NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

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

PREAMBLE

1. Sections Affected	Rulemaking Action
Article 1	New Article
Article 1	Repeal
R9-7-101	New Section
R9-7-101	Repeal
R9-7-102	Repeal
R9-7-103	Repeal
R9-7-104	Repeal
R9-7-105	Repeal
R9-7-106	Repeal
R9-7-107	Repeal
R9-7-108	Repeal
R9-7-109	Repeal
R9-7-110	Repeal
Article 2	New Article
R9-7-201	New Section
R9-7-202	New Section
R9-7-203	New Section
R9-7-204	New Section
R9-7-205	New Section
R9-7-206	New Section
R9-7-207	New Section
R9-7-208	New Section
R9-7-209	New Section
R9-7-210	New Section
Article 3	New Article
R9-7-301	New Section
R9-7-302	New Section
R9-7-303	New Section
R9-7-304	New Section
R9-7-305	New Section
R9-7-306	New Section
Article 4	New Article
R9-7-401	New Section
R9-7-402	New Section
R9-7-403	New Section
R9-7-404	New Section
R9-7-405	New Section
R9-7-406	New Section
R9-7-407	New Section
R9-7-408	New Section
R9-7-409	New Section
R9-7-410	New Section
R9-7-411	New Section
R9-7-412	New Section
Article 5	New Article
R9-7-501	New Section
R9-7-502	New Section

R9-7-503	New Section
R9-7-504	New Section
R9-7-505	New Section
Article 6	New Article
R9-7-601	New Section
R9-7-602	New Section
R9-7-603	New Section
Article 7	New Article
R9-7-701	New Section
R9-7-702	New Section
R9-7-703	New Section

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

   Authorizing statute: A.R.S. §§ 36-136(F) and 36-261(3)

   Implementing statute: A.R.S. §§ 36-797.43, 36-797.44, 36-261, 36-264, and 36-143

3. **The effective date of the rules:**

   June 30, 1992

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

   None.

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

   Name: Kathleen Phillips

   Address: Arizona Department of Health Services
   1647 East Morten
   Phoenix, Arizona 85020

   Telephone: (602) 674-4350

   Fax: (602) 861-0463
   Or

   Name: Cathryn Echeverria

   Address: Arizona Department of Health Services
   1740 West Adams Street, Suite 200
   Phoenix, Arizona 85007

   Telephone: (602) 542-1860

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6. **An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:**

   The Children's Rehabilitative Services (CRS) program of the Department of Health Services administers a state-funded program of health care services for chronically ill or physically disabled children. The CRS rules, published in 1989, delineated CRS program application requirements, scope of services, parameters for medical and financial eligibility, authorization and reimbursement requirements, as well as rules for patient payments, patient medical records, termination of services, and dispute resolution.

   On June 30, 1992, in accordance with Laws 1991, Chapter 140, Section 4, Article 1 of the CRS rules was repealed and new Articles 1 through 7 were adopted by the Director. These rules were promulgated in response to the changing needs of the CRS Program, and to more clearly delineate covered services, exclusions and limitations, and other previously undocumented program requirements. Laws 1991, Chapter 140, Section 4 provided an exemption from the Administrative Procedure Act until July 1, 1992. The exempt rules substantially changed the CRS rules as follows:

   1. The rules were expanded from 1 article to 7 articles;

   2. The number of definitions were increased from 17 to 40;

   3. Article 2 was added to describe medical staff qualifications, medical committees, provider requirements and assignments, and terms and conditions of participation for physicians and dental providers;

   4. The list of medically eligible conditions was revised and expanded to provide a detailed listing of specific disorders eligible for CRS services;

   5. The description of rules for determining medical eligibility was expanded;

   6. Rules for determining residency and financial eligibility were expanded, including descriptions of documentation required,

and methods for calculating income and payments;

7. The percent pay category table was revised;

8. The scope of medical services section was greatly expanded to include limitations and exclusions to services, as well as prior authorization requirements;

9. Standards for the maintenance of patient medical records were removed from the rules;

10. Rules for claims submission were added;

11. Rules for enrollee payments were revised and expanded;

12. Reasons for terminating CRS services were modified to include exceptions for adult sickle cell anemia and cystic fibrosis programs, and termination for CRS for enrollees declining services or not using clinic services for more than 1 year; and

13. The dispute resolution section was expanded to include Article 7, Grievance and Appeals, which sets out procedures for filing of formal grievances by enrollees and applicants for medical or financial issues, and revises the methods for filing of appeals.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable.

8. **The summary of the economic, small business, and consumer impact:**
Not applicable.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**
Not applicable.

10. **A summary of the principal comments and the agency response to them:**
Not applicable.

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
Not applicable.

12. **Incorporations by reference and their location in the rules:**
None.

13. **Was this rule previously adopted as an emergency rule?**
No.

14. **The full text of the rules follows:**

TITLE 9. HEALTH SERVICES

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

ARTICLE 1. DEFINITIONS

Section
R9-7-101. Definitions

~~ARTICLE 1. CHILDREN'S REHABILITATIVE SERVICES PROGRAM~~

~~R9-7-101. Definitions~~
~~R9-7-102. Application requirements~~
~~R9-7-103. Medical eligibility~~
~~R9-7-104. Financial eligibility~~
~~R9-7-105. Scope of services~~
~~R9-7-106. Authorization and reimbursement~~
~~R9-7-107. Patient payments~~
~~R9-7-108. Patient medical records~~
~~R9-7-109. Termination of services~~

ARTICLE 2. MEDICAL STAFF

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R9-7-202. Application for rostering
R9-7-203. Rostering procedures; exemptions
R9-7-204. Terms and conditions of participation for physicians and dental providers
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ARTICLE 3. MEDICALLY ELIGIBLE CONDITIONS

R9-7-301. Medically eligible conditions
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R9-7-303. Establishing medical eligibility
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R9-7-305. Change of service or scope of review
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ARTICLE 4. RESIDENCY AND FINANCIAL ELIGIBILITY REQUIREMENTS

R9-7-401. Initial application
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R9-7-403. Age requirement
R9-7-404. Financial eligibility
R9-7-405. Adjusted annual income

ARTICLE 1. DEFINITIONS

R9-7-101. Definitions

In this Article, unless the context otherwise requires:

1. "Acute Health Care" means emergency and follow-up health care provided in response to the initial stages of disease or injury.
2. "ADA" means the American Dental Association.
3. "AFDC" means the Aid for Dependent Children program administered by the Arizona Department of Economic Security.
4. "AHCCCS" means the Arizona Health Care Cost Containment System.
5. "Allowable charges" means the maximum amounts payable by CRS based on the Health Care Financing Administration Common Procedure Coding System for services by physicians and vendors, and on the AHCCCS reimbursement system for hospital services.
6. "ALTCS" means the Arizona Long-term Care System.
7. "Applicant" means a person for whom application to CRS is being made and the person's parents, legal guardian, legal custodian or any person legally responsible to financially support the applicant if the applicant is under 18 years of age or otherwise under legal disability.
8. "Community Clinic" means a clinic held outside regional contractor sites but not on an Indian reservation.
9. "Contractor" means any non-State entity or person with whom CRS has contracted to provide specific services.
10. "Court-ordered child support" means payments made by the applicant, the applicant's parents and any other person legally obligated to provide for the care of the applicant for a minor child living outside of the household of the applicant as ordered by the Arizona Court for child support.
11. "CRS" means Children's Rehabilitative Services, a program administered by the Division of Family Health, Arizona Department of Health Services.
12. "CRS Clinic" means an established CRS clinic held at a regional contractor site.
13. "CRS Medical Director" or "Medical Director" means the person appointed by the Director to provide appropriate advice and counsel regarding medical matters to the CRS Office Chief, and any person specifically delegated in writing by the CRS Medical Director to exercise any or all of the CRS Medical Director's authority.
14. "CRS Office Chief" means the employee of the Department appointed to act as chief administrator for the Children's Rehabilitative Services program.
15. "Department" means the Arizona Department of Health Services.
16. "DES" means the Arizona Department of Economic Security.
17. "Earned income" means cash or in-kind received from the receipt of wages, salaries, commissions or profit from activities in which an individual is engaged as an employee or self-employed person.
18. "Enrollee" or "CRS enrollee" means an applicant who has a CRS eligible medical condition confirmed at the 1st clinic visit, has completed both the CRS financial interview and signed a CRS Financial Agreement, and who has been determined as eligible for CRS and approved for participation in CRS.
19. "Family" means the applicant or enrollee, the applicant's or enrollee's parents and any other person legally responsible to financially support the applicant or enrollee.
20. "Family size" means the applicant, parents or other persons legally responsible to financially support the applicant and their dependents who reside in the same household.
21. "Fee-for-Service" means a reimbursement method in which payment is made in accordance with a particular fee or rate for individual encounters in the CRS Program.
22. "FHAMIS" means the Family Health Automated Management Information System maintained by the Department.
23. "Field clinic" means a clinic held on an Indian reservation.
24. "Handicapping" means those physical impairments that limit 1 or more major life activities.
25. "HCPCS" means the Health Care Facilities Administration common procedure coding system which is incorporated herein by reference.
26. "Incapacitated adult" means a person over 18 years of age who is subject to a mental or physical disability as determined by a court or a physician.
27. "Major life activities" means caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.
28. "Medical Assistance" means the Title XIX portion of the AHCCCS program, which also includes S.O.B.R.A., Ribicoff and ALTCS programs.
29. "Medical staff" means all physicians and dentists employed by or under contract with CRS.
30. "Multidisciplinary clinic" means a clinic setting that utilizes more than 1 medical specialty physician in the treatment of an individual.
31. "Primary care provider" means the physician or other health care provider providing primary and acute health care for medical conditions not eligible under CRS.
32. "Primary condition" means a diagnosis which qualifies as a medically eligible condition for CRS services and

which provides the medical eligibility component to qualify an applicant or enrollee to receive CRS services.

33. "Primary health care" means routine health care provided to prevent disease, treat injury or maintain general health.
34. "Regional Medical Director" means the physician appointed by the ADHS Director to provide appropriate input on medical issues to the regional administration, statewide medical executive committee and the CRS Office Chief, and any person specifically delegated in writing by the Regional Medical Director to exercise any or all of the Regional Medical Director's authority.
35. "RSDI" means benefits paid by the Social Security Administration under Title II of the Social Security Act to retired or disabled wage earners, or surviving children or spouses of wage earners.
36. "Seasonal worker" means a person who is regularly employed for less than a full twelve months each year or a person who is regularly employed for a full twelve months but who is not paid during each of the twelve months.
37. "S.O.B.R.A." means the Sixth Omnibus Reconciliation Act and refers to a program which provides Medical Assistance to eligible pregnant women as soon as possible following verification of pregnancy, and provides Medical Assistance to eligible children born on or after October 1, 1983.
38. "Title XIX" means the Federal Medicaid Program which provides health care to financially eligible persons and which is administered jointly by the U.S. Department of Health and Human Services and the State.
39. "Unearned income" means monies received for which no labors were expended, but does not include monies received from conversion of assets from one form to another.
40. "Vendor services" means services provided by agencies with which the Department directly contracts to provide services or equipment not covered under provider contracts.

