NOTICES OF FINAL RULEMAKING

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

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

[R07-79]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-101	Amend
R9-22-102	Amend
R9-22-112	Repeal
R9-22-1201	Amend
R9-22-1202	Amend
R9-22-1203	Amend
R9-22-1204	Amend
R9-22-1205	Amend
R9-22-1206	Amend
R9-22-1207	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. § 36-2903.01(F)

Implementing statute: A.R.S. § 36-2907(F)

3. The effective date of the rules:

May 5, 2007

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

Notice of Rulemaking Docket Opening: 11 A.A.R. 5546, December 30, 2005

Notice of Proposed Rulemaking: 12 A.A.R. 3932, October 27, 2006

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

Name: Jane McVay

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

Telephone: (602) 417-4135

Fax: (602) 253-9115

E-mail: Jane.McVay@azahcccs.gov

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

These rules make needed changes in the behavioral health rules for the acute care program to make the rules clear, concise, and understandable. The changes update the rules to make them consistent with the current program operation and requirements, and the claims submission process. Definitions relating specifically to the behavioral health service program detailed in Article 12 are moved from R9-22-101 or R9-22-112 to R9-22-1201. The rules repeal R9-22-112.

The Administration contracts with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) to provide behavioral health services to Title XIX members in the acute care system. ADHS

contracts with Regional Behavioral Health Agencies (RBHA's) to provide behavioral health services. RBHA's are organizations under contract with ADHS that coordinate the delivery of behavioral health services in a Geographic Service Area (GSA) of the state for eligible members. The Administration makes capitated payments to ADHS to provide behavioral health services to members. Members who are enrolled with a contractor enroll with a RBHA to receive behavioral health services. The responsibility for behavioral health services in the acute care program rests with either the contractors or the RBHA's, with the exception of Native Americans.

In the acute care program, Native Americans may choose to receive all services, including behavioral health services, from a Tribal Regional Behavioral Health Agency (TRBHA), an Indian Health Service facility, or a RBHA. A TRBHA is a Native American Indian tribe under contract with ADHS/DBHS to coordinate the delivery of behavioral health services to eligible, enrolled members of the tribal nation. Behavioral health services are provided to Native Americans through Indian Health Service (IHS) facilities. If a covered behavioral health service is not available from an IHS facility, the Native American member must enroll with a Tribal Regional Behavioral Health Authority (TRBHA), if available, or a Regional Behavioral Health Authority (RBHA), to receive services.

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 agency did not review any study related to this rulemaking.

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

Not applicable

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

AHCCCS anticipates that the economic impact of the rules on members receiving behavioral health services and small businesses will be minimal. A minimal economic impact is defined as one that has an impact of under $1,000. The rules are consistent with the current contract between AHCCCS and ADHS/DBHS and the contract between AHCCCS and the health plans, which have been in effect for the past two years. The rules reflect the current operation of the acute care behavioral health program for members.

These rules make the behavioral health service provisions more clear, concise, and understandable for members, ADHS/DBHS, subcontractors of ADHS/DBHS, and AHCCCS contractors. The rules are expected to have a minimal fiscal impact on all affected agencies, members, and contractors. The Administration has incurred minimal costs to prepare this rulemaking. Although the economic impact on members is expected to be minimal, the availability of behavioral health services is important to members. In October 2006, the approximate total enrollment of children and adults in behavioral health services funded through Title XIX and Title XXI was 97,000.

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

Technical corrections were made to the rules to conform to the *Administrative Code*. Changes were made to ensure that the rules are clear, concise, and understandable. In addition, grammatical and other changes were made as requested by G.R.R.C. staff. Rule provisions that were duplicated within the agency's rules were deleted. Rule changes were made regarding the terminology used for behavioral health adult therapeutic homes and behavioral health therapeutic home care services to comply with the requirements of the Centers for Medicaid and Medicare Services. New definitions of residual functional deficit, behavioral health adult therapeutic home, behavioral health therapeutic home care services, PPC, RBHA, and other needed terms were added to the rules. Prior authorization provisions were added for emergency and non-emergency behavioral health services.

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

The Administration did not receive any comments on the rules.

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:

An incorporation by reference to 42 CFR 456 dated October 1, 2006 is located in R9-22-1206.

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

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section
R9-22-101. Location of Definitions
R9-22-102. Scope of Services-related Definitions
R9-22-112. ~~Behavioral Health Services Related Definitions~~ Repealed

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

Section
R9-22-1201. General Requirements
R9-22-1202. ADHS and Contractor Responsibilities
R9-22-1203. Eligibility for Covered Services
R9-22-1204. General Service Requirements
R9-22-1205. Scope and Coverage of Behavioral Health Services
R9-22-1206. General Provisions and Standards for Service Providers
R9-22-1207. ~~Standards for Payments~~ General Provisions for Payment

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

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

Definition	Section or Citation
"Accommodation"	R9-22-701
"Act"	R9-22-101
~~"Active case"~~	~~R9-22-109~~
"ADHS"	R9-22-102
"Administration"	A.R.S. § 36-2901
"Adverse action"	R9-22-101
"Affiliated corporate organization"	R9-22-101
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501
"Aggregate"	R9-22-701
"AHCCCS"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-701
"AHCCCS registered provider"	R9-22-101
"Ambulance"	A.R.S. § 36-2201
~~"Ancillary department"~~	~~R9-22-701~~
~~"Annual assessment period"~~	~~R9-22-109~~
~~"Annual assessment period report"~~	~~R9-22-109~~
"Annual enrollment choice"	R9-22-117
"APC"	R9-22-701
"Appellant"	R9-22-101
"Applicant"	R9-22-101
"Application"	R9-22-101
"Assignment"	R9-22-101
"Attending physician"	R9-22-101
"Authorized representative"	R9-22-101
"Auto-assignment algorithm"	R9-22-117
"Baby Arizona"	R9-22-1401
"Behavior management services"	~~R9-22-112~~ R9-22-1201
"Behavioral health adult therapeutic home"	R9-22-1201
"Behavioral health therapeutic home care services"	R9-22-1201

"Behavioral health evaluation"	~~R9-22-112~~ R9-22-1201
"Behavioral health medical practitioner"	~~R9-22-112~~ R9-22-1201
"Behavioral health professional"	~~R9-20-101~~ R9-22-1201
"Behavioral health recipient"	R9-22-102
"Behavioral health service"	~~R9-22-112~~ R9-22-1201
"Behavioral health technician"	~~R9-20-101~~ R9-22-1201
~~"Behavior management services"~~	~~R9-22-112~~
"BHS"	R9-22-1401
"Billed charges"	R9-22-701
"Blind"	R9-22-1501
~~"Board-eligible for psychiatry"~~	~~R9-22-112~~
"Burial plot"	R9-22-1401
"Capital costs"	R9-22-701
"Capped fee-for-service"	R9-22-101
"Caretaker relative"	R9-22-1401
~~"Case"~~	~~R9-22-109~~
"Case management"	R9-22-1201
"Case record"	~~R9-22-109~~ R9-22-101
"Case review"	~~R9-22-109~~ R9-22-101
"Cash assistance"	R9-22-1401
"Categorically-eligible"	R9-22-101
"Certified psychiatric nurse practitioner"	~~R9-22-112~~ R9-22-1201
"Children's Rehabilitative Services" or "CRS"	R9-22-102
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	~~R9-22-112~~ R9-22-102
"CMDP"	R9-22-117
"CMS"	R9-22-101
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contractor"	A.R.S. § 36-2901
~~"Corrective action plan"~~	~~R9-22-109~~
~~"Cost-to-charge ratio"~~ "Cost-To-Charge Ratio"	R9-22-701
"Covered charges"	R9-22-701
"Covered services"	R9-22-102
"CPT"	R9-22-701
~~"Critical Access Hospitals"~~ "Critical Access Hospital"	R9-22-701
"Cryotherapy"	~~R9-22-120~~ R9-22-2001
"Date of eligibility posting"	R9-22-701
~~"Date of notice"~~	~~R9-22-108~~
"Day"	R9-22-101
"DBHS"	R9-22-102
"DCSE"	R9-22-1401
"De novo hearing"	42 CFR 431.201
"Dentures" and "Denture services"	R9-22-102
"Department"	A.R.S. § 36-2901
"Dependent child"	A.R.S. § 46-101
"DES"	R9-22-101

"Diagnostic services"	R9-22-102
"Director"	R9-22-101
"Disabled"	R9-22-1501
"Discussion"	R9-22-101
"Disenrollment"	R9-22-117
~~"District"~~	~~R9-22-109~~
"DME"	R9-22-102
"DRI inflation factor"	R9-22-701
"E.P.S.D.T. services"	~~42 CFR 441 Subpart B~~ 42 CFR 440.40(b)
"Eligible person"	A.R.S. § 36-2901
"Emergency behavioral health condition for the non-FES member"	R9-22-102
"Emergency behavioral health services for the non-FES member"	R9-22-102
"Emergency medical condition for the non-FES member"	R9-22-102
"Emergency medical services for the non-FES member"	R9-22-102
"Emergency services costs"	A.R.S. § 36-2903.07
"Encounter"	R9-22-701
"Enrollment"	R9-22-117
"Enumeration"	R9-22-101
"Equity"	R9-22-101
~~"Error"~~	~~R9-22-109~~
"Experimental services"	R9-22-101
~~"Existing outpatient services"~~ "Existing outpatient service"	R9-22-701
"FAA"	R9-22-1401
"Facility"	R9-22-101
"Factor"	42 CFR 447.10
"FBR"	R9-22-101
"Federal financial participation" or "FFP"	42 CFR 400.203
"Federal poverty level" or "FPL"	A.R.S. § 36-2981
"Fee-For-Service" or "FFS"	R9-22-102
"FES member"	R9-22-102
"FESP"	R9-22-101
~~"Finding"~~	~~R9-22-109~~
"First-party liability"	R9-22-1001
"Foster care maintenance payment"	42 U.S.C. 675(4)(A)
~~"Federal poverty level" or "FPL"~~	~~A.R.S. § 36-2981~~
"FQHC"	R9-22-101
~~"Freestanding children's hospital"~~	~~R9-22-701~~
"Free Standing Children Hospital"	R9-22-701
"Global Insights Prospective Hospital Market Basket"	R9-22-701
"Grievance"	R9-34-202
"GSA"	R9-22-101
"HCPCS"	R9-22-701
"Health care practitioner"	~~R9-22-112~~ R9-22-1201
"Hearing aid"	R9-22-102
"HCPCS"	R9-22-701

"HIPAA"	R9-22-701
"Home health services"	R9-22-102
"Homebound"	R9-22-1401
"Hospital"	R9-22-101
"Intermediate Care Facility for the Mentally Retarded" or "ICF-MR"	~~42 CFR 483 Subpart I~~ 42 U.S.C. 1396d(d)
"ICU"	R9-22-701
"IHS"	R9-22-117
"IMD" or "Institution for Mental Diseases"	~~42 CFR 435.1009 and R9-22-112~~ 42 CFR 435.1010 and R9-22-102
"Income"	R9-22-1401
"Inmate of a public institution"	~~42 CFR 435.1009~~ 42 CFR 435.1010
"Interested party"	R9-22-101
~~"LEEP"~~	~~R9-22-120~~
"Legal representative"	R9-22-101
"Level I trauma center"	R9-22-2101
"License" or "licensure"	R9-22-101
"Liquid assets"	R9-22-1401
"Mailing date"	R9-22-101
~~"Management evaluation review"~~	~~R9-22-109~~
"Medical education costs"	R9-22-701
"Medical expense deduction" or "MED"	R9-22-1401
"Medical record"	R9-22-101
"Medical review"	R9-22-701
"Medical services"	A.R.S. § 36-401
"Medical supplies"	R9-22-102
"Medical support"	R9-22-1401
"Medically necessary"	R9-22-101
"Medicare claim"	R9-22-101
"Medicare HMO"	R9-22-101
"Member"	A.R.S. § 36-2901
"Mental disorder"	A.R.S. § 36-501
"National Standard code sets"	R9-22-701
"New hospital"	R9-22-701
"NICU"	R9-22-701
"Noncontracting provider"	A.R.S. § 36-2901
"Non-FES member"	R9-22-102
"Non-IHS Acute Hospital"	R9-22-701
"Nonparent caretaker relative"	R9-22-1401
"Nursing facility" or "NF"	42 U.S.C. 1396r(a)
~~"NICU"~~	~~R9-22-701~~
~~"Non-IHS Acute Hospital"~~	~~R9-22-701~~
~~"Non-FES member"~~	~~R9-22-102~~
~~"Noncontracting provider"~~	~~A.R.S. § 36-2901~~
~~"Nonparent caretaker relative"~~	~~R9-22-1401~~
"Occupational therapy"	R9-22-102
"Offeror"	R9-22-101

