NOTICES OF FINAL RULEMAKING

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

NOTICE OF FINAL RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 12. BOARD OF FUNERAL DIRECTORS AND EMBALMERS

[R05-303]

PREAMBLE

1. Sections Affected — **Rulemaking Action**
R4-12-120 — New Section

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):
Authorizing statutes: A.R.S. §§ 32-1307(A)(5)(h) and 32-1383(C)

Implementing statute: A.R.S. § 32-1383(C)

3. The effective date of the rules:
October 1, 2005

4. A list of all previous notices appearing in the *Register* addressing the final rule:
Notice of Rulemaking Docket Opening: 11 A.A.R. 411, January 14, 2005

Notice of Proposed Rulemaking: 11 A.A.R. 974, March 4, 2005

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

Name:	Rodolfo R. Thomas, Executive Director
Address:	Board of Funeral Directors and Embalmers 1400 W. Washington, Room 230 Phoenix, AZ 85007
Telephone:	(602) 542-3095
Fax:	(602) 542-3093
E-mail:	rudy.thomas@funeral.bd.state.az.us

6. An explanation of the rule, including the agency's reason for initiating the rule:
The Board is proposing a rule that sets out its inspection procedures for funeral establishments and crematories as required by A.R.S. §§ 32-1307(A)(5)(h) and 32-1383(C) and to comply with the Auditor General's recommendation in its 03-04 report.

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

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

9. The summary of the economic, small business, and consumer impact:
Annual cost/revenue changes are designated as minimal when less than $1,000, moderate when between $1,000 and $10,000, and substantial when greater than $10,000.

The Board bears moderate costs for writing the rule for its inspection procedures and related economic, small business, and consumer impact statement and minimal costs for mailing the new rule to interested persons.

The rule should not impose additional costs on an applicant for a funeral establishment or crematory license or on a licensee but will benefit the applicant or licensee because the rule sets out clear and consistent inspection procedures. Approximately 65% of funeral establishment and crematory licensees are small businesses.

Consumers benefit from the rule because the rules ensure that the consumer has the satisfaction of knowing that a funeral establishment or crematory is being inspected for conformance with A.R.S. § Title 32, Chapter 12 and its rules in A.A.C. Title 4, Article 12.

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

The Board made grammatical and technical changes recommended by Council staff and the following changes to the rule, none of which constitute a substantial change:

In R4-12-120(B), the Board added "At the inspection site," to clarify where the Board provides the verbal report.

In R4-12-120(D), the Board changed "Within seven days" to "Within 15 days". The Board does not believe this is a substantial change because this is a plan of action not an actual correction. The Board is giving the applicant or licensee an additional eight days to submit the plan of correction to allow the applicant a few days to ensure that the plan of action is complete. The Board has 30 days to respond to the completeness of the plan of correction, thus an additional 8 days is not a significant change.

In R4-12-120(E)(1), the Board changed "compliance" to "substantial compliance" to conform with A.R.S. § 41-1009(F). This is not a substantial change because the change was made to conform to the statute.

In R4-12-120(F)(1), the Board changed "Committed with knowledge that they are deficiencies;" to "Committed intentionally;". The Board does not believe this is a substantial change because the Board made this change to conform with A.R.S. § 41-1009(E)(1).

The Board added the following to R4-12-120(G) to clarify when the Board will grant an extension of time to correct deficiencies: If an applicant or licensee does not correct the deficiencies within the time-frame approved by the Board, the Board may:

1. If requested by the applicant or licensee, extend the time-frame for situations beyond the control of the applicant or licensee, such as:
   a. When the applicant or licensee in good faith is unable to obtain the items necessary to correct the deficiencies within the time-frame approved by the Board, or
   b. The time needed to correct the deficiencies is longer than the time-frame approved by the Board due to the complexity, nature, or amount of deficiencies.

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

The Board received the following written comments:

Comment: Although the rule allows the Board to send a copy of its inspection report to the regulated person within 15 days after completion of an inspection, the rule permits the regulated person only seven days to submit a plan of correction. The Board should allow the regulated person to submit a plan of correction 15 days after receipt of the inspection report.

Response: Comment incorporated. In R4-12-120(D), the Board changed "Within seven days" to "Within 15 days". The Board does not believe this is a substantial change because this is a plan of action not an actual correction. The Board is giving the applicant or licensee an additional eight days to submit the plan of correction to allow the applicant a few days to ensure that the plan of action is complete. The Board has 30 days to respond to the completeness of the plan of correction, thus an additional 8 days is not a significant change.

Comment: The word "Board" should be clarified as to when it refers to Board staff and the actual Board.

Response: The rule sets out the Board's practice and procedures for inspections that have been in place for many years. The Board receives its inspection authority from A.R.S. §§ 32-1383(C) and 32-1395(C), which permit the Board or the Board's designee to inspect the premises of a funeral establishment or crematory respectively. The Board is making no changes to its inspection procedures, but is stating, in rule, the way it currently performs inspections. The Board does not believe it is necessary to make the recommended change.

