

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 11. DEPARTMENT OF HEALTH SERVICES HEALTH CARE INSTITUTIONS: RATES AND CHARGES

[R07-354]

PREAMBLE

1. Sections Affected

R9-11-101
R9-11-201
R9-11-201
R9-11-202
R9-11-203
R9-11-204
R9-11-205
R9-11-301
R9-11-301
R9-11-302
R9-11-303
R9-11-303
R9-11-304
R9-11-305
R9-11-305
R9-11-401
R9-11-402
Table 1
R9-11-501
R9-11-502

Rulemaking Action

Amend
Repeal
New Section
New Section
New Section
New Section
New Section
Repeal
New Section
New Section
Repeal
New Section
New Section
Repeal
New Section
Amend
Amend
Repeal
Amend
Amend

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

Authorizing statutes: A.R.S. § 36-136(F)

Implementing statutes: A.R.S. §§ 36-125.04, 36-125.05, 36-136(F), 36-436, 36-436.01, and 36-436.02

3. The effective date of the rules:

December 1, 2007

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

Notice of Proposed Rulemaking: 13 A.A.R. 2206, June 29, 2007

Notice of Rulemaking Docket Opening: 13 A.A.R. 487, February 16, 2007

Notice of Rule Expiration: 12 A.A.R. 1784, May 26, 2006

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

Name: Edward Welsh, Manager
Cost Reporting and Discharge Data Review Section

Address: Department of Health Services
Cost Reporting and Discharge Data Review Section

Notices of Final Rulemaking

Bureau of Public Health Statistics
150 N. 18th Ave., Suite 550
Phoenix, AZ 85007

Telephone: (602) 542-2960
Fax: (602) 542-2940
E-mail: welshe@azdhs.gov

or

Name: Kathleen Phillips, Rules Administrator and Administrative Counsel

Address: Department of Health Services
Office of Administrative Rules and Counsel
1740 W. Adams, Suite 200
Phoenix, AZ 85007

Telephone: (602) 542-1264
Fax: (602) 364-1150
E-mail: phillik@azdhs.gov

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

The Arizona Department of Health Services (Department), Cost Reporting and Discharge Data Review Section, collects financial statements, accounting reports, rates and charges information, and discharge data from health care institutions statewide. This data is used by the public, private industry, the Department, and other government agencies to promote health care cost containment and to identify the health care utilization needs of established and developing communities throughout Arizona.

A.R.S. § 36-125.04 requires hospitals to submit annual financial statements to the Department. A.R.S. § 36-125.04 also requires hospitals, nursing care institutions, and hospices to submit uniform accounting reports (UARs) to the Department. 9 A.A.C. 11, Article 2 implements A.R.S. § 36-125.04 by providing requirements for hospitals, nursing care institutions, and hospices to follow when submitting annual financial statements or UARs to the Department.

A.R.S. Title 36, Chapter 4, Article 3 requires hospitals, nursing care institutions, home health agencies, and outpatient treatment centers to submit to the Department a schedule of rates and charges and changes made to the schedule. 9 A.A.C. 11, Article 3 implements A.R.S. Title 36, Chapter 4, Article 3 by providing requirements for submitting to the Department a schedule of rates and charges or changes to the schedule.

A.R.S. § 36-125.05 requires hospitals to submit inpatient and emergency department discharge data to the Department. 9 A.A.C. 11, Articles 4 and 5 implement A.R.S. § 36-125.05 by providing requirements for submitting discharge data to the Department.

The Department prepared a five-year-review report for these rules, which was approved by the Governor's Regulatory Review Council on June 6, 2006. The purpose of this rulemaking is to clarify and update the reporting requirements in 9 A.A.C. 11 as specified in the five-year-review report according to current statutory authority and to reflect Department policy and practice requirements. The proposed rulemaking amends 9 A.A.C. 11 by:

- Revising outdated language and amending, adopting, and repealing definitions to make the rules clearer and easier to use;
- Repealing the requirement for nursing care institutions to submit uniform accounting report data using the obsolete Arizona Reporting System for Nursing Institutional Costs (ARSNIC);
- Amending and clarifying reporting requirements for hospital, nursing care institution, and hospice uniform accounting reports;
- Amending and clarifying reporting requirements for hospital, nursing care institution, and home health agency rates and charges schedules;
- Repealing the use of Forms 301 and 302 for reporting rates and charges information because Forms 301 and 302 require a large amount of financial data that would be required for rate-setting but is unrelated to reporting rates and charges information;
- Adopting new reporting requirements for outpatient treatment center rates and charges schedules;
- Repealing the obsolete hospital discharge data format specifications and data transfer medium requirement in Table I;
- Repealing the requirement for outpatient surgical centers to submit discharge data to the Department according to changes in statute; and

Notices of Final Rulemaking

- Amending and clarifying hospital inpatient and emergency department discharge data reporting requirements according to the UB-04 National Billing Data Element Specifications.

The proposed rules conform to rulemaking format and style requirements of the Governor's Regulatory Review Council and the Office of the Secretary of State.

7. A reference to any study relevant to the rules that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the 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:

The Department did not review or rely on any study related to this rulemaking.

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:

Annual cost/revenue changes are designated as minimal when less than \$1,000, moderate when between \$1,000 and \$10,000, and substantial when greater than \$10,000 in additional costs or revenues. Costs are listed as significant when meaningful or important, but not readily subject to quantification.

The Department anticipates deriving a minimal-to-moderate benefit from the new rules due to their increased clarity, improved organization of reporting requirements, and more uniform submission requirements. The Department will bear minimal-to-moderate costs for educating hospitals, nursing care institutions, hospices, home health agencies, and outpatient treatment centers about the revised reporting requirements and for enforcing the rules, and substantial costs for updating data systems within the Department to receive the data in a specified uniform format.

AHCCCS requests from the Department all nursing care institution UARs and rates and charges schedules and an occasional hospital UAR or rates and charges schedule to set disbursement monies to health care providers, analyze costs of health care, and project health care costs for the future. The Department anticipates that AHCCCS may use information from hospice UARs in a similar manner. The Department estimates that AHCCCS may receive a minimal-to-moderate benefit from the clarity and updated reporting requirements of the rules and the uniformity of the resultant data submitted to the Department, as well as the ability to use data from hospice UARs.

Hospitals submit four types of financial reports to the Department. These include a copy of the hospital audited annual financial statement, the hospital UAR, a copy of the hospital Medicare cost report, and the hospital rates and charges schedule and overview form. Hospitals also submit inpatient and emergency department discharge data. The Department estimates that changes in submission requirements of the annual financial statement and Medicare cost report specified in the new rules will provide a minimal benefit to a hospital. Since hospitals may need to alter the computer reports used to generate the data required in a hospital's UAR, rates and charges schedule, and inpatient and emergency department discharge data reports, these changes to the hospital's reports may impose a one-time minimal-to-moderate cost on the hospital, as well as possibly a minimal ongoing cost for revising incomplete or inaccurate reports. However, a hospital may receive an ongoing minimal-to-moderate benefit due to the clarity of the rules and the revised submission requirements, as well as a minimal-to-substantial benefit from the opportunity to correct errors in the submitted data before incurring civil penalties. A hospital may also receive a significant benefit from the reporting requirements in the new rules if the hospital reviews the information collected by the Department and uses the information to further the hospital's interests.

Nursing care institutions are required to submit three types of financial reports to the Department. These include a copy of the nursing care institution Medicare cost report, the nursing care institution rates and charges schedule and overview form, and the nursing care institution UAR, which under current rule is the obsolete ARSNIC report. Since nursing care institutions may need to alter the computer reports used to generate the data required in the nursing care institution UAR and rates and charges schedule, these changes to a nursing care institution's reports may impose a one-time minimal-to-moderate cost on the nursing care institution, as well as possibly a minimal ongoing cost for revising incomplete or inaccurate reports. However, a nursing care institution may receive an ongoing minimal-to-moderate benefit due to the clarity of the rules and the revised submission requirements, as well as a minimal-to-substantial benefit from the opportunity to correct errors in the submitted data before incurring civil penalties. A nursing care institution may also receive a significant benefit from the reporting requirements in the new rules if the nursing care institution reviews the information collected by the Department and uses the information to further the nursing care institution's interests.

Although A.R.S. § 36-125.04 requires hospices to submit a UAR to the Department and R9-11-201(A) requires inpatient hospices to submit a UAR, these requirements have not been enforced. While the new rules simply clarify the requirements for all hospices to submit a UAR, the new rules represent a change in practice and may, therefore, have more of an economic impact on hospices than may be apparent from comparing the two sets of rules. The Department anticipates that a hospice may need to develop computer reports to generate the data reported in the hospice's UAR, and that this may impose a one-time minimal-to-moderate cost on the hospice, as well as a minimal-to-moderate ongoing cost to prepare the report each year and possibly a minimal ongoing cost for revising incomplete or inaccurate reports. A hospice may receive an ongoing minimal-to-moderate benefit from having the time for the submission of the UAR coincide with that for the Medicare cost report, as well as a minimal-to-substantial benefit from the

Notices of Final Rulemaking

opportunity to correct errors in the submitted data before incurring civil penalties. A hospice may use information from the UARs to further the hospice's interests.

In the current rules in R9-11-301, home health agencies are required to submit a rates and charges schedule to the Department before operating in Arizona and to submit changes to the schedule before implementing a change. However, in practice, home health agencies are not submitting rates and charges schedules. The Department is reducing the burden on home health agencies as much as possible by allowing a home health agency to submit another document prepared for government reporting purposes, such as the Medicare cost report, as long as the document contains the required information. The Department expects a home health agency to receive a minimal benefit from the clarity of the new rules. Although a home health agency may bear a minimal-to-moderate cost as a result of these rules, compared to costs incurred under the present practice of not submitting a rates and charges schedule to the Department, the home health agency may receive a minimal-to-moderate benefit from being able to submit a report already prepared for other purposes, if the home health agency prepares such a report and chooses to submit it to the Department.

Although outpatient treatment centers are required by A.R.S. Title 36, Chapter 4, Article 3 to submit a rates and charges schedule to the Department before operating in Arizona and to submit changes to the schedule before implementing a change, these requirements were never put into the current rules. To conform to statutory requirements while reducing the burden on outpatient treatment centers as much as possible, the new rules require outpatient treatment centers to submit either a rates and charges schedule or a report prepared for another government reporting purpose that contains the information required in a rates and charges schedule. The Department expects an outpatient treatment center to receive a minimal benefit from the clarity of the new rules. Although an outpatient treatment center may bear a minimal-to-moderate cost as a result of these rules, compared to not submitting a rates and charges schedule to the Department, the outpatient treatment center may receive a minimal-to-moderate benefit from being able to submit a report already prepared for other purposes, if the outpatient treatment center prepares such a report and chooses to submit it to the Department.

Many persons request copies of the health care institution facility data collected by the Department. These persons include health care consultants, developers, banks, attorneys, and insurance companies. Since the data contained in these reports would be difficult or impossible to obtain from other sources, the Department estimates that business users will experience a minimal-to-substantial benefit from the rulemaking.

The Department also receives requests from the U.S. Department of Health and Human Services, universities, and various research organizations for hospital inpatient and emergency department discharge data. These persons use the data to perform epidemiological assessments of specific geographic regions and demographic groups. Much of this data is unavailable from other sources or would be time consuming and expensive to collect. The Department estimates that the U.S. Department of Health and Human Services, universities, and various research organizations will experience a minimal-to-substantial benefit from the rulemaking.

The health care institution facility data collected by the Department may benefit the public in many ways. The data will be used to promote health care cost containment and to identify regions and specific health care programs where public funding should be allocated, influencing public health program assessment and development. The Department anticipates that this use of collected data will help contain out-of-pocket health care costs and rising insurance premiums, bring health care to underserved geographic regions, and improve the level of services in health care fields where it is needed the most. The Department estimates that the public will experience a significant benefit from the rulemaking.

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

At the suggestion of the Governor's Regulatory Review Council (Council) staff, the Department expanded the definition of "generally accepted accounting principles" in R9-11-201 to include other sets of financial reporting standards in addition to those administered by the Financial Accounting Standards Board (FASB) or the Governmental Accounting Standards Board (GASB). The Department made this change in case a person regulated by the rules follows generally accepted accounting principles set by a specialized body dealing with accounting and auditing matters other than FASB or GASB. Also at the suggestion of Council staff, the Department added a definition of "rehabilitation bed" in R9-11-301 to improve clarity. Minor technical and grammatical changes were made by the Department and at the suggestion of Council staff to improve clarity, conciseness, and understandability.

The Department does not consider these changes substantial substantive changes because (1) the extent to which all persons affected by the rules should have understood that the published proposed rules would affect their interests remains the same; (2) the subject matter of the rules or the issues determined by the rules are the same as the subject matter or issues involved in the published proposed rules; and (3) the effects of the final rules do not differ substantially from the effects of the proposed rules.

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

The Department held an oral proceeding on August 8, 2007, and received one oral comment. The Department also received four sets of written comments regarding the proposed rules during the formal comment period. A summary of the comments received and the Department response to each are included in the following table:

Arizona Administrative Register / Secretary of State

Notices of Final Rulemaking

Section	Public Comment	Department Response
R9-11-204 & R9-11-303	The Executive Director of the Arizona Health Care Association (AzHCA) made an oral comment at the oral proceeding and also submitted a written comment thanking the Department for the opportunity to participate in the rule-making process and expressing AzHCA's unequivocal support of the rules.	The Department appreciates the support and thanks AzHCA for the time and effort devoted by AzHCA to the rulemaking process.
R9-11-205	An individual representing Hospice of the Valley and the Arizona Hospice and Palliative Care Organization submitted a written comment expressing gratitude that the hospice uniform accounting report has been revised in a manner that supports the hospice community.	The Department appreciates the support and thanks Hospice of the Valley and the Arizona Hospice and Palliative Care Organization for the time and effort they devoted to the rulemaking process.
R9-11-402(C)(3)(i) & R9-11-502(C)(3)(i)	The Department received a written comment from a hospital Director of Chargemaster and Coding who expressed appreciation that the rules require the submission of only the last four digits of patient Social Security numbers (instead of complete Social Security numbers) for hospital inpatient and emergency department discharge data reports.	The Department appreciates the support.
R9-11-203(E), R9-11-302(H), R9-11-305(E), R9-11-402(E), & R9-11-502(E)	<p>The Arizona Hospital and Healthcare Association (AzHHA) submitted the following written comments on the proposed rules:</p> <p>Comment</p> <p>AzHHA appreciates the work the Department has put into the proposed rules, particularly the Department's efforts to meet with stakeholders early in the rulemaking process. AzHHA believes the proposed rules are much stronger as a result of the collaborative process. AzHHA also appreciates the effort the Department took in addressing several of AzHHA's concerns regarding the proposed rules.</p>	<p>Response</p> <p>The Department appreciates the support and thanks the Arizona Hospital and Healthcare Association for the time and effort they devoted to the rulemaking process.</p>

Notices of Final Rulemaking

Comment

AzHHA continues to have concerns regarding Department revision requests for data submitted by hospitals and outpatient treatment centers (OTCs).

Comment

It is unclear whether the rule language concerning revisions refers to corrections of specific errors (e.g. data elements) identified by the Department or to resubmissions of the entire report, schedule, or schedule amendment. AzHHA requests that the rule language be clarified to require the Department to send only one letter requesting an "initial" revision, which would identify all errors to be corrected. AzHHA also requests that a "second" revision request only pertain to errors identified in the "initial" revision request that have not been corrected.

Response

No rule change will be made. The Department believes that the revision request rule language and process is fair and logical. There is no statutory obligation for the Department to allow a facility to correct errors in its data or any other report submitted to the Department under 9 A.A.C. 11. The 21-day "initial" and 7-day "second" revision periods were put in practice as an attempt to gather the most accurate data possible and allow hospitals to avoid civil penalties. This revision practice has been in place for hospital discharge data reporting for over three years. In this time the Department has received no complaints regarding the practice from hospitals and AzHHA. Hospital reporting performances have improved because of this practice. For hospital discharge data for the 2004-01 reporting period, only 39% of hospitals achieved a successful data submission by the "initial" revision attempt. For the 2006-02 reporting period, 86% of hospitals achieved a successful data submission by the "initial" revision attempt.

Because of the overwhelming success of this process for hospital discharge data revision requests, the Department is confident it will also prove useful for other hospital and OTC revision requests.

Response

No rule change will be made. The rules specify that the Department is requesting revision of a report submitted to the Department to fulfill a statutory requirement, not specific errors identified by the Department. For example, in R9-11-203(E), the rule clearly states that the Department is requesting "revision of a uniform accounting report."

