt administrative procedures covering frequency of meetings, recordkeeping, committee reports, and disseminating the reports.
- C. The HCSO's effective process in subsection (A) shall include the following:
 1. Standards for health care;
 2. Monitoring of care;
 3. Analysis of any deficiency;
 4. Correcting a deficiency including submitting a schedule for correcting the deficiency, requiring continuing education for the provider, if appropriate, and follow-up and periodic reassessment of the deficiency.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section R20-6-1908 renumbered to R20-6-1906; new Section R20-6-1908 renumbered and amended from R20-6-1911, by final rulemaking at 11 A.A.R. 4861, effective December 31, 2006 (Supp. 05-4).

R20-6-1909. Evaluation of Network

Each HCSO shall have an effective process to evaluate the adequacy of its network to provide an enrollee with timely covered services.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Former R20-6-1909 renumbered to R20-6-1907; new Section R20-6-1909 made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1910. Process for Referral, Prior Authorization, Precertification, or Network Exception

- A. An HCSO shall have an effective process for assisting an enrollee to obtain timely covered services when the enrollee or enrollee's referring provider cannot find a contracted provider who is timely accessible or available.
- B. An HCSO shall have an effective process during normal business hours for handling referrals, prior authorizations, precertifications, or network exceptions necessary for timely routine care. This process may include the HCSO's procedure for standing referrals required in A.R.S. § 20-1057.01.
- C. Each HCSO shall have an effective process to handle referrals or network exceptions necessary for timely urgent care seven days a week.
- D. An HCSO that requires prior authorization or precertification for urgent care shall have an effective process to handle requests for prior authorization or precertification 24 hours a day, seven days a week.
- E. An HCSO shall have an effective process for handling network exceptions that ensures the HCSO reimburses an enrollee for any out-of-network cost the enrollee incurs that the enrollee would not have incurred if the enrollee had received the services in-network.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1911. HCSO Communication with Providers

An HCSO shall have an effective process for communicating with contracted providers regarding the following:

1. The providers in the network,
2. Contractual or administrative changes relating to enrollee access or provider availability, and
3. Procedures for handling claims and grievances submitted by providers.

Historical Note

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Former R20-6-1911 renumbered to R20-6-1908; new R20-6-1911 made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1912. Network Directories

- A. An HCSO shall publish a provider network directory as follows:

1. An HCSO shall list the name, address, telephone number, specialty, and hospital affiliation for all in-area contracted physicians or practitioners.
2. An HCSO may list ancillary providers by corporate or group name and is not required to list individual physicians or practitioners.
3. An HCSO is not required to list physicians or practitioners in the following areas of specialties or areas of practice:
 - a. Emergency medicine;
 - b. Anesthesiology, except anesthesiologists who provide pain management services;
 - c. Hospital-based pathology;
 - d. Hospital-based radiology; and
 - e. Hospitalists.
4. An HCSO that lists any of the physicians or practitioners in subsections R20-6-1912(A)(3)(a) through (A)(3)(e) may list by corporate or group name and is not required to list individual physicians or practitioners.
5. An HCSO that uses hospitalists is not required to list the hospital affiliations of PCPs who do not admit or attend hospitalized members.
6. An HCSO shall publish a provider network directory that lists all its contracted facilities and contains:
 - a. The name, address, and telephone number of each facility;
 - b. For each hospital at which the HCSO uses hospitalists, if any, a statement that the HCSO uses hospitalists at that hospital;
 - c. For an HCSO that uses hospitalists and does not list them in the directory, information on how an enrollee can find out what hospitalists or group of hospitalists it uses at each hospital;

- B. The network directory shall conspicuously state in the directory the following:

1. Changes occur in the network after the directory is published and some providers listed in the directory may no longer be contracted,
2. Enrollee coverage may depend on the contract status of the provider,

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3. Where the enrollee can obtain more recent directory information,
 4. The effective date of the network directory, and
 5. The method for an enrollee or prospective enrollee to find out which PCPs are accepting new enrollees from the HCSO.
- C. Each HCSO shall make its network directory available on paper to enrollees or prospective enrollees requesting it. The HCSO shall:
1. Publish the paper directory at least once a year;
 2. Update or supplement the information in the paper directory at least every six months;
 3. Explain in the paper directory how an enrollee or prospective enrollee can use or get assistance using the HCSO's online or telephone directories, if any; and
 4. Have discretion to list physicians' or practitioners' hospital affiliations in its paper directory.
- D. Each HCSO that has an online network directory shall:
1. Update the online directory at least monthly;
 2. Make the online directory easy to use and user friendly; and
 3. Explain, in the online directory, how an enrollee or prospective enrollee can obtain a paper directory.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1913. Demographic Information Reports

- A. An HCSO shall report the following data to the Department:
1. For each enrollee, report annually:
 - a. Street address,
 - b. Zip code,
 - c. Gender, and
 - d. Year of birth.
 2. For all contracted providers, report semiannually:
 - a. Provider name,
 - b. Street address or addresses at which the provider provides covered services,
 - c. Zip code, and
 - d. Arizona license number,
 3. For all contracted physicians or practitioners, report semiannually:
 - a. Specialty, and
 - b. Medical or other applicable degree or information that designates the type of physician or practitioner.
- B. The HCSO shall report the information in subsection (A) to the Department by the following deadlines:
1. For information in subsection (A)(1) as of December 31 of each calendar year, by February 15 of the next calendar year.
 2. For information in subsection (A)(2) as of June 30, by August 15 of the same calendar year.
 3. For information in subsection (A)(2) as of December 31, by February 15 of the next calendar year.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1914. Access

An HCSO shall provide to or arrange for its enrollees services or appointments for services as follows:

1. For preventive care services from a contracted PCP, an appointment date within 60 days of the enrollee's request,

or sooner if necessary, for the enrollee to be immunized on schedule.

2. For routine-care services from a contracted PCP, an appointment date within 15 days of the enrollee's request to the PCP or sooner if medically necessary.
3. For specialty care services from a contracted SCP, an appointment date within 60 days of the enrollee's request or sooner if medically necessary.
4. In-area urgent care services from a contracted provider seven days per week.
5. Timely non-emergency inpatient care services from a contracted facility.
6. Timely services from a contracted physician or practitioner in a contracted facility including inpatient emergency care.
7. Services from a contracted ancillary provider during normal business hours, or sooner if medically necessary.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1915. Alternative Access

- A. As an alternative to providing access to covered services from a physician, an HCSO may provide access to covered services from an appropriately licensed practitioner.
- B. As an alternative to providing access to covered services at a hospital under R20-6-1914, an HCSO may provide access to covered services at another appropriately licensed facility.
- C. As an alternative to providing access to covered services from a physician or practitioner who sees an enrollee in person under R20-6-1914, an HCSO may provide access to necessary covered services through:
1. Telephone calls and messages,
 2. Electronic mail,
 3. Communication with the physician's or practitioner's staff,
 4. Coverage by another physician or practitioner, or
 5. Telemedicine,
- D. An HCSO that panels enrollees to PCPs may panel enrollees to appropriately licensed practitioners.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1916. Availability Ratios