Comment: Subsection (F)(1), which states that deficiencies committed with knowledge that they are deficiencies are not subject to a plan of correction, is inconsistent with A.R.S. § 41-1009(E)(1), which states that a plan of correction may submitted for deficiencies unless the Board determines the deficiencies are committed intentionally.

The Board should adopt the standard provided in A.R.S. § 41-1009(E)(1).

Response: The Board agrees the standard in A.R.S. § 41-1009(E)(1) is the standard to be followed and will make this change.

Comment: The Board should add a rule provision that conforms to A.R.S. § 1009(F), which states an agency will act on a plan of correction within 30 days of its receipt.

Response: The Board is already required to follow the provision in the statute and does not believe it is necessary to add a duplicative provision.

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

None

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

None

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

No.

15. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 12. BOARD OF FUNERAL DIRECTORS AND EMBALMERS

ARTICLE 1. GENERAL PROVISIONS

Section
R4-12-120. ~~Reserved~~ Inspection Procedures

ARTICLE 1. GENERAL PROVISIONS

R4-12-120. ~~Reserved~~ Inspection Procedures

A. The Board shall inspect a funeral establishment or crematory:
1. Before issuing an initial license under A.R.S. § 32-1383; and
2. Once every five years under A.R.S. § 32-1307(A)(5)(h).

B. The Inspection shall include:
1. Reviewing equipment and the physical plant;
2. Interviewing personnel;
3. For a funeral establishment, inspecting for compliance with A.R.S. Title 32, Chapter 12, Articles 2, 3, 3.1, 4, and 5, and A.A.C. Title 4, Chapter 12, Articles 3 and 5; and
4. For a crematory, inspecting the crematory for compliance with A.R.S. Title 32, Chapter 12, Article 6 and A.A.C. Title 4, Chapter 12, Article 6.

C. At the inspection site, the Board shall make a verbal report of findings to an applicant or licensee upon completion of an inspection.

D. Within 15 days of the inspection, the Board shall send to the applicant or licensee a written report of its findings that includes:
1. A statement that no deficiencies were found, or
2. If deficiencies are found:
   a. A list of any deficiencies identified during the inspection,
   b. A citation to each statute or rule that has not been complied with,
   c. A request for a written plan of correction, and
   d. The time-frame for correcting the deficiencies.

E. Within 15 days after receiving a request for a written plan of corrections, an applicant or licensee shall submit to the Board a written plan of correction that includes:
1. The identified deficiency,
2. How the applicant or licensee will correct the deficiency, and
3. When the applicant or licensee will correct the deficiency.

F. The Board shall accept a written plan of correction if it:
1. Describes how each deficiency will be corrected to bring the:
   a. Funeral establishment into substantial compliance with A.R.S. Title 32, Chapter 12, Articles 2, 3, 3.1, 4, and 5, and A.A.C. Title 4, Chapter 12, Articles 3 and 5; or
   b. Crematory into substantial compliance with A.R.S. Title 32, Chapter 12, Article 6 and A.A.C. Title 4, Chapter 12, Article 6.
2. Includes a date for correcting each deficiency as soon as practicable based upon the actions necessary to correct the deficiency.

G. The Board shall provide an applicant or licensee with an opportunity to correct the deficiencies unless the Board deter-

mines the deficiencies are:
1. Committed intentionally;
2. Evidence a pattern of noncompliance:
   a. For a funeral establishment, with A.R.S. Title 32, Chapter 12, Articles 2, 3, 3.1, 4, and 5, and A.A.C. Title 4, Chapter 12, Articles 3 and 5; or
   b. For a crematory, with A.R.S. Title 32, Chapter 12, Article 6 and A.A.C. Title 4, Chapter 12, Article 6; or
3. A risk to the public health, safety, or welfare.

H. If an applicant or licensee does not correct the deficiencies within the time-frame approved by the Board, the Board may:
1. If requested by the applicant or licensee, extend the time-frame for situations beyond the control of the applicant or licensee, such as:
   a. When the applicant or licensee in good faith is unable to obtain the items necessary to correct the deficiencies within the time-frame approved by the Board, or
   b. The time needed to correct the deficiencies is longer than the time-frame approved by the Board due to the complexity, nature, or amount of deficiencies.
2. If the applicant or licensee fails to correct the deficiencies within the time-frame approved by the Board, take the disciplinary actions stated in A.R.S. § 32-1390.01 or A.R.S. § 32-1398.

NOTICE OF FINAL RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 20. BOARD OF DISPENSING OPTICIANS

[R05-313]

PREAMBLE

1. Sections Affected **Rulemaking Action**

R4-20-112 Amend

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

Authorizing statute: A.R.S. § 32-1673

Implementing statute: A.R.S. § 32-1685

3. The effective date of the rules:

August 3, 2005

Immediately upon filing with the Secretary of State. The Board seeks an immediate effective date under A.R.S. § 41-1032(A)(1) to preserve the public health and safety.