The documents that a hospital submits to the Department contain a multitude of data elements. As a service to the hospital, the Department identifies specific data elements that do not make sense in the context of other submitted data elements and provides examples of where the report was not prepared according to rule. However, the identified errors are not meant to be exhaustive. When a hospital corrects an error in one identified data element, other errors that were masked by the original error may become evident. Thus a second request for revision of a document may not just identify examples of where previously identified errors were left unchanged, but may also identify errors that were introduced as part of the initial revision.

Notices of Final Rulemaking

	<p>Comment Depending on corrections identified by the Department, the seven-day “second” revision time-frame may be inadequate for compliance.</p> <p>Comment If the Department’s intent is to send multiple letters requesting initial and second revisions for specific data elements, each newly identified error should be considered a request for an “initial” revision and trigger the 21-day period.</p> <p>Comment AzHHA requests that the response times allowed for revisions of reports “be based on the date on which the hospital or OTC receives the letter, not on the date on the Department’s letter. Basing the response time on receipt of the letter equalizes the time period the providers have to respond to the notice, regardless of possible mail interruptions or other delays outside of the provider’s control.”</p>	<p>Response No rule change will be made. The Department believes the seven-day “second” revision time-frame is adequate for compliance as evidenced by the fact that the Department has not imposed civil penalties on a hospital for deficient discharge data reporting since the 2004-02 reporting period submissions.</p> <p>Response No rule change will be made. It is not the Department’s intent to send multiple letters requesting initial and second revisions for specific data elements.</p> <p>Response No rule change will be made. The Department will know when a letter is sent to a hospital or OTC, but cannot know the exact date when a letter is received by the hospital or OTC. A similar process has been in effect for hospital discharge data for years. Although the original signed notification letter requesting an initial or second revision of hospital discharge data reports is sent via U.S. Postal Service to a hospital CEO, an electronic copy of that letter and all detailed error lists are provided electronically to the hospital “data contact” the morning the original letter is mailed. Each hospital has at least one designated individual who serves as a liaison to the Department for hospital discharge data. The Department has or anticipates having a contact for other reports hospitals and OTCs are required to submit to the Department under 9 A.A.C. 11. As a result of this practice, all providers receive the same amount of time in which to make corrections. Many times errors in discharge data are corrected before the CEO even receives the mailed letter. The Department’s written policy and procedure related to discharge data review includes this practice of sending request letters and detailed error lists electronically to hospital data contacts. This notification process has been in place for hospital discharge reporting for over three years, in which time the Department received no complaints regarding the practice from hospitals and AzHHA.</p> <p>Because of the overwhelming success of this process for hospital discharge data revision requests, the Department is confident it will also prove useful for other hospital and OTC revision requests.</p>
--	---	---

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

None

Notices of Final Rulemaking

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 9. HEALTH SERVICES

CHAPTER 11. DEPARTMENT OF HEALTH SERVICES

HEALTH CARE INSTITUTIONS: RATES AND CHARGES INSTITUTION FACILITY DATA

ARTICLE 1. GENERAL DEFINITIONS

Section

R9-11-101. Definitions

ARTICLE 2. UNIFORM ACCOUNTING SYSTEM

ANNUAL FINANCIAL STATEMENTS AND UNIFORM ACCOUNTING REPORTS

Section

R9-11-201. ~~Annual Filing of Operating Statements and Reports~~ Definitions

R9-11-202. ~~Expired Hospital Annual Financial Statement~~

R9-11-203. ~~Expired Hospital Uniform Accounting Report~~

R9-11-204. ~~Reserved Nursing Care Institution Uniform Accounting Report~~

R9-11-205. ~~Reserved Hospice Uniform Accounting Report~~

ARTICLE 3. RATES AND CHARGES SCHEDULES

Section

R9-11-301. ~~Filing of Rates and Charges~~ Definitions

R9-11-302. ~~Expired Hospital Rates and Charges Schedule~~

R9-11-303. ~~Financial Report for Hospital Rate Changes; Preparation and Filing Instructions~~ Nursing Care Institution Rates and Charges Schedule

R9-11-304. ~~Expired Home Health Agency Rates and Charges Schedule~~

R9-11-305. ~~Financial Report for Nursing Care Institution Rate Changes; Preparation and Filing Instructions~~ Outpatient Treatment Center Rates and Charges Schedule

ARTICLE 4. HOSPITAL INPATIENT DISCHARGE REPORTING FOR INPATIENTS

Section

R9-11-401. Definitions

R9-11-402. Reporting Requirements

Table 1. ~~Magnetic Tape Submission — Required Data Items and Formal Specifications for Inpatient Discharges~~
Repealed

ARTICLE 5. OUTPATIENT SERVICES

EMERGENCY DEPARTMENT DISCHARGE REPORTING

Section

R9-11-501. Definitions

R9-11-502. Reporting Requirements

ARTICLE 1. GENERAL DEFINITIONS

R9-11-101. Definitions

~~A. "Accrual" means recording revenues and expenses when incurred with specific periods of time, such as a month or year, without regard to the date of receipt or payment of cash.~~

~~B. "Affiliated Organization" means the same as "related party."~~

~~C. "Annualized" means data for any period adjusted to represent a 12-month time period.~~

~~D. "Charge Code" means a numeric or alpha-numeric identifier assigned by the health care institution to a unit of service such as a procedure, test, or commodity for which a separate charge is levied to a patient and used for identification on a patient's itemized bill.~~

~~E. "Charity Allowances" means reductions in charges for services made by the health care institution because of the indi-~~

Notices of Final Rulemaking

gence of the patient. This does not include Title XIX Arizona Health Care Cost Containment Service (AHCCCS) or any other third-party payor settlements.

- F.** “Department” or “DHS” means the Department of Health Services.
- G.** “Direct costs” means those costs which are incurred by and charged directly to the revenue-producing departments of the institution.
- H.** “Director” means the Director of the Department.
- I.** “Durable Medical Equipment” means reusable equipment a health care institution makes available for patient services. The equipment can be sold, rented or furnished at no cost to a patient.
- J.** “Expendable” means those non-reusable commodities that may be sold to and are consumed by the patient.
- K.** “Formula” means a defined mathematical progression applied to the cost of a product to calculate a patient charge.
- L.** “Health care institution” or “institution” means every place, building or agency, whether organized for profit or not, which provides medical services, nursing services, or health-related services, except those institutions exempted by A.R.S. § 36-402.
- M.** “Indirect costs” means those costs which are incurred by and charged directly to the non-revenue-producing departments and then are proportionately allocated to the revenue-producing departments of the institution.
- N.** “Inpatient hospice” means a hospice licensed by the Department pursuant to A.R.S. §§ 36-405, 36-422 and A.A.C. Title 9, Chapter 10, Article 8 providing 24-hour inpatient care.
- O.** “Level of Care” means categorizing patient services according to the type of care provided by the health care institution. Patient care factors, such as nursing hours, physical assistance or administration of medications, may be assigned numeric values generating accumulated or weighted points used to apply charges.
- P.** “Managed Care” means services delivered to clients through a health maintenance organization, preferred provider organization, third-party administrator or an independent physician association.
- Q.** “Material” means a significant change in revenue or expense in relation to total revenue or significant changes that affect how a facility is managed or controlled.
- R.** “Natural Classification” means the classification of expenses as reported on the income statement; i.e., the nature of the items as accrued, such as, salaries/wages, benefits, supplies, purchased services, insurance, and depreciation.
- S.** “Nonexpendable” means those reusable items that may be rented or sold to the patient. This may include durable medical equipment.
- T.** “Pass through” means any outside service or purchased commodity that is charged to a patient at the health care institution’s cost.
- U.** “Private payor” means an individual or insurance company responsible for the payment of services. Third-party government payor programs are not considered private payors.
- V.** “Rate or Charge” means a separate dollar amount levied to a patient for use or consumption of a unit of service or commodity.
- W.** “Related Party” means an investor (individual, partner or corporation) having more than 5% ownership of another entity.
- X.** “Senior Plan” means contracted managed care services that are an alternate method of delivering services to Medicare-eligible clients.
- Y.** “Service” means a unit of care such as a procedure, test, or commodity for which a separate rate or charge is made to a patient.

In this Chapter, unless otherwise specified:

1. “Admission” or “admitted” means documented acceptance by a health care institution of an individual as an inpatient of a hospital, a resident of a nursing care institution, or a patient of a hospice.
2. “AHCCCS” means the Arizona Health Care Cost Containment System, established under A.R.S. § 36-2902.
3. “Allowance” means a charity care discount, self-pay discount, or contractual adjustment.
4. “Arizona facility ID” means a unique code assigned to a hospital by the Department to identify the source of inpatient discharge or emergency department discharge information.
5. “Assisted living facility” means the same as in A.R.S. § 36-401.
6. “Attending provider” means the medical practitioner who has primary responsibility for the services a patient receives during an episode of care.
7. “Available bed” means an inpatient bed or resident bed, as defined in A.R.S. § 36-401, for which a hospital, nursing care institution, or hospice has health professionals and commodities to provide services to a patient or resident.
8. “Bill” means a statement for money owed to a health care institution for the provision of the health care institution’s services.
9. “Business day” means any day of the week other than a Saturday, a Sunday, a legal holiday, or a day on which the Department is authorized or obligated by law or executive order to close.
10. “Calendar day” means any day of the week, including a Saturday or a Sunday.
11. “Cardiopulmonary resuscitation” means the same as in A.R.S. § 36-3251.
12. “Charge” means a specific dollar amount set by a health care institution for the use or consumption of a unit of service provided by the health care institution.

Notices of Final Rulemaking

13. “Charge source” means the unit within a health care institution that provided services to an individual for which the individual’s payer source is billed.
14. “Charity care” means services provided without charge to an individual who meets certain financial criteria established by a health care institution.
15. “Chief administrative officer” means the same as in A.A.C. R9-10-101.
16. “Chief financial officer” means an individual who is responsible for the financial records of a health care institution.
17. “Classification” means a designation that indicates the types of services a hospital provides.
18. “Clinical evaluation” means an examination performed by a medical practitioner on the body of an individual for the presence of disease or injury to the body, and review of any laboratory test results for the individual.
19. “Code” means a single number or letter, a set of numbers or letters, or a combination of numbers and letters that represents specific information.
20. “Commodity” means a non-reusable material, such as a syringe, bandage, or IV bag, utilized by a patient or resident.
21. “Contractual adjustment” means the difference between charges billed to a payer source and the amount that is paid to a health care institution based on an established agreement between the health care institution and the payer source.
22. “Control number” means a unique number assigned by a hospital for an individual’s specific episode of care.
23. “Department” means the Arizona Department of Health Services.
24. “Designee” means a person assigned by the governing authority of a health care institution or by an individual acting on behalf of the governing authority to gather information for or report information to the Department.
25. “Diagnosis” means the identification of a disease or injury, by an individual authorized by law to make the identification, that is a cause of an individual’s current medical condition.
26. “Discharge” means a health care institution’s termination of services to a patient or resident for a specific episode of care.
27. “Discharge status” means the disposition of a patient, including whether the patient was:
 - a. Discharged home.
 - b. Transferred to another health care institution, or
 - c. Died.
28. “DNR” means Do Not Resuscitate, a document prepared for a patient indicating that cardiopulmonary resuscitation is not to be used in the event that the patient’s heart stops beating.
29. “E-code” means an International Classification of Diseases code that is used:
 - a. In conjunction with other International Classification of Diseases codes that identify the principal and secondary diagnoses for an individual; and
 - b. To further designate the individual’s injury or illness as being caused by events such as:
 - i. An external cause of injury, such as a car accident;
 - ii. A poisoning; or
 - iii. An unexpected complication associated with treatment, such as an adverse reaction to a medication or a surgical error.
30. “Electronic” means the same as in A.R.S. § 36-301.
31. “Emergency” means the same as in A.A.C. R9-10-201.
32. “Emergency department” means the unit within a hospital that is designed for the provision of emergency services.
33. “Emergency services” means the same as in A.A.C. R9-10-201.
34. “Episode of care” means medical services, nursing services, or health-related services provided by a hospital to a patient for a specific period of time, ending with a discharge.
35. “Fiscal year” means a consecutive 12-month period established by a health care institution for accounting, planning, or tax purposes.
36. “Governing authority” means the same as in A.R.S. § 36-401.
37. “Health care institution” means the same as in A.R.S. § 36-401.
38. “Health-related services” means the same as in A.R.S. § 36-401.
39. “Home health agency” means the same as in A.R.S. § 36-151.
40. “Home health services” means the same as in A.R.S. § 36-151.
41. “Home office” means the person that is the owner of and controls the functioning of a nursing care institution.
42. “Hospice” means the same as in A.R.S. § 36-401.
43. “Hospital” means the same as in A.A.C. R9-10-201.
44. “Hospital administrator” means the same as “administrator” in A.A.C. R9-10-201.
45. “Hospital services” means the same as in A.A.C. R9-10-201.
46. “Inpatient” means the same as in A.A.C. R9-10-201.
47. “International Classification of Diseases Code” means a code included in a set of codes such as the ICD-9-CM or ICD-10-CM codes, which is used by a hospital for billing purposes.
48. “Licensed capacity” means the same as in A.R.S. § 36-401.
49. “Management company” means an entity that:

Arizona Administrative Register / Secretary of State
Notices of Final Rulemaking

- a. Acts as an intermediary between the governing authority of a nursing care institution and the individuals who work in the nursing care institution.
 - b. Takes direction from the governing authority of the nursing care institution, and
 - c. Ensures that the directives of the governing authority of the nursing care institution are carried out.
50. “Medical practitioner” means an individual who is:
- a. Licensed:
 - i. As a physician;
 - ii. As a dentist, under A.R.S. Title 32, Chapter 11, Article 2;
 - iii. As a podiatrist, under A.R.S. Title 32, Chapter 7;
 - iv. As a registered nurse practitioner, under A.R.S. Title 32, Chapter 15;
 - v. As a physician assistant, under A.R.S. Title 32, Chapter 25; or
 - vi. To use or prescribe drugs or devices for the evaluation, diagnosis, prevention, or treatment of illness, disease, or injury in human beings in this state; or
 - b. Licensed in another state and authorized by law to use or prescribe drugs or devices for the evaluation, diagnosis, prevention, or treatment of illness, disease, or injury in human beings in this state.
51. “Medical record number” means a unique number assigned by a hospital to an individual for identification purposes.
52. “Medical services” means the same as in A.R.S. § 36-401.
53. “Medicare” means a federal health insurance program established under Title XVIII of the Social Security Act.
54. “National provider identifier” means the unique number assigned by the Centers for Medicare and Medicaid Services to a health care institution, physician, registered nurse practitioner, or other medical practitioner to submit claims and transmit electronic health information to all payer sources.
55. “Newborn” means a human:
- a. Whose birth took place in the reporting hospital, or
 - b. Who was:
 - i. Born outside a hospital,
 - ii. Admitted to the reporting hospital within 24 hours of birth, and
 - iii. Admitted to the reporting hospital before being admitted to any other hospital.
56. “Nursing care institution” means the same as in A.R.S. § 36-446.
57. “Nursing care institution administrator” means the same as in A.R.S. § 36-446.
58. “Nursing services” means the same as in A.R.S. § 36-401.
59. “Patient” means the same as in A.A.C. R9-10-101.
60. “Payer source” means an individual or an entity, such as a private insurance company, AHCCCS, or Medicare, to which a health care institution sends a bill for the services provided to an individual by the health care institution.
61. “Physician” means an individual licensed as a doctor of allopathic medicine under A.R.S. Title 32, Chapter 13, as a doctor of naturopathic medicine under A.R.S. Title 32, Chapter 14, or as a doctor of osteopathic medicine under A.R.S. Title 32, Chapter 17.
62. “Principal diagnosis” means the reason established after a clinical evaluation of a patient to be chiefly responsible for a specific episode of care.
63. “Principal procedure” means the procedure judged by an individual working on behalf of a hospital to be:
- a. The most significant procedure performed during an episode of care, or
 - b. The procedure most closely associated with a patient’s principal diagnosis.
64. “Priority of visit” means the urgency with which a patient required medical services during an episode of care.
65. “Procedure” means a set of activities performed on a patient that:
- a. Is intended to diagnose or treat a disease, illness, or injury;
 - b. Requires the individual performing the set of activities be trained in the set of activities; and
 - c. May be invasive in nature or involve a risk to the patient from the activities themselves or from anesthesia.
66. “Prospective payment system” means a system of classifying episodes of care for billing and reimbursement purposes, based on factors such as diagnoses, age, and sex.
67. “Refer” means to direct an individual to a health care institution for services provided by the health care institution.
68. “Referral source” means a code designating the entity that referred or transferred a patient to a hospital.
69. “Registered nurse practitioner” means an individual who meets the definition of registered nurse practitioner in A.R.S. § 32-1601, and is licensed under A.R.S. Title 32, Chapter 15.
70. “Reporting period” means the specific fiscal year, calendar year, or portion of the fiscal or calendar year for which a health care institution is reporting data to the Department.
71. “Residence” means the place where an individual lives, such as:
- a. A private home,
 - b. A nursing care institution, or
 - c. An assisted living facility.
72. “Resident” means the same as in:

Notices of Final Rulemaking

- a. A.A.C. R9-10-701, or
- b. A.A.C. R9-10-901.
- 73. “Revenue code” means a code for a unit of service that a hospital includes on a bill for hospital services.
- 74. “Secondary diagnosis” means any diagnosis for an individual other than the principal diagnosis.
- 75. “Self-pay discount” means a reduction in charges billed to an individual.
- 76. “Service” means an activity performed as part of medical services, hospital services, nursing services, emergency services, health-related services, hospice services, home health services, or supportive services.
- 77. “Supportive services” means the same as in A.R.S. § 36-151.
- 78. “Transfer” means discharging an individual from a health care institution so the individual may be admitted to another health care institution.
- 79. “Trauma center” means the same as in:
 - a. A.R.S. § 36-2201, or
 - b. A.R.S. § 36-2225.
- 80. “Treatment” means the same as in A.A.C. R9-10-101.
- 81. “Type of” means a specific subcategory of the following that is provided, enumerated, or utilized by a health care institution:
 - a. An employee or contracted worker;
 - b. An accounting concept, such as asset, liability, or revenue;
 - c. A non-covered ancillary charge;
 - d. A payer source;
 - e. A charge source;
 - f. A medical condition; or
 - g. A service.
- 82. “Type of bed” means a category of available bed that specifies the services provided to an individual occupying the available bed.
- 83. “Unit” means an area within a health care institution that is designated by the health care institution to provide a specific type of service.
- 84. “Unit of service” means a procedure, service, commodity, or other item or group of items provided to a patient or resident for which a health care institution bills a payer source a specific amount.
- 85. “Written notice” means a document that is provided:
 - a. In person.
 - b. By delivery service.
 - c. By facsimile transmission.
 - d. By electronic mail, or
 - e. By mail.