- A. An HCSO shall maintain a ratio of contracted adult PCPs to adults that is adequate to provide those adults with covered services. An HCSO with a Medicare Advantage (MA) plan may have one ratio that applies to both its insured and MA populations, or a separate ratio for each.
- B. An HCSO shall maintain a ratio of contracted pediatric PCPs to children that is adequate to provide those children enrollees with covered services.
- C. An HCSO shall maintain a ratio of contracted high profile SCPs to enrollees that is adequate to provide those enrollees with covered services that include services at contracted facilities. An HCSO with a MA plan may have one ratio that applies to both its insured and MA populations, or a separate ratio for each.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

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R20-6-1917. Geographic Availability in an Urban Area

An HCSO shall provide each enrollee living in an urban area of the HCSO's service area the following:

1. Primary care services from a contracted PCP located within 10 miles or 30 minutes of the enrollee's home;
2. High profile specialty care services from a contracted SCP located within 15 miles or 45 minutes of the enrollee's home; and
3. Inpatient care in a contracted general hospital, or contracted special hospital, within 25 miles or 75 minutes of the enrollee's home.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1918. Geographic Availability in a Suburban Area

Each HCSO shall provide each enrollee member living in a suburban area within the HCSO's service area the following:

1. Primary care from a contracted PCP located within 15 miles or 45 minutes of the enrollee's home;
2. High profile specialty care services from a contracted SPC within 20 miles or 60 minutes of the enrollee's home; and
3. Inpatient care in a contracted hospital, or a contracted special hospital within 30 miles or 90 minutes of the enrollee's home.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1919. Geographic Availability in a Rural Area

An HCSO shall provide each enrollee living in a rural area with primary care services from a contracted physician or practitioner within 30 miles or 90 minutes of the enrollee's home.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1920. Travel Requirements

- A. An HCSO may require an enrollee to travel a greater distance in-area to obtain covered services from a contracted provider than the enrollee would have to travel to obtain equivalent services from a non-contracted provider, except where a network exception is medically necessary. Nothing in this Section creates an exception to R20-6-1918 through R20-6-1920.
- B. If the HCSO prior-authorizes services that require an enrollee to travel outside the HCSO service area because the services are not available in the area, the HCSO shall reimburse the enrollee for travel expenses. Except as provided under R20-6-1904(E)(6), an HCSO is not required to reimburse an enrollee for travel expenses the enrollee incurs to obtain covered services in-area.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

R20-6-1921. Enforcement Consideration

In determining the appropriate enforcement action or penalties for failure to comply with these rules, the Department shall consider any documentation the HCSO provides regarding:

1. Whether seasonal shifts in demand affect access and availability of covered services;

2. Whether the HCSO's demographic information has changed significantly since the HCSO's most recent report;
3. Whether an enrollee has refused to accept covered services the HCSO has offered in the time-frames or locations required of the HCSO by this Article;
4. Whether an enrollee has requested and obtained covered services from a contracted provider whose location, or appointment availability, or capacity result in the HCSO's non-compliance; and
5. Whether market factors indicate that on a short-term basis, compliance is not possible. Market factors include shortage of providers, enrollee or provider location, and provider practice or contracting patterns.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

ARTICLE 20. CAPTIVE INSURERS**R20-6-2001. Reserved****R20-6-2002. Fees; Examination Costs**

- A. A corporation applying for a license to do business as a captive insurer, under A.R.S. § 20-1098, shall pay a nonrefundable fee of \$1,000.00 to the Department for issuance of the license. A captive insurer that is a protected cell captive insurer, as defined in A.R.S. § 20-1098, also shall pay to the Department a nonrefundable fee of \$1,000 for each participant contract application that establishes a protected cell under A.R.S. § 20-1098.05(B)(9). The fee is payable in full at the time the applicant submits the application for license to the Department under A.R.S. § 20-1098.01.
- B. A captive insurer shall pay a nonrefundable annual renewal fee of \$5,500.00 to the Department at the time of filing its annual report under A.R.S. § 20-1098.07. Under A.R.S. § 20-1098.01(J), a captive insurer that is a protected cell captive insurer also shall pay to the Department a nonrefundable annual renewal fee of \$2,500.00 for each protected cell at the time of filing its annual report under A.R.S. § 20-1098.07.
- C. A captive insurer shall pay a nonrefundable fee of \$200.00 to the Department at the time of filing for issuance of an amended certificate of authority.
- D. In addition to the fees prescribed in subsections (A) and (B), an applicant for a captive insurer license or a licensed captive insurer shall pay the costs of any examination the Director conducts, under A.R.S. § 20-1098.08.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2478, effective July 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 2977, effective September 13, 2005 (Supp. 05-3). Subsection (A) corrected at request of the Department, Office File No. M11-252, filed July 20, 2011 (Supp. 11-3).

ARTICLE 21. CUSTOMER INFORMATION SECURITY PROGRAM

Article 21, consisting of R20-6-2101 through R20-6-2104, made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

R20-6-2101. Definitions

The following definitions apply in this Article:

1. "Consumer" means an individual, or the individual's legal representative, who seeks to obtain, obtains, or has obtained an insurance product or service from a licensee

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that is to be used primarily for personal, family, or household purposes, and about whom the licensee has nonpublic personal information. Consumer can include a prospective applicant, policyholder, certificateholder, insured, or claimant.

2. "Customer" means a consumer who has a continuing relationship with a licensee under which the licensee provides one or more insurance products or services to the consumer that are used primarily for personal, family, or household purposes.
3. "Customer information" means nonpublic personal information and privileged information about a customer whether in paper, electronic, or other form, that is maintained by or on behalf of an insurance institution, insurance producer, or insurance support organization.
4. "Customer information systems" means the electronic, or physical methods used to access, collect, store, use, transmit, protect, or dispose of customer information.
5. "Insurance institution" has the meaning prescribed in A.R.S. § 20-2102(10).
6. "Insurance producer" means a person required to be licensed under A.R.S. Title 20, Chapter 2, Article 3 to sell, solicit, or negotiate insurance and includes a managing general agent as defined in A.R.S. § 20-311.
7. "Insurance support organization" has the meaning prescribed in A.R.S. § 20-2102(13).
8. "Licensee" means an insurance institution, insurance producer, or insurance support organization, but does not include a purchasing group or an unauthorized insurer in regard to the excess line business conducted under Title 20, Chapter 2, Article 5.
9. "Personal information" has the meaning prescribed in A.R.S. § 20-2102(19).
10. "Privileged information" has the meaning prescribed in A.R.S. § 20-2102(22).
11. "Service provider" means a person that maintains, processes, or otherwise is permitted access to customer information through its provision of services directly to a licensee.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

R20-6-2102. Customer Information Security Program

A licensee shall implement a comprehensive written customer information security program that includes administrative, technical, and physical safeguards for the protection of customer information. The administrative, technical, and physical safeguards included in the information security program shall be appropriate to the size and complexity of the licensee and the nature and scope of its activities.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

R20-6-2103. Objectives of Customer Information Security Program

A licensee's customer information security program shall be designed to:

1. Ensure the security and confidentiality of customer information;
2. Protect against any anticipated threats or hazards to the security or integrity of the information; and

3. Protect against unauthorized access to or use of the information.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

R20-6-2104. Guidelines for Methods of Development and Implementation

A licensee may implement the requirements of R20-6-2102 and R20-6-2103 by the actions and procedures prescribed in this Section, which are non-exclusive illustrations:

1. A licensee may assess risk by:
 - a. Identifying reasonably foreseeable internal or external threats that could result in unauthorized disclosure, misuse, alteration, or destruction of customer information or customer information systems;
 - b. Assessing the likelihood and potential damage of these threats, taking into consideration the sensitivity of customer information; and
 - c. Assessing the sufficiency of policies, procedures, customer information systems, and other safeguards in place to control risks.
2. A licensee may manage and control risk by:
 - a. Designing its information security program to control the identified risks, commensurate with the sensitivity of the information, as well as the complexity and scope of the licensee's activities;
 - b. Training staff to implement the licensee's information security program; and
 - c. Regularly testing or otherwise regularly monitoring the key controls, systems and procedures of the information security program. The licensee shall determine the frequency and nature of these tests or other monitoring practices by the licensee's risk assessment.
3. A licensee may oversee service provider arrangements by:
 - a. Exercising appropriate due diligence in selecting its service providers; and
 - b. Requiring its service providers to implement measures designed to meet the objectives of this Article, and, where indicated by the licensee's risk assessment, taking appropriate steps to confirm that its service providers have satisfied these obligations.
4. A licensee may monitor, evaluate, and adjust, as appropriate, its information security program in light of any relevant changes in technology, the sensitivity of its customer information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements, and changes to customer information systems.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

ARTICLE 22. MILITARY PERSONNEL**R20-6-2201. Military Sales Practices****A. Definitions.**

1. "Active duty" means full-time duty in the active military service of the United States and includes members of the reserve component (National Guard and Reserve) while serving under published orders for active duty or full-time training. "Active duty" does not include members of

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the reserve component who are performing active duty or active duty under military calls or orders specifying periods of less than 31 calendar days.

2. "Department of Defense (DoD) personnel" means all active duty service members and all civilian employees, including non-appropriated fund employees and special government employees, of the Department of Defense.
3. "Division" means the Division of Insurance of the Department of Insurance and Financial Institutions.
4. "Door-to-door" means a solicitation or sales method whereby an insurance producer proceeds randomly or selectively from household to household without prior specific appointment.
5. "ERISA" means the Employee Retirement and Income Security Act.
6. "Formal banking relationship" for purposes of subsection (D), means a relationship established between a service member and a depository institution which:
 - a. Provides the service member with a deposit agreement and periodic statements and makes disclosures required by the Truth in Savings Act, 12 U.S.C. § 4301, et seq. and its accompanying regulations; and
 - b. Permits the service member to make deposits and withdrawals unrelated to the payment or processing of insurance premiums.
7. "General advertisement" means an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of insurance, or the promotion of the insurer, or the promotion of the insurance producer.
8. "Insurer" means an insurance company required to be licensed under the laws of Arizona to provide life insurance products, including annuities.
9. "Insurance producer" means a person required to be licensed pursuant to A.R.S. § 20-282.
10. "IRC" means Internal Revenue Code.
11. "Known" or "Knowingly" means the insurance producer or insurer had actual awareness, or in the exercise of ordinary care should have known at the time of the act or practice complained of, that depending on its use in this Section, the person solicited was either a service member or was a service member with a pay grade of E-4 or below.
12. "Life insurance" has the meaning defined at A.R.S. § 20-254.
13. "Military installation" means any federally owned, leased, or operated base, reservation, post, camp, building, or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.
14. "MyPay" is a Defense Finance and Accounting Service (DFAS) web-based system that enables service members to process certain discretionary pay transactions or provide updates to personal information data elements without using paper forms.
15. "Service member" means any active duty officer (commissioned and warrant) or enlisted member of the United States Armed Forces.
16. "SGLI" means Servicemembers' Group Life Insurance.
17. "Side fund" means a fund or reserve that is part of or otherwise attached to a life insurance policy (excluding individually issued annuities) by rider, endorsement, or other mechanism which accumulates premium, or deposits

with interest, or by other means. "Side fund" does not include:

- a. Accumulated value, or cash value, or secondary guarantees provided by an universal life insurance policy;
 - b. Cash values provided by a whole life policy which are subject to standard nonforfeiture law for life insurance; or
 - c. A premium deposit fund which:
 - i. Contains only premiums paid in advance which accumulate at interest;
 - ii. Imposes no penalty for withdrawal;
 - iii. Does not permit funding beyond future required premiums;
 - iv. Is not marketed or intended as an investment; and
 - v. Does not carry a commission, either paid or calculated.
 18. "Specific appointment" means a prearranged appointment agreed upon by both parties and definite as to place and time.
 19. "U.S." means United States.
 20. "U.S. Armed Forces" means all components of the Army, Navy, Air Force, Marine Corps, Coast Guard, and Space Force.
 21. "VGLI" means Veterans' Group Life Insurance.
- B. Exemptions.**
1. This Section shall not apply to solicitations or sales involving:
 - a. Credit insurance;
 - b. Group life insurance or group annuities where there is no in-person, face-to-face solicitation of individuals by an insurance producer or where the contract or certificate does not include a side fund;
 - c. An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the Division; or, when a term conversion privilege is exercised among corporate affiliates;
 - d. Individual stand-alone health policies, including disability income policies;
 - e. Contracts offered by SGLI or VGLI, as authorized by 38 U.S.C. §§ 1965 et seq.;
 - f. Life insurance contracts offered through or by a non-profit military association, qualifying under Section 501(c)(23) of the IRC, and which are not underwritten by an insurer; or
 - g. Contracts used to fund:
 - i. An employee pension or welfare benefit plan that is covered by ERISA;
 - ii. A plan described by Sections 401(a), 401(k), 403(b), 408(k), or 408(p) of the IRC, as amended, if established and maintained by an employer;
 - iii. A government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the IRC;