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

Notice of Rulemaking Docket Opening: 11 A.A.R. 619, February 4, 2005

Notice of Proposed Rulemaking: 11 A.A.R. 976, March 4, 2005

Notice of Public Information: 11 A.A.R. 1513, April 22, 2005

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

Name:	Lori D. Scott, Executive Director
Address:	1400 W. Washington, Rm 230
	Phoenix, AZ 85007
Telephone:	(602) 542-3095
Fax:	(602) 542-3093
E-mail:	director@asbdo.state.az.us

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

The Board is amending the rule to increase the fee charged for an application for a dispensing optician license, the dispensing optician license fee, the renewal fee for a dispensing optician license, and the renewal fee for an optical establishment license.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may

obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:
None

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:
The proposed amendments do not diminish a previous grant of authority of a political subdivision of this state.

9. The summary of the economic, small business, and consumer impact:
The Board anticipates minimal impact on dispensing opticians. Minimal to no impact on consumers of dispensing optician services, and owners of optical establishments with the amendments proposed. The costs to the Board are moderate for promulgation of the rules. The Board's administrative and staff costs to implement the rules are minimal. The Secretary of State's cost for publishing the rules is minimal. The cost for review of the rules by the Governor's Regulatory Review Council is minimal. The cost of licensed opticians and establishments to review new rules is minimal. There will be minimal cost for an individual applying for a license or license issuance. A licensee may choose to pass the cost onto consumers. These changes should result in a substantial increase in revenue to the Board and a moderate increase in revenue to the State General Fund.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):
None

11. A summary of the comments made regarding the rule and the agency response to them:
No written comments have been received.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
None

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

14. Was this rule previously made as an emergency rule?
No.

15. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 20. BOARD OF DISPENSING OPTICIANS

ARTICLE 1. IN GENERAL

Section
R4-20-112. Fees

ARTICLE 1. IN GENERAL

R4-20-112. Fees

A. Dispensing optician fees are as follows:
1. License application fee: $~~75~~ 100
2. License issuance fee: $~~75~~ 100
3. Renewal of dispensing optician license: $~~100~~ 135

B. Optical establishment license fees are as follows:
1. License application fee: $100
2. License issuance fee: $100
3. Renewal of optical establishment license: $~~100~~ 135

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R05-310]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-28-101	Amend
R9-28-107	Repeal
R9-28-701	Repeal
R9-28-701	New Section
R9-28-705	Amend
R9-28-711	Amend
R9-28-713	Amend

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

Authorizing statutes: A.R.S. §§ 36-2904, 36-2903.01, and 36-2932

Implementing statutes: A.R.S. §§ 36-2904, 36-2903, and 36-2903.01

3. The effective date of the rules:

October 1, 2005

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 3297, August 20, 2004

Notice of Rulemaking Docket Opening: 10 A.A.R. 4601, November 12, 2004

Notice of Rulemaking Docket Opening: 10 A.A.R. 4850, December 3, 2004

Notice of Proposed Rulemaking: 11 A.A.R. 768, February 18, 2005

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

Name: Mariaelena Ugarte

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

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

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

The rules are being amended as a result of a Five-Year Rule Review, finding that clarification was needed to address how contractors and the Administration make payments. Statutory references were updated and the rule reorganized for clarity.

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

No studies were reviewed.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

AHCCCS anticipates minimal impact.

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

A cross-reference in R9-28-705 was added for payments made in regard to non-hospital services.

In addition, the Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.

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

None received

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

Not applicable

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

None

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

No.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 1. DEFINITIONS

Section
R9-28-101. General Definitions
R9-28-107. ~~Standards for Payment Related Definitions~~ Repealed

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-28-701. ~~Scope of the Administration's Liability~~ Standards for Payment Related Definitions
R9-28-705. Payments by Program Contractors
R9-28-711. Payments Made on Behalf of a Program Contractor; Recovery of Funds~~; Postpayment Reviews~~
R9-28-713. Hospital Rate Negotiations

ARTICLE 1. DEFINITIONS

R9-28-101. General Definitions

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

Definition	Section or Citation
"Administration"	A.R.S. § 36-2931
"ADHS"	R9-22-112
"Aggregate"	~~R9-22-107~~ R9-22-701
"AHCCCS"	R9-22-101
"AHCCCS ~~Registered Provider~~ registered provider"	R9-22-101
"Algorithm"	R9-28-104
"ALTCS"	R9-28-101
"ALTCS acute care services"	R9-28-104
"Alternative HCBS setting"	R9-28-101
"Ambulance"	~~R9-22-102~~ A.R.S. § 36-2201
"Applicant"	R9-22-101
"Bed hold"	R9-28-102
"Behavior intervention"	R9-28-102
"Behavior management services"	~~R9-20-101~~ R9-22-112
"Behavioral health evaluation"	R9-22-112