**ARTICLE 2. UNIFORM ACCOUNTING SYSTEM
ANNUAL FINANCIAL STATEMENTS AND UNIFORM ACCOUNTING REPORTS**

R9-11-201. ~~Annual Filing of Operating Statements and Reports Definitions~~

- A.** ~~Every hospital, nursing care institution and inpatient hospice shall submit to the Director not later than 120 days following the institution’s fiscal year end the following statements and reports for the reporting year:~~
 - 1. ~~Hospitals shall file:~~
 - a. ~~A report of an audit by an independent certified public accountant conducted in accordance with generally accepted auditing standards in the format defined in A.R.S. § 36-125.04(B).~~
 - b. ~~A copy of the hospital’s annual Medicare Cost Report.~~
 - e. ~~A copy of the uniform accounting report pursuant to R9-11-202.~~
 - 2. ~~Nursing care institutions (NCI) shall submit a completed Arizona Reporting System for Nursing Institutional Costs (ARSNIC) forms set as their uniform accounting report, and a copy of the annual Medicare Cost Report. The ARSNIC report shall be submitted to the Department in electronic and paper copy format.~~
 - 3. ~~Inpatient Hospice: Revenue, patient statistics, and expenses related to operating an inpatient hospice shall be delineated either in the Medicare Cost Report for Hospitals or ARSNIC for Nursing Care Institutions.~~
- B.** ~~The Director may grant a 30-day extension in writing in advance of the due date of any required reports. The health care facility shall request such extension in writing at least 30 days prior to the due date pursuant to A.R.S. § 36-125.04. The request for extension of time shall include the following:~~
 - 1. ~~Name and address of the facility;~~
 - 2. ~~Reason for the request;~~
 - 3. ~~Requested due date;~~
 - 4. ~~Name(s) of the operating statements or reports for which an extension is being requested.~~

In this Article, unless otherwise specified:

1. “Accredited” means the same as in A.R.S. § 36-422.
2. “ALTCS” means the Arizona Long-term Care System established under A.R.S. § 36-2932.
3. “Asset” means the same as “asset” in generally accepted accounting principles.
4. “Assisted living facility-based hospice” means a hospice that operates as a part of an assisted living facility.
5. “Audit” means the same as “audit” in generally accepted accounting principles.
6. “Bereavement services” means activities provided by or on behalf of a hospice to the family or friends of an individual that are intended to comfort the family or friends before and after the individual’s death.
7. “Building improvement” means an addition to or reconstruction, removal, or replacement of any portion or component of an existing building that affects licensed capacity, increases the useful life of an available bed, or enhances resident safety.
8. “Caseload” means the number of assigned patients for which an individual working for a hospice is to provide hospice services.
9. “Certified nursing assistant” means the same as “nursing assistant” in A.R.S. § 32-1601.
10. “Chaplain” means an individual trained to offer support, prayer, and spiritual guidance to a patient and the patient’s family.
11. “Continuous care” means hospice services provided in a patient’s residence to a patient who requires nursing services to be available 24 hours a day.
12. “Contracted worker” means an individual who:
 - a. Performs:
 - i. Hospital services in a hospital.
 - ii. Nursing services or health-related services in a nursing care institution.
 - iii. Hospice services for a hospice, or
 - iv. Labor as a medical record coder or transcriptionist for a hospital; and
 - b. Is paid by a person with whom the hospital, nursing care institution, or hospice has a written agreement to provide hospital services, nursing services, health-related services, hospice services, or medical record coder or transcriptionist labor.
13. “Covered services” means hospice services that are provided to an individual by a hospice and are paid for by a payer source.
14. “Daily census” means a count of the number of patients to whom hospice services were provided during a 24-hour period.
15. “Direct care” means services provided to a resident that require hands-on contact with the resident.
16. “Direction” means the same as in A.R.S. § 36-401.
17. “Employee” means an individual other than a contracted worker who works for a health care institution for compensation and provides or assists in the provision of a service to patients or residents.
18. “Employee-related expenses” means costs incurred by an employer to pay for the employer’s portion of Social Security taxes, Medicare taxes, and other costs such as health insurance.
19. “Equity” means the same as “equity” in generally accepted accounting principles.
20. “Expense” means the same as “expense” in generally accepted accounting principles.
21. “Free-standing” means that a health care institution does not operate as part of another health care institution.
22. “FTE” means full-time equivalent position, which is a job for which a health care institution expects to pay an individual for 2,080 hours per year.
23. “Generally accepted accounting principles” means the set of financial reporting standards administered by the Financial Accounting Standards Board, the Governmental Accounting Standards Board, or other specialized bodies dealing with accounting and auditing matters.
24. “Health professional” means the same as in A.R.S. § 32-3201.
25. “Home health agency-based hospice” means a hospice that operates as part of a home health agency.
26. “Hospice administrator” means the chief administrative officer for a hospice.
27. “Hospice chief financial officer” means an individual who is responsible for the financial records of a hospice.
28. “Hospice inpatient facility” means the same as in A.A.C. R9-10-801.
29. “Hospice service” means the same as in A.A.C. R9-10-801.
30. “Hospice service agency” means the same as in A.R.S. § 36-401.
31. “Hospital-based hospice” means a hospice that operates as a part of a hospital.
32. “Income” means the same as “income” in generally accepted accounting principles.
33. “Inpatient services” means the same as in A.A.C. R9-10-801.
34. “Inpatient surgery” means surgery that requires a patient to receive inpatient services in a hospital.
35. “Level of care” means a designation that indicates the scope of medical services, nursing services, and health-related services that are provided to a patient or resident.
36. “Liability” means the same as “liability” in generally accepted accounting principles.

Notices of Final Rulemaking

37. "Licensed nurse" means a registered nurse practitioner, registered nurse, or practical nurse.
38. "Licensee" means the same as in R9-10-101.
39. "Median length of stay" means the midpoint in the number of patient care days for all patients who were discharged from a hospice during a specific period of time.
40. "Medicaid" means a federal health insurance program, administered by states, for individuals who meet specific income criteria established, in Arizona, by AHCCCS.
41. "Medical record coder" means an individual who assigns codes to a patient's diagnoses and procedures for billing purposes.
42. "Medical record transcriptionist" means an individual who copies and edits dictation from medical practitioners into medical records.
43. "Medical records" mean the same as in A.R.S. § 12-2291.
44. "Medicare cost report" means the annual financial and statistical documents submitted to the United States Department of Health and Human Services as required by Title XVIII of the Social Security Act.
45. "Medicare-certified" means that a health care institution is authorized by the United States Department of Health and Human Services to bill Medicare for services provided to patients or residents who are eligible to receive Medicare.
46. "Midnight census" means a count of the number of patients or residents in a health care institution at 12:00 a.m.
47. "Net assets" means the same as "net assets" in generally accepted accounting principles.
48. "Non-covered ancillary services" means activities, such as rehabilitation services, laboratory tests, or x-rays, provided to an individual in a health care institution that are paid for by:
 - a. A payer source other than ALTCS, or
 - b. ALTCS to an entity that is not a health care institution.
49. "Nursery patient" means a newborn who was born in a hospital and not admitted to a type of bed that is counted toward the hospital's licensed capacity.
50. "Nursing care institution-based hospice" means a hospice that operates as a part of a nursing care institution.
51. "Nursing personnel" means the individuals authorized by a health care institution to provide nursing services to a patient or resident.
52. "Occupancy rate" means the midnight census divided by the number of available beds, expressed as a percent.
53. "Operating expense" means the same as "operating expense" in generally accepted accounting principles.
54. "Outpatient hospice services" means hospice services provided at a location outside a hospice inpatient facility.
55. "Outpatient surgery" means surgery that does not require a patient to receive inpatient services in a hospital.
56. "Owner" means the same as in A.A.C. R9-10-101.
57. "Patient care day" means a calendar day during which a hospice provides hospice services to a patient.
58. "Patient day" means a period during which a patient received inpatient services with:
 - a. The time between the midnight census on two successive calendar days counting as one period, and
 - b. The day of discharge being counted only when the patient is admitted and discharged on the same day.
59. "Person" means the same as in A.R.S. § 41-1001.
60. "Practical nurse" means an individual licensed under A.R.S. Title 32, Chapter 15, Article 2, to practice practical nursing, as defined in A.R.S. § 32-1601.
61. "Registered nurse" means an individual licensed under A.R.S. Title 32, Chapter 15, Article 2, to practice professional nursing, as defined in A.R.S. § 32-1601.
62. "Rehabilitation services" means the same as in A.A.C. R9-10-201.
63. "Resident day" means a period during which a resident received nursing services or health-related services provided by a nursing care institution with:
 - a. The time between the midnight census on two successive calendar days counting as one period, and
 - b. The day of discharge being counted only when the resident is admitted and discharged on the same day.
64. "Respite care services" means the same as in A.R.S. § 36-401.
65. "Revenue" means the same as "revenue" in generally accepted accounting principles.
66. "Routine home care" means hospice services provided in a patient's residence to a patient who does not require nursing services to be available 24 hours a day.
67. "Rural" means the same as in A.R.S. § 36-2171.
68. "Self-pay" means that charges for hospice services are billed to an individual.
69. "Social worker" means an individual licensed according to A.R.S. §§ 32-3291, 32-3292, or 32-3293.
70. "Statement of cash flows" means the same as "statement of cash flows" in generally accepted accounting principles.
71. "Surgery" means the excision of a part of a patient's body or the incision into a patient's body for the correction of a deformity or defect; repair of an injury; or diagnosis, amelioration, or cure of disease.
72. "Turnover rate" means:
 - a. For a hospital, a percent calculated by dividing the number of individuals employed by the hospital who resign or retire from or are dismissed by the hospital during a reporting period by the average number of individuals employed during the reporting period; or

Notices of Final Rulemaking

- b. For a nursing care institution, a percent calculated by dividing the number of employees who resign or retire from or are dismissed by a nursing care institution during a reporting period by the average number of employees during the reporting period.
- 73. “Uniform accounting report” means a document that meets the requirements of A.R.S. § 36-125.04 and contains the information required in R9-11-203 for hospitals, R9-11-204 for nursing care institutions, and R9-11-205 for hospices.
- 74. “Unscheduled medical services” means the same as in A.R.S. § 36-401.
- 75. “Urban” means an area not defined as “rural.”
- 76. “Urgent care unit” means a facility under a hospital’s license that is:
 - a. Located within one-half mile of the hospital, and
 - b. Designated by the hospital for the provision of unscheduled medical services for medical conditions that are of a less critical nature than emergency medical conditions.
- 77. “Vacancy rate” means a percent calculated by dividing the number of unfilled FTEs at the end of a hospital’s reporting period by the sum of the unfilled FTEs and filled FTEs at the end of the hospital’s reporting period.
- 78. “Volunteer” means the same as in A.A.C. R9-10-801.

R9-11-202. Expired Hospital Annual Financial Statement

- A.** A hospital administrator or designee shall submit to the Department, no later than 120 calendar days after the ending date of the hospital’s fiscal year:
 - 1. An annual financial statement prepared according to generally accepted accounting principles, and
 - 2. A report of an audit by an independent certified public accountant of the annual financial statement required in subsection (A)(1).
- B.** If a hospital is part of a group of health care institutions that prepares a combined annual financial statement and is included in the combined annual financial statement, the hospital administrator or designee may submit the combined annual financial statement if the combined annual financial statement:
 - 1. Is prepared according to generally accepted accounting principles.
 - 2. Identifies the hospital, and
 - 3. Contains a financial statement specific to the hospital.
- C.** The Department shall grant a hospital a 30-day extension for submitting an annual financial statement and audit of the annual financial statement required in subsection (A) if the hospital administrator or designee submits a written request for an extension that:
 - 1. Includes the name, physical address, mailing address, and telephone number of the hospital;
 - 2. Includes the name, telephone number, mailing address, and e-mail address of:
 - a. The hospital administrator; and
 - b. An individual, in addition to the hospital administrator, who may be contacted about the extension request;
 - 3. Includes the date the hospital’s annual financial statement and audit of the annual financial statement is due to the Department;
 - 4. Specifies that the hospital is requesting a 30-day extension from submitting the annual financial statement and audit of the annual financial statement required in subsection (A); and
 - 5. Is submitted to the Department at least 30 calendar days before the annual financial statement and audit of the annual financial statement is due to the Department.
- D.** The Department shall send a written notice of approval of a 30-day extension to a hospital that submits a request for an extension that meets the requirements specified in subsection (C) within seven business days after receiving the request.
- E.** If a request by a hospital administrator or designee for a 30-day extension does not meet the requirements specified in subsection (C), the Department shall provide to the hospital a written notice that specifies the missing or incomplete information. If the Department does not receive the missing or incomplete information within 10 calendar days after the date on the written notice, the Department shall consider the hospital’s request withdrawn.
- F.** Before the end of the 30-day extension specified in subsection (C), a hospital administrator or designee may request an additional extension for submitting an annual financial statement and audit of the annual financial statement by submitting a written request that:
 - 1. Includes the information specified in subsections (C)(1) through (C)(3).
 - 2. Specifies for how many calendar days the hospital is requesting an extension from submitting the annual financial statement and audit of the annual financial statement.
 - 3. Is submitted to the Department at least 14 calendar days before the annual financial statement and audit of the annual financial statement is due to the Department, and
 - 4. Includes the reasons for the additional extension request.
- G.** In determining whether to approve or deny a request for a hospital to receive an additional extension as specified in subsection (F) for submitting an annual financial statement and audit of the annual financial statement, the Department shall consider the following:
 - 1. The reasons for the additional extension request provided according to subsection (F)(4);
 - 2. The length of time for which the additional extension is being requested according to subsection (F)(2); and

Notices of Final Rulemaking

3. If the hospital has a history of the following items:
 - a. Repeated violations of the same statutes or rules.
 - b. Patterns of noncompliance with statutes or rules.
 - c. Types of violations of statutes or rules.
 - d. Total number of violations of statutes or rules.
 - e. Length of time during which violations of statutes or rules have been occurring, and
 - f. Noncompliance with an agreement between the Department and the hospital.
- H. The Department shall send written notice of approval or denial to a hospital that requests an additional extension specified in subsection (F) for submitting an annual financial statement and audit of the annual financial statement within seven business days after receiving the request.
- I. If the Department denies a request for an additional extension specified in subsection (F), a hospital may appeal the denial according to A.R.S. Title 41, Chapter 6, Article 10.
- J. If a hospital administrator or designee does not submit an annual financial statement and a report of an audit of the annual financial statement according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