~~ARTICLE 1. CHILDREN'S REHABILITATIVE SERVICES PROGRAM~~

~~R9-7-101. Definitions~~

~~In this Article, unless the context otherwise requires:~~

1. ~~"Acute health care" means emergency and follow-up health care provided in response to the initial stages of disease or injury.~~
2. ~~"Applicant" means a child for whom application to CRS is being made.~~
3. ~~"Central nervous system" [CNS] means brain and spinal cord.~~
4. ~~"Congenital anomaly" means a physical abnormality apparent at birth which causes functional or psychological impairment.~~
5. ~~"Craniofacial anomaly" means a malformation of the head or face.~~
6. ~~"CRS" means Children's Rehabilitative Services.~~
7. ~~"CRS patients" means those persons admitted to provided hospitals or clinics under CRS authorization and those persons accepted for the purpose of evaluating their medical needs and eligibility.~~
8. ~~"Field clinic" means a clinic held outside the CRS regional clinic sites in Phoenix, Tucson, Flagstaff and Yuma.~~
9. ~~"Idiopathic" means of unknown cause.~~
10. ~~"Initial diagnostic evaluation" means a medical examination by a CRS staff physician for purposes of determining medical eligibility. This evaluation may include diagnostic tests ordered at the time of examination.~~
11. ~~"Medical Director" means the individual delegated by the Director to manage CRS.~~
12. ~~"Medical staff" means all physicians, dentists, and scientists employed by or under contract to CRS.~~
13. ~~"Neoplasm" means tumor.~~
14. ~~"Primary health care" means routine health care provided to prevent disease, treat injury, or maintain general health.~~
15. ~~"Primary care provider" means the physician or agency providing primary and acute health care for medical conditions not eligible for CRS.~~
16. ~~"Sequelae of trauma" means abnormalities resulting from a previous injury.~~
17. ~~"Service coordination" means coordination of services within CRS and to a limited extent within the community to assure the patient's treatment goals are achieved.~~

~~R9-7-102. Application requirements~~

~~A. All children under the age of 21 years, residing in Arizona at the time of service, who meet the medical criteria and whose families meet the financial criteria established by the Department shall be eligible for CRS, except as provided in R9-7-109.~~

~~B. Any patient who wishes to apply for care under CRS shall submit a complete medical history and referral to one of the CRS program sites for physician review.~~

~~R9-7-103. Medical eligibility~~

~~A. Arizona CRS shall accept children who are chronically ill or who have physically handicapping conditions which have a potential for cure or significant improvement through medical, surgical or therapy modalities. Conditions which shall be covered include:~~

1. ~~Congenital anomalies;~~
2. ~~Acquired handicapping, or potentially handicapping, orthopedic, neurologic, and cardiac disorders;~~
3. ~~Hereditary and idiopathic disorders of the nervous system;~~
4. ~~Neoplasms:~~
   a. ~~Benign, which, if not removed, would cause significant risk for a handicapping condition;~~
   b. ~~Malignant, with a favorable prognosis;~~
5. ~~Chronic eye and ear disorders which could lead to blindness or deafness;~~
6. ~~Scarring which could cause deformities;~~
7. ~~Phenylketonuria (PKU) and inborn errors of metabolism;~~
8. ~~Connective tissue disorders;~~
9. ~~Central nervous system degenerative disorders;~~
10. ~~Cystic fibrosis;~~
11. ~~Sickle cell anemia; and~~
12. ~~Sequelae of trauma.~~

~~B. Infectious diseases, acute trauma, burns, and intoxications shall not be covered by the CRS program except under limited circumstances in which there is a direct relationship between these conditions and the CRS condition.~~

~~C. Transplants other than bone and cornea shall not be covered by CRS.~~

~~D. Sequelae of traumatic spinal cord injuries shall not be covered by CRS.~~

E. In order to establish medical eligibility, an initial diagnostic evaluation shall be performed by CRS.
1. The patient or parent or legal guardian of a minor patient shall be required to sign a general consent to permit medical examination and other related tests and evaluations involving the patient.
2. If the parent or legal guardian cannot accompany the child on the first visit, the parent or legal guardian shall send a signed medical consent with the child.

R9-7-104. Financial eligibility

A. The Department shall determine whether an applicant is financially eligible for services based upon the family's adjusted annual income. All families shall be required to participate in a financial interview with a CRS employee or a specifically authorized contractor of CRS for the purpose of determining the family's financial obligation for medical treatment received.

B. The family's adjusted annual income shall be calculated by:
1. Summarizing all cash receipts, before taxes, from all sources for the previous twelve months except:
a. Assets drawn as withdrawals from a bank, or from the sale of property including a vehicle;
b. Tax refunds, gifts, lump sum inheritances, insurance reimbursements, or compensation for injury;
c. One-half the child's step-parent's income if living in the household; or
d. Loans from financial institutions or insurance policies.
2. Subtracting medical and dental expenses. These expenses include:
a. Health insurance premiums paid for any family member in the household during the previous 12-month period;
b. Unpaid medical and dental expenses incurred by family household members during the 24 months prior to the date of application which are the family's responsibility and not subject to any third party payment; and
c. Medical and dental expenses paid directly by the family for any household member during the 12 months prior to the date of application.
3. Subtracting business expenses of a self-employed patient, parent, or legal guardian.

C. The percentage of the family's financial responsibility shall be determined by comparing the adjusted annual income and family size to the following table:

FINANCIAL ELIGIBILITY SUMMARY TABLE

Size of Family Unit*	Adjusted Annual Income - Percentage of Financial Responsibility					
	0%	3%	6%	9%	12%	15%
1	$0 - 5,980	$5,981 - 7,980	$7,981 - 9,980	$9,981 - 11,980	$11,981 - 13,980	$13,981 - 15,980
2	$0 - 8,020	$8,021 - 10,020	$10,021 - 12,020	$12,021 - 14,020	$14,021 - 16,020	$16,021 - 18,020
3	$0 - 10,060	$10,061 - 12,060	$12,061 - 14,060	$14,061 - 16,060	$16,061 - 18,060	$18,061 - 20,060
4	$0 - 12,100	$12,101 - 14,100	$14,101 - 16,100	$16,101 - 18,100	$18,101 - 20,100	$20,101 - 22,100
5	$0 - 14,140	$14,141 - 16,140	$16,141 - 18,140	$18,141 - 20,141	$20,140 - 22,140	$22,141 - 24,140
6	$0 - 16,180	$16,181 - 18,180	$18,181 - 20,180	$20,181 - 22,180	$22,181 - 24,180	$24,181 - 26,180
7	$0 - 18,220	$18,221 - 20,220	$20,221 - 22,220	$22,221 - 24,220	$24,221 - 26,220	$26,221 - 28,220
8	$0 - 20,260	$20,261 - 22,260	$22,261 - 24,260	$24,261 - 26,260	$26,261 - 28,260	$28,261 - 30,260

* For family units with more than eight members, add $2,040 for each additional family member.

D. Applicants who are eligible for and enrolled in the Arizona Health Care Cost Containment System (AHCCCS) or are wards of charitable organizations or the court shall be financially eligible at the lowest payment category regardless of income. Enrollment in AHCCCS shall be verified by CRS.

E. CRS applicants who appear to be AHCCCS eligible shall be referred to AHCCCS for enrollment.

E Families with adjusted annual incomes exceeding financial eligibility limits indicated in the table may participate in the CRS program in a full-pay category if they meet at least one of the following criteria:
1. The child is being treated for scoliosis, myelomeningocele (spina bifida), cerebral palsy, craniofacial anomaly, phenylketonuria (PKU), or other related inborn error of metabolism;
2. The child is in the process of completing a course of treatment that was initiated when the family was financially eligible;
3. The child requires specialty services available through the local CRS program which are not available elsewhere in the community; or
4. The child has a CRS eligible condition of particular interest or rarity and for which coverage has been approved in writing by the Medical Director.

F. Each patient or parent or legal guardian of a minor patient shall complete and sign a payment agreement which shall acknowledge the family's financial responsibility and shall contain an assignment of benefits.

G. Unless a re-evaluation is requested by the family or the Department, the financial determination shall remain in effect for 12 months from the date of determination.

I. Another financial interview shall be conducted after each 12-month period.

J. The Department may at any time require the patient, parent or legal guardian of an applicant to provide proof of claimed income and adjustments.

R9-7-105. Scope of services

A. Services delivered under CRS shall be provided directly by the Department or through contracted facilities, agencies, and/or individuals.

B. The services which shall be provided under CRS are as follows:

1. Physician services by specialists who are members of the medical staff;
2. Regularly scheduled specialty clinics in Phoenix, Tucson, Flagstaff and Yuma; specialty field clinics in rural areas of the state as directed by the Medical Director;
3. Hospital inpatient/outpatient and surgical services when such services are related to the CRS qualifying medical condition and are authorized by the Medical Director or designee;
4. Diagnostic services, including laboratory, pathology and radiology procedures for CRS patients for the purpose of determining the CRS qualifying medical condition and for monitoring the course of treatment or the patient health status;
5. Rehabilitative services, including physical, occupational, speech and audiological services for evaluation, re-evaluation, treatment, consultation and follow-up to maintain or improve the physical status and capabilities of the child;
6. Appliances, equipment and equipment modifications necessary to maintain or improve mobility or function;
7. Orthodontic and prosthodontic dental care for CRS patients suffering from craniofacial anomalies;
8. Home health care for CRS patients discharged from the hospital and needing medical care while recovering at home; these services shall be limited to intermittent nursing care, medications, intravenous administration, nutrition therapy, pain control therapy and the in-home teaching of care techniques;
9. Social service assistance to provide casework and family assessment and to aid patients and their families in obtaining community assistance;
10. Psycho-social services on a limited basis to CRS eligible children and their families; assessment, counseling and referral shall be available as they relate specifically to the child's CRS medical condition; long term counseling needs shall be referred to the community;
11. Pharmaceuticals as prescribed by a CRS medical staff physician; and
12. Service coordination to CRS eligible children and their families.

C. CRS program staff may function as advocates in cases of dispute between families and CRS contract providers.

D. Services which are excluded from CRS are as follows:
1. Acute or primary health care; and
2. Emergency transport other than authorized transfers between CRS contract facilities.

R9-7-106. Authorization and reimbursement

A. Prior written authorization shall be required for all services delivered to CRS patients except services provided during regularly scheduled CRS clinics, or delivered in emergency situations.
1. Authorization to provide CRS services shall be obtained as follows:
   a. A CRS provider service requisition shall be obtained from the Department, completed by the child's CRS physician, and submitted to the appropriate regional CRS office for approval.
   b. CRS shall distribute the authorization to the child's CRS physician and other providers designated on the requisition. Upon receipt of the authorization, services shall be scheduled and/or provided.
   c. If the requested services are not approved, or are approved with modification, the physician may request, in writing, a review of the case by the Medical Director.
2. In the event of a medical emergency, authorization shall be requested within 96 hours of commencement of treatment.

B. Reimbursement for services provided to CRS patients shall be as follows:
1. A contract provider shall be reimbursed by the Department according to the terms of the contract.
2. A non-contract provider shall be reimbursed on a fee-for-service basis not to exceed the prevailing rates in the community.

R9-7-107. Patient payments

A. Patients shall pay their share of the medical cost based upon the financial eligibility determination.
1. Individual patient billings shall be determined by applying the financial responsibility percentage to the total allowable charges after third party payments have been deducted. Allowable charges are all charges for services other than first visit charges and/or facility or physician charges for subsequent clinic visits.
2. Patient billings shall be issued directly by the Department or by the contract provider designated under the terms of the contract.

B. If insurance benefits for CRS authorized services are paid to the patient, parent or legal guardian or a minor patient, the amount of the insurance payment shall be immediately due and payable to CRS.

R9-7-108. Patient medical records

A. The patient's medical record shall be maintained and kept by the Department except that active records shall be maintained by the providers contracted to provide CRS hospital or clinical services. All information contained in the patient's medical record shall be confidential and shall be released pursuant to the provisions of R9-1-311 et seq.

B. Copying costs shall not be charged when a record is released to a patient, legal guardian, physician or government agency. All others shall be charged according to the prevailing copy rates of the current custodian.

C. Patient records shall be retained for 20 years from the date of the last patient encounter by CRS.

D. Records shall be obtained from CRS only by submitting a written request to the Department or the CRS contract facility.