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- iv. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;
 - v. Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or
 - vi. Prearranged funeral contracts.
- 2. Nothing in this Section shall be construed to abrogate the ability of nonprofit organizations (and/or other organizations) to educate members of the U.S. Armed Forces in accordance with Department of Defense DoD Instruction 1344.07 – Personal Commercial Solicitation on DoD Installations or any successor directive.
- 3. This purposes of this Section, the following do not constitute solicitation:
 - a. General advertisements;
 - b. Direct mail;
 - c. Internet marketing; and
 - d. Telephone marketing if the caller explicitly and conspicuously discloses that the product being marketed is life insurance and makes no statements that avoid a clear and unequivocal statement that life insurance is the subject matter of the solicitation.
- 4. Any in-person, face-to-face meeting resulting from an exempt type of solicitation listed in subsection (B)(3) is not exempt and the insurer or insurance producer is subject to this Section.
- 5. The following subsections do not apply to individually issued annuities: (D)(3)(b), (D)(5)(c), (D)(5)(e), (D)(6)(a), (D)(6)(c) and (D)(6)(d).
- C. Practices Declared False, Misleading, Deceptive, or Unfair on a Military Installation.
 - 1. The following acts or practices when committed on a military installation by an insurer or insurance producer with respect to the in-person, face-to-face solicitation of life insurance are declared to be false, misleading, deceptive, or unfair:
 - a. Knowingly soliciting the purchase of any life insurance product door-to-door or without first establishing a specific appointment for each meeting with a prospective purchaser.
 - b. Soliciting service members in a group or “mass” audience or in a “captive” audience where attendance is not voluntary.
 - c. Knowingly making appointments with or soliciting service members during their normally scheduled duty hours.
 - d. Making appointments with or soliciting service members in barracks, day rooms, unit areas, transient personnel housing, or other areas where the installation commander has prohibited solicitation.
 - e. Soliciting the sale of life insurance without first obtaining permission from the installation commander or the commander’s designee.
 - f. Posting unauthorized bulletins, notices, or advertisements.
 - g. Failing to present DD Form 2885, Personal Commercial Solicitation Evaluation, to solicited service members or discouraging solicited service members from completing or submitting a DD Form 2885.
 - h. Knowingly accepting an application for life insurance or issuing a policy of life insurance on the life of an enlisted member of the U.S. Armed Forces without first obtaining a completed copy of any required form which confirms that the applicant has received counseling or fulfilled any other similar requirement for the sale of life insurance established by regulations, directives, or rules of the DoD or any branch of the U.S. Armed Forces for the insurer’s files.
 - 2. The following acts or practices when committed on a military installation by an insurer or insurance producer constitute corrupt practices, improper influences, or inducements and are declared to be false, misleading, deceptive, or unfair:
 - a. Using DoD personnel, directly or indirectly, as a representative or agent in any official or business capacity, with or without compensation, with respect to the solicitation or sale of life insurance to service members.
 - b. Using an insurance producer to participate in any U.S. Armed Forces sponsored education or orientation program.
- D. Practices declared false, misleading, deceptive, or unfair regardless of location.
 - 1. The following acts or practices by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive, or unfair:
 - a. Submitting, processing, or assisting in the submission or processing of any allotment form or similar device used by the U.S. Armed Forces to direct a service member’s pay to a third party for the purchase of life insurance. This includes, but is not limited to, using or assisting in using the service member’s “MyPay” account or other similar internet or electronic medium. This subsection does not prohibit an insurer or insurance producer assisting a service member by providing the insurer or premium information necessary to complete any allotment form.
 - b. Knowingly receiving funds from a service member for the payment of premium from a depository institution with which the service member has no formal banking relationship.
 - c. Employing any device or method or entering into any agreement where funds received from a service member by allotment for the payment of insurance premiums are identified on the service member’s “Leave and Earnings Statement” or equivalent or successor form as “Savings” or “Checking” and where the service member has no formal banking relationship.
 - d. Entering into any agreement with a depository institution for the purposes of receiving funds from a service member where the depository institution, with or without compensation, agrees to accept direct deposits from a service member with whom it has no formal banking relationship.
 - e. Using DoD personnel, directly or indirectly, as a representative or agent in any official or unofficial capacity, with or without compensation, with respect to the solicitation or sale of life insurance to service members who are junior in rank or grade or to their family members.
 - f. Offering or giving anything of value, directly or indirectly, to DoD personnel to procure their assistance in encouraging, assisting, or facilitating the

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- solicitation or sale of life insurance to a service member.
- g. Knowingly offering or giving anything of value to a service member with a pay grade of E-4 or below for their attendance to any event where an application for life insurance is solicited.
 - h. Advising a service member with a pay grade of E-4 or below to change their income tax withholding or state of legal residence for the sole purpose of increasing disposable income to purchase life insurance.
2. The following acts or practices by an insurer or insurance producer lead to confusion regarding source, sponsorship, approval, or affiliation and are declared to be false, misleading, deceptive, or unfair:
 - a. Making any representation, or using any device, title, descriptive name, or identifier that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, insurance producer, or product offered is affiliate, connected or associated with, endorsed, sponsored, sanctioned, or recommended by the U.S. government, the U.S. Armed Forces, or any state, federal agency, or government entity. Examples of prohibited insurance producer titles include, but are not limited to, "Battalion Insurance Counselor," "Unit Insurance Advisor," "Servicemen's Group Life Insurance Conversion Consultant," or "Veteran's Benefits Counselor." An insurance producer may use a professional designation awarded after the successful completion of a course of instruction in the business of insurance by an accredited institution of higher learning including, but not limited to, Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC), Certified Financial Planner (CFP), Masters of Science in Financial Services (MSFS), or Masters of Science Financial Planning (MS).
 - b. Soliciting the purchase of any life insurance product through the use of or in conjunction with any third party organization that promotes the welfare of or assists members of the U.S. Armed Forces in a manner that has a tendency or capacity to confuse or mislead a service member into believing that either the insurer, insurance producer, or insurance product is affiliated, connected or associated with, endorsed, sponsored, sanctioned, or recommended by the U.S. government or the U.S. Armed Forces.
 3. The following acts or practices by an insurer or insurance producer lead to confusion regarding premiums, costs, or investment returns and are declared to be false, misleading, deceptive, or unfair:
 - a. Using or describing the credited interest rate on a life insurance policy in a manner that implies that the credited interest rate is a net return on premium paid.
 - b. Misrepresenting the mortality costs of a life insurance product, including a statement or implication that the product costs nothing or is free.
 4. The following acts or practices by an insurer or insurance producer regarding SGLI or VGLI are declared to be false, misleading, deceptive, or unfair:
 - a. Making any representation regarding the availability, suitability, amount, cost, exclusions, or limitations to coverage provided to a service member or dependents by SGLI or VGLI, which is false, misleading, or deceptive.
 - b. Making any representation regarding conversion requirements, including the costs of coverage, or exclusions or limitations of coverage of SGLI or VGLI to private insurers which is false, misleading, or deceptive.
 - c. Suggesting, recommending, or encouraging a service member to cancel or terminate their SGLI policy or issuing a life insurance policy which replaces an existing SGLI policy unless the replacement shall take effect upon or after the service member's separation from the U.S. Armed Forces.
5. The following acts or practices by an insurer or insurance producer regarding disclosure are declared to be false, misleading, deceptive, or unfair:
 - a. Deploying, using, or contracting for any lead-generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an insurance producer, if that is the case, for the purpose of soliciting the purchase of life insurance.
 - b. Failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for an in-person, face-to-face meeting with a prospective purchaser.
 - c. Failing to clearly and conspicuously disclose that fact that the product being sold is life insurance.
 - d. Failing to make, at the time of sale or offer to an individual known to be a service member, the written disclosures required by the Military Personnel Financial Services Protection Act, Public Law 109-290, Sec. 10, p. 16, 10 U.S.C. § 992 note.
 - e. When the sale is conducted in-person and face-to-face with an individual known to be a service member, failing at the time the application is taken to provide to the applicant:
 - i. An explanation of any applicable free look period with instructions on how to cancel if a policy is issued; and
 - ii. Either a copy of the application or a written disclosure. The copy of the application or the written disclosure shall clearly and concisely set out the type of life insurance, the death benefit applied for and its expected first year cost. A basic illustration that meets the requirements of A.R.S. §§ 20-1241 through 20-1241.09, Section R20-6-202 and Section R20-6-209 shall be deemed sufficient to meet this requirement for a written disclosure.
 6. The following acts or practices by an insurer or insurance producer with respect to the sale of certain life insurance products are declared to be false, misleading, deceptive, or unfair:
 - a. Recommending the purchase of any life insurance product which includes a side fund to a service member in pay grades E-4 and below unless the insurer has reasonable grounds for believing that the life insurance death benefit, standing alone, is suitable.
 - b. Offering for sale or selling a life insurance product which includes a side fund to a service member in pay grades E-4 and below who is currently enrolled in SGLI, is presumed unsuitable unless, after the

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completion of a needs assessment, the insurer demonstrates that the applicant's SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant's insurable needs for life insurance.