R9-11-203. Expired Hospital Uniform Accounting Report

- A. A hospital administrator or designee shall submit a uniform accounting report to the Department, in a format specified by the Department, no later than 150 calendar days after the ending date of the hospital's fiscal year.
- B. A hospital administrator or designee shall submit a copy of the hospital's Medicare cost report, if applicable, as part of the uniform accounting report required in subsection (A).
- C. The uniform accounting report required in subsection (A) shall include the following information:
 1. The name, physical address, mailing address, county, and telephone number of the hospital;
 2. The name, telephone number, and e-mail address of the:
 - a. Hospital administrator;
 - b. Hospital chief financial officer, and
 - c. Individual who prepared the uniform accounting report;
 3. The identification number assigned to the hospital:
 - a. By the Department;
 - b. By AHCCCS, if applicable;
 - c. By Medicare, if applicable; and
 - d. As the hospital's national provider identifier;
 4. The hospital's classification;
 5. Whether the entity that is the owner of the hospital is:
 - a. Not for profit;
 - b. For profit; or
 - c. A federal, state, or local government agency;
 6. Whether or not the hospital is Medicare-certified;
 7. The ending date of the hospital's reporting period;
 8. If the hospital began operations during the hospital's reporting period, the date on which the hospital began operations;
 9. The date the uniform accounting report was submitted to the Department;
 10. The licensed capacity, for each type of bed, at the end of the reporting period;
 11. The licensed capacity at the end of the reporting period;
 12. The number of available beds, for each type of bed, at the end of the reporting period;
 13. The number of available beds at the end of the reporting period;
 14. The number of admissions, for each type of bed, during the reporting period;
 15. The total number of admissions during the reporting period;
 16. The total number of patient days:
 - a. During the reporting period, and
 - b. For each type of bed during the reporting period;
 17. The average occupancy rate for the reporting period;
 18. The number of inpatient surgeries during the reporting period;
 19. The number of outpatient surgeries during the reporting period;
 20. The number of births during the reporting period;
 21. The number of nursery patient admissions during the reporting period;
 22. The number of patient days for nursery patients during the reporting period;
 23. The number of episodes of care during the reporting period provided by the:
 - a. Emergency department,
 - b. Urgent care unit, and
 - c. Trauma center;

Notices of Final Rulemaking

24. The total number of episodes of care during the reporting period provided by the emergency department, urgent care unit, or trauma center;
25. The number of episodes of care in the emergency department, urgent care unit, or trauma center during the reporting period for which the patient was subsequently admitted to the hospital;
26. The total number of FTEs at the end of the reporting period;
27. The turnover rate for the reporting period;
28. The vacancy rate for the reporting period;
29. The number of FTEs, for each type of employee, during the reporting period;
30. The vacancy rate, for each type of employee, for the reporting period;
31. The number of medical record coder FTEs during the reporting period;
32. The vacancy rate for medical record coders for the reporting period;
33. The number of medical record transcriptionist FTEs during the reporting period;
34. The vacancy rate for medical record transcriptionists for the reporting period;
35. For individuals who worked for the hospital as contracted workers during the reporting period, the number of hours worked by registered nurses;
36. The amount of revenue generated, for each type of revenue, by the hospital during the reporting period;
37. The amount of allowances given, for each type of allowance, by the hospital during the reporting period;
38. The total amount of revenue generated and allowances given by the hospital during the reporting period;
39. The operating expenses incurred, for each type of operating expense, by the hospital during the reporting period;
40. The total operating expenses incurred by the hospital during the reporting period;
41. The difference between the amount identified in subsection (C)(38) and the amount identified in subsection (C)(40);
42. The income and expenses, other than revenue and operating expenses, for each type of income received and expense incurred by the hospital during the reporting period;
43. The amount of assets, for each type of asset, of the hospital at the end of the reporting period;
44. The total amount of assets of the hospital at the end of the reporting period;
45. The amount of liabilities, for each type of liability, of the hospital at the end of the reporting period;
46. The total amount of liabilities of the hospital at the end of the reporting period;
47. The amount of net assets, for each type of net asset, of the hospital at the end of the reporting period;
48. The total amount of net assets of the hospital at the end of the reporting period;
49. The difference between the amount identified in subsection (C)(48) and the amount identified in subsection (C)(46); and
50. The statement of cash flows required in A.R.S. § 36-125.04(C)(3), unless the statement of cash flows has been submitted as part of the annual financial statement required in R9-11-202.

D. A hospital administrator or designee shall:

1. On a form provided by the Department:
 - a. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (B) and (C) is accurate and complete; or
 - b. If the hospital administrator or designee has personal knowledge that the information submitted according to subsections (B) and (C) is not accurate or not complete:
 - i. Identify the information that is not accurate or not complete;
 - ii. Describe the circumstances that make the information not accurate or not complete;
 - iii. State what actions the hospital is taking to correct the inaccurate information or make the information complete; and
 - iv. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (B) and (C), except the information identified in subsection (D)(1)(b)(i), is accurate and complete; and
2. Submit the form specified in subsection (D)(1) as part of the uniform accounting report required in subsection (A).

E. A hospital administrator who receives a request from the Department for revision of a uniform accounting report not prepared according to subsections (B), (C), and (D) shall ensure that the revised uniform accounting report is submitted to the Department:

1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
2. Within seven calendar days after the date on the Department's letter requesting a second revision.

F. If a hospital administrator or designee does not submit a uniform accounting report according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

R9-11-204. Reserved Nursing Care Institution Uniform Accounting Report

A. A nursing care institution administrator or designee shall submit a uniform accounting report to the Department, in a format specified by the Department, no later than 150 calendar days after the ending date of the nursing care institution's fiscal year.

B. A nursing care institution administrator or designee shall submit a copy of the nursing care institution's Medicare cost

Notices of Final Rulemaking

report, if applicable, as part of the uniform accounting report required in subsection (A).

- C.** The uniform accounting report required in subsection (A) shall include the following information:
1. The name, physical address, mailing address, county, and telephone number of the nursing care institution;
 2. The name, physical address, mailing address, and telephone number of the nursing care institution's:
 - a. Home office, if applicable; and
 - b. Management company, if applicable;
 3. An alternative name under which the nursing care institution provides nursing services or health-related services, if applicable;
 4. The identification number assigned to the nursing care institution:
 - a. By the Department;
 - b. By AHCCCS, if applicable;
 - c. By Medicare, if applicable; and
 - d. As the nursing care institution's national provider identifier;
 5. The name, telephone number, and e-mail address of the:
 - a. Nursing care institution administrator;
 - b. Nursing care institution chief financial officer;
 - c. Individual who prepared the uniform accounting report; and
 - d. Individual whom the Department may contact about the uniform accounting report at the:
 - i. Home office, if applicable; and
 - ii. Management company, if applicable;
 6. The beginning and ending dates of the nursing care institution's reporting period;
 7. If the nursing care institution began operations during the nursing care institution's reporting period, the date on which the nursing care institution began operations;
 8. The date the uniform accounting report was submitted to the Department;
 9. Whether the entity that is the owner of the nursing care institution is:
 - a. Not for profit;
 - b. For profit; or
 - c. A federal, state, or local government agency;
 10. Whether or not the nursing care institution is Medicare-certified;
 11. The licensed capacity at the beginning and end of the reporting period;
 12. The total number of available beds at the beginning and end of the reporting period;
 13. If the nursing care institution has a distinct unit for patients whose payer source is Medicare, the number of licensed beds in that unit at the beginning and end of the reporting period;
 14. The number of resident admissions during the reporting period;
 15. The number of resident days during the reporting period:
 - a. For each payer source that is not ALTCS, and
 - b. For each level of care for residents whose payer source is ALTCS;
 16. The total number of resident days during the reporting period;
 17. The average occupancy rate for the reporting period;
 18. The number of paid hours during the reporting period for each of the following types of employees:
 - a. Registered nurses,
 - b. Practical nurses, and
 - c. Certified nursing assistants;
 19. The number of hours worked during the reporting period by each of the following types of employees:
 - a. Registered nurses,
 - b. Practical nurses, and
 - c. Certified nursing assistants;
 20. The amount in salaries paid, excluding employee-related expenses, for each of the following types of employees:
 - a. Registered nurses,
 - b. Practical nurses, and
 - c. Certified nursing assistants;
 21. The number of each of the following types of employees at the beginning of the reporting period:
 - a. Registered nurses,
 - b. Practical nurses, and
 - c. Certified nursing assistants;
 22. The number of each of the following types of employees at the end of the reporting period:
 - a. Registered nurses,
 - b. Practical nurses, and
 - c. Certified nursing assistants;

Notices of Final Rulemaking

23. For staff employed by the nursing care institution during the reporting period as registered nurses, practical nurses, or certified nursing assistants, the total:
 - a. Number of paid hours;
 - b. Number of hours worked;
 - c. Amount in salaries paid, excluding employee-related expenses;
 - d. Number of staff at the beginning of the reporting period; and
 - e. Number of staff at the end of the reporting period;
24. The turnover rate for the reporting period for:
 - a. Registered nurses,
 - b. Practical nurses, and
 - c. Certified nursing assistants;
25. The total turnover rate for the reporting period for all employees of the nursing care institution who are registered nurses, practical nurses, or certified nursing assistants;
26. The number of hours worked during the reporting period by each of the following types of contracted workers:
 - a. Registered nurses,
 - b. Practical nurses, and
 - c. Certified nursing assistants;
27. The total number of hours worked during the reporting period by contracted workers who are registered nurses, practical nurses, or certified nursing assistants;
28. The amount paid during the reporting period for each of the following types of contracted workers:
 - a. Registered nurses,
 - b. Practical nurses, and
 - c. Certified nursing assistants;
29. The total amount paid during the reporting period to contracted workers who are registered nurses, practical nurses, or certified nursing assistants;
30. The amount of revenue generated and allowances given, for each type of revenue or allowance, by the nursing care institution during the reporting period;
31. The total amount of revenue generated and allowances given by the nursing care institution during the reporting period;
32. The operating expenses incurred by the nursing care institution during the reporting period for each type of operating expense;
33. The total operating expenses incurred by the nursing care institution during the reporting period;
34. The income and expenses, other than revenue and operating expenses, for each type of income received and expense incurred by the nursing care institution during the reporting period;
35. The charges for non-covered ancillary services during the reporting period:
 - a. For each type of non-covered ancillary service,
 - b. For each type of payer source, and
 - c. For each type of non-covered ancillary service for each type of payer source;
36. The total amount of non-covered ancillary charges for the reporting period;
37. If the nursing care institution has documentation of building improvement costs that:
 - a. Affected the licensed capacity:
 - i. The year in which each building improvement was completed;
 - ii. The cost of each building improvement;
 - iii. The licensed capacity before the building improvement was begun;
 - iv. The number of beds that were added as a result of the building improvement, if applicable;
 - v. The number of beds that were removed as a result of the building improvement, if applicable; and
 - vi. The licensed capacity after the building improvement was completed; and
 - b. Did not affect the licensed capacity:
 - i. The year in which each building improvement was completed; and
 - ii. The cost of each building improvement;
38. The amount of assets, for each type of asset, of the nursing care institution at the end of the reporting period;
39. The total amount of assets of the nursing care institution at the end of the reporting period;
40. The amount of liabilities, for each type of liability, of the nursing care institution at the end of the reporting period;
41. The total amount of liabilities of the nursing care institution at the end of the reporting period;
42. The amount of equity, for each type of equity, of the nursing care institution at the end of the reporting period;
43. The total amount of equity of the nursing care institution at the end of the reporting period;
44. The difference between the amount identified in subsection (C)(43) and the amount identified in subsection (C)(41); and
45. An equity reconciliation statement, including:

Notices of Final Rulemaking

- a. Net equity at the beginning of the reporting period;
 - b. The difference between the amount identified in subsection (C)(31) and the amount identified in subsection (C)(33);
 - c. Additions to equity, for each type of additional equity, for the reporting period;
 - d. The total amount of additional equity for the reporting period;
 - e. Deductions from equity, for each type of equity deduction, for the reporting period;
 - f. The total amount of equity deduction for the reporting period; and
 - g. Net equity at the end of the reporting period.
- D.** A nursing care institution administrator or designee shall:
- 1. On a form provided by the Department:
 - a. Attest that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (B) and (C) is accurate and complete; or
 - b. If the nursing care institution administrator or designee has personal knowledge that the information submitted according to subsections (B) and (C) is not accurate or not complete:
 - i. Identify the information that is not accurate or not complete;
 - ii. Describe the circumstances that make the information not accurate or not complete;
 - iii. State what actions the nursing care institution is taking to correct the inaccurate information or make the information complete; and
 - iv. Attest that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (B) and (C), except the information identified in subsection (D)(1)(b)(i), is accurate and complete; and
 - 2. Submit the form specified in subsection (D)(1) as part of the uniform accounting report required in subsection (A).
- E.** A nursing care institution administrator who receives a request from the Department for revision of a uniform accounting report not prepared according to subsections (B), (C), and (D) shall ensure that the revised uniform accounting report is submitted to the Department:
- 1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
 - 2. Within seven calendar days after the date on the Department's letter requesting a second revision.
- F.** If a nursing care institution administrator or designee does not submit a uniform accounting report according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

R9-11-205. ~~Reserved~~ Hospice Uniform Accounting Report

- A.** A hospice administrator or designee shall submit a uniform accounting report to the Department, in a format specified by the Department, within 150 calendar days after the end of the hospice's fiscal year.
- B.** A hospice administrator or designee shall submit a copy of the hospice's Medicare and Medicaid cost reports, if applicable, as part of the uniform accounting report required in subsection (A).
- C.** The uniform accounting report required in subsection (A) shall include the following information:
- 1. The name, physical address, mailing address, county, and telephone number of the hospice;
 - 2. The identification number assigned to the hospice:
 - a. By the Department;
 - b. By AHCCCS, if applicable;
 - c. By Medicare, if applicable; and
 - d. As the hospice's national provider identifier;
 - 3. The beginning and ending dates of the hospice's reporting period;
 - 4. If the hospice began operations during the hospice's reporting period, the date on which the hospice began operations;
 - 5. The name, telephone number, and e-mail address of the:
 - a. Hospice administrator,
 - b. Hospice chief financial officer, and
 - c. Individual who prepared the uniform accounting report;
 - 6. The date the uniform accounting report was submitted to the Department;
 - 7. Whether the hospice operates as a:
 - a. Hospice service agency, or
 - b. Hospice service agency with one or more hospice inpatient facilities;
 - 8. Whether the entity that is the owner of the hospice is:
 - a. Not for profit;
 - b. For profit; or
 - c. A federal, state, or local government agency;
 - 9. Whether or not the hospice is Medicare-certified;
 - 10. The entity by which the hospice is accredited, if applicable;
 - 11. Whether the hospice provides hospice services in an area that:
 - a. Is equal to or more than two-thirds urban,

Notices of Final Rulemaking

- b. Is equal to or more than two-thirds rural, or
- c. Is less than two-thirds urban and less than two-thirds rural;
- 12. Whether the hospice is:
 - a. Free-standing,
 - b. A hospital-based hospice,
 - c. A nursing care institution-based hospice,
 - d. An assisted living facility-based hospice, or
 - e. A home health agency-based hospice;
- 13. If the hospice operates one or more hospice inpatient facilities, list for each hospice inpatient facility:
 - a. The identification number assigned to the hospice inpatient facility by the Department;
 - b. Whether the hospice inpatient facility is:
 - i. Located within a hospital;
 - ii. Located within a nursing care institution;
 - iii. Located within an assisted living facility; or
 - iv. Not located within a hospital, nursing care institution, or assisted living facility;
 - c. The levels of care provided;
 - d. The licensed capacity of the hospice inpatient facility;
 - e. The total number of available beds at the beginning and end of the reporting period; and
 - f. The average occupancy rate for the reporting period;
- 14. The number of patients during the reporting period that were:
 - a. Referred to the hospice,
 - b. Admitted to the hospice,
 - c. Died while admitted to the hospice, and
 - d. Discharged from the hospice while living;
- 15. The number of patient care days, for all patients, during the reporting period in which the hospice provided:
 - a. Routine home care,
 - b. Respite care services,
 - c. Continuous care, and
 - d. Inpatient services;
- 16. The total number of patient care days during the reporting period for all patients;
- 17. The average daily census for the reporting period, calculated as the number specified in subsection (C)(16) divided by the number of days in the reporting period;
- 18. Average length of stay, calculated as the number of patient care days for patients discharged during the reporting period divided by the sum of the numbers specified in subsections (C)(14)(c) and (C)(14)(d);
- 19. Median length of stay for patients discharged during the reporting period;
- 20. The number of patients admitted to the hospice during the reporting period:
 - a. By gender;
 - b. By age group;
 - c. By race and ethnicity;
 - d. From:
 - i. A private home owned or leased by, or on behalf of, a patient;
 - ii. An assisted living facility;
 - iii. A nursing care institution;
 - iv. A hospital; and
 - v. A hospice;
 - e. With a principal diagnosis of:
 - i. Cancer,
 - ii. Heart disease,
 - iii. Dementia,
 - iv. Lung disease,
 - v. Kidney disease,
 - vi. Stroke or coma,
 - vii. Liver disease,
 - viii. HIV-related disease,
 - ix. Motorneuron disorder,
 - x. Unspecified debility, and
 - xi. A disease not specified in subsections (C)(20)(e)(i) through (C)(20)(e)(x); and
 - f. Whose payer source is:
 - i. Medicare,