R9-7-109. Termination of services

CRS patient services shall terminate upon the occurrence of any of the following:
1. Patient establishes residence outside the state of Arizona.
2. Patient reaches the age of 21 years unless the patient is completing an approved course of treatment begun before the patient reached the age of 21;
3. Change in the patient's medical eligibility factors;
4. Change in financial eligibility, except as provided in R9-7-104(F)(2); or
5. Death of the patient.

R9-7-110. Dispute resolution

Any applicant or family who wishes to protest a medical or financial determination or a denial of requested services shall file a written protest with the local CRS representative within 30 days of the disputed action. The local CRS representative or the CRS medical director shall acknowledge a protest in writing, within 15 working days of receipt, shall review the merits of the protest and

~~send written notice of the decision, conclusions, and reasons to the applicant within 30 working days of the acknowledgement. The applicant may file an appeal, in writing, with the Arizona Department of Health Services, Director's Office.~~

ARTICLE 2. MEDICAL STAFF

R9-7-201. Provider services; participation

A. Physician and dental services delivered under contract to CRS enrollees shall be provided only by physicians and dentists who meet the terms and conditions of provider participation in CRS and who are placed on a Department roster pursuant to R9-7-202 and R9-7-203.

B. Each physician or dental provider contracting with CRS shall sign an acceptance of the terms and conditions of participation in CRS.

C. The Medical Director shall maintain the roster of all physician and dental providers who are eligible to provide CRS services.

D. Physicians and dental practitioners who are members of the medical staff and whose active status and assignment to a clinic have previously been determined prior to the effective date of R9-7-202, R9-7-203, R9-7-207.A, R9-7-208 and R9-7-209 shall be exempt from those rules. A member of the active staff who does not have a clinic assignment shall be similarly exempt except for R9-7-209. Physicians and dental practitioners who are members of the medical staff but who are on provisional status prior to the effective date of R9-7-202, R9-7-203 and R9-7-208.A shall be exempt from those rules.

E. Clinic assignments for physician or dental providers shall be based upon the need to ensure that necessary services to CRS enrollees are effectively and efficiently provided within CRS's appropriation.

F. A physician or dental practitioner shall not receive reimbursement for CRS billable services unless 1st rostered for participation with the Department.

R9-7-202. Application for rostering

A. A physician or dental practitioner shall apply for CRS rostering by submitting an application to the CRS Regional Medical Director which shall then be reviewed and a recommendation made by the CRS regional medical executive committee to the CRS Medical Director.

B. To be eligible for rostering and participation in CRS under the conditions of participation, a physician or dental practitioner shall:
   1. Be a resident of Arizona and licensed to practice medicine or dentistry in the state;
   2. Provide evidence of demonstrated competency in a CRS specialty by producing such documentation as may be requested and specified by the Medical Director regarding past medical outcomes, past medical diagnoses and past medical interventions;
   3. Provide evidence of demonstrated skill and experience in the treatment of children;
   4. Submit 3 sponsoring letters from specialists in the same specialty field as the candidate who are licensed to practice in Arizona, who are unrelated to and not currently associated with the candidate, but who have personal knowledge of the candidate's current clinical ability in the provision of care, ethical character, and ability to work cooperatively with others.

C. Physicians and dental practitioners who apply for rostering and participation in CRS shall provide CRS with evidence of the following:
   1. For physicians and dental practitioners who provide CRS services in hospitals which also contract with CRS to provide services, medical malpractice insurance in such amounts as are required by those hospitals.
   2. For physicians and dental practitioners not included in subsection (C)(1), medical malpractice insurance in such amounts as are required by the group or individual contract under which the physician or dental practitioner provides CRS services.
   3. Current licensure.

D. In addition to (B) and (C), a physician applying for rostering shall comply with the following:
   1. The physician shall provide evidence of appropriate training and experience in the CRS specialty in which the candidate anticipates participation, including evidence of board certification by a board recognized by the American Board of Medical Specialties or the American Board of Osteopathic Specialties, or evidence of eligibility for such boards.
   2. A physician having no experience in the treatment of infants or young children but who otherwise complies with subsections (B)(1), (2), and (4), (C)(1), (2), and (3), and (D)(1) of this rule may be approved to supervise the care of children over 13 years of age.
   3. Provisional rostering may be considered for a candidate who does not comply with subsection (D)(1) and who practices in a geographical area where there are no physicians rostered in the candidate's specialty, upon the candidate providing evidence of appropriate training and experience. Such evidence shall demonstrate that the criteria for the candidate's formal academic training is similar to the requirements of a specialty board recognized by the American Board of Medical Specialties or the American Board of Osteopathic Specialties. Provisional rostering shall be valid for a period of 2 years. A physician who is provisionally rostered shall qualify for board certification before the expiration of that time period or the physician shall be removed from rostering and participation. An extension of this time period may be granted for good cause by the CRS Medical Director.

E. In addition to (B) and (C) above, a dental practitioner applying for rostering shall comply with the following:
   1. Provide evidence of board certification by a board recognized by the American Board of Orthodontics, the American Board of Prosthodontics or the American Board of Pediatric Dentistry; and
   2. Have had either a minimum of 2 years of graduate training in orthodontics or prosthodontics or a recognized preceptorship training.

R9-7-203. Rostering procedures; exemptions

A. Following a review of an application and required documentation, a regional medical executive committee and the regional medical director shall submit a signed recommendation to the CRS Medical Director requesting approval or denial of rostering for the physician or dental practitioner. The recommendation shall verify that the regional medical executive committee has reviewed the candidate for compliance with all standards required by these rules for medical staff. The CRS Medical Director shall, in writing, grant or deny the application for rostering.

B. Rostering may be granted without review in exceptional circumstances by the CRS Medical Director:
   1. Temporary rostering may be approved for a physician or dental practitioner by the CRS Medical Director. Requests for temporary rostering shall be made by the

Regional Medical Director or chairperson of the contracted medical staff prior to the medical event which requires the services of the physician or dental practitioner. A physician or dental practitioner shall be allowed 2 temporary rostering events per year. Any further participation shall be allowed only after completion of the formal application for rostered status.

2. In emergency situations, a physician or dental practitioner who is not rostered may be utilized if a rostered physician or dental practitioner is not immediately available and approval is 1st secured from the CRS Medical Director either by phone with a follow-up by written documentation outlining the emergency, or in writing with adequate documentation. A failure to provide advance planning shall not constitute an emergency.

R9-7-204. Terms and conditions of participation for physicians and dental practitioners.

A. Physicians and dental practitioners who are approved for rostering and participation in CRS shall acknowledge and agree to the following terms and conditions:

1. There is no evidence of professional performance by the physician or dental practitioner which is not consistent with recognized standards of care or professional conduct. Further, there is no prior or current adverse action taken against the physician or dental practitioner based upon professional standards or performance grounds taken by a hospital medical board, a professional society, the Secretary of Health and Human Services, or by any licensing or regulatory organization or court of competent jurisdiction.
2. The physician or dental practitioner shall maintain staff membership and admission privileges in good standing at the appropriate CRS-contracted regional clinics, regional hospital, or both, at which the physician's or dental practitioner's services are to be provided.
3. The physician or dental practitioner shall actively participate in CRS through clinics, office visits, consults, committees, or other functions as assigned by the Medical Director.
4. The physician or dental practitioner shall provide services in accordance with standards prescribed by state and federal laws and rules and regulations relating to CRS and Title XIX of the Social Security Act, and in the best interests of a CRS enrollee.
5. The physician or dental practitioner shall provide services in accordance with standards prescribed by national professional organizations for the care of handicapped children and in compliance with all CRS rules and policies.
6. The physician or dental practitioner shall provide only such treatment and services as are medically necessary and appropriate and covered under CRS, irrespective of contingent medical conditions, and which are within the scope of the provider's license and specialty.
7. The physician or dental practitioner shall provide services to enrollees only upon receipt of a written referral from the attending physician/clinic site.
8. The physician or dental practitioner shall coordinate the provision of covered services to enrollees by counseling, authorizing referrals for specific covered CRS services and providers, monitoring progress and managing utilization of services.
9. The physician or dental practitioner shall comply with CRS billing practices, including billing format, timeliness, 3rd-party collections and CRS reimbursement.
10. The contractor shall submit accurate and complete claims, using current CRS codes, modifiers, and forms.
11. The State is the payor of last resort. The physician or dental practitioner shall pursue collection from insurance companies and 3rd-party payors and may bill a family only that percentage of the CRS allowable charges which was determined to be the family's financial responsibility percentage when the family's financial eligibility was established. A physician or dental practitioner shall not bill a family which has a CRS financial responsibility of 0%, or more than a family's financial responsibility percentage of a CRS allowable charge. Percentage of family responsibility shall appear on all service authorization forms.
12. The physician or dental practitioner shall not bill AHCCCS for covered CRS services to AHCCCS-enrolled clients when such services have been authorized by CRS; nor shall the contractor bill enrollees, families or guardians for covered CRS services provided to AHCCCS enrollees.
13. The physician or dental practitioner shall make and maintain a record of service for each CRS-covered enrollee encounter.
14. The physician or dental practitioner shall submit service requisitions and report all CRS client services provided to CRS in accordance with CRS procedures.
15. The physician or dental practitioner shall obtain prior written authorization from CRS for all hospital admissions, outpatient surgeries, office visits and related medical procedures, except where emergency treatment is indicated.
16. If participating in CRS programs which involve instruction of medical residents or other similar educational components, the physician or dental practitioner shall abide by the medical and educational protocols approved by the Medical Director for such programs.

B. All physicians and dental practitioners who are rostered and participate in CRS shall, every 2 years, sign a form acknowledging the terms and conditions set forth in subsection A of this rule.

R9-7-205. Medical executive committees

A. There is established a statewide medical executive committee of physicians and dental practitioners, who are rostered and participate in CRS, to provide advice in the areas of CRS policy, quality assurance, utilization review, rostering, staffing and assignment of clinic privileges, and the suspension or revocation of rostering, staffing and clinic assignment to the CRS Medical Director, CRS Chief and the Director of the Department.

1. The committee shall consist of the president and vice presidents of each of the regional executive medical committees. The regional medical directors, the regional program administrators and the CRS Medical Director and Chief shall be non-voting members.
2. The statewide medical executive committee shall carry out its responsibilities in accordance with these rules and such bylaws as it may adopt and which are approved by the Director.

B. There is established a regional medical executive committee for each of the 4 regions/clinic sites, elected by the active medical staff serving each region, to provide advice to the Regional Medical Director and the Statewide Medical Executive Committee on issues of CRS policy, quality assurance, utilization review, rostering, staffing and assignment of clinic privileges at the local clinic site.

1. Each regional medical executive committee shall consist of members of the active staff providing CRS services in the region who are elected by that staff, the Regional Medical Director and the chief administrator of the clinic site, both of the latter shall be non-voting members.
2. The regional medical executive committee shall determine and establish such offices, at a minimum to include a president and vice-president, number of members, terms of office and such bylaws as are necessary to carry out the responsibilities of the committee.

R9-7-206. Medical staff assignment; categories

The regional medical executive committee for the area in which a physician or dental practitioner offers services shall review the physician and dental practitioner application for staffing in accordance with the criteria set forth in R9-7-207 and R9-7-208 and shall make a recommendation to the Regional Medical Director regarding assignment of such applicant to the CRS medical staff as either active or provisional staff. The Regional Medical Director shall transmit such recommendations to the CRS Medical Director who may approve or amend the recommendation.

R9-7-207. Active medical staff

A. Appointment to the active staff shall be based upon the following factors:
   1. Length of service on the provisional staff, but not less than 2 years,
   2. Need for additional physician or dental services on the active staff,
   3. Evaluation of the provisional staff member's administrative or managerial skill,
   4. Attendance and performance at staff meetings,
   5. Attendance and performance while doing rounds,
   6. Attendance and performance during surgery and at outpatient clinics,
   7. Professional competence and clinical judgment in the treatment of patients,
   8. Compliance with rules,
   9. Ability to work effectively with patients, CRS personnel and the public,
   10. The evaluation and recommendation of the chief or the senior member of the service involved, and
   11. Length and quality of service on the medical staffs of other institutions comparable to CRS.