"Behavioral health medical practitioner"	R9-22-112
"Behavioral health professional"	R9-20-101
"Behavioral health service"	R9-20-101
"Behavioral health technician"	R9-20-101
"Billed charges"	~~R9-22-107~~ R9-22-701
"Board-eligible for psychiatry"	R9-22-112
"Capped fee-for-service"	R9-22-101
"Case management plan"	R9-28-101
"Case manager"	R9-28-101
"Case record"	R9-22-101
"Categorically-eligible"	R9-22-101
"Certification"	R9-28-105
"Certified psychiatric nurse practitioner"	R9-22-112
"CFR"	R9-28-101
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-22-112
"CMS"	R9-22-101
"Community ~~Spouse~~ spouse"	R9-28-104
"Contract"	R9-22-101
"Contract year"	R9-28-101
"Contractor"	A.R.S. § 36-2901
"County of fiscal responsibility"	~~R9-28-107~~ R9-28-701
"Covered services"	R9-28-101
"CPT"	~~R9-22-107~~ R9-22-701
"CSRD"	R9-28-104
"Day"	R9-22-101
"Department"	A.R.S. § 36-2901
"De novo hearing"	42 CFR 431.201
"Developmental disability"	A.R.S. § 36-551
"Diagnostic services"	R9-22-102
"Director"	R9-22-101
"Disenrollment"	R9-22-117
"DME"	R9-22-102
"EPD"	R9-28-301
"Eligible person"	A.R.S. § 36-2931
"Emergency medical services"	R9-22-102
"Encounter"	~~R9-22-107~~ R9-22-701
"Enrollment"	R9-22-117
"Estate"	A.R.S. § 14-1201
"Facility"	R9-22-101
"Factor"	~~R9-22-101~~ 42 CFR 447.10
"Fair consideration"	R9-28-104
"FBR"	R9-22-101
"Fee-For-Service" or "FFS"	R9-28-101
"Grievance"	~~R9-22-108~~ R9-34-202
"GSA"	R9-22-101
"Guardian"	A.R.S. § 14-5311
"HCBS" or "Home and community based services"	A.R.S. §§ 36-2931 and 36-2939
"Health care practitioner"	R9-22-112
~~"Hearing"~~	~~R9-22-108~~
"Home"	R9-28-101
"Home health services"	R9-22-102
"Hospital"	R9-22-101
"ICF-MR" or "Intermediate care facility for the mentally retarded"	42 CFR 483 Subpart I
"IHS"	R9-28-101
"IMD" or "Institution for mental diseases"	42 CFR 435.1009 ~~and R9-28-111~~

~~"Indian"~~	~~42 CFR 36.1~~
"Institutionalized"	R9-28-104
"Interested Party"	R9-28-106
"JCAHO"	R9-28-101
"License" or "licensure"	R9-22-101
"Medical record"	R9-22-101
"Medical services"	~~R9-22-101~~ A.R.S. § 36-401
"Medical supplies"	R9-22-102
"Medically eligible"	R9-28-104
"Medically necessary"	R9-22-101
"Member"	A.R.S. § 36-2931
"Mental disorder"	A.R.S. § 36-501
"MMMNA"	R9-28-104
"Nursing facility" or "NF"	42 U.S.C. 1396r(a)
"Noncontracting provider"	A.R.S. § 36-2931
"Occupational therapy"	R9-22-102
"Partial care"	R9-22-112
"PAS"	R9-28-103
"Pharmaceutical service"	R9-22-102
"Physical therapy"	R9-22-102
"Physician"	R9-22-102
"Post-stabilization care services"	42 CFR 438.114
"Practitioner"	R9-22-102
"Primary care provider (PCP)"	R9-22-102
"Primary care provider services"	R9-22-102
"Prior authorization"	R9-22-102
"Prior period coverage" or "PPC"	~~R9-22-107~~ R9-22-701
"Private duty nursing services"	R9-22-102
"Program contractor"	A.R.S. § 36-2931
"Provider"	A.R.S. § 36-2931
"Psychiatrist"	R9-22-112
"Psychologist"	R9-22-112
"Psychosocial rehabilitation services"	~~R9-20-101~~ R9-22-112
"Quality management"	R9-22-105
"Regional behavioral health authority" or "RBHA"	A.R.S. § 36-3401
"Radiology"	R9-22-102
"Reassessment"	R9-28-103
"Redetermination"	R9-28-104
"Referral"	R9-22-101
"Reinsurance"	~~R9-22-107~~ R9-22-701
"Representative"	R9-28-104
"Respiratory therapy"	R9-22-102
"Respite care"	R9-28-102
"RFP"	R9-22-106
"Room and board"	R9-28-102
"Scope of services"	R9-28-102
"Section 1115 Waiver"	A.R.S. § 36-2901
"Speech therapy"	R9-22-102
"Spouse"	R9-28-104
"SSA"	42 CFR 1000.10
"SSI"	~~R9-22-101~~ 42 CFR 435.4
"Subcontract"	R9-22-101
"Utilization management"	R9-22-105
"Ventilator dependent"	R9-28-102

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

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

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

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

Community residential setting defined in A.R.S. § 36-551;

Group home defined in A.R.S. § 36-551;

State-operated group home under A.R.S. § 36-591;

Group foster home under R6-5-5903;

Licensed residential facility for a person with traumatic brain injury under A.R.S. § 36-2939;

Adult therapeutic foster home under 9 A.A.C 20, Articles 1 and 15;

Level 2 and Level 3 behavioral health residential agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6; and

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

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

Adult foster care ~~homes~~ defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939;

Assisted living home or assisted living center, units only, under A.R.S. § 36-401, and as authorized in A.R.S. § 36-2939;

Licensed residential facility for a person with a traumatic brain injury specified in A.R.S. § 36-2939;

Adult therapeutic foster home under 9 A.A.C. 20, Articles 1 and 15;

Level ~~II~~ 2 and Level ~~III~~ 3 behavioral health residential agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6;

Rural Substance Abuse Transitional Agencies under 9 A.A.C. 20, Articles 1 and 14; and

Alzheimer's treatment assistive living facility ~~demonstration pilot project~~ as specified in Laws 1999, Ch. 313, § 35 as amended by Laws 2001, Ch. 140, § 1 and Laws 2003, Ch. 76, § 1.