Notices of Final Rulemaking

- ii. AHCCCS.
 - iii. Self-pay.
 - iv. A private insurance company, and
 - v. A payer source not specified in subsections (C)(20)(f)(i) through (C)(20)(f)(iv);
21. The total number of patient care days during the reporting period that the hospice provided hospice services to a patient whose principal diagnosis was related to:
- a. Cancer.
 - b. Heart disease.
 - c. Dementia.
 - d. Lung disease.
 - e. Kidney disease.
 - f. Stroke or Coma.
 - g. Liver disease.
 - h. HIV-related disease.
 - i. Motoneuron disorder.
 - j. Unspecified debility, and
 - k. Any other disease not specified in subsections (C)(21)(a) through (C)(21)(j);
22. The number of FTEs providing hospice services, for each type of employee, during the reporting period;
23. The total number of FTEs providing hospice services during the reporting period;
24. The average caseload during the reporting period for a licensed nurse, calculated as the total number of patients assigned to licensed nurses working for the hospice during the reporting period, divided by the total number of licensed nurses working for the hospice during the reporting period, for:
- a. Outpatient hospice services, and
 - b. Hospice services provided in hospice inpatient facilities;
25. The average caseload during the reporting period for a social worker, calculated as the total number of patients assigned to social workers working for the hospice during the reporting period, divided by the total number of social workers working for the hospice during the reporting period, for:
- a. Outpatient hospice services, and
 - b. Hospice services provided in hospice inpatient facilities;
26. The average caseload during the reporting period for nursing personnel other than a licensed nurse, calculated as the total number of patients assigned to nursing personnel other than licensed nurses working for the hospice during the reporting period, divided by the total number of nursing personnel other than licensed nurses working for the hospice during the reporting period, for:
- a. Outpatient hospice services, and
 - b. Hospice services provided in hospice inpatient facilities;
27. The average caseload during the reporting period for a chaplain, calculated as the total number of patients assigned to chaplains working for the hospice during the reporting period, divided by the total number of chaplains working for the hospice during the reporting period, for:
- a. Outpatient hospice services, and
 - b. Hospice services provided in hospice inpatient facilities;
28. The number of individuals who received bereavement services from the hospice during the reporting period;
29. The number of individuals from the hospice who provided bereavement services during the reporting period;
30. The total number of volunteers during the reporting period;
31. The total number of hours that volunteers provided hospice services during the reporting period;
32. The number of patient care days during the reporting period, for whom:
- a. The payer source was:
 - i. Medicare.
 - ii. AHCCCS.
 - iii. Self-pay.
 - iv. A private insurance company, and
 - v. A payer source not specified in subsections (C)(32)(a)(i) through (C)(32)(a)(iv), and
 - b. There was no payer source identified;
33. The total number of patient care days specified in subsections (C)(32);
34. The total amount of money billed, during the reporting period to:
- a. Medicare.
 - b. AHCCCS.
 - c. Self-pay.
 - d. A private insurance company, and
 - e. A payer source not specified in subsections (C)(34)(a) through (C)(34)(d);

Notices of Final Rulemaking

- 35. The total amount of money billed during the reporting period;
 - 36. The amount of revenue generated, for each type of revenue, by the hospice during the reporting period;
 - 37. The amount of allowances given, for each type of allowance, by the hospice during the reporting period;
 - 38. The total amount of revenue generated and allowances given by the hospice during the reporting period;
 - 39. The operating expenses incurred, for each type of operating expense, by the hospice during the reporting period;
 - 40. The total operating expenses incurred by the hospice during the reporting period;
 - 41. The difference between the amount identified in subsection (C)(38) and the amount identified in subsection (C)(40);
 - 42. The income and expenses, other than revenue and operating expenses, for each type of income received and expense incurred by the hospice during the reporting period;
 - 43. The amount of assets, for each type of asset, of the hospice at the end of the reporting period;
 - 44. The total amount of assets of the hospice at the end of the reporting period;
 - 45. The amount of liabilities, for each type of liability, of the hospice at the end of the reporting period;
 - 46. The total amount of liabilities of the hospice at the end of the reporting period;
 - 47. The amount of net assets, for each type of net asset, of the hospice at the end of the reporting period;
 - 48. The total amount of net assets of the hospice at the end of the reporting period;
 - 49. The difference between the amount identified in subsection (C)(48) and the amount identified in subsection (C)(46);
and
 - 50. The statement of cash flows required in A.R.S. § 36-125.04(C)(3).
- D.** A hospice administrator or designee shall:
- 1. On a form provided by the Department:
 - a. Attest that, to the best of the knowledge and belief of the hospice administrator or designee, the information submitted according to subsections (B) and (C) is accurate and complete; or
 - b. If the hospice administrator or designee has personal knowledge that the information submitted according to subsections (B) and (C) is not accurate or not complete:
 - i. Identify the information that is not accurate or not complete;
 - ii. Describe the circumstances that make the information not accurate or not complete;
 - iii. State what actions the hospice is taking to correct the inaccurate information or make the information complete; and
 - iv. Attest that, to the best of the knowledge and belief of the hospice administrator or designee, the information submitted according to subsections (B) and (C), except the information identified in subsection (D)(1)(b)(i), is accurate and complete; and
 - 2. Submit the form specified in subsection (D)(1) as part of the uniform accounting report required in subsection (A).
- E.** A hospice administrator who receives a request from the Department for revision of a uniform accounting report not prepared according to subsections (B), (C), and (D) shall ensure that the revised uniform accounting report is submitted to the Department:
- 1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
 - 2. Within seven calendar days after the date on the Department's letter requesting a second revision.
- F.** If a hospice administrator or designee does not submit a uniform accounting report according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

ARTICLE 3. RATES AND CHARGES SCHEDULES

R9-11-301. Filing of Rates and Charges Definitions

- A.** ~~Each hospital, nursing care institution, supervisory care facility, and home health agency shall file with the Department all schedules of rates or charges, and other information specified in subsection (F) of this rule. This information shall be regarded as the existing schedule of rates or charges for such institutions.~~
- B.** ~~A new hospital, nursing care institution, supervisory care facility or home health agency shall not engage in business within this state until its schedule of rates or charges has been filed with the Department and reviewed as provided in A.R.S. § 36-436 et seq.~~
- C.** ~~No rate or charge for a new service or procedure shall be implemented by a hospital or nursing care institution until the requirements of A.R.S. § 36-421 and § 36-436 have been completed in accordance with the following:~~
 - 1. ~~Rates or charges for a new service or procedure not requiring a permit pursuant to A.R.S. § 36-421 shall be filed with the Director and accompanied by a per unit cost analysis using direct expense by natural classification, and number of units anticipated over a 12-month period. The Director may issue written findings. Upon submission of all required information, rates will be effective no later than 60 days subsequent to the filing. A schedule of rates and charges for a new service not requiring a permit shall be submitted no more than once quarterly.~~
 - 2. ~~Rates or charges for a new service or procedure requiring a permit pursuant to A.R.S. § 36-421 shall be accompanied by an analysis consisting of two consecutive 12-month periods projecting each of the following elements:~~
 - a. ~~Volume in units,~~
 - b. ~~Gross Revenue,~~

Notices of Final Rulemaking

- e. Deductions from Revenue;
 - d. Direct expenses by natural classification, and
 - e. Indirect expenses.
- D.** No decrease or deletion shall be made by any hospital or nursing care institution in any rate or charge until the proposed decrease or deletion has been filed for informational purposes with the Director.
- E.** Supervisory care and home health agencies shall submit to the Department increases in rates or charges 30 days prior to implementation.
- F.** All schedules of rates or charges required to be filed shall include each service and item for which a separate charge is made. The schedule of rates or charges must contain the following information:
- 1. Facility License Number;
 - 2. Facility Name;
 - 3. Table of contents or record layout that defines the order or sort of the information that would enable the Department to easily locate items by charge code within each department;
 - 4. Department Name and Number;
 - 5. Charge Code;
 - 6. Service description;
 - 7. Existing Charge;
 - 8. Proposed Charge;
 - 9. A copy of all rules, criteria and discounts, such as acuity methodology, pricing rationale, and formulae which may in any way change, affect or determine any part of the aggregate of the rates or charges therein or the value of the services or commodities covered by the schedule.
- G.** The schedule of rates or charges may be submitted in an electronic format if written approval has been granted by the Department prior to submission.
- H.** Charges for expendable items received from an outside supplier (excluding capital items for which the patient does not acquire ownership), which are generally numerous in quantity and subject to frequent cost changes, such as pharmacy or central supply items, may be listed on the schedule of rates and charges in the form of a formula, provided that the formula is adopted as a rule or regulation of the institution. The formula shall include, but is not limited to, the following elements:
- 1. The net purchase cost of the item, which shall reflect all invoiced discounts, allowances or rebates.
 - 2. The percent of cost or dollar markup.
- I.** If the formula method of listing rates and charges is used, the institution is not required to report or file those rate changes resulting exclusively from a change in the net purchase cost of the item to the institution. Any change in other elements of the formula shall constitute a change in the rate schedule and will require filing of the proposed new rate as provided in A.R.S. §§ 36-436.02 and 36-436.03.
- J.** If a charge is priced for outside services rendered by those individuals licensed pursuant to A.R.S. Title 32 or facilities licensed pursuant to A.R.S. Title 36, Article 4, the schedule of rates and charges shall include the pricing policy or formula.
- K.** The effective date of a proposed schedule of rates or charges of a new institution or of a change in the schedule of rates or charges of an existing institution shall be as determined by the institution but not earlier than:
- 1. The date of the findings of the Director, or
 - 2. Sixty days after the date of filing the proposed schedule together with all supporting data required by A.R.S. § 36-436 and subsections (F) through (J) of this Section, whichever occurs first.
- L.** The filing date shall be determined by the Department as defined in R9-11-303 and R9-11-305.
- M.** If increased rates or charges are not reflected on the patient bills along with discounts, if any, within 30 days after the review period has expired, the institution abandons its right to implement the increased schedule of rates or charges unless written consent is granted by the Director prior to the expiration of the 30-day period.

In this Article, unless otherwise specified:

- 1. “Adolescent” means an individual the hospital designates as an adolescent based on the hospital’s criteria.
- 2. “Adult” means the same as in A.A.C. R9-10-201.
- 3. “Behavioral health service” means the same as in A.A.C. R9-20-101.
- 4. “Blood bank cross match” means a laboratory analysis, performed by a facility that stores and preserves donated blood, to test the compatibility of a quantity of blood donated by one individual with another individual who is the intended recipient of the blood.
- 5. “Complete blood count with differential” means enumerating the number of red blood cells, platelets, and white blood cells in a sample of an individual’s blood, and including in the enumeration of white blood cells the number of each type of white blood cell.
- 6. “Contrast medium” means a substance opaque to x-rays, radio waves, or electromagnetic radiation that enhances an image of internal body structures.
- 7. “CT” means Computed Tomography, a diagnostic procedure in which x-ray measurements from many angles are used to provide images of internal body structures.

Notices of Final Rulemaking

8. “Current rates and charges information” means the most recent rates and charges schedule for a health care institution on file with the Department, and all documents changing the most recent rates and charges schedule.
9. “Drug” means the same as in A.R.S. § 32-1901.
10. “EEG” means electroencephalogram, a diagnostic procedure used to measure the electrical activity of the brain.
11. “EKG” means electrocardiogram, a diagnostic procedure used to measure the electrical activity of the heart.
12. “Facility” means a building and associated personnel and equipment that perform a particular service or activity.
13. “Formulary” means a list of drugs that are available to a patient through a hospital.
14. “Home health agency” means the same as in A.R.S. § 36-151.
15. “Home health agency administrator” means the chief administrative officer for a home health agency.
16. “Hospital department” means a subdivision of a hospital providing administrative oversight for one or more charge sources.
17. “Implementation date” means the month, day, and year a health care institution intends to begin using specific rates and charges when billing a patient or resident.
18. “Intensive care bed” means an available bed used to provide intensive care services, as defined in A.A.C. R9-10-201, to a patient.
19. “IVP” means intravenous pyelography, a diagnostic procedure that uses an injection of a contrast medium into a vein and x-rays to provide images of the kidneys, ureters, bladder, and urethra.
20. “Labor and delivery” means services provided to a woman related to childbirth.
21. “Lithotripsy” means a procedure that uses sound waves to break up hardened deposits of mineral salts inside the human body.
22. “Mark-up” means the difference between the dollar amount a hospital pays for a drug, commodity, or service and the charge billed to a patient.
23. “MRI” means Magnetic Resonance Imaging, a diagnostic procedure that uses a magnetic field and radio waves to provide images of internal body structures.
24. “Neonate” means the same as in A.A.C. R9-10-201.
25. “Nursery bed” means an available bed used to provide hospital services to a neonate.
26. “Outpatient treatment center” means the same as in A.A.C. R9-10-101.
27. “Outpatient treatment center administrator” means the chief administrative officer for an outpatient treatment center.
28. “Overview form” means a document:
 - a. Submitted by a hospital to the Department as part of a rates and charges schedule or a change to the hospital’s current rates and charges information, and
 - b. That contains the information required in R9-11-302(B)(2) for the hospital.
29. “Pediatric” means the same as in A.A.C. R9-10-201.
30. “Pediatric bed” means an available bed used to provide hospital services to a pediatric patient.
31. “Physical therapy” means the same as in A.R.S. § 32-2001.
32. “Post-hospital extended care services” means the services that are described in and meet the requirements of 42 CFR 409.31.
33. “Private room” means a room that contains one available bed.
34. “Rate” means a specific dollar amount per unit of service set by a health care institution.
35. “Rates and charges schedule” means a document that meets the requirements of A.R.S. Title 36, Chapter 4, Article 3 and contains the information required in R9-11-302(B) for hospitals, R9-11-303(A)(2) for nursing care institutions, R9-11-304(A)(2) for home health agencies, or R9-11-305(A)(2) for outpatient treatment centers.
36. “Rehabilitation bed” means a type of bed used to provide services to a patient to restore or to optimize the patient’s functional capability.
37. “Review” means an analysis of a document to ensure that the document is in compliance with the requirements of this Article.
38. “Semi-private room” means a room that contains two available beds.
39. “Skilled nursing bed” means an available bed used for a patient requiring skilled nursing services.
40. “Skilled nursing services” means nursing services provided by an individual licensed under A.R.S. Title 32, Chapter 15.
41. “Small volume nebulizer” means a device that:
 - a. Holds liquid medicine that is turned into a mist by an air compressor, and
 - b. Is used for treatments lasting less than 20 minutes.
42. “Swing bed” means an available bed for which a hospital has been granted an approval from the Centers for Medicare and Medicaid Services to provide post-hospital extended care services and be reimbursed as a swing-bed hospital.
43. “Swing-bed hospital” means the same as in 42 CFR 413.114.
44. “Trauma team activation” means a notification by a health care institution:
 - a. That alerts individuals designated by the health care institution to respond to a particular type of emergency;
 - b. That is based on a patient’s triage information; and

Notices of Final Rulemaking

- c. For which the health care institution uses Revenue Category 068X of the National Uniform Billing Committee, UB-04 Data Specifications Manual to bill charges.
- 45. “Ultrasound” means a diagnostic procedure that uses high-frequency sound waves to provide images of internal body structures.