B. Members of the active medical staff may perform for CRS enrollees, without restriction, surgery and other professional services in accordance with their specialties and privileges. Except as otherwise provided by these rules, only active staff members shall be in charge of clinics. All business of the CRS medical staff shall be transacted by the active staff.

R9-7-208. Provisional medical staff

A. Those physicians or dental practitioners not assigned to the active staff shall be designated as provisional staff.

B. A provisional staff member may refer patients only from the member's own practice. Provisional staff shall not be assigned primary responsibility for the diagnosis and treatment of CRS enrollees referred from sources other than their own practices.

C. Provisional staff members may be assigned to areas of service where their activities may be observed by active staff. Provisional staff may assist in clinics and surgery and participate in teaching, rounds and meetings.

D. Provisional staff may be assigned to a clinic or placed in temporary charge of a clinic when no active staff qualified in the provisional staff member's specialty is available to meet the service need.

R9-7-209. Clinic assignments

A. A member of the active staff may request appointment to a clinic assignment. The regional medical executive committee shall review such request in accordance with subsection B for purposes of making a recommendation to the Regional Medical Director for submission to the statewide medical executive committee regarding appointment. The statewide committee shall review the recommendation and make a recommendation to the Director regarding appointment to the clinic.

B. Clinic appointments shall be based upon the following criteria:
   1. The physician's or dental practitioner's education and training,
   2. The physician's or dental practitioner's experience,
   3. Demonstrated competence by the physician or dental practitioner, and
   4. References, including an appraisal by the clinic department in which privileges are sought.

R9-7-210. Suspension or revocation of participation, staffing and clinic assignment

A. The Department may suspend or revoke the rostering and participation, staffing and clinic assignment of any physician or dental practitioner in CRS who violates any of the terms and conditions of participation set forth in R9-7-204(A), or any other rule set forth in this chapter, after notice and opportunity for a hearing pursuant to A.R.S. § 41-1061 et seq. and the Department's rules of practice and procedure, 9 A.A.C. 1, Article 1.

B. Censure of a rostered and participating physician or dental practitioner by a national or local medical or dental society, or sanctions imposed by any state licensing board for physicians or dental practitioners shall constitute grounds for suspension or revocation of rostering and participation, staffing and clinic assignment.

C. If the Department finds that the health, safety or welfare of any CRS enrollee is jeopardized by any physician or dental practitioner rostered and participating in providing CRS services and that it imperatively requires emergency action, and incorporates a finding to that effect in its order, the summary suspension of rostering and participation, staffing and clinic assignment of such physician or dental practitioner may be ordered pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined.

ARTICLE 3. MEDICALLY ELIGIBLE CONDITIONS

R9-7-301. Medically eligible conditions; ineligible conditions

A. Applicants with the following medical conditions shall be eligible for treatment by the CRS program:
   1. Cerebral palsy,
   2. Cleft lip and cleft palate,
   3. Myelomeningocele (spina bifida),
   4. Cystic fibrosis, and
   5. Neurofibromatosis,
   6. Metabolic diseases:
      a. Phenylketonuria,
      b. Galactosemia,
      c. Homocystinuria,
      d. Hypothyroidism,
      e. Maple syrup urine disease, and

f. Biotinidase deficiency.
7. Scoliosis.
8. Sickle cell anemia.
9. Cardiovascular system disorder:
   a. Congenital heart disease.
   b. Cardiomyopathies.
   c. Valvular disorders.
   d. Arrhythmias.
   e. Conduction defects.
   f. Rheumatic heart disease which is not in acute stage.
   g. Renal vascular hypertension, catecholamine hypertension.
   h. Arteriovenous fistulas, and
   i. Kawasaki disease which is not in the acute stage.
10. Endocrine system disorders:
   a. Hypothyroidism.
   b. Hyperthyroidism.
   c. Adrenogenital syndromes.
   d. Addison's Disease.
   e. Hypoparathyroidism.
   f. Hyperparathyroidism.
   g. Panhypopituitarism, and
   h. Diabetes insipidus.
11. Genito-urinary system disorders:
   a. Vesicoureteral reflux, chronic;
   b. Ectopic ureter;
   c. Ambiguous genitalia;
   d. Ureteral stricture;
   e. Hypospadias, complex;
   f. Obstructive uropathy, hydronephrosis;
   g. Deformity and dysfunction secondary to trauma; and
   h. Pyelonephritis which has failed medical management and requires surgical intervention.
12. Ear, nose, and throat disorders:
   a. Cholesteatoma;
   b. Chronic mastoiditis;
   c. Deformity and dysfunction secondary to trauma;
   d. Neurosensory hearing loss;
   e. Congenital malformations; and
   f. Significant conductive hearing loss equal to or greater than 30 decibels, pure bone average, which, despite medical treatment, requires hearing augmentation device.
13. Musculoskeletal system disorders:
   a. Osteochondrodysplasias:
      i. Achondroplasia,
      ii. Diastrophic,
      iii. Dwarfism, and
      iv. Larsen Syndrome.
   b. Juvenile rheumatoid arthritis and seronegative spondyloarthropathies.
   c. Orthopaedic complications of hemophilia, and
   d. Neuromuscular disorders:
      i. Progressive muscular dystrophy,
      ii. Arthrogryposis multiplex congenita, and
      iii. Spinal muscular atrophy.
   e. Bone and joint infections in a chronic stage.
   f. Upper limb malformations:
      i. Amputations and
      ii. Syndactly.
   g. Spinal deformity:
      i. Idiopathic scoliosis,
      ii. Congenital spine deformity,
      iii. Scheuermann's Disease, and
      iv. Spondylolisthesis.
   h. Cervical spine abnormalities, congenital and developmental, and
   i. Lower limb malformation:
      i. Leg length discrepancies,
      ii. Congenital deformity, and
      iii. Amputations.
   j. Collagen and vascular diseases.
14. Gastrointestinal system disorders:
   a. Tracheoesophageal fistula;
   b. Anorectal atresia;
   c. Hirschsprung's Disease;
   d. Diaphragmatic hernia;
   e. Gastroesophageal reflux which has failed medical management and requires surgical intervention;
   f. Deformity and dysfunction of at lease 3 months duration secondary to trauma;
   g. Biliary atresia;
   h. Congenital atresia, stenosis, fistuli or rotational abnormalities of the gastrointestinal tract; and
   i. Omphalocele after gastroschisis.
15. Nervous system disorders:
   a. Uncontrolled seizure disorders where there has been more than 2 seizures with documented adequate blood levels of 1 or more medications.
   b. Seizure disorders, simple or controlled, only when the enrollee is not covered by AHCCCS or private insurance.
   c. Myopathies and muscular dystrophies.
   d. Myoneural disorders.
   e. Neuropathies, hereditary and idiopathic.
   f. Central nervous system degenerative diseases.
   g. Central nervous system malformations and structural abnormalities.
   h. Hydrocephalus.
   i. Craniosynostosis of the sagittal or unilateral coronal sutures of a child less than 18 months of age.
   j. Myasthenia gravis, congenital or acquired.
   k. Benign intracranial tumor.
   l. Benign intraspinal tumor.
   m. Residual dysfunction after resolution of an acute stage of vascular accident, inflammatory condition or infection of the central nervous system.
   n. Tourette's Syndrome.
   o. Trigonotrigonocephly, with evidence of intracranial pressure as determined by medical review by the regional medical director.
16. Ophthalmologic disorders:
   a. Cataracts.
   b. Glaucoma.
   c. Disorders of the optic nerve.
   d. Disorders of the lacrimal duct system. AHCCCS members shall be treated through an AHCCCS provider.
   e. Retinopathy prematurity.
   f. Disorders of the iris, ciliary bodies, retina or lens.
17. Respiratory system disorders which manifest themselves as anomalies of larynx, trachea, and bronchi and which require surgical intervention.
18. Dermatologic disorders which are medically confirmed by the CRS Regional Medical Director:
   a. Craniofacial anomalies which require multidisciplinary treatments.
   b. Burn scars which are functionally limiting.

c. Microtia which are grossly deforming,
d. Macrotia which are grossly deforming,
e. Complicated nevi requiring staged procedure,
f. Hemangioma of functional or diagnostic concern, and
g. Craniosynostosis.

19. Genetic and metabolic disorders:
a. Amino acid and organic acidopathies,
b. Inborn errors of metabolism, and
c. Storage diseases.

20. Dental disorders:
a. Documented significant functional malocclusion;
b. Enrollees with shunts;
c. Cardiac enrollees at risk for septic bacterial endocarditis; and
d. Treatment-related problems (dilantin hyperplasia), for seizure disorder.

B. Any medical condition not specifically designated as eligible in this section or in R9-7-302 is ineligible for treatment by CRS.

R9-7-302. Special medical conditions

A. Both children and adult CRS enrollees shall be covered for all manifestations and complications usually associated with cystic fibrosis and sickle cell anemia.
B. Adults with cystic fibrosis or sickle cell anemia who are AHCCCS eligible shall not be eligible for CRS services.

R9-7-303. Establishing medical eligibility

A. Upon receipt of the Pediatric History and Referral Form, a medical review of the case shall be completed by the Regional Medical Director to determine medical eligibility.
B. For those cases where eligibility is in question, the applicant shall submit to an evaluation in a CRS pediatric screening clinic or specialty clinic by a member of the CRS medical professional staff. The Regional Medical Director shall then determine if the applicant has a primary condition which is eligible for treatment in CRS. In cases where, following such examination, medical eligibility is still in question, the final determination regarding eligibility shall be referred to and determined by the CRS Medical Director.

R9-7-304. Primary condition determination

Applicants enrolled in an AHCCCS plan shall include with the Pediatric History and Referral form all pertinent documentation and diagnostic test results to establish the potential CRS primary condition. The CRS physician or clinic shall determine the need for any additional diagnostic testing at the time of the 1st clinic visit.

R9-7-305. Change of service or scope of review

Referral of a CRS enrollee for a change in medical service or specialty not directly related to the current eligible medical condition shall be reviewed and documented by the Regional Medical Director.

R9-7-306. Discharge and notification

Upon discharge from a CRS clinic, a CRS clinic patient discharge form shall be completed and placed in the discharged enrollee's chart by the regional contractor. Entry into the ADHS or clinic computer system shall be updated. Written notification shall be sent to parents, legal guardians, CRS and contracted eligibility workers.

ARTICLE 4. RESIDENCY AND FINANCIAL ELIGIBILITY REQUIREMENTS

R9-7-401. Initial application

A. A person shall apply for care under CRS by submitting a complete Pediatric History and Referral form and a CRS Financial Application to 1 of the CRS regional clinics for screening by the Regional Medical Director. If the applicant is enrolled in an AHCCCS program, the Pediatric History and Referral form shall include the applicant's primary diagnosis by the primary care physician and all diagnostic testing results used to determine the primary diagnosis.
B. Upon receipt, the Pediatric History and Referral form shall be reviewed by the Regional Medical Director within 3 working days unless additional medical records are requested to determine if the applicant has an eligible medical condition for treatment under the CRS Program.
1. If the condition claimed on the Pediatric History and Referral form is not a CRS eligible medical condition, a denial letter shall be sent to the applicant and the referral source by the CRS regional clinic.
2. If the medical condition is CRS eligible, a medical appointment shall be made and written notification shall be sent to the applicant and the referral source.
C. The applicant shall provide all necessary information to an on-site representative of DES or a CRS staff member to determine financial eligibility. An applicant shall complete the Medical Assistance Screening form if the applicant is not determined to be in the 100 percent pay category or is not already receiving Title XIX assistance.
D. An applicant shall not be eligible to receive vendor services at the time of or after the initial clinic visit until the CRS financial determination has been made and the CRS financial agreement has been signed unless newborn screening is indicated.
E. At the 1st clinic visit, an applicant shall sign a general authorization to permit medical examination and other related procedures, tests and evaluations involving the applicant. If the parent, guardian or legal custodian cannot accompany a minor applicant on the 1st clinic visit, the parent, guardian or legal custodian shall provide a signed and notarized medical consent form to accompany the minor.