"Operating costs"	R9-22-701
"Outlier"	R9-22-701
"Outpatient hospital service"	R9-22-701
"Ownership change"	R9-22-701
"Ownership interest"	42 CFR 455.101
~~"Operating costs"~~	~~R9-22-701~~
~~"Outlier"~~	~~R9-22-701~~
~~"Outpatient hospital service"~~	~~R9-22-701~~
~~"Ownership change"~~	~~R9-22-701~~
"Partial Care"	~~R9-22-112~~ R9-22-1201
"Peer group"	R9-22-701
~~"Performance measures"~~	~~R9-22-109~~
"Pharmaceutical service"	R9-22-102
"Physical therapy"	R9-22-102
"Physician"	R9-22-102
"Physician assistant"	R9-22-1201
"Post-stabilization services"	R9-22-102 or 42 CFR 422.113
"Practitioner"	R9-22-102
"Pre-enrollment process"	R9-22-1401
~~"Preponderance of evidence"~~	~~R9-22-109~~
"Prescription"	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"	R9-22-101
"Procedure code"	R9-22-701
"Proposal"	R9-22-101
"Prospective rates"	R9-22-701
"Psychiatrist"	~~R9-22-112~~ R9-22-1201
"Psychologist"	~~R9-22-112~~ R9-22-1201
"Psychosocial rehabilitation services"	~~R9-22-112~~ R9-22-102
"Public hospital"	R9-22-701
"Qualified alien"	A.R.S. § 36-2903.03
"Quality management"	R9-22-501
"Radiology"	R9-22-102
~~"Random sample"~~	~~R9-22-109~~
"RBHA" or "Regional Behavioral Health Authority"	~~R9-22-112~~ R9-22-102
"Rebase"	R9-22-701
"Referral"	R9-22-101
"Rehabilitation services"	R9-22-102
"Reinsurance"	R9-22-701
"Remittance advice"	R9-22-701
"Residual functional deficit"	R9-22-102
"Resources"	R9-22-1401
"Respiratory therapy"	R9-22-102
"Respite"	R9-22-1201
"Responsible offeror"	R9-22-101

"Responsive offeror"	R9-22-101
~~"Revenue code"~~ "Revenue Code"	R9-22-701
"Review"	R9-22-101
"Review month"	R9-22-101
~~"Review period"~~	~~R9-22-109~~
"RFP"	R9-22-101
"Scope of services"	R9-22-102
"Section 1115 Waiver"	A.R.S. § 36-2901
"Service location"	R9-22-101
"Service site"	R9-22-101
"SOBRA"	R9-22-101
"Specialist"	R9-22-102
"Speech therapy"	R9-22-102
"Spendthrift restriction"	R9-22-1401
"Spouse"	R9-22-101
"SSA"	42 CFR 1000.10
"SSI"	42 CFR 435.4
"SSN"	R9-22-101
"Stabilize"	42 U.S.C. 1395dd
"Standard of care"	R9-22-101
"Sterilization"	R9-22-102
"Subcontract"	R9-22-101
"Submitted"	A.R.S. § 36-2904
"Substance abuse"	R9-22-102
~~"Summary report"~~	~~R9-22-109~~
"SVES"	R9-22-1401
"Third-party"	R9-22-1001
"Third-party liability"	R9-22-1001
"Tier"	R9-22-701
"Tiered per diem"	R9-22-701
"Title IV-D"	R9-22-1401
"Title IV-E"	R9-22-1401
~~"Tolerance level"~~	~~R9-22-109~~
"Trauma and Emergency Services Fund"	A.R.S. § 36-2903.07
"TRBHA" or "Tribal Regional Behavioral Health Authority"	R9-22-1201
"Tribal Facility"	~~R9-22-101~~ A.R.S. § 36-2981
~~"Unrecovered trauma readiness costs"~~ "Unrecovered trauma center readiness costs"	R9-22-2101
"Utilization management"	R9-22-501
"WWHP"	~~R9-22-120~~ R9-22-2001

B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Act" means the Social Security Act.

"Adverse action" means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

"Affiliated corporate organization" means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation. ~~relationships.~~

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS registered provider" means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A)~~;~~, and

Meets license or certification requirements to provide covered services.

"Appellant" means an applicant or member who is appealing an adverse action by the Department or Administration.

"Applicant" means a person who submits or whose authorized representative submits, a written, signed, and dated application for AHCCCS benefits.

"Application" means an official request for AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a ~~fee-for-service~~ Fee-For-Service member.

"Authorized representative" means a person who is authorized to apply for medical assistance or act on behalf of another person.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific covered service or equipment provided to a member. A payment is made in accordance with an upper, or capped, limit established by the Director. This capped limit can be either a specific dollar amount or a percentage of billed charges.

"Case record" means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.

"Case review" means the Administration's evaluation of an individual's or family's circumstances and case record in a review month.

"Categorically-eligible" means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) or 36-2934.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means a period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

"Day" means a calendar day unless otherwise specified.

"DES" means the Department of Economic Security.

~~"Discussion" means an oral or written exchange of information or any form of negotiation.~~

"Director" means the Director of the Administration or the Director's designee.

"Discussion" means an oral or written exchange of information or any form of negotiation.

~~"Eligible person" means the same as in A.R.S. § 36-2901.~~

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

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

"Experimental services" means services that are associated with treatment or diagnostic evaluation and that are not generally and widely accepted as a standard of care in the practice of medicine in the United States unless:

The weight of the evidence in peer-reviewed articles in medical journals published in the United States supports the safety and effectiveness of the service; or

In the absence of peer-reviewed articles, for services that are rarely used, novel, or relatively unknown in the general professional medical community, the weight of opinions from specialists who provide the service attests to the safety and effectiveness of the service.

"Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

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

"FESP" means the federal emergency services program under R9-22-217 which covers services to treat an emergency

medical or behavioral health condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

"FQHC" means federally qualified health center.

"GSA" means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with the contractor.

"Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

"Interested party" means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.

"Legal representative" means a custodial parent of a child under 18, a guardian, or a conservator.

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

"Mailing date" when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered as the date on the document if there is no legible postmark or postage meter mark.

"Medical record" means a document that relates to medical or behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and is kept at the site of the provider.

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

"Medicare claim" means a claim for Medicare-covered services for a member with Medicare coverage.

"Medicare HMO" means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid Services for participation in the Medicare program under 42 CFR 417 Subpart L.

"Offeror" means an individual or entity that submits a proposal to the Administration in response to an RFP.

"Prior period coverage" means the period prior to the member's enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, whichever is later, and continues until the day the member is enrolled with a contractor.

"Proposal" means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

"Referral" means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

"Responsible offeror" means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

"Responsive offeror" means an individual or entity that submits a proposal that conforms in all material respects to an RFP.

"Review" means a review of all factors affecting a member's eligibility.

"Review month" means the month in which the individual's or family's circumstances and case record are reviewed.

"RFP" means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

"Service location" means a location at which a member obtains a covered service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

"Service site" means a location designated by a contractor as the location at which a member is to receive covered services.

"SOBRA" means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

"Spouse" means a person who has entered into a contract of marriage recognized as valid by this state.

"SSN" means Social Security number.

"Standard of care" means a medical procedure or process that is accepted as treatment for a specific illness, injury, or medical condition through custom, peer review, or consensus by the professional medical community.

"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member;

A marketing organization; or

Any other organization or person who agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

~~"Tribal Facility" means a facility that is operated by an Indian tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended.~~

R9-22-102. Scope of Services-related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"ADHS" means the Arizona Department of Health Services.

"Behavioral health recipient" means a Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS/DBHS.

"Children's Rehabilitative Services" or "CRS" means the program within ADHS that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.

"Clinical supervision" means a Clinical Supervisor under 9 A.A.C. 20, Article 2 reviews the skills and knowledge of the individual supervised and provides guidance in improving or developing the skills and knowledge.

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

"DBHS" means the Division of Behavioral Health Services within the Arizona Department of Health Services.

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

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

"DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

"Emergency behavioral health condition for the non-FES member" means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the person, including mental health, in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. Serious physical harm to another person.

"Emergency behavioral health services for the non-FES member" means those behavioral health services provided for the treatment of an emergency behavioral health condition.

"Emergency medical condition for the non-FES member" means treatment for a medical condition, including labor and delivery, ~~which~~ that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the member's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

"Emergency medical services for the non-FES member" means services provided for the treatment of an emergency medical condition.

~~"FES member" means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.~~

"Fee-For-Service" or "FFS" means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a ~~person~~ member not enrolled with a contractor.

"FES member" means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.

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

"Home health services" means services and supplies that are provided by a home health agency that coordinates in-home intermittent services for curative, habilitative care, including home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.

"IMD" or "Institution for Mental Diseases" means an Institution for Mental Diseases as described in 42 CFR 435.1010 and licensed by ADHS.

"Medical supplies" means consumable items that are designed specifically to meet a medical purpose.

"Non-FES member" means ~~a person who is AHCCCS eligible and~~ an eligible person who is entitled to full AHCCCS services.

"Occupational therapy" means medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual's ability to perform tasks required for independent functioning.

"Pharmaceutical service" means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.

"Physical therapy" means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.

"Physician" means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

"Post-stabilization services" means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.

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

"Prescription" means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.

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

"Primary care provider services" means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.

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

"Psychosocial rehabilitation services" means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:

Living skills training,

Cognitive rehabilitation,

Health promotion,

Supported employment, and

Other services that increase social and communication skills to maximize a member's ability to participate in the community and function independently.

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

"RBHA" or "Regional Behavioral Health Authority" means the same as in A.R.S. § 36-3401.

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

"Residual functional deficit" means a member's inability to return to a previous level of functioning, usually after experiencing a severe psychotic break or state of decompensation.

"Respiratory therapy" means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.

"Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

"Specialist" means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a

specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for~~,~~ or has not been issued certification.

"Speech therapy" means medically prescribed diagnostic and treatment services provided by~~,~~ or under the supervision of~~,~~ a certified speech therapist.

"Sterilization" means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:

Prevent the progression of disease, disability, or adverse health conditions; or

Prolong life and promote physical health.

"Substance abuse" means the chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are 21 years of age or older.

R9-22-112. ~~Behavioral Health Services Related Definitions~~ Repealed

~~In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:~~

~~"ADHS" means the Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.~~

~~"Behavior management services" means those services that assist the member in carrying out daily living tasks and other activities essential for living in the community.~~

~~"Behavioral health evaluation" means the assessment of a member's medical, psychological, psychiatric, or social condition to determine if a behavioral health disorder exists and, if so, to establish a treatment plan for all medically necessary services.~~

~~"Behavioral health medical practitioner" means a health care practitioner with at least one year of full-time behavioral health work experience.~~

~~"Behavioral health professional" defined in 9 A.A.C. 20.~~

~~"Behavioral health service" means those services provided for the evaluation and diagnosis of a mental health or substance abuse condition, and the planned care, treatment, and rehabilitation of the member.~~

~~"Behavioral health technician" defined in 9 A.A.C. 20.~~

~~"Board-eligible for psychiatry" means completion of an accredited psychiatry residency program approved by the American College of Graduate Medical Education, or the American Osteopathic Association. Documentation of completion of a residency program includes a certificate of residency training including exact dates of residency, or a letter of verification of residency training from the training director including the exact dates of training period.~~

~~"Certified psychiatric nurse practitioner" under A.R.S. § 32-1601 and certified under the American Nursing Association's Statement and Standards for Psychiatric-Mental Health Clinical Nursing Practice under A.A.C. R4-19-505.~~

~~"Clinical supervision" means a review of skills and knowledge and guidance in improving or developing skills and knowledge provided by a Clinical Supervisor under 9 A.A.C. 20, Article 2.~~

~~"De novo hearing" defined in 42 CFR 431.201.~~

~~"Health care practitioner" means a:~~

~~Physician;~~

~~Physician assistant;~~

~~Nurse practitioner; or~~

~~Other individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. § 32-1901.~~

~~"IMD" means an Institution for Mental Diseases as described in 42 CFR 435.1009 and licensed by ADHS.~~

~~"Mental disorder" defined in A.R.S.§ 36-501.~~

~~"Partial care" means a day program of services provided to individual members or groups designed to improve the ability of a person to function in the community.~~

~~"Psychiatrist" under A.R.S. § § 32-1401 or 32-1800 and 36-501.~~

~~"Psychologist" under A.R.S. § 32-2061 and 36-501.~~

~~"Psychosocial rehabilitation services" means those services that include the provision of education, coaching, training, and demonstration to remediate residual or prevent anticipated functional deficits and may include services that may assist~~

~~a member to secure and maintain employment. Psychosocial rehabilitation services may include:~~

~~Living skills training,~~

~~Cognitive rehabilitation,~~

~~Health promotion,~~

~~Supported employment, and~~

~~Other services which increase social and communication skills in order to maximize a member's ability to participate in the community and function independently.~~

~~"RBHA" means the Regional Behavioral Health Authority defined in A.R.S. § 36-3401.~~

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-22-1201. General Requirements

General requirements. The following general requirements apply to behavioral health services provided under this Article, subject to all exclusions and limitations~~.~~ specified in this Article.