- i. "Insurable needs" are the risks associated with premature death taking into consideration the financial obligations and immediate and future cash needs of the applicant's estate and/or survivors or dependents.
- ii. "Other military survivor benefits" include, but are not limited to: the Death Gratuity, Funeral Reimbursement, Transition Assistance, Survivor and Dependents' Educational Assistance, Dependency and Indemnity Compensation, TRICARE Healthcare benefits, Survivor Housing Benefits and Allowances, Federal Income Tax Forgiveness, and Social Security Survivor Benefits.
- c. Offering for sale or selling any life insurance contract which includes a side fund:
 - i. Unless interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty;
 - ii. Unless the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined product. For this disclosure, the effective rate of return will consider all premiums and cash contributions made by the policyholder and all cash accumulations and cash surrender values available to the policyholder in addition to life insurance coverage. This schedule will be provided for at least each policy year from year one to year ten and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and
 - iii. Which by default diverts or transfers funds accumulated to the side fund to pay, reduce, or offset any premiums due.
- d. Offering for sale or selling any life insurance contract which after considering all policy benefits, including but not limited to endowment, return of premium or persistency, does not comply with standard nonforfeiture law for life insurance.

Historical Note

New Section made by final rulemaking at 13 A.A.R. 4215, effective January 5, 2008 (Supp. 07-4). Amended by final rulemaking at 28 A.A.R. 687 (April 1, 2022), effective May 7, 2022 (Supp. 22-1).

ARTICLE 23. THRESHOLD RATE REVIEW – INDIVIDUAL HEALTH INSURANCE**R20-6-2301. Applicability; Definitions**

- A. This Article applies to rates charged by health insurers for individual health insurance. This Article does not apply to rates charged by health insurers for the following:
 1. Health insurance that a health insurer issues to an employer or to any group described in either A.R.S. § 20-1401 or A.R.S. § 20-1404(A), except health insurance issued to an association or its individual members as described in R20-6-2301(B)(7)(b);
 2. Grandfathered health plan coverage as defined in 45 CFR 147.140; or

3. Health insurance that covers excepted benefits as described in section 2791(c) of the PHS Act, 42 U.S.C. 300gg-91(c).

B. In this Article, the following definitions apply:

1. "Department" means the Arizona Department of Insurance.
2. "Blanket disability insurance" has the meaning prescribed in A.R.S. § 20-1404(A).
3. "CMS" means the Centers for Medicare & Medicaid Services.
4. "Federal medical loss ratio standard" means the applicable medical loss ratio standard determined under 45 CFR 158, Subpart B.
5. "Health insurance" means disability insurance as defined in A.R.S. § 20-253, a health care plan as defined in A.R.S. § 20-1051(5) and disability insurance or a health care plan offered by a hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation as defined in A.R.S. § 20-822(3).
6. "Health insurer" means an insurer, as that term is defined in A.R.S. § 20-104, authorized to transact disability insurance in Arizona, a health care services organization as defined in A.R.S. § 20-1051(7) or a hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation as defined in A.R.S. § 20-822(3).
7. "Individual health insurance" means health insurance that a health insurer issues to either:
 - a. An individual, to cover:
 - i. The individual, or
 - ii. The individual's dependents, or
 - iii. The individual and the individual's dependents.
 - b. An association or its individual members to cover the individual members and their dependents, and which the Department would regulate under A.R.S. Title 20, Chapter 6 as individual health insurance if the health insurer did not issue it to an association or individual members of an association.
8. "PHS Act" means Part A of Title XXVII of the Public Health Service Act, 42 U.S.C. Chapter 6A.
9. "Product" means a package of health insurance benefits with a discrete set of rating and pricing methodologies that a health insurer offers as individual insurance in Arizona.
10. "Preliminary justification" means a justification that consists of the parts described in R20-6-2302(A).
11. "Rate increase" means an increase of the rates for an individual health insurance product that a health insurer offers in Arizona that:
 - a. Results from a change to the underlying rate structure of the product, and
 - b. May result in premium changes for the product.
12. "Secretary" means the Secretary of the United States Department of Health and Human Services.
13. "Threshold rate increase" means a rate increase that meets or exceeds an Arizona-specific threshold as noticed by the Secretary in 45 CFR 154.200, provided:
 - a. The average increase for all enrollees weighted by premium volume meets or exceeds the applicable threshold; and
 - b. If a rate increase that does not otherwise meet or exceed the Arizona-specific threshold meets or exceeds the Arizona-specific threshold when com-

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bined with a previous increase or increases during the 12-month period preceding the date on which the rate increase would become effective, then the rate increase must be considered to meet or exceed the Arizona-specific threshold and is subject to threshold rate review that shall include a review of the aggregate rate increases during the applicable 12-month period.

14. "Threshold rate review" means the review by the Department under this Article of a threshold rate increase.
15. "Unreasonable rate increase" means a rate increase that results in benefits that are not reasonable in relation to the premium the health insurer charges for the product. The following factors are relevant in determining whether a rate increase results in benefits that are unreasonable in relation to premium:
 - a. The rate increase results in a projected medical loss ratio below the federal medical loss ratio standard after accounting for any adjustments allowable under federal law;
 - b. One or more of the assumptions on which the health insurer based the rate increase is not supported by sound actuarial reasoning, data and analysis;
 - c. The choice of assumptions or combination of assumptions on which the insurer based the rate increase is unreasonable;
 - d. The health issuer provides data or documentation that is incomplete, inadequate or otherwise does not provide a basis upon which the Department can determine the reasonableness of a rate increase; or
 - e. The increase results in premium differences between insureds within similar risk categories that are unfairly discriminatory under A.R.S. Title 20, Chapter 2, Article 6.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2302. Disclosure of Preliminary Justification

- A. Preliminary Justification. For each threshold rate increase for each affected product, a health insurer shall submit to the Department and to CMS, on a form and in the manner prescribed by the Secretary in 45 CFR 154.215, a preliminary justification that contains all of the following:
 1. Preliminary Justification Part I. A summary of the content of the threshold rate increase that includes:
 - a. Historical and projected claims experience;
 - b. Trend projections related to utilization, and service or unit cost;
 - c. Any claims assumptions related to benefit changes;
 - d. Allocation of the overall rate increase to claims and non-claims costs;
 - e. Per enrollee per month allocation of current and projected premium; and
 - f. Three year history of rate increases for the product associated with the rate increase.
 2. Preliminary Justification Part II. A written description that justifies the rate increase and that contains a simple and brief narrative describing the data and assumptions the health insurer used to develop the rate increase, and includes the following:
 - a. An explanation of the most significant factors causing the rate increase, including a brief description of

the relevant claims and non-claims expense increases reported in subsection (A)(1); and

- b. A brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.
- B. A health insurer may submit a single, combined preliminary justification that contains all the information in subsections (A)(1) and (2) for threshold rate increases that affect more than one product if the health insurer has aggregated the claims experience of all products to calculate the rate increases and the rate increases are the same for all products.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2303. Timing for Submission of Preliminary Justification