R9-7-402. Residency requirements

A. An applicant shall show written proof of residency. All applicants shall sign an affidavit stating current residency and intent to remain in Arizona at the initial CRS financial interview.
B. Arizona residency shall be established by providing 1 of the following types of documents:
1. Rent or mortgage receipt, or lease in the applicant's name showing the residential address.
2. Non-relative landlord statement indicating the applicant's name and address as well as the landlord's name and address and telephone, if available.
3. Statement from the nursing facility in which the applicant resides
4. Arizona driver's license.
5. Arizona motor vehicle registration
6. Employer's statement.
7. Utility bill in the applicant's name indicating the applicant's address.
8. Current phone directory showing applicant's name and address.
9. United States Post Office records which show the applicant's name and address.

10. A current city directory showing the applicant's name and address.
11. Certified copy of a church record which indicates the applicant's name and address.
12. Certified copy of a school record which indicates the applicant's current address.
13. If all reasonable efforts have been made by the applicant to obtain documented verification, the affidavit signed by the applicant attesting to the applicant's present residence in Arizona and intent to remain shall be sufficient.

R9-7-403. Age Requirement

An applicant shall provide proof of age at the initial CRS financial interview. Documents which may be used to verify age are as follows:

1. Alien documents;
2. Federal or state census records;
3. Hospital records of birth;
4. Certified copy of birth certificate;
5. Military records;
6. Notification of birth registration;
7. Religious records showing age or date of birth;
8. School records;
9. Affidavit signed by the licensed physician, licensed midwife or other health care professional who was in attendance at the time of the birth attesting to the date of birth;
10. U.S. Passport; and
11. If all reasonable efforts have been made by the applicant to obtain documented verification, an affidavit signed by the applicant may be accepted.

R9-7-404. Financial Eligibility

Every CRS applicant shall participate in a face-to-face financial interview with a designated CRS staff member or a DES on-site worker, except for applicants who are enrolled in a Title XIX AHCCCS program and who do not have insurance.

1. An applicant shall complete the CRS financial eligibility process and Medical Assistance screening.
2. If the applicant is requested to provide additional verification documentation, the applicant shall provide the required documentation and complete the eligibility process within 10 working days of receipt of the request.
3. An applicant shall sign the CRS Financial Agreement. If an applicant is a ward of the Arizona court or enrolled in an AHCCCS program, the CRS Financial Agreement shall be signed only if the applicant has insurance.
4. An applicant shall complete the CRS financial and Medical Assistance screening and sign the CRS Financial Agreement, if required, in order to receive services from the CRS Program beyond the 1st clinic visit.
5. A family's adjusted gross income shall be determined based upon verification of income and documented dental and medical bills and such deductions as are otherwise permitted by these rules. The percent of financial responsibility shall be determined by comparing the family's adjusted gross income and family size to the program's financial eligibility standards as specified in Table 1;
6. An applicant assigned to the 100 percent pay category who is not eligible for CRS services in accordance with R9-7-410 may elect to be screened to determine eligibility for Medical Assistance.
   a. If the applicant is found to be ineligible for Medical Assistance, a referral to the CRS clinic social services may be offered.
   b. If the applicant is found to be potentially eligible for Medical Assistance, the applicant shall complete the Medical Assistance application at the DES local site or at the CRS regional contractor site if CRS coverage is desired. If potentially eligible for ALTCS, the applicant shall attend an interview at an ALTCS office.
7. If a family is determined to be either partially financially responsible or having no financial responsibility, an applicant shall complete the Medical Assistance financial screening to receive CRS coverage:
   a. If the applicant is found to be potentially eligible for Medical Assistance, the applicant shall complete the Medical Assistance application at the DES local site or at the CRS Regional Contractor site if CRS coverage is desired.
   b. An applicant who does not complete the Medical Assistance application process shall be denied services. CRS shall enroll an applicant upon completion of the CRS financial interview and signing of the CRS Financial Agreement. An enrollee shall thereafter be terminated from services if the enrollee fails to complete the Medical Assistance application and eligibility process where the screening indicated the enrollee as potentially eligible for Title XIX services.

R9-7-405. Adjusted annual income; percent pay category

A. A family's adjusted gross income shall be calculated in the following manner:
   1. Total income, both earned and unearned, shall be calculated.
      a. For a family whose members receive wages or salaries or are unemployed, calculate the gross monthly earned income and determine annual earned income by multiplying the monthly amount by 12.
      b. For a family whose members are self-employed or seasonal workers, the previous year's annual earned income shall be used as the total earned income. If the self-employed applicant was not self-employed for a full year, annual earned income shall be calculated based upon those months of income since self-employment began.
   2. Total medical and dental expenses, paid or unpaid, dependent care costs, adult or child, and the cost of employment deductions shall be determined for the past 12 months. If dependent care costs do not change monthly, then the total amount of dependent care cost shall be determined by multiplying 1 month's cost by 12.
   3. Total income minus total expenses equals adjusted gross income.
B. The adjusted gross income and family size shall be compared to the Family Eligibility Summary Table to determine the percent pay category of the applicant.
C. Individuals who are enrolled in an AHCCCS health plan or AHCCCS program contractor shall be financially eligible at the 0 percent payment category.
D. Wards of the Arizona court shall be financially eligible at the 0 percent payment category.

R9-7-406. Earned income

The following types of income shall be considered earned income for a family for purposes of determining eligibility for CRS applicants and shall be counted in the month of receipt:

1. Arizona Training Program salaries to handicapped persons working in a sheltered workshop;
2. Earnings from the Arizona Works! sponsored on-the-job training or Public Service Employment or from full or part-time job entries resulting out of participation in Arizona Works! but not including work incentive payments and reimbursements for training related expenses.
3. Earnings from baby-sitting, including DES day care;
4. Blood and plasma sales;
5. Can or bottle collections and sales;
6. Earnings received by applicants employed on a contractual basis;
7. Income earned as a housekeeper or home health care aide;
8. The value of any item which the applicant receives in return for labor expended;
9. Job Training Partnership Act earnings;
10. Jury pay;
11. Earned rental income, less expenses, received from rental property when work is involved;
12. Earnings from self-employment, calculated by taking the gross business receipts less business expenses;
13. Wages from Vocational Rehabilitation-sponsored on-the-job training;
14. Gross earnings from employment, including;
    a. Advances, bonuses and commissions;
    b. The amount of a reimbursement from an employer for a job-related expense which is in excess of the actual expense,
    c. Sick pay and vacation pay, and
    d. The actual amount of tip received.
15. Any other earned income received by the applicant which is not specifically excluded by R9-7-408 or any provision of state or federal law.

R9-7-407. Unearned income

The following types of income shall be considered unearned income for a family for the purpose of determining eligibility for a CRS applicant and shall, unless otherwise specified, be counted in the month of receipt:

1. AFDC income;
2. Alimony or spousal maintenance;
3. Assistance payments received from General Assistance, Tuberculosis Control, and Emergency Assistance, or AFDC payments from another state.
4. Bureau of Indian Affairs payments:
    a. General Assistance Payments,
    b. Tribal Work Experience Program or Tribal Assistance Project Program except for the portion of the income which is an incentive payment
    c. Work Study Program payments for living expenses paid directly to the student.
5. Child support received from the noncustodial parent in an amount in excess of $50 per child per month;
6. Cash contributions in excess of $50 per month unless the contribution is considered to be a loan.
7. The amount of an educational loan, scholarship, or grant remaining after subtracting applicable deductions shall be averaged for the period of months for which the loan, scholarship, or grant is intended to cover with the result constituting the monthly income;
8. Any Emergency Assistance received directly by an applicant or recipient of AFDC;
9. Small, nonrecurring cash gifts that exceed $500 per calendar year;
10. Payments received as compensation for an industrial injury, less any amounts paid as attorney fees.
11. Insurance payments or benefits:
    a. Medical insurance payments made directly to the insured.
    b. Insurance payments not designated as payment for a specific bill, debt or estimate.
    c. Insurance benefits which are used for, or are intended to meet, basic daily needs.
12. Interest, dividend and royalty payments made directly to the applicant. Funds left on deposit or converted into additional securities shall not be counted;
13. Gross lease payments or royalty from Indian land where an applicant owns or is allotted part of the reservation land which the applicant may lease to others an applicant owns land that is not part of the reservation:
    a. Land lease income shall be counted when it is received by the BIA and posted to the applicant's account, making it available for pick-up by the applicant.
    b. If land lease income is available every month, it shall be counted monthly.
    c. Land lease income that is received less frequently than monthly shall be considered income at the time it is available.
    d. Funds in the BIA account prior to the month of application shall not be counted as income. All deposits of land lease moneys made after the application date shall be counted as income.
14. Legal settlements, less attorney's fees, which are not designated as payment for a specific bill, debt or estimate;
15. Payments received from mortgages, sales contracts or promissory notes shall be considered unearned income for the amount of payment which is interest;
16. Railroad Retirement Benefits;
17. Rental income generated solely from rental payments and not for services provided, less expenses;
18. Retirement income, pensions and annuities;
19. Social Security Administration benefits:
    a. Social Security benefits.
    b. Social Security Administration Educational Benefits for persons 18 to 22 years of age who are full-time students.
    c. RSDI Benefits paid to a representative payee on behalf of the applicant or the applicant's family and the payee lives in the same household as the applicant. When the representative payee does not live in the household, the RSDI Benefits shall be counted only to the extent that the payee makes them available for the support of the beneficiary.
20. Profits made on sales of stock;
21. Strike pay;
22. All payments received by the applicant or the applicant's family from a trust fund;
23. Unemployment Insurance benefits;
24. Veterans' Administration benefits;
25. VISTA income which exceeds the State or Federal minimum wage, whichever is greater;
26. Winnings from lotteries, bingo or any other form of gambling; and,
27. Other unearned income not excluded in R9-7-408 or any provision of state or federal law.

R9-7-408. Deductions from income

The following amounts shall be deducted from income in determining CRS financial eligibility:

1. Medical and dental expenses
   a. Health insurance premiums paid by the family for any family member in the household within the previous twelve (12) months.
   b. Unpaid medical and dental expenses incurred by any family member in the family's household prior to the date of application which are the family's financial responsibility and not subject to any applicable 3rd-party payment.
   c. Medical and dental expenses paid directly by the family for any family member in the household during the twelve (12) months prior to the date of application and not subject to any applicable 3rd-party payment.
2. If the family received earned income and anticipates receiving earned income for the next 12 months, the cost of the care of a child or incapacitated adult, for whom written proof of the disability is provided, living in the same household shall be excluded from the amount as follows:
   a. Child care costs paid to any baby-sitter or day care provider.
      i. If all persons legally responsible for the financial support of the applicant are employed on a full-time basis (86 hours or more per month), up to $200.00 per month per child under 2 years of age shall be excluded. Up to $175.00 per month per child age 2 or older shall be excluded.
      ii. If all persons responsible for the care of the applicant are employed on a part-time basis (less than 86 hours per month), up to $100.00 per month per child under 2 years of age shall be excluded. Up to $88.00 per month per child age 2 or older shall be excluded.
   b. Incapacitated adult care costs paid to a provider for the care of an incapacitated adult shall be excluded as follows:
      i. If all of the persons legally responsible for the financial support of the applicant are employed on a full-time basis (86 hours or more per month), up to $175.00 per month shall be excluded.
      ii. If all persons legally responsible for the financial support of the applicant are employed on a part-time basis (less than 86 hours per month), up to $88.00 per month shall be excluded.
3. For any family member whose earned income is included in the adjusted gross income, $90.00 shall be deducted from earning each month for the cost of employment to compensate for job-related personal expenses.