R9-11-302. Expired Hospital Rates and Charges Schedule

- A.** Before a hospital provides services to patients, a hospital administrator or designee shall submit to the Department a rates and charges package that contains:
 - 1. A cover letter that includes:
 - a. The name, physical address, mailing address, county, and telephone number of the hospital;
 - b. The identification number assigned to the hospital:
 - i. By the Department;
 - ii. By AHCCCS, if applicable;
 - iii. By Medicare, if applicable; and
 - iv. As the hospital’s national provider identifier;
 - c. The name, telephone number, and e-mail address of:
 - i. The hospital administrator;
 - ii. The hospital chief financial officer, and
 - iii. Another individual involved in the preparation of the rates and charges package whom the Department may contact regarding the rates and charges package; and
 - d. The planned implementation date for the rates and charges;
 - 2. A rates and charges schedule prepared as specified in subsection (B); and
 - 3. A form provided by the Department, on which the hospital administrator or designee:
 - a. Attests that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (A)(1) and (B) is accurate and complete; or
 - b. If the hospital administrator or designee has personal knowledge that the information submitted according to subsections (A)(1) and (B) is not accurate or not complete:
 - i. Identifies the information that is not accurate or not complete;
 - ii. Describes the circumstances that make the information not accurate or not complete;
 - iii. States what actions the hospital is taking to correct the inaccurate information or make the information complete; and
 - iv. Attests that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (A)(1) and (B), except the information identified in subsection (A)(3)(b)(i), is accurate and complete.
- B.** A hospital administrator shall ensure that a rates and charges schedule:
 - 1. Contains a table of contents for the rates and charges schedule that lists:
 - a. The beginning line number or page number for the hospital rates and charges overview form required in subsection (B)(2);
 - b. For each hospital department:
 - i. The hospital department’s name and identification number;
 - ii. The beginning line number or page number of the rates and charges schedule for the hospital department, and
 - iii. The charge source’s name and identification number for each charge source within the hospital department;
 - c. The beginning line number or page number for the list required in subsection (B)(4) that matches the name of each charge source with its charge source identification number;
 - d. The beginning line number or page number for the formula section for formulary, commodity, and contracted services mark-ups required in subsection (B)(5); and
 - e. The beginning line number or page number for the copy of the hospital’s allowance rules and formulae required in subsection (B)(6);
 - 2. Contains an overview form, in a format specified by the Department, that includes:
 - a. The hospital’s name, city, and county;
 - b. The identification number assigned to the hospital by the Department;
 - c. The name, telephone number, and e-mail of the individual who prepared the overview form;
 - d. The date the overview form was submitted to the Department;
 - e. The hospital’s licensed capacity;
 - f. Whether the entity that is the owner of the hospital is:
 - i. Not for profit;
 - ii. For profit; or
 - iii. A federal, state, or local government agency;
 - g. The hospital’s classification;

Notices of Final Rulemaking

- hospital's mark-up;
- (4) The current and new allowance rules and formulae for each change in the hospital's allowance rules and formulae; and
 - (5) How the hospital rates and charges overview form required in subsection (B)(2) is affected by the changes specified in subsections (C)(2)(b)(i)(1) through (C)(2)(b)(i)(4);
- ii. The line number or page number in the hospital's current rates and charges information for each change listed in subsection (C)(2)(b)(i); and
 - iii. A list of each previous change:
 - (1) To a rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula being changed;
 - (2) That was submitted since the last rates and charges schedule submitted according to subsection (A)(2) or (C)(2)(a); and
 - (3) Including:
 - (a) The date the rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula was previously changed; and
 - (b) A description of how the rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula was previously changed; and
3. A form provided by the Department, on which the hospital administrator or designee:
- a. Attests that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (C)(1) and (C)(2) is accurate and complete; or
 - b. If the hospital administrator or designee has personal knowledge that the information submitted according to subsections (C)(1) and (C)(2) is not accurate or not complete:
 - i. Identifies the information that is not accurate or not complete;
 - ii. Describes the circumstances that make the information not accurate or not complete;
 - iii. States what actions the hospital is taking to correct the inaccurate information or make the information complete; and
 - iv. Attests that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (C)(1) and (C)(2), except the information identified in subsection (C)(3)(b)(i), is accurate and complete.
- D.** A hospital administrator shall implement rates and charges for a rates and charges schedule, submitted as specified in subsection (A), on a date determined by the hospital but not earlier than:
- 1. The date the Department notifies the hospital that the Department has completed a review of the rates and charges schedule, or
 - 2. Sixty calendar days after the Department notifies the hospital that the Department received the rates and charges schedule.
- E.** A hospital administrator shall implement a change in the hospital's current rates and charges information submitted as specified in subsection (C):
- 1. That is:
 - a. A new rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula;
 - b. An increase in a rate or charge;
 - c. A change to a formulary, commodity, or contracted services formula, which results in an increase in a rate or charge; or
 - d. A change to an allowance rule or formula, which results in an increase in a rate or charge; and
 - 2. On a date determined by the hospital, but not earlier than:
 - a. The date the Department notifies the hospital that the Department has completed a review of the information submitted as specified in subsection (C), or
 - b. Sixty calendar days after the Department notifies the hospital that the Department received the information submitted as specified in subsection (C).
- F.** A hospital administrator shall implement a change in the hospital's current rates and charges information submitted as specified in subsection (C):
- 1. That is:
 - a. A deletion of a rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula;
 - b. A reduction in a rate or charge;
 - c. A change to a formulary, commodity, or contracted services formula, which results in a reduction in a rate or charge; or
 - d. A change to an allowance rule or formula, which results in a reduction in a rate or charge; and
 - 2. On a date:

Notices of Final Rulemaking

- a. Determined by the hospital, and
- b. Not earlier than the date the Department notifies the hospital that the Department received the information submitted as specified in subsection (C).
- G. When the Department receives from a hospital a rates and charges schedule submitted as specified in subsection (A), or a change in the hospital's current rates and charges information submitted as specified in subsection (C), the Department shall:
 - 1. Provide written notice to the hospital within five business days of receipt of the rates and charges information, and
 - 2. Provide written notice to the hospital within 60 calendar days that the Department has reviewed the rates and charges information.
- H. A hospital administrator, who receives a request from the Department for a revision of a rates and charges schedule not prepared as specified in subsection (A) or for a revision of a change in the hospital's current rates and charges information not prepared as specified in subsection (C), shall ensure that the revised rates and charges schedule or the revised information changing the current rates and charges information is submitted to the Department:
 - 1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
 - 2. Within seven calendar days after the date on the Department's letter requesting a second revision.
- I. If a hospital administrator or designee does not submit a rates and charges schedule or information about changes to the hospital's rates or charges according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-431.01.

R9-11-303. ~~Financial Report for Hospital Rate Changes; Preparation and Filing Instructions~~ Nursing Care Institution Rates and Charges Schedule

- A. ~~Form 301 shall be prepared and filed with the Department by hospitals proposing increases in rates and charges pursuant to A.R.S. § 36-436.~~
- B. ~~No proposed rates shall be charged to patients until the Director has issued findings on the proposed increase or 60 days have elapsed from the date of a complete filing, whichever occurs first.~~
- C. ~~A complete rate package shall include:~~
 - 1. ~~A complete and accurate Form 301.~~
 - 2. ~~A schedule of the rates and charges as defined in R9-11-301.~~
 - 3. ~~Written justification for a rate increase and the planned date of implementation.~~
 - 4. ~~The pricing policy of the hospital for establishing rates.~~
 - 5. ~~The hospital cost containment program for the Projected Year and a quantified estimate of economic savings for the Base Year.~~
 - 6. ~~Financing information or a prospectus and applicable debt retirement schedules, if new debt has been incurred or the current debt has been refinanced since the last rate review filing.~~
 - 7. ~~A copy of the current management agreement and lease, if applicable.~~
 - a. ~~Details of management fees or corporate cost allocations from a home office including the allocation or charge methodology for each function or service.~~
 - b. ~~Details of lease expenses paid to a related party for property, plant and equipment, submitted with Form 301 in a supplemental schedule which shall include cost, depreciation basis, debt amortization (interest expense and principal payments) for the applicable assets.~~
- D. ~~All required reports and documents pursuant to A.R.S. § 36-125.04 and A.A.C. R9-11-201 and R9-11-303(C) shall be complete and on file with the Department before a filing date is established. Incomplete reports shall not be accepted unless prior written approval to omit specified information has been obtained from the Department. Form 301 shall not be considered as filed, and the 60-day review period shall not commence, until receipt of all required information.~~
 - 1. ~~Information may be requested by the Department after the initial review of the application in order to clarify any financial or statistical data contained in the rate package.~~
 - 2. ~~The 60-day review period shall begin from the most recent submission date if the information submitted by the institution at the Department's request or submitted due to revisions initiated by the institution, results in any of the following for the Base Year or Projected Year:~~
 - a. ~~A modification to the schedule of proposed rates and charges.~~
 - b. ~~A change in annual revenue that exceeds 0.5% of the original submittal.~~
 - c. ~~A change in annual operating expense that exceeds 0.5% of the original submittal.~~
 - d. ~~A modification of the Statement of Cash Flows.~~
- E. ~~The following instructions shall apply to the preparation of Form 301:~~
 - 1. ~~Each hospital shall submit a completed Form 301 to the Department in an electronic format supplied by the Department.~~
 - 2. ~~If schedules or sections are not applicable, those lines should be left blank. Any or all items left blank are subject to the approval of the Department.~~
 - 3. ~~No printed line item descriptions, titles, or column headings shall be altered or changed.~~
 - 4. ~~An institution may supplement Form 301 with additional information necessary to justify the proposed increase.~~

Notices of Final Rulemaking

5. Financial amounts shall be rounded to the nearest dollar amount.
6. If the date of the filing is within the first six months of the institution's current fiscal year, the following reporting periods shall apply:
 - a. "Base Year" means the fiscal year immediately preceding the filing date predicated on actual information, plus the estimated results for the balance of the year, if applicable.
 - b. "Prior Year" means the fiscal year immediately preceding the "Base Year" predicated on actual information.
 - c. "Projected Year" means the current fiscal year predicated on actual year-to-date information, plus the projected results for the balance of the year.
7. If the date of the filing is within the last six months of the institution's current fiscal year, the following reporting periods shall apply:
 - a. "Base Year" means the current fiscal year predicated on actual year-to-date information, plus the estimated results for the balance of the year.
 - b. "Prior Year" means the fiscal year immediately preceding the "Base Year" predicated on actual information.
 - c. "Projected Year" means the fiscal year subsequent to the "Base Year" predicated entirely on projected results.
- F. When completing Form 301, the hospital shall define any cost center descriptions added in the space provided or group the cost center on a line item with the same unit of measure.
- G. The hospital shall report the number of units of service and the definition of each unit by revenue center. The hospital must obtain prior written permission from the Department to use a definition for a unit of service that is different than those listed in Schedule 14 and 15 of Form 301, or to change their definition of a unit of service in any revenue center between reporting periods.
- H. For any patient care services provided in alternate areas, the patient days, revenues and costs shall be reclassified to the responsible unit prior to preparing Form 301.
- I. The financial and statistical information reported in Form 301 shall be reported on the accrual basis of accounting.
- A. Before a nursing care institution provides services to residents, a nursing care institution administrator or designee shall submit to the Department a rates and charges package that contains:
 1. A cover letter that includes:
 - a. The name, physical address, mailing address, county, and telephone number of the nursing care institution;
 - b. The name, physical address, mailing address, and telephone number of the nursing care institution's:
 - i. Home office, if applicable; and
 - ii. Management company, if applicable;
 - c. The identification number assigned to the nursing care institution:
 - i. By the Department;
 - ii. By AHCCCS, if applicable;
 - iii. By Medicare, if applicable; and
 - iv. As the nursing care institution's national provider identifier;
 - d. The name, telephone number, and e-mail address of:
 - i. The nursing care institution administrator;
 - ii. The nursing care institution chief financial officer, and
 - iii. Another individual involved in the preparation of the rates and charges package whom the Department may contact regarding the rates and charges package; and
 - e. The planned implementation date for the rates and charges;
 2. A rates and charges schedule, in a format specified by the Department, containing:
 - a. A table of contents;
 - b. A description of and the rates and charges for:
 - i. Each type of bed; and
 - ii. Each unit of service, other than a type of bed, for which a separate rate or charge is billed; and
 - c. A copy of any nursing care institution rules or formulae which may affect the rate or charge for a type of bed or other unit of service; and
 3. A form provided by the Department, on which the nursing care institution administrator or designee:
 - a. Attests that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (A)(1) and (A)(2) is accurate and complete; or
 - b. If the nursing care institution administrator or designee has personal knowledge that the information submitted according to subsections (A)(1) and (A)(2) is not accurate or not complete:
 - i. Identifies the information that is not accurate or not complete;
 - ii. Describes the circumstances that make the information not accurate or not complete;
 - iii. States what actions the nursing care institution is taking to correct the inaccurate information or make the information complete; and
 - iv. Attests that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (A)(1) and (A)(2), except the information identified in

Notices of Final Rulemaking

- subsection (A)(3)(b)(i), is accurate and complete.
- B.** To change a nursing care institution's current rates and charges information, a nursing care institution administrator or designee shall submit to the Department:
1. A cover letter:
 - a. Containing the information specified in subsection (A)(1), and
 - b. Stating that the accompanying information is changing the nursing care institution's current rates and charges information;
 2. Either:
 - a. The rates and charges schedule specified in subsection (A)(2); or
 - b. The following information:
 - i. A description of:
 - (1) The current and new rate or charge for each type of bed or other unit of service undergoing a change, and
 - (2) The current and new rules and formulae for each change to the nursing care institution rules or formulae that may affect the rate or charge for a type of bed or other unit of service;
 - ii. The line number or page number in the nursing care institution's current rates and charges information for each change listed in subsection (B)(2)(b)(i); and
 - iii. A list of each previous change:
 - (1) To a rate, charge, rule, or formula being changed;
 - (2) That was submitted since the last rates and charges schedule submitted according to subsection (A)(2) or (B)(2)(a); and
 - (3) Including:
 - (a) The date the rate, charge, rule, or formula was previously changed; and
 - (b) A description of how the rate, charge, rule, or formula was previously changed; and
 3. A form provided by the Department, on which the nursing care institution administrator or designee:
 - a. Attests that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (B)(1) and (B)(2) is accurate and complete; or
 - b. If the nursing care institution administrator or designee has personal knowledge that the information submitted according to subsections (B)(1) and (B)(2) is not accurate or not complete:
 - i. Identifies the information that is not accurate or not complete;
 - ii. Describes the circumstances that make the information not accurate or not complete;
 - iii. States what actions the nursing care institution is taking to correct the inaccurate information or make the information complete; and
 - iv. Attests that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (B)(1) and (B)(2), except the information identified in subsection (B)(3)(b)(i), is accurate and complete.

C. A nursing care institution administrator shall implement rates and charges for a rates and charges schedule, submitted as specified in subsection (A), on a date determined by the nursing care institution but not earlier than:

 1. The date the Department notifies the nursing care institution that the Department has completed a review of the rates and charges schedule, or
 2. Sixty calendar days after the Department notifies the nursing care institution that the Department received the rates and charges schedule.

D. A nursing care institution administrator shall implement a change in the nursing care institution's current rates and charges information submitted as specified in subsection (B):

 1. That is:
 - a. A new rate, charge, rule, or formula;
 - b. An increase in a rate or charge; or
 - c. A change to a rule or formula, which results in an increase in a rate or charge; and
 2. On a date determined by the nursing care institution, but not earlier than:
 - a. The date the Department notifies the nursing care institution that the Department has completed a review of the information submitted as specified in subsection (B), or
 - b. Sixty calendar days after the Department notifies the nursing care institution that the Department received the information submitted as specified in subsection (B).

E. A nursing care institution administrator shall implement a change in the nursing care institution's current rates and charges information submitted as specified in subsection (B):

 1. That is:
 - a. A deletion of rate or charge;
 - b. A reduction in a rate or charge; or
 - c. A change to a rule or formula, which results in a reduction in a rate or charge; and

Notices of Final Rulemaking

2. On a date:
 - a. Determined by the nursing care institution, and
 - b. Not earlier than the date the Department notifies the nursing care institution that the Department received the information submitted as specified in subsection (B).
- F. When the Department receives from a nursing care institution a rates and charges schedule submitted as specified in subsection (A), or a change in the nursing care institution's current rates and charges information submitted as specified in subsection (B), the Department shall:
 1. Provide written notice to the nursing care institution within five business days of receipt of the rates and charges information, and
 2. Provide written notice to the nursing care institution within 60 calendar days that the Department has reviewed the rates and charges information.
- G. A nursing care institution administrator, who receives a request from the Department for a revision of a rates and charges schedule not prepared as specified in subsection (A) or for a revision of a change in the nursing care institution's current rates and charges information not prepared as specified in subsection (B), shall ensure that the revised rates and charges schedule or the revised information changing the current rates and charges information is submitted to the Department:
 1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
 2. Within seven calendar days after the date on the Department's letter requesting a second revision.
- H. If a nursing care institution administrator or designee does not submit a rates and charges schedule or information about changes to the nursing care institution's rates and charges according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-431.01.