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

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

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

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

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

"Fee-For-Service" or "FFS" means a method of payment to an AHCCCS registered provider on an amount-per-service basis.

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

Health care institution under A.R.S. § 36-401;

Residential care institution under A.R.S. § 36-401;

Community residential setting under A.R.S. § 36-551; or

Behavioral health service under 9 A.A.C. 20, Articles 1, 4, 5, and 6.

"IHS" means the Indian Health Service.

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

R9-28-107. ~~Standards for Payment Related Definitions~~ Repealed

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

~~"County of fiscal responsibility" means the county that is financially responsible for the state's share of ALTCS funding.~~

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-28-701. ~~Scope of the Administration's Liability~~ Standards for Payment Related Definitions

~~The Administration shall bear no liability for providing covered services or completing a plan of treatment for a member beyond the date of termination of the member's eligibility.~~

Definitions. In this Article, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, the following phrase has the following meaning unless the context of the Article explicitly requires another meaning:

"County of fiscal responsibility" means the county that is financially responsible for the state's share of ALTCS funding.

R9-28-705. Payments by Program Contractors

~~**A.** Authorization. A program contractor shall pay for all ALTCS covered services rendered to a member when the service or admission has been arranged by a program contractor's agent, an employee, a provider, or other individual acting on a program contractor's behalf, and for which necessary authorization has been obtained.~~

~~**B.** Timeliness of provider claim payment. A program contractor shall pay a claim or shall provide a notice for a denied or a reduced claim as specified in A.A.C. R9-22-705.~~

~~**C.** Payment for a long-term care service in an institutional and a home and community-based setting. A program contractor shall submit annually to the Administration, a program contractor's proposed payment methodology for reimbursement of a participating provider for long-term care services in an institutional and a home and community-based setting. All payment methods and rates of payment shall be subject to the approval of the Administration based on the reasonableness of the methods and rates. A program contractor shall use the following types of reimbursement:~~

~~1. The Administration's fee-for-service schedule;~~
~~2. Subcapitation;~~
~~3. Prospective payment when payment is tied to quality of care;~~
~~4. Volume purchase; and~~
~~5. Selective contracting and competitive bidding.~~

~~**D.** Payment for in-state medically necessary acute outpatient services. A program contractor shall reimburse an in-state provider and a noncontracting provider for the provision of medically necessary outpatient services to a program contractor's member.~~

~~**E.** Payment for acute inpatient hospital services and out-of-state hospital services. A program contractor shall reimburse a provider and a noncontracting provider for the provision of medically necessary inpatient hospital services to a program contractor's member.~~

~~**F.** Reimbursement standards for emergency services. A program contractor shall pay for all emergency care services rendered to a program contractor's member by a noncontracting provider or a provider when the services:~~

~~1. Are rendered according to the prudent layperson standard;~~
~~2. Conform to the definitions of emergency medical and acute mental health services defined in 9 A.A.C. 22, Article 1; and~~
~~3. Conform to the notification requirements in 9 A.A.C. 22, Article 2.~~

~~**G.** "."Transportation. A program contractor shall pay for ground or air ambulance transport in response to a 9-1-1 or other emergency response system call specified in A.A.C. R9-22-705.~~

A. General requirements. A contractor shall contract with providers as described in A.A.C. R9-22-705.

B. Timely submission of claims. A contractor shall pay timely submitted claims as described in A.A.C. R9-22-705.

C. Date of claim. A contractor shall determine the date of receipt of a claim as described in A.A.C. R9-22-705.

D. Payment for inpatient hospital services. A contractor shall reimburse a provider for inpatient hospital services as described in A.A.C. R9-22-705.

E. Payment for outpatient hospital services. A contractor shall reimburse a provider for outpatient hospital services as described in A.A.C. R9-22-705.

F. Inpatient and outpatient out-of-state hospital payments. A contractor shall reimburse a provider for out-of-state services as described in A.A.C. R9-22-705.

G. Payment for observation days. A contractor shall reimburse a provider for services related to observation days as described in A.A.C. R9-22-705.

H. Review of claims. If a contractor conducts a review of claims, the contractor shall conduct the review as described in A.A.C. R9-22-705.

I. Non-hospital claims. A contractor shall pay claims for services other than hospital services as described in A.A.C. R9-22-705.