R9-7-409. Payment agreement

A. Each applicant not enrolled in AHCCCS shall complete and sign a payment agreement which shall provide for the following:
   1. Acknowledgment of the family's financial responsibility for the determined percentage of the cost of CRS services delivered;
   2. An assignment of insurance benefits to the CRS;
   3. Than any moneys received by the applicant as a court award or settlement of a claim which provides for the medical care of the applicant shall be used to pay CRS providers for care which is authorized and provided;
   4. When insurance benefits, court awards, claim settlements or other 3rd-party benefits are available, they shall be exhausted before CRS funds shall be used to provide care for the applicant or shall be used to reimburse CRS for all care provided to the applicant;
   5. That if applicant receives and converts any benefits described by this subsection to the applicant's personal use and not for payment of the applicant's CRS services, that applicant shall be personally responsible for the payment of the services for which the benefits were intended to pay.

B. An applicant who is a member of AHCCCS and who has insurance, a court award, a settlement, an unresolved claim relating to the applicant's CRS-eligible condition or other 3rd-party benefit shall sign the CRS payment agreement for purposes of subsection A.2 through A.5.

C. Unless the applicant is an AHCCCS member with no insurance, an applicant shall not be enrolled in CRS until a payment agreement has been completed.

R9-7-410. Financial eligibility exceptions

A. An applicant with an adjusted annual family income exceeding CRS financial eligibility limits shall be permitted to participate in CRS at the 100 percent pay category upon meeting 1 of the following criteria:
   1. The applicant is being treated for cerebral palsy, cleft lip or palate, adult cystic fibrosis, myelomeningocele, metabolic diseases, scoliosis, adult sickle cell anemia, or neurofibromatosis.
   2. The applicant is 21 years of age and is in the process of completing an active intervention program approved by the CRS Medical Director that was initiated when the applicant was financially eligible.
   3. The applicant requires specialty services which are not available elsewhere in the community;
   4. The applicant has a CRS eligible medical condition of particular interest or rarity, other than the diagnoses specified in paragraph 1 above. CRS coverage for such case shall be requested, in writing, by the applicant's attending physician, and shall be approved on an individual basis by the Regional Medical Director in consultation with the CRS Office Chief and Medical Director.

B. An applicant who meets the requirements of this section shall complete the CRS financial interview and shall complete and sign a payment agreement. Such applicant shall not be required to complete a Medical Assistance screening but shall be offered the opportunity to complete this screen.

R9-7-411. Health or medical insurance; court awards

A. An enrollee shall make available to CRS all health or medical insurance benefits of any kind and moneys received as an award by a court or in settlement of a claim for damages for purposes of the care of an enrollee in order to pay CRS providers for the cost of care which is authorized and provided before the expenditure of any CRS funds for the services.

B. Enrollees who receive insurance or other 3rd-party payments for medical care received from CRS shall remit those payments to the CRS providers who rendered the care. An applicant who receives and converts any benefits described by this section to the applicant's personal use and not for payment of the applicant's CRS services shall be personally responsible

for the payment of the services for which the benefits were intended to compensate.

R9-7-412. Redeterminations

A. All CRS enrollees who are receiving medical coverage provided by an AHCCCS health care plan, except those in ALTCS and SOBRA, shall complete a CRS financial eligibility redetermination every 6 months after the initial eligibility determination. Other CRS enrollees and ALTCS members shall complete a CRS financial eligibility determination once a year. Non-AHCCCS enrollees shall sign a CRS Financial Agreement at each redetermination during the financial eligibility interview.

B. A Notice for Redetermination shall be sent to non-AHCCCS enrollees prior to the expiration of financial eligibility informing the enrollee of the date eligibility expires, the requirement that the enrollee make an appointment for redetermination by the end of the current month, and the requirement that the applicant shall complete the redetermination prior to the expiration date of the CRS financial determination. The enrollee shall also be notified that if the redetermination is not completed by the expiration date, the medical coverage under CRS shall be suspended. Thereafter, the enrollee shall complete the financial eligibility redetermination before CRS medical services shall be reinstated.

1. If the enrollee is Title XIX or non-Title XIX AHCCCS recipient, other than ALTCS or S.O.B.R.A. pregnant woman, the 1st CRS redetermination shall be scheduled at the same time that the AHCCCS redetermination is due. Every 6 months thereafter, a combined redetermination shall be completed for CRS and Medical Assistance.
2. If the enrollee is an ALTCS member, the 1st redetermination shall be scheduled at the same time that the ALTCS redetermination is due. Every 12 months thereafter, a redetermination shall be completed for CRS and ALTCS.
3. If the enrollee is a S.O.B.R.A. pregnant woman, the CRS redetermination shall occur at the end of the post partum period. When a S.O.B.R.A. pregnant woman's S.O.B.R.A. eligibility is discontinued, a redetermination shall be completed no later than the end of the last month of S.O.B.R.A. eligibility. At that time, the enrollee shall be evaluated for both CRS and Medical Assistance eligibility.
4. In addition to the regularly scheduled redeterminations, a redetermination may be requested by an applicant or may be authorized by the CRS Chief at any time if there is reason to believe that the applicant's financial status has changed.

Table 1. 1992 CRS Percent Pay Category Table

1992 CRS PERCENT PAY CATEGORY TABLE (APRIL 1, 1992 - MARCH 31, 1993)						
Size of Unit	0%	3%	6%	9%	12%	15%
1	0-6,810	6,811-8,810	8,811-10,810	10,811-12,810	12,811-14,810	14,811-16,810
2	0-9,190	9,191-11,190	11,191-13,190	13,191-15,190	15,191-17,190	17,191-19,190
3	0-11,570	11,571-13,570	13,571-15,570	15,571-17,570	17,571-19,570	19,571-21,570
4	0-13,950	13,951-15,950	15,951-17,950	17,951-19,950	19,951-21,950	21,951-23,950
5	0-16,330	16,331-18,330	18,331-20,330	20,331-22,330	22,331-24,330	24,331-26,330
6	0-18,710	18,711-20,710	20,711-22,710	22,711-24,710	24,711-26,710	26,711-28,710
7	0-21,090	21,191-23,090	23,091-25,090	25,091-27,090	27,091-29,090	29,091-31,090
8	0-23,470	23,471-25,470	25,471-27,470	27,471-29,470	29,471-31,470	31,471-33,470

* For family units with more than eight (8) members, add $2,380 for each additional family member.

ARTICLE 5. SCOPE OF SERVICES

R9-7-501. Scope of medical services

The CRS program shall provide the following medical, surgical and therapy modalities for CRS enrollees:

A. Hospital inpatient services.
   1. CRS shall cover hospitalization only at the CRS contracted provider sites for enrollees with a CRS covered condition.
   2. The contractor shall effect discharge planning upon admission.

B. Outpatient services.
   1. The CRS prior authorization office shall determine if surgery may be performed on a outpatient basis. Prior written authorization shall be obtained.
   2. The regional contractors shall be responsible for all authorized hospital or clinic-based outpatient services.

C. Dental and orthodontia services.
   1. Services may be provided through CRS clinics or, where clinics are unavailable, through the practitioner's private office.
   2. All dental and orthodontic treatment shall require prior written authorization by the CRS prior authorization office if provided outside the CRS clinic.

D. CRS enrollees shall receive physician services only from physicians who are rostered and approved to participate in the CRS program.

E. Clinic services.
   1. An enrollee shall be assigned to receive authorized services for all CRS covered conditions at the CRS clinic closest to the enrollees residence:
      a. Clinic appointments shall be based upon a review of the enrollee's needs, the physician's request, and available appointment slots.
      b. Appointments shall be made on a non-priority basis.
   2. Specialty and multidisciplinary clinics:
      a. CRS applicants may enter the CRS program directly into a specialty clinic only after an assessment and evaluation by the regional medical director or the regional medical director's designee authorized to determine medical eligibility.
      b. All specialty clinics shall be authorized by the Regional Medical Director.
   3. Community and field clinics:
      a. All community and field clinics shall be authorized by the CRS Medical Director.
      b. All applicants to be seen in field clinics shall complete the Pediatric History and Referral Form, the

CRS Financial Application and, where applicable, the Medical Assistance screening at the time of the 1st visit. The CRS Financial Agreement and the medical assistance determination must be completed and the applicant enrolled in CRS prior to the applicant being permitted any subsequent visits.

c. An applicant shall not be eligible to receive vendor services at the time of or after the initial clinic visit until the required CRS financial determination has been made and the applicant has signed the CRS Financial Agreement.

F. Home health care services.
1. Home health care is provided to CRS enrollees where available and is limited to the post hospitalization rehabilitative or recovery period, not to exceed 30 calendar days. Requests for extension shall be submitted to and must be approved by the CRS Medical Director and coordinated with the CRS clinic.
2. Home health care may be provided by all CRS contracted health care providers in lieu of hospitalization if it has been determined medically appropriate by the Regional Medical Director. Such home health care shall not exceed 30 calendar days.
3. Total parental nutrition, home aides, and 24-hour nursing services are excluded from CRS home health services.

G. Diagnostic testing and laboratory services.
1. CRS enrollees who are not AHCCCS members may receive diagnostic testing services. Diagnostic testing for determining a CRS eligible primary condition shall not be a covered service unless approved by the Regional Medical Director.
2. Follow-up laboratory evaluations where discovered laboratory abnormalities are unrelated to the CRS eligible medical condition are not covered services. The CRS enrollee shall be referred to the primary care physician for follow-up care.

H. Nursing services.
1. Direct patient care;
2. Teaching; and,
3. Coordination and communication among CRS contractor staff and other community-based agencies.

I. Pharmaceuticals and medical supplies.
1. CRS enrollees shall receive pharmaceuticals and medical supplies for CRS covered conditions when ordered by a physician and when appropriate to the treatment of the CRS covered condition.
2. Covered pharmaceuticals and medical supplies shall include special formulation nutrition needs for metabolic patients. Pharmaceuticals or supplies that would normally be ordered by the primary care physician for the overall health maintenance of the enrollee are not covered.

J. Vision services.
1. Eyeglasses and contact lenses shall be provided only when ordered by the CRS physician for the purpose of treating a CRS covered condition.
2. Except for the initial prescription or revision of that prescription, CRS shall provide only 1-a-year replacement for broken or lost glasses or contact lenses.

K. Physical and occupational therapy services.
1. CRS enrollees shall receive physical and occupational therapy services only for the purpose of treating the CRS covered condition. Enrollees shall be evaluated in a CRS medical or surgical clinic to determine eligibility for therapy services. CRS shall not provide maintenance therapies.
2. Individual outpatient physical and occupational therapy services shall be offered, not to exceed 12 weeks or 24 sessions in total unless authorized by the CRS Medical Director, for 1 or any combination of the following categories:
a. For enrollees who meet 1 or more of the following conditions:
i. Pre- and post surgery and post-casting enrollees, neurologic or orthopaedic, who have received treatment through the CRS Program. Therapy services shall be initiated within 5 working days from referral.
ii. Post prosthetic enrollees.
b. For CRS enrollees for whom prognosis shall be positive for a change in functional status as a result of intervention and who meet 1 of the following conditions:
i. Individuals age 5 and under who are not currently receiving direct therapy and have a chronic neurological impairment with a strong potential for rehabilitation related to equipment needs, family education, home exercise program, and the ability to be cared for by others.
ii. Individuals 3 to 21 years of age for whom no other services are available or are referred by specialty clinics. Therapy services shall be initiated within 21 working days from referral.
3. Consultation sessions for assessment, therapy and training are available for caregivers of CRS enrollees, ages birth to 21, with moderate to severe impairment of functional skills, for whom no other services are available. The duration of services may not exceed 6 weeks or 6 sessions, unless authorized by the CRS Medical Director.