R9-11-304. Expired Home Health Agency Rates and Charges Schedule

- A. Before a home health agency provides services to patients, a home health agency administrator or designee shall submit to the Department a rates and charges package that contains:
 1. A cover letter that includes:
 - a. The name, physical address, mailing address, county, and telephone number of the home health agency;
 - b. The identification number assigned to the home health agency:
 - i. By the Department;
 - ii. By AHCCCS, if applicable;
 - iii. By Medicare, if applicable; and
 - iv. As the home health agency's national provider identifier;
 - c. The name, telephone number, and e-mail address of:
 - i. The home health agency administrator;
 - ii. The home health agency chief financial officer, and
 - iii. Another individual involved in the preparation of the rates and charges package whom the Department may contact regarding the rates and charges package; and
 - d. The planned implementation date for the rates and charges;
 2. Either:
 - a. A rates and charges schedule, in a format specified by the Department, containing:
 - i. A table of contents;
 - ii. For each unit of service offered for which a separate rate or charge is billed:
 - (1) The unit of service code;
 - (2) A description of the unit of service, and
 - (3) The rate or charge for the unit of service; and
 - iii. A copy of any home health agency rules or formulae that may affect the rate or charge for a unit of service;
or
 - b. Current cost reports and financial information that the home health agency files for other government reporting purposes if the current cost reports and financial information submitted to the Department contain the information required in subsections (A)(2)(a)(ii) and (A)(2)(a)(iii); and
 3. A form provided by the Department, on which the home health agency administrator or designee:
 - a. Attests that, to the best of the knowledge and belief of the home health agency administrator or designee, the information submitted according to subsections (A)(1) and (A)(2) is accurate and complete; or
 - b. If the home health agency administrator or designee has personal knowledge that the information submitted according to subsections (A)(1) and (A)(2) is not accurate or not complete:
 - i. Identifies the information that is not accurate or not complete;
 - ii. Describes the circumstances that make the information not accurate or not complete;
 - iii. States what actions the home health agency is taking to correct the inaccurate information or make the information complete; and
 - iv. Attests that, to the best of the knowledge and belief of the home health agency administrator or designee, the information submitted according to subsections (A)(1) and (A)(2), except the information identified in sub-

Notices of Final Rulemaking

- section (A)(3)(b)(i), is accurate and complete.
- B.** To change a home health agency's current rates and charges information, a home health agency administrator or designee shall submit to the Department:
1. A cover letter:
 - a. Containing the information specified in subsection (A)(1), and
 - b. Stating that the accompanying information is changing the home health agency's current rates and charges information;
 2. Either:
 - a. The rates and charges schedule specified in subsection (A)(2)(a) or the current cost reports and financial information specified in subsection (A)(2)(b); or
 - b. The following information:
 - i. A description of:
 - (1) The current and new rate or charge for each unit of service undergoing a change, and
 - (2) The current and new rules and formulae for each change to the home health agency rules or formulae which may affect the rate or charge for a unit of service;
 - ii. The line number or page number in the home health agency's current rates and charges information for each change listed in subsection (B)(2)(b)(i); and
 - iii. A list of each previous change:
 - (1) To a rate, charge, rule, or formula being changed;
 - (2) That was submitted since the last submission made according to subsection (A)(2) or (B)(2)(a); and
 - (3) Including:
 - (a) The date the rate, charge, rule, or formula was previously changed; and
 - (b) A description of how the rate, charge, rule, or formula was previously changed; and
 3. A form provided by the Department, on which the home health agency administrator or designee:
 - a. Attests that, to the best of the knowledge and belief of the home health agency administrator or designee, the information submitted according to subsections (B)(1) and (B)(2) is accurate and complete; or
 - b. If the home health agency administrator or designee has personal knowledge that the information submitted according to subsections (B)(1) and (B)(2) is not accurate or not complete:
 - i. Identifies the information that is not accurate or not complete;
 - ii. Describes the circumstances that make the information not accurate or not complete;
 - iii. States what actions the home health agency is taking to correct the inaccurate information or make the information complete; and
 - iv. Attests that, to the best of the knowledge and belief of the home health agency administrator or designee, the information submitted according to subsections (B)(1) and (B)(2), except the information identified in subsection (B)(3)(b)(i), is accurate and complete.

C. A home health agency administrator shall implement rates and charges for a rates and charges schedule submitted as specified in subsection (A) or for a change in the home health agency's current rates and charges information submitted as specified in subsection (B) on a date determined by the home health agency but not earlier than the date the Department notifies the home health agency that the Department received the rates and charges information.

D. When the Department receives from a home health agency a rates and charges schedule submitted as specified in subsection (A) or a change in the home health agency's current rates and charges information submitted as specified in subsection (B), the Department shall provide written notice to the home health agency within five business days of receipt of the rates and charges information.

E. A home health agency administrator, who receives a request from the Department for a revision of a rates and charges schedule not prepared as specified in subsection (A) or for a revision of a change in the home health agency's current rates and charges information not prepared as specified in subsection (B), shall ensure that the revised rates and charges schedule or the revised information changing the current rates and charges information is submitted to the Department:

 1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
 2. Within seven calendar days after the date on the Department's letter requesting a second revision.

F. If a home health agency administrator or designee does not submit a rates and charges schedule or information about changes to the home health agency's rates and charges according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-431.01.

R9-11-305. Financial Report for Nursing Care Institution Rate Changes, Preparation and Filing Instructions Out-patient Treatment Center Rates and Charges Schedule

- ~~**A.** Form 302 shall be prepared and filed by all Nursing Care Institutions (NCI) proposing increases in rates and charges.~~
- ~~**B.** A hospital based NCI, licensed for 60 beds or less, may apply in writing to the Department for a waiver from completing Form 302. The waiver request shall be submitted prior to proposing an increase in rates and charges of the NCI. The hospital based NCI shall document in the application that the following apply:~~
- ~~1. The NCI is separated from the hospital campus by no more than one common public or private thoroughfare;~~

Notices of Final Rulemaking

2. The hospital includes the NCI as a discrete operating department in the Financial Report for Review of Proposed Rate Increases—Hospitals, Form 301; and
 3. The NCI charges are included in the hospital's charge master.
- C.** No proposed rate shall be charged to patients until the Director has issued findings on the proposed increase, or 60 days have elapsed from the date of a completed filing, as determined by the Department, whichever occurs first.
- D.** A complete rate package shall include:
1. A complete and accurate Form 302.
 2. Schedule of current and proposed rates and charges for all services rendered to patients according to the NCI's level of care definitions together with a copy of the rules and criteria as defined in R9-11-301.
 3. Written justification for a rate increase and the planned date of implementation.
 4. A copy of the current management agreement and lease, if applicable.
 - a. Detail of management fees and corporate cost allocations charged from a home office including the methodology used to determine the allocations and fees.
 - b. Details of lease expense paid to a related party for property, plant and equipment, submitted with Form 302 in a supplemental schedule which shall include cost, depreciation basis, debt amortization (interest expense and principle payments) for the applicable assets.
- E.** All required reports and documents pursuant to A.R.S. § 36-125.04 and A.A.C. R9-11-305(D) shall be complete and on file with the Department before a filing date is established. Incomplete reports shall not be accepted unless prior written approval to omit specified information has been obtained from the Department. Form 302 shall not be considered as filed, and the 60-day review period shall not commence, until receipt of all the required information.
1. Information may be requested by the Department after the initial review of the application in order to clarify any financial or statistical data contained in the rate package.
 2. The 60-day review period shall begin from the most recent submission date if the information submitted by the institution at the Department's request or submitted due to revisions initiated by the institution, results in any of the following for the Base Year or Projected Year:
 - a. A modification to the schedule of proposed rates and charges.
 - b. A change in annual revenue that exceeds 0.5% of the original submittal.
 - c. A change in annual operating expense that exceeds 0.5% of the original submittal.
 - d. A modification of the Statement of Cash Flows.
- F.** The following general instructions apply to the preparation of Form 302:
1. Each NCI shall submit a completed Form 302 to the Department in an electronic format supplied by the Department and a printout of the report. A manual Form 302 shall be accepted in lieu of an electronic format.
 2. If schedules or sections are not applicable, those lines should be left blank. Any or all items left blank are subject to the approval of the Department.
 3. No printed line item descriptions, titles, or column headings shall be altered or changed.
 4. An institution may supplement Form 302 with additional information necessary to justify the proposed increase.
 5. Financial amounts shall be rounded to the nearest dollar amount.
 6. If the date of the filing is within the first six months of the institution's current fiscal year, the following reporting periods shall apply:
 - a. "Base Year" means the fiscal year immediately preceding the filing date predicated on actual information, plus the estimated results for the balance of the year, if applicable.
 - b. "Prior Year" means the fiscal year immediately preceding the "Base Year" predicated on actual information.
 - c. "Projected Year" means the current fiscal year predicated on actual year-to-date information, plus the projected results for the balance of the year.
 7. If the date of the filing is within the last six months of the institution's current fiscal year, the following reporting periods shall apply:
 - a. "Base Year" means the current fiscal year predicated on actual year-to-date information, plus the estimated results for the balance of the year.
 - b. "Prior Year" means the fiscal year immediately preceding the "Base Year" predicated on actual information.
 - c. "Projected Year" means the fiscal year subsequent to the "Base Year" predicated entirely on projected results.
- A.** Before an outpatient treatment center provides services to patients, an outpatient treatment center administrator or designee shall submit to the Department a rates and charges package that contains:
1. A cover letter that includes:
 - a. The name, physical address, mailing address, county, and telephone number of the outpatient treatment center;
 - b. The identification number assigned to the outpatient treatment center:
 - i. By the Department;
 - ii. By AHCCCS, if applicable;
 - iii. By Medicare, if applicable; and
 - iv. As the outpatient treatment center's national provider identifier;

Notices of Final Rulemaking

- iii. States what actions the outpatient treatment center is taking to correct the inaccurate information or make the information complete; and
 - iv. Attests that, to the best of the knowledge and belief of the outpatient treatment center administrator or designee, the information submitted according to subsections (B)(1) and (B)(2), except the information identified in subsection (B)(3)(b)(i), is accurate and complete.
- C.** An outpatient treatment center administrator shall implement rates and charges for a rates and charges schedule submitted as specified in subsection (A) or for a change in the outpatient treatment center's current rates and charges information submitted as specified in subsection (B) on a date determined by the outpatient treatment center but not earlier than the date the Department notifies the outpatient treatment center that the Department received the rates and charges information.
- D.** When the Department receives from an outpatient treatment center a rates and charges schedule submitted as specified in subsection (A) or a change in the outpatient treatment center's rates and charges information submitted as specified in subsection (B), the Department shall provide written notice to the outpatient treatment center within five business days of receipt of the rates and charges information.
- E.** An outpatient treatment center administrator, who receives a request from the Department for a revision of a rates and charges schedule not prepared as specified in subsection (A) or for a revision of a change in the outpatient treatment center's current rates and charges information not prepared as specified in subsection (B), shall ensure that the revised rates and charges schedule or the revised information changing the current rates and charges information is submitted to the Department:
- 1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
 - 2. Within seven calendar days after the date on the Department's letter requesting a second revision.
- F.** If an outpatient treatment center administrator or designee does not submit a rates and charges schedule or information about changes to the outpatient treatment center's rates and charges according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-431.01.

ARTICLE 4. HOSPITAL INPATIENT DISCHARGE REPORTING FOR INPATIENTS

R9-11-401. Definitions

In this Article, unless the context otherwise requires:

- 1. "AHCCCS" means the Arizona Health Care Cost Containment System.
- 2. "AHCCCS/Medicaid" means care provided pursuant to A.R.S. § 36-2905.
- 3. "AHCCCS Health Group" means reimbursement for care provided to non-AHCCCS eligible clients but who are enrolled with the AHCCCS through their employer health group plan.
- 4. "BPI" means bits per inch.
- 5. "Charity" means reduction in charges for services made by the health care institution because of the indigence of the patient but does not include Title XIX, AHCCCS, contractual obligations of the facility, or other third-party payor settlements.
- 6. "EBCDIC" means extended binary coded decimal interchange code.
- 7. "E code" means the environmental events, circumstances, and conditions that caused the injury, poisoning, and other adverse effects.
- 8. "Foreign national" means reimbursement of a hospital for care provided to another country's national health care system client.
- 9. "HMO" means a health maintenance organization.
- 10. "Home IV provider" means individuals or organizations who assist in the delivery of drugs and devices to patients pursuant to A.R.S. Title 32, Chapter 18.
- 11. "Hospital identification number" means the federal tax identification number.
- 12. "ICD" means international classification of diseases.
- 13. "Medicare risk" means contracted services provided by a HMO that represent an alternate method to the federal system of delivering services to individuals 65 and over.
- 14. "Patient" means a person who is admitted to the hospital as an inpatient only.
- 15. "Patient certificate/social security number" means an insured's unique identification number utilized by the payer organization.
- 16. "Patient control number" means the medical record number or other hospital assigned number for patient identification purposes.
- 17. "Payer code" means the expected primary source of payment for the majority of the charges associated with treatment.
- 18. "Physician number" means the state license number of an individual licensed pursuant to A.R.S. Title 32.
- 19. "PPO" means a preferred provider organization.
- 20. "Self pay" means payment made directly by the patient, guarantor, relatives, or friends for a patient who does not have medical insurance.

Notices of Final Rulemaking

21. ~~“SNF” means a skilled nursing facility pursuant to A.R.S. Title 36, Article 7.~~

22. ~~“Total patient charges” means the gross charges incurred by a patient that are billed by the hospital.~~

In this Article, unless otherwise specified:

1. “Admitting diagnosis” means the reason an individual is admitted to a hospital.

2. “DRG” means Diagnosis Related Group, a type of prospective payment system used in billing for inpatient episodes of care.

3. “HIPPS” means the Health Insurance Prospective Payment System, a type of prospective payment system used by specific health care institutions, such as rehabilitation hospitals, for billing for services provided by the health care institutions.

4. “Inpatient discharge report” means a document that meets the requirements of A.R.S. § 36-125.05 and contains the information required in R9-11-402.

5. “Length of stay” means the total number of calendar days for a specific episode of care, from the date of admission to the date of discharge.