- A. If R20-6-607 applies to a threshold rate increase, the health insurer shall submit its preliminary justification to the Department and to CMS on the date on which the health insurer files the rate increase request under R20-6-607.
- B. If R20-6-607 does not apply to a threshold rate increase, the health insurer shall submit the preliminary justification to the Department and to CMS at least 60 days prior to the date the health insurer intends to implement the threshold rate increase in Arizona.
- C. The Department shall provide access from its website to the Parts I and II of the Preliminary Justifications of the proposed rate increases that it reviews and have a mechanism for receiving public comments on those proposed rate increases.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2304. Response to Unreasonableness Determination

If the health insurer receives from CMS a notice that the Department has determined that the health insurer's threshold rate increase is unreasonable, the health insurer shall select one of the following three options:

1. Option to not implement the rate increase determined unreasonable. Within 30 days of receiving from CMS the Department's determination, the health insurer shall notify the Department and CMS that it will not implement the rate increase and request the Department to withdraw the rate increase request;
2. Option to implement a smaller rate increase than the rate determined unreasonable. Within 30 days of receiving from CMS the Department's determination, the health insurer shall notify the Department and CMS, on a form and in the manner prescribed by the Secretary, that it intends to implement a rate increase that is smaller than the one determined unreasonable. One of the following shall apply to this option:
 - a. If the health insurer selects this option and the smaller rate increase is not a threshold rate increase, the smaller rate increase is not subject to this Article;
 - b. If the health insurer selects this option, and R20-6-607 applied to the rate increase the Department determined to be unreasonable, the health insurer shall revise the rate increase filing to reflect the smaller rate increase or file a new rate increase. If the smaller rate increase is a threshold rate increase, the health insurer shall submit a new preliminary

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- justification on the date the health insurer revises the rate increase filing or files a new rate increase; or
- c. If the health insurer selects this option, and R20-6-607 did not apply to the rate increase the Department determined to be unreasonable, and the smaller increase is a threshold rate increase, the health insurer shall submit to the Department and to CMS a new preliminary justification at least 60 days prior to the date the health insurer intends to implement the smaller increase in Arizona.
3. Option to implement the rate increase determined unreasonable. Within 10 business days after the health insurer either implements the rate increase that the Department determined unreasonable, or receives from CMS the Department's determination, the health insurer shall:
 - a. Submit, to the Department and to CMS, a final justification in response to the Department's determination. The information in the final justification shall be the same as the information submitted by the insurer under R20-6-2302(A)(1) and (2) in the preliminary justification supporting the rate increase; and
 - b. Prominently post on its website, on a form and in the manner prescribed by the Secretary under 45 CFR 154.230 the following information:
 - i. The Department's determination that the rate increase is unreasonable and Department's explanation of the Department's analysis of the relevant factors set forth in R20-6-2305(A)(1) and (2), and
 - ii. The health insurer's final justification for implementing the rate increase.
 - c. Continue to make the information in subsection (3)(b) available to the public on its website for at least three years.
7. The impact of changes in reserve needs;
 8. The impact of changes in administrative costs related to programs that improve health care quality;
 9. The impact of changes in other administrative costs;
 10. The impact of changes in applicable taxes, licensing or regulatory fees;
 11. Medical loss ratio;
 12. The health insurance insurer's capital and surplus; and
 13. Other relevant documentation at the discretion of the Director.
- C. A health insurer shall submit all documentation required under subsection (A) or (B) at the same time that:
 1. The health insurer submits the preliminary justification required under R20-6-2302, or
 2. The health insurer submits any new preliminary justification required under R20-6-2304(2)(b) and (c).

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

ARTICLE 24. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION**R20-6-2401. Definitions**

The definitions in A.R.S. § 20-3111 and this Section apply to this Article.

1. "Allowed Amount" is the amount reimbursable for a covered service under the terms of the enrollee's benefit plan. The allowed amount includes both the amount payable by the insurer and the amount of the enrollee's cost sharing requirements.
2. "Alternative Arbitrator" is an individual who is mutually agreeable to the health insurer and health care provider to act as the arbitrator of a surprise out-of-network billing dispute. If the person is contracted with the State of Arizona to conduct arbitration proceedings, the provisions of that contract shall apply. Department staff may not serve as an Alternative Arbitrator.
3. "Amount of the enrollee's cost sharing requirements" means the amount determined by the insurer prior to the dispute resolution process to be owed by the enrollee for out-of-network copayment, coinsurance and deductible pursuant to the enrollee's health care policy.
4. "Arbitrator" has the same meaning as A.R.S. § 20-3111(2) and may include a mediator, arbitrator or other alternative dispute resolution professional who is contracted with the Department to arbitrate a surprise out-of-network billing dispute. Department staff may not serve as an Arbitrator.
5. "A.R.S. § 20-3113 Disclosure" means a written, dated document that contains the following information:
 - a. The name of the billing health care provider;
 - b. A statement that the health care provider is not a contracted provider;
 - c. The estimated total cost to be billed by the health care provider or the provider's representative for the health care services being provided;
 - d. A notice that the enrollee or the enrollee's authorized representative is not required to sign the A.R.S. § 20-3113 Disclosure to obtain health care services;
 - e. A notice that if the enrollee or the enrollee's authorized representative signs the A.R.S. § 20-3113 Disclosure, they may have waived any rights to request

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2305. Threshold Rate Increase Documentation Requirements

- A. For a threshold rate increase, a health insurer shall submit to the Department documentation that is sufficient to allow the Department to assess:
 1. The reasonableness of the assumptions used by the health insurer to develop the proposed rate increase and the validity of the historical data underlying the assumptions, and
 2. The health insurer's data related to past projections and actual experience.
- B. To the extent applicable to the submission under review by the Department, the health insurer shall submit documentation that includes all of the following:
 1. The impact of medical trend changes by major service categories;
 2. The impact of utilization changes by major service categories;
 3. The impact of cost-sharing changes by major service categories;
 4. The impact of benefit changes;
 5. The impact of changes in enrollee risk profile;
 6. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;