L. Speech and language therapy services.
1. Speech and language therapy services shall be available to CRS enrollees whose communication disorder is directly related to a CRS eligible condition. CRS shall not treat isolated speech or language disorders.
2. Speech and language therapy services shall be available for the following:
a. Pre- and post-surgery enrollees or those enrollees with a hospital discharge recommendation for speech and language therapy.
b. Individuals 5 years of age and under who are not currently receiving direct therapy services.
c. Individuals 3 to 21 years of age for whom no other services are available or who may be referred by specialty clinics.
3. The duration of therapy in these categories shall not exceed 12 weeks or 24 sessions, unless otherwise authorized by the CRS Medical Director as medically necessary. Therapy services shall be initiated within 21 working days.
4. Enrolles who are receiving speech and language therapy through another program shall not be eligible to receive those services through CRS.

M. Equipment shall be available to an enrollee who is being followed in a CRS medical or surgical clinic for the purpose of rehabilitative care directly related to the CRS covered condition.

1. CRS shall provide and modify wheelchairs for enrollees, as well as ambulation assistive devices. Rehabilitative equipment shall be available for enrollees as follows:
   a. Rehabilitative equipment shall not duplicate or serve essentially the same purpose as existing equipment. Equipment shall not be changed when existing equipment is functional and can be repaired to ensure safety.
   b. Equipment shall be adjustable to accommodate growth whenever possible.
   c. The physical setting of the home shall accommodate the equipment.
   d. The family shall be able to care for and transport the equipment.
   e. Practical and functional use of the equipment by the enrollee shall be demonstrated and documented by the CRS clinic staff.
   f. Equipment used solely for school purposes is the responsibility of the local education agency.
   g. CRS shall not pay for repairs or maintenance of equipment which has been replaced by another device serving the same purpose.
   h. Equipment needs shall be met through recycled items if the item meets needed recommendations.
   i. Trays for wheelchairs shall be provided only if documentation proves that the need is directly related to improvement in functional skill level.
   j. Use of ambulation equipment or wheelchairs is limited to 30 calendar days unless an extension is requested of and approved by the CRS Medical Director.
2. The following items shall not be provided by CRS:
   a. Adaptive power switches for wheel chairs,
   b. Bathing aides,
   c. Bicycles,
   d. Car seats,
   e. Corner chairs,
   f. Crawlers,
   g. Cribs or beds,
   h. Dressing aides,
   i. Exercise mats,
   j. Feeder seats,
   k. Helmets,
   l. Medical supplies,
   m. Motorized caster carts,
   n. Motorized vehicles,
   o. Motorized wheelchairs,
   p. Pillows,
   q. Ramps,
   r. Roll chairs,
   s. Rolls,
   t. Sand bags,
   u. Side lying positioner,
   v. Standers,
   w. Strollers,
   x. Toileting aids,
   y. Transfer aids,
   z. Van lifts,
   aa. Wedges for positioning,
   bb. Weights,
   cc. Wheelchair carriers, or
   dd. Convenience accessories for mobility equipment.
3. Equipment maintenance policy.
   a. CRS shall pay for equipment modifications which are necessary because of the enrollee's growth or due to changes in the enrollee's orthopaedic or health needs. These modifications shall be made only after being recommended as needed by the physician or the physical or occupational therapist and approved by CRS.
   b. CRS shall not pay for routine maintenance due to normal wear and tear or for repairs needed because of improper use or neglect, unless medical necessity is documented by the CRS professional staff or contracted therapist. The enrollee's family shall be responsible to pay for these services privately or through other assistance which the enrollee receives.
4. Oxygen and related supplies shall be available to the enrollee from CRS when ordered by a CRS physician as necessary for the treatment of the CRS covered condition. Such services shall not exceed 30 days. Any requests for extensions shall be submitted to and approved by the CRS Medical Director.

N. Prosthetic and Orthotic devices.
1. CRS shall provide and repair prosthetic and orthotic devices for CRS enrollees. CRS shall provide for prosthetic and orthotic modifications which are necessary because of the enrollee's growth, or due to changes in the enrollee's orthopedic or health needs. Modifications shall be recommended as needed, by the physician or the physical or occupational therapist and shall be approved by the CRS Medical Director.
2. CRS shall provide and replace ocular prostheses for a CRS enrollees which are necessary because of the enrollee's growth or due to health needs.
3. Shoes shall not be provided by CRS.

O. Audiology services.
1. CRS shall provide audiology services to CRS enrollees who are hearing impaired or who are at risk for hearing impairment. The following services shall be offered through all regional CRS programs:
   a. Audiologic assessments; CRS may provide Brainstem Audiology Evoked Response evaluations at the request of the CRS physician.
   b. Hearing aid evaluations.
   c. Hearing aids shall be provided and are reevaluated annually at the CRS clinic. A hearing aid shall be replaced only once every 3 years unless 1 of the following exceptions is met:
      i. Change in hearing levels
      ii. Exceptional circumstances as determined by staff audiologists
      iii. If an enrollee loses a hearing aid before the end of the 3-year period, does not have insurance, and does not meet 1 of the exception criteria listed in a or b above. Enrollee shall be fitted with a reconditioned or loaner hearing aid as available.
2. Individuals shall not be required to purchase insurance for hearing aids.
3. Accessory items such as dry aid kits, batteries and swimmer's ear molds are not covered by CRS. Only accessory items necessary for proper functioning and maintenance of hearing aids shall be provided by CRS.
4. Implantable bone conduction devices shall be provided on an individual basis upon prior authorization of the CRS Medical Director.

5. Tactile hearing aids shall be provided on an individual basis upon prior authorization of the CRS Medical Director. Each application for CRS coverage of a tactile hearing aid shall be submitted by the CRS audiologist to the CRS Medical Director for review and approval.
6. CRS shall not provide cochlear implants.

P. Educational services.
1. Hospitalized CRS enrollees may be provided educational services for the purpose of establishing educational needs and goals for the inpatient stay, when available from the local CRS contractor.
2. CRS enrollees may be provided with an educational liaison for enrollees in the outpatient clinic to coordinate services with school district staff and school nurses, when available from the local CRS contractor.

Q. Child Life Services.
1. CRS enrollees may receive structured child life activities when hospitalized, either in a playroom or at the bedside, or at the outpatient clinic waiting room or play areas for enrollees and siblings, when available from the local CRS contractor.
2. Child life activities may include:
   a. Group activities of expressive play;
   b. Pre-operative teaching and medical play designed to decrease fears while increasing understanding and confidence;
   c. Explanations comprehensible to the child of sequence, nature, and reasons for procedures and routines; and,
   d. Support and coping strategies for the child during painful procedures.

R. Nutrition services.
1. CRS contractors shall provide nutrition services for enrollees with special nutritional needs. Nutrition services shall be provided by a registered dietitian to enrollees with the following medical conditions:
   a. Metabolic diseases,
   b. Spina bifida,
   c. Cerebral palsy,
   d. Epilepsy,
   e. Cleft lip and palate, and
   f. Cystic Fibrosis.
2. No enrollee shall receive total parenteral nutrition for over 30 days unless an extension is approved by the CRS Medical Director.
3. CRS shall provide nutritional supplements on a limited basis upon referral from CRS physicians with consultation by a registered dietitian, as follows:
   a. Formulas for metabolic disorders that are treated by a special diet are covered in accordance with the following guidelines:
      i. Specified formulas for treatment of metabolic disorders and formula component products.
      ii. Quantity provided shall be as needed, based upon demands for growth and maintenance; to be determined by the registered dietitian.
      iii. Duration shall be for as long as treatment through dietary modification continues, up to 21 years of age.
      iv. Lactose-free formulas for galactosemia; infant formulas or milk products used in conjunction with modified amino acid formulas; low protein food products such as pasta, breads, and cookies for amino acid disorders are not covered.
   b. Short term coverage for tube feedings shall be available when related to a primary CRS medical condition and no other resources or community nutrition support programs are available.
      i. Commercially available tube feeding formulas shall be provided.
      ii. The quantity shall be as needed, based upon demands for growth and maintenance; to be determined by the physician or registered dietitian.
      iii. The duration shall be limited to 30 calendar days of coverage. An extension for coverage requires the approval of the Regional Medical Director.
      iv. Tube feeding equipment shall be provided by CRS when deemed medically essential to provide adequate nutrition and such equipment is not covered by another provider's plan. Equipment may be provided by CRS while the formula is provided by another resource.
      v. Foods and beverages recommended for blenderized recipes shall not be provided.
   c. Short term coverage may be available for cystic fibrosis enrollees when appropriate growth and maintenance needs to be established with a supplemental product, and no other resources or community nutrition support programs are available:
      i. Commercially available nutrition supplements for additional calories and other nutrients may be provided.
      ii. The quantity shall be limited to approximately 50 percent of daily caloric needs as a supplement to a regular diet unless the cystic fibrosis enrollee is also being tube fed.
      iii. The duration shall be limited to 30 calendar days of coverage. An extension for coverage requires the approval of the Regional Medical Director.
      iv. Foods and beverages that constitute the enrollee's regular diet shall not be provided.
   d. Other medical conditions which require nutrition supplementation may be covered if related to the enrollee's CRS primary condition.

S. Psychological services.
1. An enrollee shall receive psychological services upon referral by a CRS physician or a member of the professional staff to a board-certified CRS psychologist. An enrollee may receive short term crisis intervention, assessment, evaluation and referral. Psychological services are limited to three (3) visits per calendar year and shall be related to the primary CRS condition. CRS shall not provide ongoing psychological counseling or services.
2. Psychiatric services shall be available only upon evaluation and referral of an enrollee by a CRS psychologist to a CRS psychiatrist. Psychiatric services shall be limited to one (1) visit per calendar year related to the primary CRS condition.
3. Enrollees shall not receive ongoing psychiatric therapy. Enrollees shall be referred to an appropriate agency for ongoing services.

T. Social work services.
1. CRS shall provide coordination and discharge planning with the hospital social work department and nursing staff during all CRS enrollee inpatient hospitalization

and shall coordinate with the outpatient CRS social worker for all CRS enrollee admissions.

2. Upon referral, CRS shall provide coordination, discharge planning and coordinating of admissions with the inpatient CRS social worker and attending multidisciplinary clinics in the outpatient clinic for enrollees and families.

U. CRS shall provide only corneal and incidental bone grafting transplants.

V. CRS covered services shall not be provided out-of-state unless all of the following are verified:
1. The medical specialty or the procedure is not available in Arizona;
2. Two CRS participating medical specialists of that specialty recommended out-of-state treatment;
3. The treatment is considered to be lifesaving or will result in significant functional improvement;
4. The Chief of CRS and the CRS Medical Director have approved.

W. CRS covered services shall not be available to applicants with a CRS-eligible condition who are in the hospital at the time of application. Such applicants shall be eligible for enrollment and CRS services only after discharge from the hospital.

X. Transportation shall not be a reimbursable service unless it is provided between CRS contracted hospitals and facilities and has the prior authorization of the CRS Medical Director.

R9-7-502. Hospital admission and decertification

A. Only CRS physicians may admit and treat enrollees:
1. Prior authorization shall be obtained for all admissions other than those of an emergency nature related to the CRS covered condition.
2. The hospitalization shall be directly related to the CRS condition.
3. CRS shall not provide long term care or hospitalization for the sole purpose of maintaining the enrollee.
4. CRS shall not provide long term care or hospitalization for weight gain or loss prior to surgery.