J. Payments to hospitals. A contractor shall reimburse a hospital as described in A.A.C. R9-22-705.

K. Interest payment. A contractor shall pay interest on late claims as described in A.A.C. R9-22-705.

R9-28-711. Payments Made on Behalf of a Program Contractor; Recovery of Funds~~; Postpayment Reviews~~

~~**A.**~~ The Administration may make payments on behalf of a program contractor and may recover funds from a program contractor or AHCCCS registered provider according to standards under A.A.C. R9-22-713. For purposes of this Section, the

term "contractor" as it appears in A.A.C. R9-22-713 means "program contractor."

~~**B.** The Administration shall conduct postpayment reviews of claims paid by the Administration and shall recoup any monies erroneously paid according to standards under A.A.C. R9-22-703. Program contractors may conduct postpayment reviews of claims paid by program contractors and may recoup any monies erroneously paid.~~

R9-28-713. Hospital Rate Negotiations

A. A program contractor that negotiates with a hospital for inpatient hospital and outpatient hospital services shall reimburse ~~hospitals~~ the hospital for a member's care under A.A.C. ~~R9-22-715(A)~~ R9-22-715.

B. ~~If the~~ The Administration ~~negotiates or contracts~~ may negotiate or contract as described under R9-22-715 ~~with hospitals on behalf of program contractors for discounted hospital rates, the negotiated discounted rates shall be included in contracts between a program contractor and a hospital when in the best interest of the state.~~

~~**C.** The Director shall apportion any cost avoidance in the hospital component of provider capitation rates between the Administration and program contractor. The Administration's portion of the cost avoidance shall be reflected in reduced capitation rates paid to a program contractor.~~

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R05-311]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-31-705	Amend
R9-31-715	Amend
R9-31-717	Repeal
R9-31-1619	Amend

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

Authorizing statutes: A.R.S. §§ 36-2904, 36-2903.01, and 36-2982

Implementing statutes: A.R.S. §§ 36-2904, 36-2903, and 36-2903.01

3. The effective date of the rules:

October 1, 2005

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 3298, August 20, 2004

Notice of Proposed Rulemaking: 11 A.A.R. 775, February 18, 2005

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

Name: Mariaelena Ugarte

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

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

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

The rules are being amended as a result of a Five-Year Rule Review, finding that clarification was needed to address how contractors and the Administration make payments. Statutory references were updated and the rule reorganized for clarity.

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

No studies were reviewed.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

AHCCCS anticipates no impact.

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

A cross-reference to R9-22-705 was made in R9-31-705 for payments made in regard to non-hospital services.

In addition, the Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.

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

None received

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

Not applicable

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

None

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

No.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-31-705. Payments by Contractors
R9-31-715. Hospital Rate Negotiations
R9-31-717. ~~Hospital Claims Review~~ Repealed

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

Section
R9-31-1619. ~~Hospital~~ Claims Review

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-31-705. Payments by Contractors

~~**A.** Authorization. A contractor shall pay for all admissions and covered services rendered to its members if the covered services or admissions have been arranged by the contractor's agents or employees, subcontracting providers, or other individuals acting on the contractor's behalf and if necessary authorization has been obtained. A contractor is not required to pay a claim for covered services that is submitted more than six months after the date of the service or that is submitted as a clean claim more than 12 months after the date of the service.~~

~~**B.** Timeliness of provider claim payment.~~

~~1. A contractor shall reimburse, or provide written notice for a claim that is denied or reduced by a contractor, to a subcontracting provider for the provision of medically necessary health care services to a contractor's member, within the time period specified by the subcontract.~~

2. Unless the subcontract specifies otherwise, a contractor shall pay valid clean claims according to 42 U.S.C. 1396u-2, as of August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments and states that:
   a. 90% of valid claims shall be paid within 30 days of the date of receipt of a claim,
   b. 99% of valid clean claims shall be paid within 90 days of the date of receipt of a claim, and
   c. The remaining 1% of valid clean claims shall be paid within 12 months of the date of receipt of a claim.
3. Unless the subcontract specifies otherwise, a contractor shall provide notice of a denial or a reduction of a claim for:
   a. 90% of the claims within 30 days of the date of receipt of a claim,
   b. 99% of the claims within 90 days of the date of receipt of a claim, and
   c. The remaining 1% of the claims within 12 months of the date of receipt of a claim.
4. A notice of denial or reduction shall include a statement describing the right to grieve the contractor's denial or reduction of a claim according to 9 A.A.C. 22, Article 8.

C. Date of claim. A contractor's date of receipt of an inpatient or outpatient hospital claim shall be the date the claim is received by the contractor as indicated by the date stamp on the claim, the claim reference number, or the date-specific number system assigned by the contractor. A hospital claim shall be considered paid on the date indicated on the disbursement check. A denied hospital claim shall be considered adjudicated on the date of its denial. Claims that are pending for additional supporting documentation will receive new dates of receipt upon receipt of the additional documentation; however, claims that are pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2987 or 36-2904, as applicable, will not receive new dates of receipt. A contractor and a hospital may, through a contract approved in accordance with R9-31-715(A), adopt a method for identifying, tracking, and adjudicating claims that is different from the method described in this subsection.