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- arbitration of a qualifying surprise out-of-network bill.
6. "Balance bill" means all charges that exceed the enrollee's cost sharing requirements and the amount paid by the insurer.
 7. "Date of service" means the latest date on which the health care provider rendered a related health care service that is the subject of a qualifying surprise out-of-network bill.
 8. "Days" as used in this Article means calendar days unless specified as business days and does not include the day of the filing of a document.
 9. "Department" means the Arizona Department of Insurance or an entity with which it contracts to administer the out-of-network claim dispute resolution process.
 10. "Enrollee's authorized representative" means a person to whom an enrollee has given express written consent to represent the enrollee, the enrollee's parent or legal guardian, a person appointed by the court to act on behalf of the enrollee or the enrollee's legal representative. An enrollee's authorized representative shall not be someone who represents the provider's interests.
 11. "Final resolution of a health care appeal" means that a member has a final decision under the review process provided by A.R.S. Title 20, Chapter 15, Article 2.
 12. "Informal Settlement Teleconference" means a teleconference arranged by the Department that is held to settle the enrollee's qualifying surprise out-of-network bill prior to an Arbitration being scheduled. The parties to the Informal Settlement Teleconference are: (a) the enrollee or the enrollee's authorized representative; (b) the health insurer; and (c) the provider or the provider's representative.
 13. "Qualifying surprise out-of-network bill" is a surprise out-of-network bill for health care services provided on or after January 1, 2019, that is disputed by the enrollee and:
 - a. Is for health care services covered by the enrollee's health plan;
 - b. Is for health care services provided in a network health care facility;
 - c. Is for health care services performed by a provider who is not contracted to participate in the network that serves the enrollee's health plan;
 - d. The enrollee has resolved any health care appeal pursuant to A.R.S. Title 20, Chapter 15, Article 2, that the enrollee may have had against the insurer following the health insurer's initial adjudication of the claim;
 - e. The enrollee has not instituted a civil lawsuit or other legal action against the insurer or health care provider related to the surprise out-of-network bill or the health care services provided;
 - f. The amount of the surprise out-of-network bill for which the enrollee is responsible for all related health care services provided by the health care provider whether contained in one or multiple bills, after deduction of the enrollee's cost sharing requirements and the insurer's allowable reimbursement, is at least \$1,000.00; and
 - g. One of the following applies:
 - i. The bill is for emergency services, including under circumstances described by A.R.S. § 20-2803(A);
 - ii. The bill is for health care services directly related to the emergency services that are provided during an inpatient admission to any network facility;
 - iii. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative did not provide the enrollee a written dated A.R.S. § 20-3113 Disclosure;
 - iv. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative did not provide the enrollee a written dated A.R.S. § 20-3113 Disclosure within a reasonable amount of time before the enrollee received the service;
 - v. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative provided the enrollee a written dated A.R.S. § 20-3113 Disclosure ("Disclosure") and the enrollee or the enrollee's authorized representative chose not to sign the Disclosure;
 - vi. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative provided the enrollee a written dated A.R.S. § 20-3113 Disclosure ("Disclosure") and the enrollee or the enrollee's authorized representative signed the Disclosure but the amount actually billed to the enrollee is greater than the estimated cost provided in the signed Disclosure.

Historical Note

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

R20-6-2402. Request for Arbitration

- A. Request for Arbitration. An enrollee may request dispute resolution of a surprise out-of-network bill by filing a timely Request for Arbitration with the Department on a Request for Arbitration form available on the Department's website.
- B. Deadline for filing a Request for Arbitration with the Department. A Request for Arbitration must be received by the Department within one year after the date of service listed on the surprise out-of-network bill. If the enrollee filed a health care appeal pursuant to A.R.S. Title 20, Chapter 15, Article 2, the one year deadline is tolled from the date the enrollee filed the health care appeal to the date of the final resolution of the appeal.
- C. Evaluation of the Request for Arbitration by the Department. Within 15 days after receipt of a Request for Arbitration, the Department shall do one of the following:
 1. Determine that the surprise out-of-network bill is a qualifying surprise out-of-network bill and notify the enrollee, health insurer and health care provider that the Request for Arbitration qualifies for Arbitration;
 2. Determine that the surprise out-of-network bill is not a qualifying surprise out-of-network bill and notify the enrollee of the reason for the Department's determination;
 3. Determine that the Request for Arbitration is incomplete; or

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4. Return the Request for Arbitration to the enrollee without making a determination if the enrollee's request should instead be filed as a health care appeal within the meaning of A.R.S. Title 20, Chapter 15, Article 2.
- D. Request for additional information for an incomplete Request for Arbitration. If the Department determines that the Request for Arbitration is incomplete, the Department may send a written request for additional information to the enrollee, health insurer, health care provider or health care provider's billing company.
- E. Time to respond to the Department's Request for Additional Information. The enrollee, health insurer, health care provider or the health care provider's billing company shall have 15 days from the date of the request to respond to the Department's Request for Additional Information.
- F. Failure to respond to the Department's Request for Additional Information.
 1. If the enrollee fails to respond to the Department's Request for Additional Information, the Department shall deny the enrollee's Request for Arbitration.
 2. If either the health insurer or the health care provider or health care provider's billing company fail to respond to the Department's Request for Additional Information, the Department shall deem that the enrollee's Request for Arbitration qualifies for arbitration.
- G. Receipt of Additional Information. Upon receipt of the additional information requested by the Department under subsection (D) of this Section, the Department shall determine, within seven days, whether the enrollee's Request for Arbitration qualifies for Arbitration and send the notice required under subsection (C)(1) or subsection (C)(2) of this Section, whichever applies.
- H. Final Determination. The Department's determination whether an enrollee's Request for Arbitration qualifies for Arbitration is a final decision and not an appealable agency action within the meaning of A.R.S. § 41-1092(3). A claim that is the subject of a qualifying surprise out-of-network bill is not subject to the timely payment of claims law during the pendency of the Arbitration.
- I. Enrollee's payment responsibility.
 1. Notwithstanding any informal settlement or Arbitrator's Final Written Decision, the enrollee is responsible for only the following:
 - a. The amount of the enrollee's cost sharing requirements; and
 - b. Any amount received by the enrollee from the enrollee's health insurer as payment for the health care services at issue in a qualifying surprise out-of-network bill.
 2. A health care provider may not issue, either directly or indirectly through its billing company, any additional balance bill to the enrollee for the same health care services.
- B. Notice of Informal Settlement Teleconference. At least 14 days prior to the scheduled date, the Department shall send a Notice of Informal Settlement Teleconference to the enrollee, the enrollee's authorized representative, the health insurer, the health care provider and the health care provider's representative informing them of the date, time and instructions on how to participate in the Informal Settlement Teleconference.
- C. Health Insurer documentation. On or before the Informal Settlement Teleconference, the health insurer shall provide to the parties the enrollee's cost sharing requirements under the enrollee's health plan based on the qualifying surprise out-of-network bill.
- D. Consequences of non-participation in the Informal Settlement Teleconference. If a party fails to participate in the Informal Settlement Teleconference, it shall be subject to the following consequences:
 1. If the health insurer, provider or provider's representative fails to participate in an Informal Settlement Teleconference scheduled by the Department, the participating party may notify the Department which shall promptly schedule the Arbitration. The non-participating party shall pay the entire cost of the Arbitration.
 2. If the enrollee or the enrollee's authorized representative fails to participate in the original Informal Settlement Teleconference, the original Informal Settlement Teleconference is terminated.
 3. If the enrollee or the enrollee's authorized representative fails to participate in a rescheduled Informal Settlement Teleconference, the enrollee's Request for Arbitration is terminated.
- E. One-time opportunity for the enrollee to reschedule the Informal Settlement Teleconference. If the enrollee or the enrollee's representative fails to participate in the Informal Settlement Teleconference originally scheduled by the Department, the enrollee may request that the Department reschedule the Informal Settlement Conference. The enrollee's request to reschedule must be received by the Department within 14 days after the originally scheduled Informal Settlement Teleconference. Failure to submit a request to the Department to reschedule the Informal Settlement Teleconference within the 14 day period terminates the enrollee's Request for Arbitration.
- F. Notification to the Department after the Informal Settlement Teleconference. Within seven days after the date of the Informal Settlement Teleconference, the health insurer shall:
 1. Notify the Department whether a settlement was reached between the parties; and
 2. If a settlement was reached, notify the Department of the terms of the settlement on a form prescribed by the Department.
- G. Failure to settle. If the parties fail to settle the qualifying surprise out-of-network bill at the Informal Settlement Teleconference, the Department shall arrange for the Arbitration.
- H. Settlement. If the parties settle the qualifying surprise out-of-network bill at the Informal Settlement Teleconference, the health insurer shall remit its portion of the payment to the health care provider within 30 days after the Informal Settlement Teleconference. A claim that is reprocessed by a health insurer as a result of informal settlement is not in violation of A.R.S. § 20-3102(L).