1. Administration. The program shall be administered as specified in A.R.S. § 36-2903.
2. Provision of services. Behavioral health services shall be provided as specified in A.R.S. § 36-2907 and this Chapter.
3. Definitions. The following definitions apply to this Article:
   - ~~a.~~ ~~"Case management" means supportive services and activities that enhance treatment, compliance, and effectiveness of treatment.~~
   - ~~b.~~ ~~"Physician assistant" specified in A.R.S. § 32-2501. In addition, a physician assistant providing a behavioral health service shall be supervised by an AHCCCS-registered psychiatrist.~~
   - ~~c.~~ ~~"Respite" means a period of care and supervision of a member to provide an interval of rest or relief to a family member or other person caring for the member. Respite provides activities and services to meet the social, emotional, and physical needs of the member during the respite period.~~
   - ~~d.~~ ~~"Substance abuse" means the chronic, habitual, or compulsive use of any chemical matter which, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not a considered substance abuse for adults who are 21 years of age or older.~~
   - ~~e.~~ ~~"TRBHA" means a Tribal Regional Behavioral Health Authority.~~
   - ~~f.~~ ~~"Therapeutic foster care services" means services provided in a licensed foster home by qualified and trained foster parents who implement the in-home portion of a member's behavioral health treatment plan. The implementation of the plan allows the member to remain in the community versus requiring more intensive level of services.~~
   - a. "Agency" for the purposes of this Article means the same as in A.A.C. R9-20-101.
   - b. "Behavior management services" means services that assist the member in carrying out daily living tasks and other activities essential for living in the community, including personal care services.
   - c. "Behavioral health adult therapeutic home" means a licensed behavioral health service agency that is the licensee's residence where behavioral health adult therapeutic home care services are provided to at least one, but no more than three individuals, who reside at the residence, have been diagnosed with behavioral health issues, and are provided with food and are integrated into the licensee's family.
   - d. "Behavioral health therapeutic home care services" means interactions that teach the client living, social, and communication skills to maximize the client's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services indicated by the client's treatment plan, as appropriate.
   - e. "Behavioral health evaluation" means the assessment of a member's medical, psychological, psychiatric, or social condition to determine if a behavioral health disorder exists and, if so, to establish a treatment plan for all medically necessary services.
   - f. "Behavioral health medical practitioner" means a health care practitioner with at least one year of full-time behavioral health work experience.
   - g. "Behavioral health professional" means the same as in A.A.C. R9-20-101.
   - h. "Behavioral health service" means a service provided for the evaluation and diagnosis of a mental health or substance abuse condition and the planned care, treatment, and rehabilitation of the member.
   - i. "Behavioral health technician" means the same as in A.A.C. R9-20-101.
   - j "Case management" for the purposes of this Article, means services and activities that enhance treatment, compliance, and effectiveness of treatment.
   - k. "Certified psychiatric nurse practitioner" means a registered nurse practitioner who meets the psychiatric specialty area requirements under A.A.C. R4-19-505(C).
   - l. "Client" for the purposes of this rule means the same as in A.A.C. R9-22-101.
   - m. "Cost avoid" means to avoid payment of a third-party liability claim when the probable existence of third-party

liability has been established under 42 CFR 433.139(b).

n. "Health care practitioner" means a:
Physician;
Physician assistant;
Nurse practitioner; or
Other individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. § 32-1901.

o "Licensee" means the same as in A.A.C. R9-20-101.

p. "OBHL" means the same as in A.A.C. R9-20-101.

q. "Partial care" means a day program of services provided to individual members or groups that is designed to improve the ability of a person to function in a community, and includes basic, therapeutic, and medical day programs.

r. "Physician assistant" means the same as in A.R.S. § 32-2501 except that when providing a behavioral health service, the physician assistant shall be supervised by an AHCCCS-registered psychiatrist.

s. "Psychiatrist" means a physician who meets the licensing requirements under A.R.S. § 32-1401 or a doctor of osteopathy who meets the licensing requirements under A.R.S. § 32-1800, and meets the additional requirements of a psychiatrist under A.R.S. § 36-501.

t. "Psychologist" means a person who meets the licensing requirements under A.R.S. §§ 32-2061 and 36-501.

u. "Qualified behavioral health service provider" means a behavioral health service provider that meets the requirements of R9-22-1206.

v. "Respite" means a period of care and supervision of a member to provide rest or relief to a family member or other person caring for the member. Respite provides activities and services to meet the social, emotional, and physical needs of the member during respite.

w. "TRBHA" or "Tribal Regional Behavioral Health Authority" means a Native American tribe under contract with ADHS/DBHS to coordinate the delivery of behavioral health services to eligible and enrolled members of the federally-recognized tribal nation.

R9-22-1202. ADHS and Contractor Responsibilities

A. ADHS responsibilities. ~~Behavioral~~ Except as provided in subsection (B), behavioral health services shall be provided by a RBHA through a contract with ADHS/DBHS. ADHS/DBHS shall:

1. Be responsible for providing all inpatient emergency behavioral health services for a non-FES member with a psychiatric or substance abuse diagnosis who is enrolled with a contractor in accordance with R9-22-210.01(A)(3);
2. Be responsible for providing all inpatient emergency behavioral health services for a FFS member with a psychiatric or substance abuse diagnosis who is not enrolled with a contractor in accordance with R9-22-210.01(A)(3);
3. Be responsible for providing all non-inpatient emergency behavioral health services for a non-FES member in accordance with R9-22-210.01;
4. Be responsible for providing all non-emergency behavioral health services for a non-FES member;
~~1.~~5. Contract with a RBHA for the provision of behavioral health services in R9-22-1205 for all Title XIX members under A.R.S. § 36-2907. ADHS/DBHS shall ensure that a RBHA provides behavioral health services to members directly, or through subcontracts, with qualified service providers who meet the qualifications specified in R9-22-1206. If behavioral health services are unavailable within a ~~RBHA's service area,~~ RBHA's GSA, ADHS/DBHS shall ensure that a RBHA provides behavioral health services to a Title XIX member outside the ~~RBHA's service area~~. RBHA's GSA;
~~2.~~6. Ensure that a member's behavioral health service is provided in collaboration with a member's primary care provider~~.~~; and
~~3.~~7. Coordinate the transition of care and medical records, under A.R.S. §§ 36-2903, 36-509, ~~A.A.C.~~ R9-22-512, and in contract, when a member transitions from:
   a. A behavioral health provider to another behavioral health provider,
   b. A RBHA to another RBHA,
   c. A RBHA to a ~~health plan~~ contractor,
   d. A contractor to ~~an~~ a RBHA, or
   e. A contractor to another ~~health plan~~ contractor.

B. ADHS/DBHS may contract with a TRBHA for the provision of behavioral health services for Native American members. ~~In the absence of a contract with ADHS,~~ Native American members may~~:~~ receive covered behavioral health services:

~~1. Receive behavioral health services from an IHS facility or a TRBHA, or,~~
~~2. Be referred off-reservation to a RBHA for covered behavioral health services.~~
1. From an IHS facility,
2. From a TRBHA, or
3. From a RBHA.

C. Contractor responsibilities. A ~~health~~ contractor shall:

1. Refer a member to a RBHA under the contract terms;
2. Provide EPSDT developmental and behavioral health screening as specified in R9-22-213;
3. Provide inpatient emergency behavioral health services as specified in R9-22-1205 and R9-22-210.01 for a member not yet enrolled with a RBHA~~;~~ or TRBHA and all behavioral health services as specified in contract;
4. Provide psychotropic medication services for a member, in consultation with the member's RBHA as needed, for behavioral health conditions specified in contract and within the primary care provider's scope of practice; and
5. Coordinate a member's transition of care and medical records under ~~R9-22-1202.~~ subsection (A)(7).

R9-22-1203. Eligibility for Covered Services

A. Title XIX members. A member determined eligible under A.R.S. § 36-2901(6)(a), shall receive medically necessary covered services under R9-22-1205~~.~~ and R9-22-201.

B. FES members. A person who would be eligible under A.R.S. § 36-2901(6)(a)(i), A.R.S. § 36-2901(6)(a)(ii), ~~and~~ or A.R.S. § 36-2901(6)(a)(iii) except for the failure to meet the U.S. citizenship or qualified alien status requirements under A.R.S. § 36-2903.03(A) and A.R.S. § 36-2903.03(B) ~~or A.R.S. § 36-2903.03(C)~~ is eligible for emergency services only.

~~**C.** Ineligibility. A person is not eligible for behavioral health services if the person is:~~
~~1. An inmate of a public institution as defined in 42 CFR 435.1009,~~
~~2. A resident of an institution for the treatment of tuberculosis, or~~
~~3. Age 21 through 64 who is a resident of an IMD, and exceeds the limits under R9-22-1205.~~

R9-22-1204. General Service Requirements

A. Services. Behavioral health services include both mental health and substance abuse services.

B. Medical necessity. A service shall be medically necessary as provided under R9-22-201.

C. Prior authorization. A service shall be provided to a member under Title 36, Chapter 29, Article 1, by ~~contractors, subcontractors, and providers~~ a contractor, subcontractor, or provider consistent with the prior authorization requirements ~~established by the Director and under R9-22-210 and R9-22-1205.~~ in contract and the following:
1. Emergency behavioral health services. A provider is not required to obtain prior authorization for emergency behavioral health services.
2. Non-emergency behavioral health services. When a member's behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the prior authorization requirements of ADHS/DBHS or the RBHA/TRBHA.

D. EPSDT. For Title XIX members under age 21, EPSDT services ~~shall~~ include all medically necessary ~~Title XIX~~ covered ~~services that are necessary to provide behavioral health services to a member.~~ behavioral health services.

E. Experimental services. ~~The Director shall determine if a service is experimental, or whether a service is provided primarily for the purpose of research. Those services shall not be covered.~~ Experimental services and services that are provided primarily for the purpose of research are not covered.

F. Gratuities. A service or an item, if furnished gratuitously to a member, is not covered and payment to a provider shall be denied. ~~to a provider.~~

G. ~~Service area.~~ GSA. Behavioral health services rendered to a member shall be provided within the ~~RBHA's service area~~ RBHA's GSA except when:
1. A contractor's primary care provider refers a member to another area for medical specialty care,
2. A member's medically necessary covered service is not available within the ~~service area,~~ GSA, or
3. A net savings in behavioral health service delivery costs ~~can be~~ is documented by the RBHA for a member. Undue travel time or hardship ~~shall be~~ for a member or a member's family is considered for a member or a member's family in determining whether there is a net savings.

H. Travel. If a member travels or temporarily resides ~~out~~ outside of a behavioral health service area, covered services are restricted to emergency behavioral health care, unless otherwise authorized by the member's RBHA~~.~~ or TRBHA.

I. Non-covered services. If a member requests a behavioral health service that is not covered ~~by AHCCCS~~ or is not authorized by a RBHA~~,~~ or TRBHA, ~~the behavioral health service may be provided by an AHCCCS-registered behavioral health service provider~~ an AHCCCS-registered behavioral health service provider may provide the service ~~under the following conditions:~~ according to R9-22-702.
~~1. The requested service and the itemized cost of each service is documented and provided to the member or member's guardian; and~~
~~2. The member or the member's guardian signs a statement acknowledging:~~
~~a. Services have been explained to the member or member's guardian, and~~
~~b. The member or member's guardian accepts responsibility for payment.~~

J. Referral. If a member is referred ~~out~~ outside of a ~~RBHA service area~~ RBHA's or TRBHA's service area to receive ~~an~~ authorized, medically necessary behavioral health ~~service, or a medically necessary covered service~~ services, ~~the services shall be provided by the contractor or RBHA.~~ the TRBHA or RBHA is responsible for reimbursement if the claim is otherwise payable under this Chapter.