D. Payment for medically necessary outpatient hospital services.
1. A contractor shall reimburse subcontracting and noncontracting providers for the provision of outpatient hospital services rendered at either a rate specified by subcontract or, in absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval under A.R.S. §§ 36-2987, 36-2904, and R9-31-715.
2. A contractor shall pay for all emergency care services rendered to its members by noncontracting providers or non-providers when the services:
   a. Are rendered according to the prudent layperson standard,
   b. Conform to the definitions of emergency medical and acute mental health services in Article 1 of this Chapter, and
   c. Conform to the notification requirements in Article 2 of this Chapter.

E. Payment for inpatient hospital services. A contractor shall reimburse out-of-state hospitals for the provision of hospital services at negotiated discounted rates, the AHCCCS average cost-to-charge ratio multiplied by covered charges or, if reasonably and promptly available, the Medicaid rate that is in effect at the time services are provided in the state in which the hospital is located, whichever is lowest. A contractor shall reimburse in-state subcontractors and noncontracting providers for the provision of inpatient hospital services at either a rate specified by subcontract or, in absence of a subcontract, the prospective tiered-per-diem amount in A.R.S. §§ 36-2987, 36-2904, 36-2903.01, and A.A.C. R9-22-712 and R9-22-718, as applicable. Discounts and penalties shall be as specified in A.R.S. § 36-2987(C). Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. §§ 36-2987, 36-2904, and R9-31-715.

F. Payment for observation days. A contractor may reimburse subcontracting and noncontracting providers for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges.

G. Review of hospital claims.
1. If a contractor and a hospital do not agree on reimbursement levels, terms, and conditions, the reimbursement levels established under A.R.S. §§ 36-2987, 36-2904, 36-2903.01, and A.A.C. R9-22-712 or R9-31-718 shall apply. In these cases, a hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. A contractor shall consider the medical condition of the member, length of stay, and other factors when issuing its prior authorization. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of their contract regarding utilization control activities that may include prior authorization of nonemergency admissions. Failure to obtain prior authorization when it is required shall be cause for nonpayment or denial of the claim. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and make the hospital's medical records, specific to a member enrolled with the contractor, available for review.
2. Regardless of prior authorization or concurrent review activities, all hospital claims, including outlier claims, are subject to prepayment medical review and post-payment review by the contractor. Post-payment reviews shall be consistent with A.R.S. § 36-2987, and erroneously paid claims are subject to recoupment. If prior authorization was given for a specific level of care, but medical review of the claim indicates that a different level of care was appropriate, the contractor may adjust the claim to reflect the more appropriate level of care. An adjustment in level of care shall be effective on the date when the different level of care was medically appropriate.

3. ~~A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures different from those in this subsection if the subcontract binds both parties and meets the requirements of R9-31-715.~~

~~**H.** Timeliness of hospital claim payment. Payment by a contractor for inpatient hospital admissions and outpatient hospital services shall be subject to A.R.S. §§ 36-2987, 36-2904, and 36-2903.01.~~

A. General requirements. A contractor shall contract with providers as described in A.A.C. R9-22-705.

B. Timely submission of claims. A contractor shall pay timely submitted claims as described in A.A.C. R9-22-705.

C. Date of claim. A contractor shall determine the date of receipt of a claim as described in A.A.C. R9-22-705.

D. Payment for inpatient hospital services. A contractor shall reimburse a provider for inpatient hospital services as described in A.A.C. R9-22-705.

E. Payment for outpatient hospital services. A contractor shall reimburse a provider for outpatient hospital services as described in A.A.C. R9-22-705.

F. Inpatient and outpatient out-of-state hospital payments. A contractor shall reimburse a provider for out-of-state services as described in A.A.C. R9-22-705.

G. Payment for observation days. A contractor shall reimburse a provider for services related to observation days as described in A.A.C. R9-22-705.

H. Review of claims. If a contractor conducts a review of claims, the contractor shall conduct the review as described in A.A.C. R9-22-705.

I. Non-hospital claims. A contractor shall pay claims for services other than hospital services as described in A.A.C. R9-22-705.

J. Payments to hospitals. A contractor shall reimburse for hospital services as described in A.A.C. R9-22-705.

K. Interest payment. A contractor shall pay interest on late claims as described in A.A.C. R9-22-705.

R9-31-715. Hospital Rate Negotiations

A. ~~Effective for inpatient hospital admissions and outpatient hospital services contractors that negotiate~~ A contractor that negotiates with hospitals for inpatient or outpatient services shall reimburse hospitals for inpatient hospital admissions and outpatient hospital services ~~member care based on the prospective tiered per diem amount, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges in A.R.S. § 36-2987 and A.A.C. R9-22-712, or the negotiated rate that, when considered in the aggregate with other hospital reimbursement levels, does not exceed what would have been paid under A.R.S. § 36-2987 and A.A.C. R9-22-712.~~ as described in A.A.C. R9-22-715.