Historical Note

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

R20-6-2403. Informal Settlement Teleconference

- A. Deadline to arrange the Informal Settlement Teleconference. Upon a determination that an enrollee has made a Request for Arbitration that qualifies for Arbitration, the Department shall arrange an Informal Settlement Teleconference between the parties within 30 days of notifying the enrollee that the enrollee's Request for Arbitration qualifies for Arbitration required by Section R20-6-2402(C)(1).

Historical Note

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

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R20-6-2404. Arbitrators

- A.** Contracted entities. The Department shall contract with one or more persons to provide Arbitrators. The Department must have a list of at least four Arbitrators to assign to Arbitrations. The Department shall publish the list of contracted entities and a list of each entity's qualified Arbitrators on its website.
- B.** Arbitrator Qualifications. Any person contracting with the Department must be able to provide Arbitrators who possess at least three years of experience in health care services claims.
- C.** Alternative Arbitrators. A health insurer and provider may mutually agree to use an Alternative Arbitrator if either the health insurer or the health care provider objects to an Arbitrator appointed by the Department.
- D.** Appointment of an Arbitrator.
 - 1. The Department shall appoint an Arbitrator for each Arbitration.
 - 2. If the health insurer and health care provider do not agree to the Arbitrator appointed by the Department, they shall either:
 - a. Mutually agree to use an Alternative Arbitrator; or
 - b. Participate in the following procedure:
 - i. The Department shall assign three Arbitrators.
 - ii. The health insurer shall strike one Arbitrator.
 - iii. The health care provider shall strike one Arbitrator.
 - iv. If one Arbitrator remains, the Department shall appoint the remaining Arbitrator to the Arbitration.
 - v. If the health insurer and health care provider strike the same Arbitrator, the Department shall randomly assign the Arbitrator from the remaining two Arbitrators.

Historical Note

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

R20-6-2405. Before the Arbitration

- A.** Enrollee's duties. Before the Arbitration, the enrollee shall:
 - 1. Pay or make arrangements in writing to pay to the health care provider the amount stated by the health insurer in the Informal Settlement Teleconference which shall be the total amount of the enrollee's cost sharing requirements due for the health care services that are the subject of the qualifying surprise out-of-network bill.
 - 2. Pay to the health care provider any amount that the enrollee has received from the health insurer as payment for the health care services that are the subject of the qualifying surprise out-of-network bill.
- B.** Health insurer's duties. Before the Arbitration, the health insurer shall remit any amount due to the health care provider if the health care insurer pays for out-of-network services directly to health care providers and the health insurer has not remitted any amounts due.

Historical Note

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

R20-6-2406. The Arbitration

- A.** Conduct of Arbitration. An Arbitration of a qualifying out-of-network surprise bill shall be conducted:
 - 1. Telephonically unless the parties agree otherwise;
 - 2. With or without the enrollee's participation;
 - 3. Within 120 days after the Department's Notice of Arbitration unless agreed otherwise by the parties; and

- 4. For a maximum duration of four hours unless agreed otherwise by the parties.
- B.** Arbitrator's Determination. The Arbitrator or Alternative Arbitrator shall determine the amount the health care provider is entitled to receive as payment for the health care services that are the subject of the qualifying surprise out-of-network bill.
- C.** Allowable Evidence. The Arbitrator or Alternative Arbitrator shall allow each party to provide relevant information for evaluating the qualifying surprise out-of-network bill including:
 - 1. The average contracted amount that the health insurer pays for the health care services at issue in the county where the health care provider performed the health care services;
 - 2. The average amount that the health care provider has contracted to accept for the health care services at issue in the county where the health care provider performed the services;
 - 3. The amount Medicare and Medicaid pay for the health care services at issue;
 - 4. The health care provider's direct pay rate for the health care services at issue, if any, under A.R.S. § 32-3216;
 - 5. Any information that would be evaluated in determining whether a fee is reasonable under title 32 and not excessive for the health care services at issue, including the usual and customary charges for the health care services at issue performed by a health care provider in the same or similar specialty and provided in the same geographic area; and
 - 6. Any other reliable sources of information, including databases, that provide the amount paid for the health care services at issue in the county where the health care provider performed the services.
- D.** Final Written Decision. Within 10 business days following the Arbitration, the Arbitrator or Alternative Arbitrator shall issue a Final Written Decision and provide a copy to the enrollee, the health insurer, the health care provider, the health care provider's billing company (if applicable) and the health care provider's authorized representative (if applicable).
- E.** Payment of the claim. The health insurer shall remit its portion of the payment awarded by the Arbitrator or Alternative Arbitrator to the health care provider within 30 days of the date of the Final Written Decision. A claim that is reprocessed by a health insurer as a result of the Arbitration is not in violation of A.R.S. § 20-3102(L).
- F.** Payment of the Costs of Arbitration. The health insurer and health care provider shall make payment arrangements with the Arbitrator or Alternative Arbitrator to pay their respective shares of the costs of the Arbitration within 30 days after the date of the Final Written Decision. The respective shares of the costs of Arbitration are determined as follows:
 - 1. The enrollee is not responsible for any portion of the cost of the Arbitration.
 - 2. The health insurer and the health care provider shall share the costs of the Arbitration equally unless one of the following exceptions applies:
 - a. The health insurer and health care provider agree to share the costs of the Arbitration in non-equal portions.
 - b. The health insurer pays the entire cost of the Arbitration for failing to participate in the Informal Settlement Teleconference after receiving proper notice from the Department.

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- c. The health care provider or the health care provider's representative pays the entire cost of the Arbitration for failing to participate in the Informal Settlement Teleconference after receiving proper notice from the Department.
- G. Confidentiality. In connection with the Arbitration of a qualifying surprise out-of-network bill, all of the following apply:
 - 1. All pricing information provided by a health insurer or health care provider is confidential.
 - 2. Pricing information provided by a health insurer or health care provider may not be disclosed by the Arbitrator, Alternative Arbitrator or any other party participating in the Arbitration.
 - 3. Pricing information provided by a health insurer or health care provider may not be used by anyone, except the party providing the information, for any purpose other than to resolve the qualifying surprise out-of-network bill.
- 4. All information received by the Department in connection with the Arbitration is confidential and may not be disclosed to any person except the Arbitrator or Alternative Arbitrator.
- H. Arbitrator's Report. At the conclusion of each Arbitration, the Arbitrator shall produce a report to the Department that contains the following information:
 - 1. Date of Arbitration;
 - 2. Date the Arbitrator issued the Final Written Decision;
 - 3. Whether the parties settled the qualifying surprise out-of-network bill during the Arbitration;
 - 4. The initial amount billed by the health care provider;
 - 5. The payment amount awarded to the health care provider; and
 - 6. Any other information the Department may request an Arbitrator to report prior to an Arbitration.

Historical Note

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).