K. Restrictions and limitations.

1. The restrictions, limitations, and exclusions in this Article ~~shall~~ do not apply to a contractor, ~~or a RBHA~~ ADHS/DBHS, or a RBHA when electing to provide a noncovered service.
2. Room and board is not a covered service unless provided in an inpatient, Level 1 sub-acute, or residential facility under R9-22-1205.

R9-22-1205. Scope and Coverage of Behavioral Health Services

A. Inpatient behavioral health services. The following inpatient services are covered subject to the limitations and exclusions in this Article.
1. Covered inpatient behavioral health services include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment, if the service is provided under the direction of a physician in a Medicare-certified:
   a. General acute care hospital, or
   b. Inpatient psychiatric hospital.
2. Inpatient service limitations:
   a. Inpatient services, other than emergency services specified in this Section, are not covered unless prior authorized.
   b. Inpatient services and room and board are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
      i. A licensed psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A licensed physician assistant,
      iv. A licensed psychologist,
      v. A licensed clinical social worker,
      vi. A licensed marriage and family therapist,
      vii. A licensed professional counselor,
      viii. A licensed independent substance abuse counselor, ~~or~~ and
      ix. A behavioral health medical practitioner.
   c. A member age 21 through 64 is eligible for behavioral health services provided in a hospital listed in subsection (A)(1)(b) that meets the criteria for an IMD up to 30 days per admission and no more than 60 days per contract year as allowed under the Administration's Section 1115 Waiver with CMS.

B. Level 1 residential treatment center services. Services provided in a Level 1 residential treatment center as defined in ~~R9-20-101~~ A.A.C. R9-20-101 are covered subject to the limitations and exclusions under this Article.
1. Level 1 residential treatment center services are not covered unless provided under the direction of a licensed physician in a licensed Level 1 residential treatment center accredited by an AHCCCS-approved accrediting body as specified in contract.
2. Covered residential treatment center services include room and board and treatment services for behavioral health and substance abuse conditions.
3. Residential treatment center service limitations.
   a. Services are not covered unless prior authorized, except for emergency services as specified in this Section.
   b. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
      i. A licensed psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A licensed physician assistant,
      iv. A licensed psychologist,
      v. A licensed clinical social worker,
      vi. A licensed marriage and family therapist,
      vii. A licensed professional counselor,
      viii. A licensed independent substance abuse counselor, ~~or~~ and
      ix. A behavioral health medical practitioner.
4. The following may be billed independently if prescribed by a provider as specified in this Section who is operating within the scope of practice:
   a. Laboratory services,
   b. Radiology services, and
   c. Psychotropic medication.

C. Covered ~~level~~ Level 1 sub-acute agency services. Services provided in a Level 1 sub-acute agency as defined in ~~R9-22-101~~ A.A.C. R9-20-101 are covered subject to the limitations and exclusions under this Article.
1. Level 1 sub-acute agency services are not covered unless provided under the direction of a licensed physician in a licensed Level 1 sub-acute agency that is accredited by an AHCCCS-approved accrediting body as specified in contract.

2. Covered ~~level~~ Level 1 sub-acute agency services include room and board and treatment services for behavioral health and substance abuse conditions.
3. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
   a. A licensed psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A licensed physician assistant,
   d. A licensed psychologist,
   e. A licensed clinical social worker,
   f. A licensed marriage and family therapist,
   g. A licensed professional counselor,
   h. A licensed independent substance abuse counselor, ~~or~~ and
   i. A behavioral health medical practitioner.
4. The following may be billed independently if prescribed by a provider ~~as~~ specified in this Section who is operating within the scope of practice:
   a. Laboratory services,
   b. Radiology services, and
   c. Psychotropic medication.
5. A member age 21 through 64 is eligible for behavioral health services provided in a ~~level~~ Level 1 sub-acute agency that meets the criteria for an IMD for up to 30 days per admission and no more than 60 days per contract year as allowed under the Administration's Section 1115 Waiver with CMS. These limitations do not apply to a member under age 21 or age 65 or over.

D. Level 2 behavioral health residential agency services. Services provided in a ~~level~~ Level 2 behavioral health residential agency are covered subject to the limitations and exclusions in this Article.
1. Level 2 behavioral health residential agency services are not covered unless provided by a licensed Level 2 behavioral health residential agency as defined in ~~R9-20-101.~~ A.A.C. R9-20-101.
2. Covered services include all services except room and board.
3. The following licensed or certified providers may bill independently for services:
   a. A licensed psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A licensed physician assistant,
   d. A licensed psychologist,
   e. A licensed clinical social worker,
   f. A licensed marriage and family therapist,
   g. A licensed professional counselor,
   h. A licensed independent substance abuse counselor, ~~or~~ and
   i. A behavioral health medical practitioner.

E. Level 3 behavioral health residential agency services. Services provided in a licensed Level 3 behavioral health residential agency as defined in ~~R9-22-101~~ A.A.C. R9-20-101 are covered subject to the limitations and exclusions under this Article.
1. Level 3 behavioral health residential agency services are not covered unless provided by a licensed Level 3 behavioral health residential agency.
2. Covered services include all ~~non-emergency travel, non-legend~~ non-prescription drugs as defined in ~~A.R.S. § 32-1975,~~ A.R.S. § 32-1901, non-customized medical supplies, and clinical supervision of the ~~level~~ Level 3 behavioral health residential agency staff. Room and board are not covered services.
3. The following licensed and certified providers may bill independently for services:
   a. A licensed psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A licensed physician assistant,
   d. A licensed psychologist,
   e. A licensed clinical social worker,
   f. A licensed marriage and family therapist,
   g. A licensed professional counselor,
   h. A licensed independent substance abuse counselor, ~~or~~ and
   i. A behavioral health medical practitioner.

F. Partial care. Partial care services are covered subject to the limitations and exclusions in this Article.
1. Partial care services are not covered unless provided by a licensed and AHCCCS-registered behavioral health agency that provides a regularly scheduled day program of individual member, group, or family activities that are designed to improve the ability of the member to function in the community. Partial care services include basic, therapeutic, and

medical day programs.

2. Partial care ~~service exclusions.~~ services. Educational services that are ~~not~~ therapeutic and are ~~not~~ included in the member's behavioral health treatment plan are ~~excluded~~ included in ~~from~~ per diem reimbursement for partial care services.

G. Outpatient services. Outpatient services are covered subject to the limitations and exclusions in this Article.

1. Outpatient services include the following:
   a. Screening provided by a behavioral health professional or a behavioral health technician as defined in ~~R9-22-101;~~ R9-22-1201;
   b. A behavioral health evaluation provided by a behavioral health professional or a behavioral health technician;
   c. Counseling including individual therapy, group, and family therapy provided by a behavioral health professional or a behavioral health technician;
   d. Behavior management services as defined in ~~R9-22-112;~~ R9-22-1201; and
   e. Psychosocial rehabilitation services as defined in ~~R9-22-112.~~ R9-22-102.
2. Outpatient service limitations.
   a. The following licensed or certified providers may bill independently for outpatient services:
      i. A licensed psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A licensed physician assistant as defined in R9-22-1201,
      iv. A licensed psychologist,
      v. A licensed clinical social worker,
      vi. A licensed professional counselor,
      vii. A licensed marriage and family therapist,
      viii. A licensed independent substance abuse counselor,
      ix. A behavioral health medical practitioner~~,~~ and
      ~~x. A therapeutic foster parent, and~~
      ~~xi.~~x. An outpatient clinic or a Level IV transitional agency licensed under 9 A.A.C. 20, Article 1, that is an AHCCCS-registered provider.
   b. A behavioral health practitioner not specified in subsection (G)(2)(a)(i) through (G)(2)(a)(x), who is contracted with or employed by an ~~AHCCCS-registered behavioral health agency,~~ AHCCCS-registered behavioral health agency shall not bill independently.

~~**H.** Emergency behavioral health services. The following emergency behavioral health services are covered subject to the limitations and exclusions under this Article.~~

~~1. ADHS shall ensure that emergency behavioral health services are provided by qualified service providers under R9-22-1206. ADHS shall ensure that emergency behavioral health services are available 24 hours-per-day, seven days-per-week in each GSA for an emergency behavioral health condition as defined in R9-22-102.~~

~~2. Emergency behavioral health services for non-FES members are provided under R9-22-210.01. Emergency behavioral health services for FES members are provided under R9-22-217.~~

H. Emergency behavioral health services are covered subject to the limitations and exclusions under this Article. In order to be covered, behavioral health services shall be provided by qualified service providers under R9-22-1206. ADHS/DBHS shall ensure that emergency behavioral health services are available 24 hours-per-day, seven days-per-week in each GSA for an emergency behavioral health condition for a non-FES member as defined in R9-22-102.

I. Other covered behavioral health services. Other covered behavioral health services include:

1. Case management as defined in R9-22-1201;
2. Laboratory and radiology services for behavioral health diagnosis and medication management;
3. Psychotropic medication and related medication;
4. Monitoring, administration, and adjustment for psychotropic medication and related medications;
5. Respite care;
6. ~~Therapeutic foster care services provided in a professional foster home defined in 6 A.A.C. 5, Article 58 or an adult therapeutic foster home as defined in 9 A.A.C. 20, Article 1;~~ Behavioral health therapeutic home care services provided by a RBHA in a professional foster home defined in 6 A.A.C. 5, Article 58 or in a behavioral health adult therapeutic home as defined in 9 A.A.C. 20, Article 1;
7. Personal care services, including assistance with daily living skills and tasks, homemaking, bathing, dressing, food preparation, oral hygiene, self-administration of medications, and monitoring of the behavioral health recipient's condition and functioning level provided by a licensed and AHCCCS-registered behavioral health agency or a behavioral health professional, behavioral health technician, or behavioral health paraprofessional as defined in 9 A.A.C. 20, Article 1; and
8. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.

J. Transportation services. Transportation services are covered under R9-22-211.

~~1. Emergency transportation is covered for a behavioral health emergency under R9-22-211. Coverage for emergency~~

~~transportation is limited to behavioral health emergencies.~~

~~2. Non-emergency transportation is covered if used to travel to and from a registered provider of behavioral health services.~~

R9-22-1206. General Provisions and Standards for Service Providers

A. Qualified service provider. A qualified behavioral health service provider shall:

~~1. Be a non-contracting provider or employed by, or contracted in writing with, a RBHA or a contractor to provide behavioral health services to a member;~~

~~2.~~1. Have all applicable state licenses or certifications, or comply with alternative requirements established by the Administration;

~~3.~~2. Register with the Administration as a service provider; ~~and~~

~~4.~~3. Comply with all requirements under Article 5 and this Article.

4. Register with ADHS/DBHS as a behavioral health service provider, and

5. Contract with the appropriate RBHA/TRBHA.

B. Quality and utilization management.

1. Service providers shall cooperate with the quality and utilization management programs of a RBHA, a TRBHA, a contractor, ADHS~~,~~/DBHS, and the Administration ~~under R9-22-522 and contract.~~ as specified in this Chapter and in contract.
2. Service providers shall comply with applicable procedures under 42 CFR 456~~.~~, as of October 1, 2006, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol St., NW, Washington, DC 20401. This incorporation contains no future editions or amendments.

R9-22-1207. ~~Standards for Payments~~ General Provisions for Payment

A. ~~Payment to ADHS. ADHS/DBHS. ADHS shall receive a monthly capitation payment, based on the number of acute care members at the beginning of each month. ADHS administrative costs shall be incorporated into the capitation payment.~~ Payment to ADHS/DBHS. The Administration shall make a monthly capitation payment to ADHS/DBHS based on the number of acute members at the beginning of each month. The Administration shall incorporate ADHS'/DBHS' administrative costs into the capitation payment.

B. Claims submissions.

1. ADHS/DBHS shall require all ~~contracted~~ service providers to submit clean claims no later than the time-frame specified in ~~the~~ ADHS/DBHS' contract with the Administration.

~~2. A claim for emergency services for a member not yet enrolled with an RBHA shall be submitted to a health plan by a provider and shall comply with the time-frames and other applicable payment procedures in Article 7.~~

2. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member enrolled in a RBHA to the appropriate RBHA, and if not enrolled in a RBHA, to ADHS/DBHS.
3. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member enrolled in a RBHA to the appropriate RBHA, and if not enrolled in a RBHA, to ADHS/DBHS.
4. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.
5. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.
6. A provider of emergency behavioral health services, that are the responsibility of ADHS/DBHS or a contractor, shall submit a claim to the entity responsible for emergency behavioral health services under R9-22-210.01(A).
7. A provider shall comply with the time-frames and other payment procedures in Article 7 of this Chapter, if applicable, and A.R.S. § 36-2904.
8. ADHS/DBHS or a contractor, whichever entity is responsible for covering behavioral health services, shall cost avoid any behavioral health service claims if it establishes the existence or probable existence of first-party liability or third-party liability.