B. Decertification.
1. The contractor may request that an enrollee be decertified from a CRS authorized admission. If an extended hospital stay is the result of a non-CRS covered condition, and this was not identified during the discharge planning process, the contractor shall notify the Chief of the CRS Program, the AHCCCS plan if the enrollee is a member of AHCCCS, and other responsible parties.
2. The Chief of the CRS Program shall review the medical record and notify the contractor of a decision within 24 hours of the time of notification from the contractor. If permission is granted to decertify, the contractor shall notify and coordinate with the AHCCCS plan if the enrollee is a member of AHCCCS, and shall notify the family and other responsible parties within 24 hours. The notification to all responsible parties shall allow 24 hours from the time of notification before the enrollee is decertified.
3. CRS shall give timely verbal notification to the attending physician that the physician's patient has been identified as no longer meeting CRS medical eligibility requirements, or that there has been a modification of coverage. If CRS will no longer be financially responsible for hospitalization or the physician component of care, the verbal notification shall include this information.
4. All elective and urgent hospital and ambulatory admissions are reviewed by the CRS prior-authorization office of the Department. During the course of admission, continued stay or retrospective review, if the enrollee is determined to be medically ineligible or ineligible for reimbursement, the following shall occur:
   a. CRS utilization review staff shall review the pertinent information with the CRS Medical Director or designee;
   b. The authorization status shall be changed to reflect decertification; and,
   c. CRS utilization review staff shall coordinate with the regional clinics and the contracting hospital regarding the change in authorization status. Notification of decertification shall be mailed to the attending physician and responsible parties.
5. Decertification may be appealed by the enrollee or the physician in accordance with these rules.

R9-7-503. Transfers

A. CRS shall cover hospital transfers for CRS enrollees only when the admission is for treatment directly related to the primary CRS eligible medical condition and the CRS Medical Director has authorized the transfer in advance.

B. The CRS Medical Director shall give prior authorization to transfer only between contracted CRS facilities and only for CRS enrollees who are medically and financially eligible, when the transportation is ordered by a CRS participating physician.

C. Upon prior approval, the transferring agency shall complete applications for transfers, whether verbal or written, and shall include full diagnostic information on the CRS eligible medical condition. Failure of the transferring agency to provide this information may result in back-transferring of the enrollee at the expense of the agency from which the enrollee is transferred.

R9-7-504. Prior authorization for services

A. Prior authorization shall be obtained by the provider for physician services and inpatient services. The provider shall be responsible for securing any necessary prior authorization.

B. Hospitals and physicians shall notify the CRS provider service office located at each regional contractor site within 24 hours from the time an enrollee appears at a CRS contracted facility or hospital for emergency services. A determination as to whether the services were "emergency services" shall be provided through retrospective medical review. If the date of notification falls on a weekend or holiday, notification shall be made on the 1st working day following the weekend or holiday.

C. The prior authorization process shall be conducted in the following manner:
1. A provider or physician shall complete the CRS Provider Services Requisition form and transmit it to the regional contractor site where the service is to be provided. CRS shall be notified as soon as a health care service is planned.
2. The following baseline demographic information shall be provided on the CRS Provider Services Requisition form:
   a. Requesting physician and Arizona Medical license number;
   b. Hospital or other CRS provider;
   c. Individual name and date of birth;
   d. Complete service category;
   e. Proposed date and service;

f. Proposed service to be provided;
g. Diagnosis, including both primary and service diagnosis;
h. Narrative description of the indications for the proposed service;
i. Name of surgeon and assistant surgeon, if applicable, and
j. Signature of requesting physician and date of request.

3. The prior authorization registered nurse shall research each request and obtain medical case information as needed in order to certify the CRS medical eligibility for the particular health care service. The following service reviews shall take place for inpatient admission or ambulatory service:
   a. Determine if the service to be provided is related to the CRS eligible medical condition. Any condition or treatment other than for a CRS covered condition shall not be authorized.
   b. Review the baseline information provided in FHAMIS.
   c. Evaluate the indications for surgery as they relate to the CRS eligible medical condition. The prior authorization registered nurse shall confer with the CRS Medical Director when unable to certify a requested health care service. Adverse decisions shall only be rendered by the CRS Medical Director.
   d. The prior authorization nurse shall also assess the appropriate level of care, timeliness of the admission to avoid unnecessary preoperative days, and necessity for an assistant surgeon.
   e. The prior authorization nurse shall confer with the CRS Medical Director when unable to certify the requested health care service.
4. A contractor's provider service representative shall mail completed authorizations to the requesting provider or physician and facility on a daily basis.

D. All requests for prior authorization shall be reviewed by the CRS medical staff under the direction of the CRS Medical Director. A request for prior authorization shall be subject to the following review:
   1. Verification of the individual's enrollment in the CRS Program;
   2. Verification that the services are covered by CRS;
   3. Verification of other insurance coverage to which the enrollee may be entitled, including any requirements for pre-certification by other carriers or liable parties;
   4. Determination as to whether the requested services is medically necessary and appropriate; and
   5. Determine as to whether the medical review requires additional supportive documentation and medical records.

E. Reimbursement shall be made only when documentation supports the claim and service rendered, regardless of prior authorization and the issuance of an authorization number.

F. An adverse prior authorization decision is appealable in accordance with the CRS grievance and appeal rules.

G. No authorization shall be given for any non-emergency or non-urgent service which has already been rendered. A CRS prior authorization nurse shall perform a retrospective analysis of these cases to determine if the health care service was urgent or emergent, or if it was elective or scheduled, and shall authorize accordingly.

R9-7-505. Termination of service

CRS services shall terminate upon the occurrence of 1 of the following:
1. Enrollee establishes residence outside the State of Arizona.
2. Enrollee reaches the age of 21 years unless the enrollee is completing an approved course of treatment begun before the enrollee reached the age of 21, or is enrolled in the adult cystic fibrosis or sickle cell anemia programs.
3. Enrollee no longer has a medically eligible condition.
4. Enrollee is no longer financially eligible except as provided in R9-7-411.
5. Enrollee declines services.
6. Death of the enrollee.
7. Enrollee has not had a clinic visit for more than 1 year.

ARTICLE 6. PAYMENT FOR SERVICES

R9-7-601. Claims submission

A. Bills for services rendered shall be submitted to CRS within 6 months of the date of service. Claims received more than 6 months after the service has been rendered shall not be reimbursed.

B. Claims for service shall contain the following information:
   1. Completion of all fields on the HCFA 1500 claim form;
   2. The PSR authorization number;
   3. Accurate HCPCS or ADA codes as unlisted HCPCS or ADA codes shall not be accepted;
   4. Usual and customary charges, which shall be broken out for each HCPCS and ADA code submitted;
   5. Accurate modifiers;
   6. Operative report for surgical procedures;
   7. Physicians' orders and progress notes for durable medical equipment;
   8. All supportive documentation for services other than surgery; and,
   9. All Explanations of Benefits that relate to the claim.

C. Claims submitted without the information required in subsection B or with inaccurate codes shall be returned to the provider along with a request for additional documentation to support the claim for proper resubmission or other disposition not later than 12 months following the date of service.

D. All regional site contractors shall adhere to billing requirements according to the terms of their contract.

R9-7-602. Reimbursement rates

Reimbursement for services provided to CRS enrollees shall be as follows:
1. A contract provider shall be reimbursed by CRS according to the terms of the contract.
2. A non-contract provider shall be reimbursed by CRS on a fee-for-service basis, not to exceed the CRS usual and customary fees.

R9-7-603. Enrollee payments for services

A. The 1st clinic visit shall be provided at no cost to the family but shall be billed to 3rd-party payors, where applicable, or to a parent or other person legally responsible to financially support the applicant in the 100 percent pay category.

B. After the 1st visit, families shall participate in the cost of care provided under the CRS Program at the percent pay category at which they have been determined. Insurance companies, other 3rd-party payors, or the family shall be billed for services.
   1. The total for a billing for a family shall be determined by applying the family's percent pay obligation to the

total allowable charges. Families who are in the zero (0) percent pay category shall not be billed.

2. Insurance companies and other 3rd-party payors shall be billed the provider's usual and customary charges, without regard to the family's percent pay category.
3. Billings to families shall be issued directly by CRS or by the CRS contractor.
4. If insurance benefits or other payments made for CRS authorized services are paid directly to the family, the amount received from the insurance payment shall be sent immediately to CRS.

C. A family shall not be responsible for payment of otherwise covered services where the CRS provider has failed to obtain prior authorization from the CRS Medical Director.

D. The State of Arizona shall be the payor of last resort. Contract providers shall use all reasonable efforts to collect from insurance companies and 3rd-party payors. The contractor shall bill a family only that percentage of the CRS allowable charges which was determined to be the family's financial responsibility percentage when the family's financial eligibility was established. A physician or other provider shall not bill a family who has a CRS financial responsibility of 0%, or more than a family's financial responsibility percentage of a CRS allowable charge.

ARTICLE 7. GRIEVANCE AND APPEALS

R9-7-701. Enrollee and applicant grievances

A. An enrollee or applicant aggrieved by any adverse decision or action by a contractor may file a grievance as specified in this section. This section shall not apply to an action or decision affecting an enrollee's or applicant's financial eligibility or percent of financial participation for which the enrollee or applicant may file a grievance directly with the CRS Office Chief in accordance with R9-7-702.

B. Enrollee or applicant grievance to Contractor.

1. All grievances filed by enrollees or applicants relating to the contract shall be filed with the contractor for review, investigation and resolution in accordance with the contractor's internal grievance procedure.
2. All grievances shall be filed in writing with the contractor no later than 15 days after the date of the adverse decision or action.
3. The contractor shall record and retain sufficient information to identify the grievant, date of receipt, nature of the grievance, and the date and nature of the decision rendered.
4. A final decision shall be rendered by the contractor on grievances within 15 days of filing. A copy of the decision by the contractor shall be personally delivered or mailed by regular mail to all parties and shall state the basis for the decision as well as information regarding the enrollee's right to appeal the decision to the CRS Medical Director of Office Chief.
5. At the time of enrollment, each enrollee shall be given material explaining grievance procedures available through the contractor, CRS Medical Director, CRS Office Chief and the Director of the Department.

R9-7-702. Review and appeal

A. All CRS applicants, enrollees and all providers of services to CRS enrollees may request review of a final notice of an adverse decision issued by a CRS or its contractors.

1. Within 15 days of receipt of an adverse decision relating to medical condition or services, an applicant, enrollee or provider may submit a written request to the CRS Medical Director for review.
2. Within 15 days of receipt of an adverse decision relating to non-medical issues, an applicant, enrollee or provider may submit a written request to the CRS Office Chief for review.
3. The CRS Medical Director or Office Chief shall provide a written reply to the review request within 30 days of receipt of the request. Additional time may be necessary if medical records are required to complete the case analysis. The reply shall state whether the adverse decision has been upheld, modified or reversed. The reply shall be mailed to the requesting party and to other appropriate participating parties.

B. All CRS applicants, enrollees and providers of services to CRS enrollees may file a formal appeal, requesting a hearing, in response to any adverse reply from the CRS Medical Director or Office Chief to a review request.

1. An appeal shall be in writing and filed within 15 days of receipt of an adverse reply to a review request with the Office of the Director, Arizona Department of Health Services. The appeal shall clearly state in detail the basis of the grievance and the relief being requested.
2. The appeal shall be conducted in accordance with the Department's rules and practice and procedure, A.A.C., Title 9, Chapter 1, Article 1.

R9-7-703. Computation of time

In computing any period of time prescribed or allowed by these rules, the day of the act, event or default after which the designated period of time begins to run shall not be included. The last day of the period shall be included unless it is a Saturday, Sunday or a state holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday nor a state holiday. The computation shall include intermediate Saturdays, Sundays and holidays.