1. ~~Contractors may engage in rate negotiations with hospitals at any time during the contract period.~~
2. ~~Within seven days of the completion of the agreement process, contractors shall submit copies of their negotiated rate agreements, including all rates, terms, and conditions, with hospitals to the Administration for approval. Contractors shall demonstrate to the Administration that the effect of their negotiated rate agreement will, when considered in the aggregate, be the same as or produce greater dollar savings than would have been paid under A.R.S. § 36-2987 and A.A.C. R9-22-712.~~
   a. ~~To demonstrate the aggregate effect of its negotiated rate agreement, contractors shall present their assumptions related to projected utilization of various hospitals to the Administration. The contractor may consider inpatient assumptions related to:~~
      i. ~~Member mix;~~
      ii. ~~Admissions by AHCCCS specified tiers;~~
      iii. ~~Average length of stay by tier and pattern of admissions, excluding emergency admissions;~~
      iv. ~~Outliers; and~~
      v. ~~Risk sharing arrangements.~~
   b. ~~The contractor also may consider outpatient assumptions related to member mix and outpatient service utilization. The Administration reserves the right to approve, deny, or require mutually agreed to modifications of these assumptions.~~
   c. ~~When a contractor adjusts or modifies an assumption, the reason for the adjustment or modification shall be presented to the Administration, as well as the new assumption. The Administration may approve, deny, or require mutually agreed to modification of an assumption.~~
   d. ~~To determine whether a negotiated rate agreement produces reimbursement levels that do not in the aggregate exceed what would be paid under A.R.S. § 36-2987 and A.A.C. R9-22-712, a contractor shall require its independent auditors to evaluate the reasonableness of its assumptions as part of its annual audit. The contractor shall ensure that its independent auditor's audit program is consistent with AHCCCS audit requirements and is submitted to the Administration for prior approval.~~
   e. ~~Negotiated inpatient or outpatient rate agreements with hospitals with a contractor has a related party interest are subject to additional related party disclosure and evaluation. These evaluations are in addition to the procedures described in subsection (A)(2)(c) and shall be performed by the contractor's independent auditors, or, at the contractor's option, by the Administration.~~
   f. ~~The Administration shall subject a contractor's independent auditor's report to any examination or review necessary to ensure accuracy of all findings related to aggregate rate determinations.~~

~~g. The Administration shall use its standards, consistent with the Request for Proposals and R9-31-502, to determine whether a contractor's inpatient or outpatient hospital subcontractors will limit the availability or accessibility of services. The Administration reserves the right to reject hospital subcontracts that limit the availability or accessibility of services.~~

B. The Administration may negotiate or contract with a hospital on behalf of a contractor as described in A.A.C. R9-22-715.~~with a hospital on behalf of a contractor for discounted hospital rates and may require that the negotiated discounted rates be included in a subcontract between the contractor and hospital.~~

~~**C.** The Director shall apportion any cost avoidance in the hospital component of provider capitation rates between the Administration and provider. The Administration's portion of the cost avoidance shall be reflected in reduced capitation rates paid to providers.~~

R9-31-717. ~~Hospital Claims Review~~ Repealed

~~**A.** The contractors shall review hospital claims that are timely received as specified in A.A.C. R9-22-703(A).~~

~~**B.** A charge for hospital services provided to a member during a time when the member was not the financial responsibility of the contractor shall be denied.~~

~~**C.** Personal care items supplied by a hospital, including but not limited to the following, are not covered services:~~

~~1. Patient care kit,~~
~~2. Toothbrush,~~
~~3. Toothpaste,~~
~~4. Petroleum jelly,~~
~~5. Deodorant,~~
~~6. Septi-soap,~~
~~7. Razor,~~
~~8. Shaving cream,~~
~~9. Slippers,~~
~~10. Mouthwash,~~
~~11. Disposable razor,~~
~~12. Shampoo,~~
~~13. Powder,~~
~~14. Lotion,~~
~~15. Comb, and~~
~~16. Patient gown.~~

~~**D.** The following hospital supplies and equipment, if medically necessary and used, are covered services:~~

~~1. Arm board,~~
~~2. Diaper,~~
~~3. Underpad,~~
~~4. Special mattress and special bed,~~
~~5. Gloves,~~
~~6. Wrist restraint,~~
~~7. Limb holder,~~
~~8. Disposable item used in lieu of a durable item,~~
~~9. Universal precaution,~~
~~10. Stat charge, and~~
~~11. Portable charge.~~

~~**E.** The hospital claims review shall determine whether services rendered were:~~

~~1. Title XXI covered services;~~
~~2. Medically necessary;~~
~~3. Provided in the most appropriate, cost-effective, least restrictive setting; and~~
~~4. Substantiated by the minimum documentation specified in A.R.S. § 36-2987.~~

~~**F.** If a claim is denied by the contractor, a grievance challenging the denial may be filed against the entity denying the claim. The grievance shall be filed no later than 12 months from the date of service or 60 days from the date of notice of adverse action, whichever is latest. Any grievance challenging a postpayment review recoupment action shall be filed by the provider no later than 12 months from the date of service or 60 days from the date of the notice of recoupment, whichever is latest.~~

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1619. ~~Hospital~~ Claims Review
The IHS and a Tribal Facility shall follow the procedures for a ~~hospital~~ claims review as specified in A.A.C. ~~R9-22-717~~ R9-22-703.