C. Prior authorization. Payment to a provider for behavioral health services or items requiring prior authorization may be denied if a provider does not obtain prior authorization ~~is not obtained~~ from ~~the Administration,~~ ~~an~~ a RBHA, ADHS/DBHS, ~~or a health plan as specified in R9-22-705.~~ a TRBHA, or a contractor.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

[R07-88]

PREAMBLE

1. Sections Affected | **Rulemaking Action**

R9-22-707	Repeal
R9-22-709	Amend
R9-22-713	Amend
R9-22-720	Amend

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

Authorizing statute: A.R.S. §§ 36-2903, 36-2903.01, 36-2904

Implementing statute: A.R.S. §§ 36-2903.01, 36-2906, 36-2909, 36-2986,

3. The effective date of the rules:

May 5, 2007

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

Notice of Rulemaking Docket Opening: 12 A.A.R. 4024, October 27, 2006

Notice of Proposed Rulemaking: 12 A.A.R. 4301, November 24, 2006

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

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Administrative Legal Services
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 reasons for initiating the rule:

The rules outline the provisions that apply to payments. The proposed rulemaking is intended to update these rules, ensuring that they represent the Agency's current practice.

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:

Not applicable

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

Not applicable

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

The economic impact is anticipated to be minimal to none because the rules have been updated for clarity and conciseness only and do not require changes to processes or revenue for providers or contractors.

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

There are no substantial differences from the proposed rule language to the final submission of the rule language. 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:

The Administration did not receive any comments regarding the rules.

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

Not applicable

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

Not applicable

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

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-707. ~~Payments for Newborns~~ Repealed
R9-22-709. Contractor's Liability to Hospitals for the Provision of Emergency and ~~Subsequent~~ Post-Stabilization Care
R9-22-713. ~~Payments Made on Behalf of a Contractor;~~ Overpayment and Recovery of Indebtedness
R9-22-720. Reinsurance

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-707. ~~Payments for Newborns~~ Repealed

~~If a mother is enrolled on the date of her newborn's birth, a contractor shall be financially liable under the mother's capitation to provide all AHCCCS-covered services to the newborn from the date of birth until the Administration is notified of the birth.~~

R9-22-709. Contractor's Liability to Hospitals for the Provision of Emergency and ~~Subsequent~~ Post-Stabilization Care

~~**A.** A contractor is liable for the cost of services for an emergency medical or acute mental health condition of a member only until the member's condition is stabilized and the member is transferable, or until the member is discharged following stabilization subject to the requirements of A.R.S. § 36-2909 and Article 2 of this Chapter.~~

~~**B.** Subject to subsection (A), if a member cannot be transferred following stabilization to a facility that has a subcontract with the contractor of record, the contractor of record shall pay for all appropriately documented, prior authorized, and medically necessary treatment provided to the member before the discharge date or transfer under R9-22-705.~~

~~**C.** If a member refuses transfer from a noncontracting provider or noncontracting hospital to a hospital affiliated with the member's contractor of record, neither the Administration nor the contractor shall be liable for any costs incurred after the date of refusal if:~~

~~1. After consultation with the member's contractor of record, the member continues to refuse the transfer; and~~
~~2. The member has been provided and signs a written statement, before the date the member is liable for payment, informing the member of the medical and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by two witnesses indicating that the member was informed may be substituted.~~

A contractor is liable for emergency hospitalization and post-stabilization care as described in R9-22-210 and R9-22-210.01.

R9-22-713. ~~Payments Made on Behalf of a Contractor;~~ Overpayment and Recovery of Indebtedness

~~**A.** The Administration may make payments on behalf of a contractor in order to prevent a suspension or termination of AHCCCS services after considering whether:~~

~~1. A contractor does not adjudicate a valid accrued claim within the period set forth under subcontract, or~~
~~2. A contractor does not adjudicate 99 percent of valid accrued claims within 90 days of receipt from the AHCCCS registered provider.~~

~~B~~A. If a contractor or a subcontracting provider receives an overpayment from the Administration or otherwise becomes indebted to the Administration, the contractor or subcontracting provider shall immediately remit the amount of the indebtedness or overpayment to the Administration for deposit in the AHCCCS fund.

~~C~~B. If the funds described in subsection (~~B~~A) are not remitted, the Administration may recover the funds ~~indebtedness or overpayment~~ paid by the Administration to a contractor or subcontracting provider through:

1. ~~Negotiation of a~~ A repayment agreement executed with the Administration;

2. Withholding or offsetting against current or future payments to be paid to the contractor or subcontracting provider; or
3. Enforcement of, or collection against, the performance bond, financial reserve, or other financial security under A.R.S. § 36-2903.

~~**D.** Except as specifically provided for in this Article, the Administration is not liable for payment for medical expenses incurred by enrolled members of prepaid capitated contractors.~~

R9-22-720. Reinsurance

A. Reinsurance is a stop-loss program provided by the Administration to a contractor for partial reimbursement of the cost of covered services for a member with an acute medical condition when the cost of covered services exceeds a pre-determined deductible level amount within a contract year. The Administration self-insures the reinsurance program through a reduction to capitation rates. The reinsurance program also includes a catastrophic reinsurance program for members diagnosed with specific medical conditions.

~~**A.**~~**B.** ~~For purposes of the Administration's reinsurance program, the insured entity is a prepaid plan with which the Administration contracts.~~ The Administration shall specify in contract guidelines for claims submission, processing, ~~and~~ payment, and the types of care and services that are provided to a member whose care is covered by reinsurance.

~~**B.**~~**C.** When the Administration determines that a contractor does not follow the specified guidelines for care or services and the care or services could ~~be~~ have been provided at a lower cost according to the guidelines, the Administration shall reimburse the contractor ~~is entitled to reimbursement~~ as if the care or services had been provided as specified in the guidelines. ~~had been provided at a lower cost.~~

NOTICE OF FINAL RULEMAKING

TITLE 17. TRANSPORTATION

CHAPTER 5. DEPARTMENT OF TRANSPORTATION COMMERCIAL PROGRAMS

[R07-75]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

Article 5	Amend
R17-5-502	Repeal
R17-5-503	Repeal
Article 8	New Article
R17-5-801	New Section
R17-5-802	New Section
R17-5-803	New Section
R17-5-804	New Section
R17-5-805	New Section
R17-5-806	New Section
R17-5-807	New Section
R17-5-808	New Section
R17-5-809	New Section
R17-5-810	New Section
R17-5-811	New Section

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

Authorizing statute: A.R.S. § 28-366

Implementing statute: A.R.S. §§ 20-237, 28-4002, 28-4007, 28-4033, 28-4076, 28-4084, 28-4135, and 28-4148

3. The effective date of the rules:

March 6, 2007

The Division is requesting an immediate effective date upon filing with the Secretary of State as allowed under A.R.S. § 41-1032(A). The immediate effective date is requested in the interest of preserving the public safety. The rules increase the Division's ability to ensure the timely communication and recording of a driver's proof of future financial responsibility as required under the law. The rules also preserve the public safety by limiting the number of

vehicles covered under a $40,000 certificate of deposit on file with the state treasurer, as alternate proof of financial responsibility, to a maximum of 25 non-commercial vehicles registered in the person's name.

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

Notice of Rulemaking Docket Opening: 12 A.A.R. 1565, May 12, 2006

Notice of Proposed Rulemaking: 12 A.A.R. 3875, October 20, 2006

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

Name: John Lindley, Administrative Rules Analyst

Address: Administrative Rules Unit
Department of Transportation, Motor Vehicle Division
1801 W. Jefferson St., Mail Drop 530M
Phoenix, AZ 85007

Telephone: (602) 712-8804

Fax: (602) 712-3081

E-mail: jlindley@azdot.gov

Please visit the ADOT web site to track progress of this rule and any other agency rulemaking matters at www.azdot.gov/mvd/mvdrules/rules.asp.

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

The Arizona Department of Transportation, Motor Vehicle Division, is repealing Sections R17-5-502 and R17-5-503, which currently contain antiquated electronic reporting guidelines and processes for insurance companies authorized to conduct business in Arizona, and creating a new Article within Chapter 5; Article 8, Mandatory Insurance and Financial Responsibility. This new Article will incorporate updated electronic reporting guidelines, mandatory insurance rules, and financial responsibility rules that reflect current business practices and are more clear, concise, and understandable. This action complies with recommendations made in the Division's five-year-review report approved by the Governor's Regulatory Review Council on August 2, 2005.

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

None

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

Not applicable

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

The Division anticipates, as a result of this rulemaking, a minimal economic impact to qualified persons and business entities seeking to self-insure under A.R.S. §§ 28-4007 and 28-4076. Costs may include administrative expenses for preparing the application and providing the Division with the required annual update documentation needed to maintain a current self-insurance certificate. However, the Division anticipates a benefit of substantial savings for self-insuring entities in standard financial responsibility coverage of fleet vehicles.

The Division anticipates that the new electronic SR22 and SR26 reporting requirement under R17-5-802 will have a moderate economic impact on affected insurance companies for initial programming and implementation. However, the insurance companies and their customers will benefit from the proposed rules, since the SR22 and SR26 electronic reporting system will be the same system used by the insurance companies to electronically report liability insurance information to the Division. Customers of the insurance companies will receive a significant benefit, since their insurance information on file with the Division will be immediately updated.

The proposed rules also provide an exemption from the electronic SR22 and SR26 reporting requirement for companies issuing less than 1000 SR22 policies per calendar year. The Division anticipates this exemption may benefit the smaller businesses by allowing them to voluntarily convert their manual SR22 and SR26 policy reporting to the electronic reporting process as appropriate for their business needs.

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

The definition of "Customer number" was added and minor grammatical and formatting changes were made at the request of G.R.R.C. staff.

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

ADOT received no comments on these rules.

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. Were these rules previously made as emergency rules?
No

15. The full text of the rules follows:

TITLE 17. TRANSPORTATION

CHAPTER 5. DEPARTMENT OF TRANSPORTATION
COMMERCIAL PROGRAMS

ARTICLE 5. MOTOR CARRIER FINANCIAL RESPONSIBILITY

Section
R17-5-502. ~~Insurance Company Reporting Requirements~~ Repealed
R17-5-503. ~~Reporting Formats, Cartridge Tape Specifications, and Required Information for Manual Reporting~~ Repealed

ARTICLE 8. MANDATORY INSURANCE AND FINANCIAL RESPONSIBILITY

Section
R17-5-801. Definitions
R17-5-802. Insurance Company Electronic Reporting Requirement; Applicability
R17-5-803. Insurance Company Reportable Activity
R17-5-804. Record Matching Criteria for a Vehicle-specific Policy
R17-5-805. Record Matching Criteria for a Non-vehicle-specific Commercial Policy
R17-5-806. Division-authorized EDI Reporting Methods; Reporting Schedule
R17-5-807. X12 Data Format for Policy Receipt and Error Return
R17-5-808. Insurance Company Reporting Errors; Resolution; Noncompliance
R17-5-809. Insurance Company Failure to Submit Required Data; Request for Hearing
R17-5-810. Self-insurance as Alternate Proof of Financial Responsibility; Provisions; Applicability
R17-5-811. Certificate of Deposit as Alternate Proof of Financial Responsibility; Applicability

ARTICLE 5. MOTOR CARRIER FINANCIAL RESPONSIBILITY

R17-5-502. ~~Insurance Company Reporting Requirements~~ Repealed

~~**A.** Definitions. In this Section and in R17-5-503, unless the context otherwise requires:~~
~~1. "Business week" means Monday through Friday, except holidays.~~
~~2. "Cartridge tape" means a data delivery medium that conforms to the cartridge tape specifications stated at R17-5-503(C).~~
~~3. "Cartridge tape reporting" means weekly delivery from a company to the Division of data placed on cartridge tape.~~
~~4. "Company" means an insurance or indemnity company authorized to write motor vehicle liability coverage in Arizona.~~
~~5. "Division" means the Arizona Department of Transportation, Motor Vehicle Division.~~
~~6. "Electronic data interchange" or "EDI" means the transmission of data in a standardized format from one computer to another computer without magnetic tape.~~
~~7. "EDI reporting" means weekly computer-to-computer transmission of data from a company to the Division, followed by error return from the Division to the company.~~
~~8. "File transfer protocol" means EDI reporting transmitted to the Division over the Internet.~~
~~9. "Information exchange" means EDI reporting where:~~
~~a. A company or a service provider transmits a report to the Division through a connection to a private information network, and~~
~~b. The private information network bases the charges for the connection to the network on the number of characters and messages transmitted.~~
~~10. "Manual reporting" means weekly delivery from a company to the Division of:~~
~~a. A report typed on company letterhead, or~~
~~b. An e-mail report.~~
~~11. "Motor vehicle liability policy" has the meaning prescribed in A.R.S. § 28-4001(4).~~

12. "Network job entry" means EDI reporting where:
    a. A company or service provider transmits a report to the Division through a connection to a private information network, and
    b. The private information network bases the charges for the connection to the network on the installation and lease of a dedicated communications line.
13. "Private information network" means a group of interconnected computers, including the hardware and software used to connect them.
14. "Reportable activity" means:
    a. A policy cancellation,
    b. A policy nonrenewal,
    c. A new policy issue,
    d. A vehicle added to a policy,
    e. A vehicle deleted from a policy, or
    f. A policy reinstatement.
15. "Service provider" means a person or entity that provides:
    a. A connection to a private information network for EDI reporting, or
    b. Cartridge tape reporting for a company.
16. "X12 811" means the standard format for delivering or transmitting insurance data.

B. Reporting schedule. At least once each business week, a company shall submit to the Division:
1. All reportable activities, not previously reported, processed by the company seven or fewer days before the reporting date; or
2. If no reportable activities occurred by the reporting date, a statement of inactivity:
    a. Typed on company letterhead,
    b. Transmitted by e-mail, or
    c. Transmitted by EDI.

C. EDI and X12 conversion schedule. By February 1, 2001, a company that submits cartridge tape reporting or manual reporting and does not qualify for an exception under subsection (F), shall establish a schedule under subsection (D)(1) or subsection (D)(2) and the main provision of subsection (E) by contacting the Division as follows:
1. Arizona Department of Transportation, Motor Vehicle Division, Mail Drop 532M, 1801 West Jefferson, Phoenix, Arizona 85007; or
2. Telephone number (602) 712-8308.

D. EDI types. Beginning August 1, 2001, a company shall submit the information required under subsection (B)(1) by EDI reporting, unless qualified for an exception under subsection (F).
1. For EDI reporting by information exchange or network job entry, a company shall:
    a. Obtain:
        i. A connection to a private information network, or
        ii. A service provider;
    b. Obtain any necessary software;
    c. Obtain the Division's service provider account number; and
    d. Arrange for and conduct an initial transmission of data to the Division.
2. For EDI reporting by file transfer protocol, a company shall:
    a. Obtain:
        i. An on-line connection to the Internet, or
        ii. A service provider;
    b. Obtain the Division's Internet address; and
    c. Arrange for and conduct an initial transmission of data to the Division.

E. Reporting formats. Beginning August 1, 2001, a company shall submit the information required under subsection (B)(1) in the format titled Arizona Adaptation of X12 (TS811) for Policy Receipt, incorporated by reference at R17-5-503(A), unless qualified for an exception under subsection (F).
1. If qualified for an exception under subsection (F)(1), a company shall submit cartridge tape reporting:
    a. On a cartridge tape that meets the specifications of R17-5-503(C), and
    b. In the format located at R17-5-503(D).
2. If qualified for an exception under subsection (F)(2), a company shall submit manual reporting with all the information listed in column 1 of the format located at R17-5-503(D).

F. EDI and X12 exceptions. A company shall submit weekly EDI reporting in the format titled Arizona Adaptation of X12 (TS811) for Policy Receipt unless qualified for an exception under this subsection.
1. For cartridge tape reporting after July 31, 2001, a company shall affirm in writing by February 1, 2001, and by February 1 of each following year, that:
    a. The company had fewer than 10,000 motor vehicle liability policies in place in Arizona on January 1 of the year;

b. The company does not submit EDI reporting to any other state; and
c. The company will sustain a financial burden from EDI reporting.

2. For manual reporting after July 31, 2001, a company shall affirm in writing by February 1, 2001, and by February 1 of each following year, that:
   a. The company had fewer than 100 motor vehicle liability policies in place in Arizona on January 1 of the year;
   b. The company does not submit EDI reporting or cartridge tape reporting to any other state; and
   c. The company will sustain a financial burden from either EDI reporting or cartridge tape reporting.
3. An officer or director of a company shall sign a written affirmation made under subsection (F)(1) or subsection (F)(2).
4. A company shall submit the signed affirmation to the Arizona Department of Transportation, Motor Vehicle Division, Mail Drop 532M, 1801 West Jefferson, Phoenix, Arizona 85007.
5. A company that qualifies for an exception to EDI reporting under subsection (F)(2) shall obtain the Division's approval of the type of manual reporting used by the company.

G. Error return. The Division shall return reporting errors to a company as follows:
1. If a company uses the Arizona Adaptation of X12 (TS811) for Policy Receipt, the Division shall use the Arizona Adaptation of X12 (TS811) for Policy Error Return, incorporated by reference at R17-5-503(B), to return reporting errors to the company after submission of the information required under subsection (B)(1); or
2. If a company qualifies for an exception under subsection (F), the Division shall instruct the company to correct cartridge tape reporting errors or manual reporting errors that affect the Division's processing of the information required under subsection (B)(1).

H. Noncompliance procedures. If a company fails to submit the information required under subsection (B)(1), the Division shall:
1. Send a dated written notice to the company that:
   a. Identifies the business week when the company did not submit the information required under subsection (B)(1);
   b. Instructs the company to submit the information for the identified business week by seven days after the date of the notice; and
   c. Warns the company to comply with the notice or the Division will proceed under A.R.S. § 20-237; and
2. If the company does not comply with the notice sent under subsection (H)(1), proceed under A.R.S. § 20-237.

R17-5-503. Reporting Formats, Cartridge Tape Specifications, and Required Information for Manual Reporting Repealed

A. X-12 reporting format. Beginning August 1, 2001, a company not qualifying for an exception under R17-5-502(F) shall submit EDI reporting in the format titled Arizona Adaptation of X12 (TS811) for Policy Receipt, September 24, 1999, incorporated by reference and on file with the Division and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. X-12 error return format. To return errors to a company using the format specified at subsection (A), the Division shall use the format titled Arizona Adaptation of X12 (TS811) for Policy Error Return, September 24, 1999, incorporated by reference and on file with the Division and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

C. Cartridge tape specifications. A cartridge tape used for reporting by a company to the Division shall meet the following specifications:

Record Length	197 Bytes
Blocking Factor	1970 (10 records per block)
Tape Medium	Standard IBM 3480 Cartridge
Tape Density	Standard 3480, Not Compressed
Tape Internal Label	NL (Nonlabeled tapes)

D. Cartridge tape format. A company may use the following reporting format only through July 31, 2001, unless the company qualifies for an exception under R17-5-502(F)(1):

Information Required	Bytes	Field Type	Field Description
VIN [except as provided in A.R.S. § 28-4148(D)]	25	Alpha/ Numeric	Complete VIN, left justified
Make	5	Alpha	
Year	2	Numeric	

~~Cancel Date~~	~~6~~	~~Numeric~~	~~MMDDYY (all zeroes new issues; no future dates for cancellations)~~
~~Policy Number~~	~~30~~	~~Alpha/ Numeric~~	~~Left Justified~~
~~Insurance Code~~	~~4~~	~~Numeric~~	
~~Name (Last, First)~~	~~40~~	~~Alpha/ Numeric~~	~~Left Justified~~
~~Address~~	~~40~~	~~Alpha/ Numeric~~	~~Left Justified~~
~~City~~	~~25~~	~~Alpha/ Numeric~~	~~Left Justified~~
~~State~~	~~2~~	~~Alpha~~	
~~Zip Code~~	~~9~~	~~Numeric~~	~~Left Justified~~
~~Driver's License Number~~	~~9~~	~~Alpha/ Numeric~~	~~Left Justified, optional~~

~~**E.** Manual reporting requirements. A company that qualifies for an exception under R17-5-502(F)(2) shall provide all the information listed in column 1 of the format located at subsection (D).~~

ARTICLE 8. MANDATORY INSURANCE AND FINANCIAL RESPONSIBILITY

R17-5-801. Definitions

In addition to the definitions under A.R.S. §§ 28-101 and 28-4001, in this Chapter, unless otherwise specified:

"Company" means an insurance or indemnity company authorized to write motor vehicle liability coverage in Arizona.

"Customer number" means the system-generated, or other distinguishing number, assigned by the Division to each person conducting business with the Division. The customer number of a private individual is generally the person's driver license or non-operating identification license number. The customer number of a business is generally its federal employer identification number.

"Division" means the Arizona Department of Transportation's Motor Vehicle Division.

"EDI" means electronic data interchange, which is the transmission of data in a standardized format from one computer to another without the use of magnetic tape.

"EDI reporting" means the weekly computer-to-computer transmission of data from a company to the Division.

"Error return" means the immediate computer-to-computer transmission, from the Division to a company, of all data reporting errors received during EDI reporting.

"FEIN" means the federal employer identification number or federal tax identification number used to identify a business entity.

"FTP" means file transfer protocol, which is a common protocol used by the Division for exchanging files over any network that supports EDI reporting transmitted through the Internet or Intranet.

"Information exchange" means EDI reporting where a company or service provider transmits a report to the Division through a connection to a private information network.

"MVD" means the Arizona Department of Transportation's Motor Vehicle Division.

"NAIC" means the National Association of Insurance Commissioners.

"Private information network" means the value-added network used by a company or service provider to facilitate EDI transmissions to the Division and to provide other network services where fees are charged for the network connection based on the number of characters and messages transmitted.

"Reportable activity" means the information required to be transmitted to the Division under A.R.S. § 28-4148 and this Article.

"Self-insurer" means a person or entity that has met the qualifications, completed the application process, and received a certificate of self-insurance issued by the Division under Section R17-5-810.

"Service provider" means a person or entity that provides the connection to a private information network for EDI reporting.

"SR22" means a certification filed, by a company duly authorized to transact business in this state, as proof of financial responsibility for the future, which guarantees that the insured owner or operator has in effect at least the minimum motor vehicle liability insurance coverage required under A.R.S. Title 28, Chapter 9, Article 3.

"SR26" means a certification filed by a company duly authorized to transact business in this state, which notifies the Division that an insured owner or operator required to maintain proof of financial responsibility for the future, under A.R.S. Title 28, Chapter 9, Article 3, is no longer covered under a previously reported SR22.

"Value-added Network" means a private network provider that is hired by a company to facilitate EDI or provide other network services.

"X12" means the American National Standards Institute, Accredited Standards Committee, uniform standards for the inter-industry electronic exchange of business transactions by EDI.

"X12 (TS811)" means X12 Transaction Set 811, Consolidated Service Invoice – Statement, version 3050, which is the specific set of EDI transactions developed for the insurance industry in the X12 standard format for automobile liability insurance reporting.

R17-5-802. Insurance Company Electronic Reporting Requirement; Applicability

A. A company that provides motor vehicle liability insurance coverage for an Arizona vehicle shall electronically transmit to the Division all reportable activity under A.R.S. § 28-4148 and R17-5-803 using one of the authorized EDI reporting methods identified in R17-5-806. Each transmission shall include all of the applicable record matching criteria prescribed under R17-5-804 or R17-5-805.

B. Effective May 1, 2007, a company that issues 1,000 or more SR22 policies per calendar year shall electronically transmit to the Division all SR22 and SR26 activity using one of the Division-authorized EDI reporting methods identified in R17-5-806. Each transmission shall include all of the applicable record matching criteria prescribed under R17-5-804 or R17-5-805.

C. The Division shall not accept or record an out-of-state motor vehicle liability insurance policy for a passenger vehicle, even if written by a company authorized to transact business in this state.

R17-5-803. Insurance Company Reportable Activity

A. A company shall transmit to the Division:
1. All reportable activity, not previously reported, that was processed by the company seven or fewer days before each reporting date; or
2. A statement of inactivity, if no reportable activity occurred by the reporting date.

B. For the purpose of this Article, reportable activity shall include:
1. A policy cancellation;
2. A policy non-renewal;
3. A new policy issuance;
4. A vehicle added to a policy;
5. A vehicle deleted from a policy;
6. A policy reinstatement; and
7. Effective May 1, 2007, all SR22 and SR26 filings by insurance companies issuing 1,000 or more SR22 policies per calendar year.

C. Reportable activity does not include the addition or deletion of a vehicle to or from a non-vehicle-specific commercial policy.

R17-5-804. Record Matching Criteria for a Vehicle-specific Policy

For each vehicle-specific policy transmitted to the Division, a company shall include all of the following information to assist with the matching of policies to MVD customers:
1. The complete and valid vehicle identification number;
2. The policy number; and
3. The NAIC number of the reporting company.

R17-5-805. Record Matching Criteria for a Non-vehicle-specific Commercial Policy

A. For each non-vehicle-specific commercial policy transmitted to the Division, a company shall include all of the following information to assist with the matching of policies to MVD customers:
1. The MVD Customer number of the insured:
   a. If a policy covers all vehicles registered in the name of a business or organization, the Customer number is the FEIN of the business or organization; or
   b. If a policy covers all vehicles registered in the name of a private individual, the Customer number is the Arizona Driver License number of the private individual;
2. The policy number; and
3. The NAIC number of the reporting company.

B. If the MVD Customer number required under subsection (A)(1) is not available to a company, the company may provide the complete and valid vehicle identification number of each vehicle covered under the policy in-lieu of the MVD Customer number.

R17-5-806. Division-authorized EDI Reporting Methods; Reporting Schedule

A. A company shall transmit to the Division all reportable activity listed in R17-5-803 using one of the following Division-authorized EDI reporting methods:
1. EDI reporting by information exchange; or
2. EDI reporting by encrypted FTP.

B. A company shall transmit all reportable activity to the Division at least once every seven days.

R17-5-807. X12 Data Format for Policy Receipt and Error Return

A. Reporting format. A company shall transmit to the Division all reportable activity using the format prescribed in the Arizona Mandatory Insurance Reporting System Guide for Insurance Companies provided by the Division.

B. Error return format. The Division shall return to a company all reporting errors received during a transmission of reportable activity using the format prescribed in the Arizona Mandatory Insurance Reporting System Guide for Insurance Companies.

R17-5-808. Insurance Company Reporting Errors; Resolution; Noncompliance

A. The Division shall:
1. Return to a company, using the X12 Error Return format provided in R17-5-807(B), all reporting errors received during a transmission; and
2. Instruct the company to correct all reporting errors affecting the Division's processing of the required data.

B. All companies reporting electronic policy information shall notify the Division prior to making changes to any reporting systems, or previously established policy reporting formats, that may affect the Division's ability to match and process the information received.

R17-5-809. Insurance Company Failure to Submit Required Data; Request for Hearing

If a company fails to submit the data required under A.R.S. § 28-4148, and this Article, the Division shall:
1. Send to the company, a dated written notice, which:
   a. Identifies the business week or reporting period in which the company did not submit the required information;
   b. Instructs the company to submit the information for the identified business week or reporting period within seven days of the date of the notice;
   c. Informs the company that a failure to respond to the Division's request within the allotted time-frame, shall result in a referral of the matter to the Arizona Department of Insurance, under A.R.S. § 20-237, which may result in a civil penalty of up to $250 per day for each day the insurer is in violation of A.R.S. § 28-4148; and
   d. Provides notice of the company's right to request a hearing with the Arizona Department of Insurance under A.R.S. § 20-237; and
2. Advise the Arizona Department of Insurance if the company fails to comply with the Division's written notice provided under this Section.

R17-5-810. Self-insurance as Alternate Proof of Financial Responsibility; Provisions; Applicability

A. Self-insurance applicant qualification. A person or entity may apply for self-insurance under this Section if the applicant:
1. Owns the minimum number of vehicles prescribed under A.R.S. § 28-4007(A) with current Arizona registration;
2. Demonstrates minimum assets of $1 million on documentation required under subsections (C) and (D);
3. Meets any additional financial responsibility requirements under A.R.S. § 28-4033(A), according to the insured vehicle's weight and/or intended use; and
4. Provides a business office contact for the company with a current phone number and mailing information.

B. A self-insurance applicant shall provide, on a self-insurance application form provided by the Division, the following information:
1. Applicant's name;
2. Business name, if applicable;
3. Mailing address, city, state, and ZIP code;
4. A selection of coverage type:
   a. Public liability only; or
   b. Public liability and property damage;
5. Number of vehicles in the applicant's fleet;
6. A selection list that describes the nature of the applicant's business;
7. A description of any hazardous materials transported by type, class, and weight;
8. A report of all accidents in the prior 39-month period before the application date;
9. The applicant's signature and official business title to certify that all information is true and correct; and
10. Acknowledgment by a notary public or by the signature of an authorized Motor Vehicle Division agent.

C. Supplementary documentation. In addition to a completed self-insurance application form, the applicant shall submit a profit and loss statement certified by a Certified Public Accountant for the 12-month period before the application date. The profit and loss statement shall include one of the following:

1. A balance sheet; or
2. An annual financial report.

D. On approval of an application, the Division shall issue a certificate of self-insurance that is continuously valid but shall require the self-insurer to submit a 12-month update of supplementary documentation prescribed under subsection (C) on or before July 1 of each successive year.

E. An initial self-insurance applicant or a self-insurer making an annual update shall submit documentation required under subsections (B) through (D) to the following address:

Motor Vehicle Division
Financial Responsibility Unit
P.O. Box 2100, Mail Drop 535M
Phoenix, AZ 85001-2100

F. A self-insurer shall keep a copy of the self-insurance certificate in each covered vehicle at all times.

G. A self-insurer shall submit written notification to the Division of each vehicle to be added or removed from self-insurance coverage. The written notification shall include the vehicle identification number of each vehicle.

H. A self-insurer that terminates self-insurance shall provide new evidence of financial responsibility as required under A.R.S. § 28-4135 for each vehicle previously covered under a self-insurance certificate.

I. In addition to the reasonable grounds prescribed under A.R.S. § 28-4007(C), the Division may cancel a self-insurance certificate under the following circumstances:

1. A self-insurer fails to comply with provisions of the Division's annual update requirement under subsection (D), or
2. A self-insurer no longer owns the covered business or fleet.

J. For the purpose of A.R.S. § 28-4007(C) and this Section, the Division shall conduct a self-insurance cancellation hearing according to the provisions prescribed under 17 A.A.C. 1, Article 5.

R17-5-811. Certificate of Deposit as Alternate Proof of Financial Responsibility; Applicability

For the purpose of A.R.S. §§ 28-4076(2) and 28-4084, a person depositing a $40,000 certificate of deposit with the state treasurer as alternate proof of financial responsibility may apply the certificate to a maximum of 25 non-commercial vehicles registered in the person's name.

NOTICE OF FINAL RULEMAKING

TITLE 17. TRANSPORTATION

CHAPTER 6. DEPARTMENT OF TRANSPORTATION
OVERDIMENSIONAL PERMITS

[R07-78]

PREAMBLE

1. Sections affected — **Rulemaking Action**

R17-6-101	Amend
R17-6-113	New Section
R17-6-305	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. § 28-366

Implementing statutes: A.R.S. §§ 1-242, 28-601, 28-947, 28-1091, 28-1100, 28-1103, 28-1110, 28-1141, 28-1142, 28-1145, 28-1150, 28-2001, 41-2142, 23 CFR 658.5, and 49 CFR 71

3. The effective date of the rules:

March 6, 2007

The Division is requesting an immediate effective date upon filing with the Secretary of State as allowed under A.R.S. § 41-1032(A). An immediate effective date is permitted because the rules preserve the public safety by ensuring uninterrupted escort vehicle operations while an escort vehicle operator is working in good faith to acquire all appropriate training and certification required under the new law. No penalty is associated with a violation of the rules.

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

Notice of Rulemaking Docket Opening: 12 A.A.R. 3814, October 13, 2006

Notice of Proposed Rulemaking: 12 A.A.R. 3883, October 20, 2006

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

Name: John Lindley, Administrative Rules Analyst

Address: Administrative Rules Unit
Department of Transportation, Motor Vehicle Division
1801 W. Jefferson St., Mail Drop 530M
Phoenix, AZ 85007

Telephone: (602) 712-8804

Fax: (602) 712-3081

E-mail: jlindley@azdot.gov

Please visit the ADOT web site to track progress of this rule and any other agency rulemaking matters at www.azdot.gov/mvd/mvdrules/rules.asp.

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

The Arizona Department of Transportation, Motor Vehicle Division, and the Overdimensional Permit Council are amending existing rules and creating additional rules to incorporate recent legislative changes provided under Laws 2006, Ch. 219, §§ 1, 3, 4, 5, and 6. The rules provide further clarification on the new escort vehicle operator requirements and prescribe the electronic format that all affected local authorities shall use to provide the Division with all current local ordinances and rules relating to overdimensional permitting. Additionally, minor changes were made to update related citations, provide modernization in the rule drafting style, and to improve the clarity, conciseness, and understandability of the rules.

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

None

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

Not applicable

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

The rules prescribe the most effective process for the Department to ensure all current ordinances and rules of a local authority relating to excess size and weight special permits are made available to the public in an electronic format as required by Laws 2006, Chapter 219.

Since many local authorities currently maintain a web site with public access to their ordinances and rules, the Department anticipates only a minimal economic impact, which may affect the remaining local authorities that currently do not provide electronic public access to their ordinances and rules. Anticipated costs involve, the resources necessary to develop and maintain an Internet web site capable of providing appropriate public access to the local authority's ordinances and rules, and any administrative resources needed to facilitate the linking of each web site to the Department's web site.

A minimal impact to the Department is anticipated, which involves costs related to: the resources necessary for rulemaking; the development of a workable web page to house all web links submitted by local authorities for linking to the Department's web site; and the routine maintenance of the web page after its inception.

The proposed rules will have an un-quantifiable, but highly significant, benefit to the purchasers of excess size and weight special permits. The benefit is the immediate availability of all information necessary for the permittee to appropriately plan and successfully move oversize and overweight vehicles and loads in the interest of public safety.

Other amendments in the proposed rules were made to reflect modernization in rule drafting style, update related citations, and improve the clarity, conciseness, and understandability of the rules.

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

Minor grammatical and formatting changes were made at the request G.R.R.C. staff.

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

ADOT received no comments on these rules.

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. Were these rules previously made as emergency rules?
No

15. The full text of the rules follows:

TITLE 17. TRANSPORTATION

CHAPTER 6. DEPARTMENT OF TRANSPORTATION OVERDIMENSIONAL PERMITS

ARTICLE 1. GENERAL PROVISIONS

Section
R17-6-101. General Provision; Definitions; Time of Day
R17-6-113. Electronic Access to Local Permit Ordinances and Rules

ARTICLE 3. SAFETY REQUIREMENTS

Section
R17-6-305. Escort Vehicles

ARTICLE 1. GENERAL PROVISIONS

R17-6-101. General Provision; Definitions; Time of Day

A. General Provision. The Division Director of the Arizona Department of Transportation, Motor Vehicle Division, in cooperation with the Intermodal Transportation Division, shall issue and regulate overdimensional permits under this Chapter. The ~~agency~~ Department implements these Sections under the general authority of A.R.S. § 28-1103(B), ~~and~~ in collaboration with the Overdimensional Permit ~~Advisory~~ Council as prescribed under A.R.S. § 28-1150(C)(3).

B. Definitions. ~~The following definitions apply to this Chapter~~ In addition to the definitions prescribed under A.R.S. § 28-601, the following terms apply to this Chapter:

~~1.~~ "AASHTO" means the American Association of State Highway Transportation Officials.

~~2.~~ "ADOT" ~~or "Department"~~ means the Arizona Department of Transportation.

~~3.~~ "Appurtenance" means any not readily removable manufacturer- or dealer-installed fixture attached to a vehicle or load that increases a peripheral dimension of the vehicle or load.

~~4.~~ "Arizona Central Commercial Permits" means the statewide ADOT-MVD ~~headquarters~~ office for overdimensional permit applications and information:

14370 ~~West~~ W. Van Buren
Goodyear, ~~Arizona~~ AZ 85338
Voice line: (623) 932-2247
Facsimile: (623) 932-2441
Internet: ~~www.dot.state.az.us/mvd/centralpermits/index.htm~~ www.azdot.gov/mvd/index.asp

~~5.~~ "Articulated vehicle" ~~or "combination vehicle" means any combination of a truck or truck tractor and one or more trailers or semitrailers that operates so that two or more frames are connected by couplings, but does not include a manufactured or mobile home~~ has the same meaning as combination vehicle.

"Combination vehicle" has the same meaning as prescribed under A.R.S. § 28-101, combination of vehicles, but excludes a manufactured or mobile home.

~~6.~~ "Continuous travel" means to operate a vehicle continuously throughout any 24-hour period.

"Department" means the Arizona Department of Transportation.

~~7. "Director" means:~~

~~a. The Division Director of the Arizona Department of Transportation, Motor Vehicle Division; or~~

~~b. The Division Director's designee.~~

"Director" means the Arizona Department of Transportation's Assistant Director for the Motor Vehicle Division, or the Division Director's designee.

~~8.~~ "Division" ~~or "MVD"~~ means the Arizona Department of ~~Transportation,~~ Transportation's Motor Vehicle Division.

~~9.~~ "Envelope" ~~is~~ has the same meaning as prescribed under A.R.S. § 28-1141, and encompasses the ~~outmost~~ outermost dimensions of a load or vehicle that does not:

~~a.~~ Exceed 120 feet in length;

~~b.~~ Exceed 16 feet in height;

~~c.~~ Exceed 14 feet in width;

~~d.~~ Exceed 250,000 pounds gross weight, ~~and does not exceed~~ or the maximum permitted weight computations for overweight axle group weight distribution as prescribed under R17-6-411, Table 3.01 through Table 3.09; ~~and~~ or
~~e.~~ Have fewer than four axles.

~~10.~~ "Envelope permit" has the same meaning as prescribed under A.R.S. § ~~28-1141(2) and~~ 28-1141, which:
~~a.~~ ~~Is restricted~~ Restricts the loads to non-reducible ~~loads~~ only,
~~b.~~ Allows unlimited trips within the permit's validity period,
~~c.~~ Allows the permitted carrier unlimited load changes,
~~d.~~ Requires a transported load to meet envelope dimensional criteria, ~~and~~
~~e.~~ Restricts operation to certain routes~~.~~, and
Excludes the transporting of a manufactured or mobile home.

~~11.~~ "Established place of business" means a permanent site or location where the business of an overdimensional permit holder is conducted.

~~12. "Fixed load," "non-reducible load," "non-divisible load," or "non-divisible vehicle" have the meaning preseribed under 23 CFR 658.5 April 2001, and means an overdimensional load or vehicle that if separated into smaller components would:~~
~~a. Destroy load or vehicle value,~~
~~b. Render a load or vehicle unusable for its intended purpose, or~~
~~c. Require more than eight hours to dismantle using appropriate equipment with the burden of proof on the permit applicant as to the number of dismantle hours necessary.~~

~~13.~~ "Highway feature" means a roadway, structure, traffic control device, right-of-way, or any item connected with highway travel.

~~14.~~ "ITD" means the Arizona Department of Transportation's Intermodal Transportation Division.

"Law enforcement escort" means law enforcement personnel accompanying an overdimensional permitted vehicle in the conduct of normal duties, under contract to a governmental entity, or as required by the Department under this Chapter.

~~15.~~ "LCV" ~~or "longer combination vehicle" means any combination of a truck or truck tractor and one or more trailers or semitrailers that operates at a gross vehicle weight exceeding 80,000 pounds~~ means longer combination vehicle, which has the same meaning as prescribed under 23 CFR 658.5.

~~16.~~ "Maintenance Permits Services" means ~~Arizona Department of Transportation Intermodal Transportation Division headquarters~~ the statewide ADOT-MVD office for class C overdimensional permit approval and technical information:
~~206 South 17th Avenue, Mail Drop 004R~~ 1225 N. 25th Ave., Mail Drop 524M
Phoenix, ~~Arizona 85007~~ AZ 85009
Voice line: (602) 712-8280 or 712-8176
Facsimile: (602) 712-3380

~~17.~~ "Manufactured home" has the same meaning as prescribed under A.R.S. § ~~41-2142(2) and (24)~~ 41-2142.

~~18. "Metropolitan Phoenix" means linear distance on a state highway between post markers as designated:~~

~~Highway type~~	~~Highway number~~	~~Post marker and street name coordinate range~~
~~Interstate~~	~~10~~	~~133 - SR101 Ave to 161 - Chandler Boulevard~~
~~Interstate~~	~~17~~	~~210 - SR101 to 150A - I 10 junction at 24th Street~~
~~State route~~	~~51~~	~~All~~
~~US route~~	~~60~~	~~188 - Power Road to 172 - I-10 junction~~
~~State route~~	~~143~~	~~All~~
~~State route~~	~~153~~	~~All~~
~~State route~~	~~202~~	~~All~~

"Metropolitan Phoenix" means the linear distances between all of the following state highway milepost markers:
Interstate 10: from milepost 133 - SR101, to milepost 161 - Chandler Boulevard;
Interstate 17: from milepost 210 - SR101, to exit 150A - I-10 junction at 24th Street;
State Route 51: All;
US Route 60: from milepost 188 - Power Road, to milepost 172 - I-10 junction;
State Route 143: All;
State Route 153: All; and
State Route 202: All.

~~19. "Metropolitan Tucson" means linear distance on a state highway between post markers as designated:~~

~~Highway type~~	~~Highway number~~	~~Post marker and street name coordinate range~~
~~Interstate~~	~~10~~	~~242.5 - Cortaro Road to 268 - Craycroft Road~~

~~Interstate~~	~~19~~	~~95 - Valencia to I-10 junction~~
~~State route~~	~~77~~	~~82 - Tangerine Road to I-10 junction~~
~~State route~~	~~86~~	~~166.5 - Kinney Road to 19B junction~~

"Metropolitan Tucson" means the linear distances between all of the following state highway milepost markers:
Interstate 10: from milepost 242.5 - Cortaro Road, to milepost 268 - Craycroft Road;
Interstate 19: from milepost 59 (kilometer post 95) - Valencia, to I-10 junction;
State Route 77: from milepost 82 - Tangerine Road, to I-10 junction; and
State Route 86: from milepost 166.5 - Kinney Road, to I-19B junction.

~~20.~~ "Mobile home" has the same meaning as prescribed under A.R.S. § 28-2001(B)(1) and as more specifically prescribed under A.R.S. § 41-2142.

~~21. "M.S.T." or~~ "Mountain Standard Time" means the standard time in Arizona as prescribed under ~~49 CFR 71.2(b)~~ 49 CFR 71 and A.R.S. § ~~1-242(A)~~ 1-242.

"MVD" means the Arizona Department of Transportation's Motor Vehicle Division.

"Non-reducible load or vehicle" has the same meaning as prescribed under 23 CFR 658.5, nondivisible load or vehicle.

~~22.~~ "Overdimensional" means any size or weight measurement exceeding a measurement prescribed under R17-6-102, Table 1.

~~23. "Permit supervisor" means a managing official of Arizona Central Commercial Permits or an MVD Enforcement Services port of entry daily officer in charge.~~

~~24.~~ "Permittee" means a person or entity authorized, under a permit issued by the Department, to transport an overdimensional vehicle or load.

~~25.~~ "Power unit" has the same meaning as prescribed ~~in~~ under A.R.S. § ~~28-1141(3)~~ 28-1141.

~~26.~~ "Specified load" means any item or series of items transported throughout an entire permit period with no alteration except for exact dimensional duplicate item substitution.

~~27.~~ "Sunrise" and "sunset" have the same meaning and daily calculation as prescribed by the United States Naval Observatory (USNO) ~~that~~, which:

~~a.~~ The Department uses to determine normal permit transport start and stop times as prescribed under ~~R17-6-401(A)~~ R17-6-401; and

~~b.~~ An interested person may ~~obtain~~ access on the Internet from the USNO ~~internet address:~~ at http://aa.usno.navy.mil, or in hardcopy format from the ~~Department~~ Arizona Central Commercial Permits office ~~prescribed under R17-6-101(B)(4)~~.

~~28.~~ "Tandem axle" has the same meaning as prescribed ~~in~~ under A.R.S. § 28-1100(B).

~~29.~~ "Tare weight" means a vehicle's empty or starting weight.

~~30. "Vehicle combination" has the meaning prescribed under A.R.S. § 28-101(10).~~

C. Time of Day. In ~~any Section of~~ this Chapter, a time of day prescribed is Mountain Standard Time ~~(M.S.T.)~~ as defined in subsection (B)~~(21)~~ except where a state highway traverses a tribal nation that adopts ~~daylight-saving time~~ Daylight Saving Time under 49 CFR 71.2.

R17-6-113. Electronic Access to Local Permit Ordinances and Rules

A. A local authority that issues excess size and weight special permits under A.R.S. § 28-1103 and this Chapter, shall make available, to the Arizona Central Commercial Permits office, an Internet web link to where the local authority's current ordinances and rules relating to the excess size and weight special permits can be electronically accessed.

B. The Arizona Central Commercial Permits office shall immediately post, to the Arizona Central Commercial Permits web site at www.azdot.gov/mvd/index.asp, each Internet web link provided by a local authority under subsection (A) and A.R.S. § 28-1103.

ARTICLE 3. SAFETY REQUIREMENTS

R17-6-305. Escort Vehicles

A. Service requirement.

1. If required by the Department, a permittee ~~of an overdimensional vehicle or load~~ shall have an escort vehicle while transporting an overdimensional vehicle or load on a highway ~~prescribed under~~ restricted by R17-6-412, Table 4.
2. The Department shall determine ~~if an overdimensional permitted vehicle must be accompanied by one or more escort vehicles~~ whether one or more escort vehicles must accompany an overdimensional permitted vehicle by considering the following:
   a. Proposed transport route:
      i. Highway width, height, road dynamics;
      ii. Surface condition~~,~~; and
      iii. Grade;
   b. ~~Load size~~ Overall vehicle and load dimensions;

c. Need for frequent stops; ~~or~~
d. Concern for public safety~~.~~; and
e. Time of movement.

3. According to the criteria applicable under subsection (A)(2), the Department shall require two or more overdimensional permitted vehicles traveling together to be accompanied by at least one escort vehicle per load.

B. Vehicle ~~qualification~~, operator, and equipment requirements.

1. A vehicle qualifies as an escort vehicle if it:
   a. Is a passenger car or two-axle truck ~~not exceeding 20,000 pounds, and~~ operating as a single unit,
   b. Is currently registered~~.~~, and
   c. Meets insurance requirements as provided by law.
2. An escort vehicle operator, except for a law enforcement escort, shall meet all requirements under A.R.S. § 28-1110, and maintain certification through a program that meets the escort vehicle operator training and certification standards of the Commercial Vehicle Safety Alliance or an equivalent program, whether in this state or another state, that meets the same objectives.
3. Effective September 21, 2006, an escort vehicle operator is in compliance with subsection (B)(2), if the escort vehicle operator:
   a. Files an application with a program that meets the escort vehicle operator training and certification standards of the Commercial Vehicle Safety Alliance or an equivalent program that meets the same objectives, whether in this state or another state; and
   b. Completes the training and certification program within 120 days of the date of application.

~~2.~~4. An escort vehicle operator shall possess all of the following equipment:
   a. Warning flags as prescribed under R17-6-302, when accompanying an overdimensional permitted vehicle ~~or load~~;
   b. Warning lights as prescribed under A.R.S. § 28-947(D);
   c. An "OVERSIZE LOAD" sign:
      i. Constructed as prescribed under R17-6-303(C)~~,~~;
      ii. Mounted above the vehicle's roofline~~,~~;
      iii. Displayed as prescribed under R17-6-303(D)~~, and,~~;
      iv. ~~Not visible when not in use;~~ Accompanied by two flags, one mounted on each side of the oversize load sign; and
      v. Not visible when not in use;
   d. A two-way radio:
      i. Capable of transmitting and receiving a minimum of one-half mile~~,~~; and
      ii. Compatible with each two-way radio in an accompanying escort vehicle and each escorted ~~overdimensionally-permitted~~ overdimensional permitted vehicle; and
   e. Emergency equipment ~~as follows~~ to include:
      i. At least eight ~~flares~~ emergency warning devices; and
      ii. Two emergency staff-mounted warning flags manufactured to the specifications prescribed under R17-6-302(A).

C. Operation.

1. Lighting requirement. While in service, an escort vehicle operator shall maintain continuous illumination of headlights and overhead warning lights.
2. Lead- and follow-distance.
   a. On an open highway, except when visual contact cannot be maintained, an escort vehicle operator shall maintain a lead- or follow-distance not exceeding 1,500 feet from the escorted vehicle.
   b. In an urban setting, an escort vehicle operator shall maintain a lead- or follow-distance not exceeding 250 feet from the escorted vehicle.
3. Stop provisions at a traffic signal-controlled intersection.
   a. When ~~a load-bearing~~ an overdimensional permitted vehicle is required to stop, the lead-escort vehicle operator shall ~~stop safely on the right-hand roadside after proceeding~~ proceed through the intersection and stop safely off the roadway. The lead-escort vehicle operator shall resume normal lead distance ~~after the load-bearing vehicle clears the intersection~~ as soon as is safely possible.
   b. When a following-escort vehicle is required to stop, the operator of ~~a load-bearing~~ an overdimensional permitted vehicle shall proceed without stopping. The following-escort vehicle operator shall resume its normal distance behind the ~~load-bearing~~ overdimensional permitted vehicle as soon as is safely possible after clearing an intersection.