R9-11-402. Reporting Requirements

~~A. Each hospital shall report statistical and demographic information, as specified in subsections (B) through (E), to the Department for each patient discharged by the hospital, in accordance with the following schedule:~~

~~1. For each patient discharged between January 1 and June 30, the information shall be submitted by August 15; and~~

~~2. For each patient discharged between July 1 and December 31, the information shall be submitted by February 15.~~

~~B. Hospitals shall report to the Department the diagnosis, procedures, and revenue codes pertaining to each discharged patient in a uniform format as specified by the UB-92, National Uniform Billing Data Element Specifications, October 8, 1993, Arizona Hospital Association, 1501 West Fountainhead Parkway, Suite 650, Tempe, Arizona 85282, incorporated herein by reference and on file with the Office of the Secretary of State.~~

~~C. Hospitals shall submit the following data elements for each discharged patient in accordance with the physical layout in the Table included in this Article:~~

~~1. Hospital identification number;~~

~~2. Patient control number;~~

~~3. Patient certificate/social security number;~~

~~4. Patient race;~~

~~5. Patient street address;~~

~~6. Patient city;~~

~~7. Patient state;~~

~~8. Patient zip code;~~

~~9. Patient date of birth;~~

~~10. Patient sex;~~

~~11. Patient date of admission;~~

~~12. Patient date of discharge;~~

~~13. Patient discharge status;~~

~~14. Diagnostic related group code;~~

~~15. Total patient charges;~~

~~16. Payer code;~~

~~17. Revenue codes:~~

~~a. All inclusive rate;~~

~~b. Room and board—private;~~

~~e. Room and board—two bed;~~

~~d. Room and board—3 or 4 bed;~~

~~e. Private (deluxe);~~

~~f. Room and board—ward;~~

~~g. Other room and board;~~

~~h. Nursery;~~

~~i. Intensive Care;~~

~~j. Coronary Care;~~

~~k. Special charges;~~

~~l. Incremental charges;~~

~~m. All inclusive ancillary;~~

~~n. Pharmacy;~~

~~o. IV therapy;~~

~~p. Medical/Surgical supplies;~~

~~q. Oncology;~~

~~r. Durable medical equipment (other than renal);~~

Notices of Final Rulemaking

- s. Laboratory;
- t. Laboratory pathology;
- u. Radiology—diagnostic;
- v. Radiology—therapeutic;
- w. Nuclear Medicine;
- x. CT scan;
- y. Operating room;
- z. Anesthesia;
- aa. Blood;
- bb. Blood storage and processing;
- cc. Other imaging;
- dd. Respiratory services;
- ee. Physical therapy;
- ff. Occupational therapy;
- gg. Speech therapy;
- hh. Emergency room;
- ii. Pulmonary function;
- jj. Audiology;
- kk. Cardiology;
- ll. Osteopathic services;
- mm. Ambulance;
- nn. Medical social services;
- oo. MRI;
- pp. Medical/Surgical supplies (Extension of 27X);
- qq. Drugs requiring specific identification;
- rr. Cast room;
- ss. Recovery room;
- tt. Labor/Delivery;
- uu. EKG/ECG;
- vv. EEG;
- ww. Gastrointestinal services;
- xx. Treatment/observation room;
- yy. Lithotripsy;
- zz. Inpatient renal dialysis;
- aaa. Organ acquisition;
- bbb. Miscellaneous dialysis;
- ccc. Psychiatric treatment;
- ddd. Psychiatric services;
- eee. Other diagnostic services;
- fff. Other therapeutic services;
- ggg. Professional fees (96X);
- hhh. Professional fees (97X);
- iii. Professional fees (98X);
- jjj. Patient convenience items;
- kkk. All other not covered in (a) through (jjj);
- 18. Physician name;
- 19. Physician number;
- 20. Physician licensing board;
- 21. Other physician name;
- 22. Other physician number;
- 23. Other physician licensing board;
- 24. Type of admission;
- 25. Source of admission;
- 26. Principal diagnosis;
- 27. Second diagnosis;
- 28. Third diagnosis;
- 29. Fourth diagnosis;
- 30. Fifth diagnosis;
- 31. Sixth diagnosis;

Notices of Final Rulemaking

- 32. Seventh diagnosis;
 - 33. Eighth diagnosis;
 - 34. Ninth diagnosis;
 - 35. External causes of injury (E code);
 - 36. Second external cause of injury (E code);
 - 37. Principal procedure date;
 - 38. Principal procedure;
 - 39. Second procedure;
 - 40. Third procedure;
 - 41. Fourth procedure;
 - 42. Fifth procedure;
 - 43. Sixth procedure; and
 - 44. Newborn birth weight.
- D.** Hospitals shall provide the information required in subsection (C) to the Department in the following format:
- 1. Medium—Untitled, 9 track, 1/2 inch tape
 - 2. Bits per inch—6250
 - 3. Record length—694 characters
 - 4. Blocksize—27760 characters
 - 5. Data format—Extended Binary Coded Decimal Interchange Code
- E.** The Director shall approve an exception to the format described in subsection (D) in accordance with the following:
- 1. A hospital shall submit a written request to use an alternate format 90 days prior to the next due date.
 - 2. The alternate format shall include:
 - a. Name of the software program that the data is to be submitted in; and
 - b. A written description of the file layout.
 - 3. The request shall include a test sample of discharge information as specified in subsection (C).
 - 4. The Department shall notify the hospital of its decision not less than 60 days prior to the next due date for filing the report.
- F.** The Director shall revoke, in writing, 120 days prior to the next submission date, an alternate format granted under subsection (E) when the Department determines that it can no longer convert the submitted information into a usable file format.
- A.** A hospital administrator shall ensure that the following information, in a format specified by the Department, is submitted to the Department with the inpatient discharge report required in subsection (C):
- 1. The name of the hospital;
 - 2. The hospital's Arizona facility ID and national provider identifier;
 - 3. The name, mailing address, telephone number, and e-mail address of the individual at the hospital whom the Department may contact about the inpatient discharge report;
 - 4. If the entity submitting the inpatient discharge report to the Department is different from the hospital:
 - a. The name of the entity submitting the inpatient discharge report to the Department; and
 - b. The name, mailing address, telephone number, and e-mail address of the individual at the entity specified in subsection (A)(4)(a) who prepared the inpatient discharge report;
 - 5. The reporting period; and
 - 6. The name of the electronic file containing the inpatient discharge report specified in subsection (C).
- B.** A hospital administrator or designee shall:
- 1. On a form provided by the Department:
 - a. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C) is accurate and complete; or
 - b. If the hospital administrator or designee has personal knowledge that the information submitted according to subsection (C) is not accurate or not complete:
 - i. Identify the information that is not accurate or not complete;
 - ii. Describe the circumstances that make the information not accurate or not complete;
 - iii. State what actions the hospital is taking to correct the inaccurate information or make the information complete; and
 - iv. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C), except the information identified in subsection (B)(1)(b)(i), is accurate and complete.
- C.** A hospital administrator shall ensure that an inpatient discharge report:
- 1. Is prepared and named in a format specified by the Department;
 - 2. Uses codes and a coding format specified by the Department for data items specified in subsection (C)(3) that require codes; and

Notices of Final Rulemaking

3. Contains the following information for each inpatient discharge that occurred during the reporting period specified in subsection (A)(5):
 - a. The Arizona facility ID and national provider identifier for the hospital;
 - b. A code indicating that the information submitted about the patient is for an inpatient episode of care;
 - c. The patient's medical record number;
 - d. The patient's control number;
 - e. The patient's name;
 - f. The patient's mailing address;
 - g. If the patient is not a resident of the United States, a code indicating the country in which the patient resides;
 - h. A code indicating that the patient is homeless, if applicable;
 - i. The patient's date of birth and last four digits of the patient's Social Security number;
 - j. Codes indicating the patient's gender, race, ethnicity, and marital status;
 - k. The date and a code indicating the hour the patient was admitted to the hospital;
 - l. A code indicating the priority of visit;
 - m. A code indicating the referral source;
 - n. The date and a code indicating the hour the patient was discharged from the hospital;
 - o. A code indicating the patient's discharge status;
 - p. If the patient is a newborn, the patient's birth weight in grams;
 - q. Whether the patient has a DNR known to the hospital;
 - r. The date the bill for hospital services was created;
 - s. The total charges billed for the episode of care;
 - t. A code indicating the expected payer source;
 - u. For each unit of service billed for the episode of care, the:
 - i. Revenue code;
 - ii. Charge billed; and
 - iii. HIPPS code, if applicable;
 - v. The DRG code for the episode of care;
 - w. The code designating the version of the set of International Classification of Diseases codes used to prepare the bill for the episode of care;
 - x. The International Classification of Diseases codes for the patient's admitting, principal, and secondary diagnoses;
 - y. If applicable, the E-codes associated with the episode of care;
 - z. If applicable, the state in which an accident leading to the episode of care occurred;
 - aa. If applicable, the date of the onset of symptoms leading to the episode of care;
 - bb. If a procedure was performed during the episode of care:
 - i. The International Classification of Diseases codes for the principal procedure and any other procedures performed during the episode of care, and
 - ii. The dates the principal procedure and any other procedures were performed;
 - cc. The name, state license number, and, if applicable, national provider identifier of the patient's attending provider;
 - dd. The code for the state licensing board that issued the license for the patient's attending provider;
 - ee. The name, state license number, and, if applicable, national provider identifier of the medical practitioner who performed the patient's principal procedure, if applicable;
 - ff. The code for the state licensing board that issued the license for the medical practitioner who performed the patient's principal procedure, if applicable;
 - gg. The name, state license number, and, if applicable, national provider identifier of any other medical practitioner associated with the patient's episode of care; and
 - hh. The code for the state licensing board that issued the license for each of the individuals specified in subsection (C)(3)(gg).
- D.** A hospital administrator shall ensure that the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) are submitted to the Department twice each calendar year, according to the following schedule:
 1. For each inpatient discharge between January 1 and June 30, the reports, information, and attestation statement shall be submitted after June 30 and no later than August 15; and
 2. For each inpatient discharge between July 1 and December 31, the reports, information, and attestation statement shall be submitted after December 31 and no later than February 15.
- E.** A hospital administrator who receives a request from the Department for revision of a report not prepared according to subsections (A), (B), and (C) shall ensure that the revised report is submitted to the Department:
 1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
 2. Within seven calendar days after the date on the Department's letter requesting a second revision.

Notices of Final Rulemaking

E. If a hospital administrator or designee does not submit the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

**TABLE 1. MAGNETIC TAPE SUBMISSION — REQUIRED DATA ITEMS AND
FORMAT SPECIFICATIONS FOR INPATIENT DISCHARGES Repealed**

CHARACTERS	POSITION	DATA ELEMENT NAME	UNIFORM BILLING LOCATOR NUMBER	CODES AND VALUES	EDIT REQUIREMENTS
10	1-10	Hospital ID — Federal Tax No	5	Alpha-Numeric	All digits must be filled- in. Do not change ID with- out prior permission from DHS.
17	11-27	Patient's Medical- Record Number	23	Alpha-Numeric	Must be filled-in. Right- justified with leading- zeros.
19	28-46	Certificate, Social- Security Number, or Health Insurance- Claim Number	60	Alpha-Numeric	Must be filled-in. Right- justified
1	47	Patient Race	-	Race 1 = American- Indian, Aleut, Eskimo 2 = Asian, Pacific Islander 3 = Black 4 = Caucasian, His- panic 5 = Caucasian, Non- Hispanic 6 = Other 9 = Refused	Must be entered.
30	48-77	Patient Street Address	13	Alpha-Numeric	Must be filled-in.
20	78-97	Patient City	13	Alpha-Numeric	Must be filled-in.
2	98-99	Patient State	13	Alpha-Numeric	Must be filled-in.
10	100-109	Patient's Zip Code	13	Alpha-Numeric	Postal zip code for the patient's residence at the time of admission. If zip plus four is used indicate as XXXXX- YYYY. Must be filled- in. If a foreign resident, fill in with name of the country.
8	110-117	Patient's Date of Birth	14	Enter month-day- year, without dashes MMDDYYYY	All digits must be filled- in. If any portion of birthday is unknown enter all zeros for the birthday.
1	118	Patient's Sex	15	Patient's Sex M = Male F = Female	Must be filled-in.

Arizona Administrative Register / Secretary of State

Notices of Final Rulemaking

8	119-126	Date of Admission	6	The month, day and year of the patient's admission to the hospital. MM-DD-YY	All digits must be filled in including dashes.
8	127-134	Date of Discharge	6	The month, day and year of the patient's discharge from the hospital. MM-DD-YY	All digits must be filled in including dashes.
2	135-136	Patient's Discharge Status	22	The circumstances under which the patient left the hospital: 01 = Discharged to home or self care. 02 = Discharged/ transferred to another short term general hospital. 03 = Discharged/ transferred to skilled nursing (SNF). 04 = Discharged/ transferred to an intermediate care facility (ICF). 05 = Discharged/ transferred to another type of institution. 06 = Discharged/ transferred to home under care of organized home health service organization. 07 = Left against medical advice. 08 = Discharged/ transferred to home under care of a Home IV provider. 20 = Expired. 09 = All Other	Must be filled in. Right justified with a leading zero. Zero if unknown.
3	137-139	DRG Code	78	The condition established after study as being chiefly responsible for the admission of a patient to the hospital for care.	All digits must be filled in. Right justified with leading zeros.
7	140-146	Total Charges	47	The total gross charges incurred by the patient. Hospital charges only.	All digits must be filled in. Right justified with leading zeros. Note, whole dollars only, rounded.

Arizona Administrative Register / Secretary of State

Notices of Final Rulemaking

2	147-148	Payer Code	50	<p>The expected source of payment for the majority of the charges associated with this treatment:</p> <p>00 = Self pay 01 = Commercial (Indemnity) 02 = HMO 03 = PPO 04 = AHCCCS Health Care Group 05 = Medicare 06 = AHCCCS/Medicaid 07 = CHAMPUS/MEDEXCEL 08 = Children's Rehabilitation Services 09 = Workers' Compensation 10 = Indian Health Services 11 = Medicare Risk 12 = Charity 13 = Foreign National 14 = Other</p>	Must be filled in. Right justified with leading zeros.
---	---------	------------	----	---	--

Arizona Administrative Register / Secretary of State

Notices of Final Rulemaking

6-		Revenue Codes	42	Total gross charges for each revenue code.	All digits must be filled in. Right justified with leading zeros. Note, whole dollars only, rounded.
	149-154	All inclusive rate	10x		
	155-160	Room and board—private	11x		
	161-166	Room and board—two bed	12x		
	167-172	Room and board—3/4 bed	13x		
	173-178	Private (deluxe)	14x		
	179-184	Room and board—ward	15x		
	185-190		16x		
		Other room and board			
	191-196	Nursery	17x		
	197-202	Intensive Care	20x		
	203-208	Coronary Care	21x		
	209-214	Special charges	22x		
	215-220	Incremental charges	23x		
	221-226	All inclusive ancillary	24x		
		Pharmacy			
	227-232	IV therapy	25x		
	233-238	Medical, surgical	26x		
	239-244	supplies	27x		
		Oncology			
	245-250	DME (other than	28x		
	251-256	renal)	29x		
	257-262	Laboratory	30x		
	263-268	Laboratory pathology	31x		
	269-274	Radiology—diagnostic	32x		
	275-280	Radiology—therapeutic	33x		
	281-286		34x		
	287-292	Nuclear Medicine	35x		
		CT scan			
	293-298	Operating room	36x		
	299-304	Anesthesia	37x		
	305-310	Blood	38x		
	311-316	Blood Storage/Processing	39x		
	317-322	Other imaging	40x		
323-328	Respiratory services	41x			
329-334	Physical therapy	42x			
335-340	Occupational therapy	43x			

Arizona Administrative Register / Secretary of State

Notices of Final Rulemaking

	341-346 347-352 353-358 359-364 365-370 371-376 377-382 383-388 389-394 395-400 401-406 407-412 413-418 419-424 425-430 431-436 437-442 443-448 449-454 455-460 461-466 467-472 473-478 479-484 485-490 491-496 497-502 503-508 509-514 515-520 521-526	Speech therapy Emergency room Pulmonary function Audiology Cardiology Osteopathic services Ambulance Medical social services MRI Med/Surg (Ext. of 27x) Drugs required specific ID Cast room Recovery room Labor / Delivery EKG / ECG EEG Gastrointestinal services Treatment / Observation room Lithotripsy Inpatient renal dialysis Organ acquisition Miscellaneous dialysis Psychiatric treatment Psychiatric services Other diagnostic services Other therapeutic services Professional fees Professional fees Professional fees Patient convenience items All other	44x 45x 46x 47x 48x 53x 54x 56x 61x 62x 63x 70x 71x 72x 73x 74x 75x 76x 79x 80x 81x 88x 90x 91x 92x 94x 96x 97x 98x 99x -		
22	527-548	Physician Name	82	Attending physician's name. Last, First, Middle Initial.	Left justified. Use "unknown physician" if unknown.
6	549-554	Physician State License No.	82	Attending physician's or other practitioner's Arizona License Number.	All digits must be filled in. Right justified with leading zeros. Fill with zeros if unknown. Can be Alpha numeric (locum tenens).

Arizona Administrative Register / Secretary of State

Notices of Final Rulemaking

4	555	Licensing Board	-	Board: 1 = Medical Examiners 2 = Dental Examiners 3 = Podiatry Examiners 4 = Osteopathic Examiners 5 = Nursing 9 = Other	Must be filled in.
22	556-577	Other Physician-Name	83	Primary procedure physician's name Last, First, Middle-Initial.	Left justified. Use "unknown physician" if unknown.
6	578-583	Other Physician State-License No.	83	Physician, or other practitioner's Arizona License Number who performed the primary procedure.	All digits must be filled in. Right justified with leading zeros. Fill with zeros if unknown. Can be Alpha-numeric (locum tenens).
4	584	Licensing Board	-	Board: 1 = Medical Examiners 2 = Dental Examiners 3 = Podiatry Examiners 4 = Osteopathic Examiners 5 = Nursing 9 = Other	Must be filled in.
4	585	Type of Admission	49	Indicates the priority (type) of admission: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 9 = Information not available	Must be filled in. If 4 (newborn), Source of Admission must be 1-4, or 9 (unknown).

Arizona Administrative Register / Secretary of State

Notices of Final Rulemaking

4	586	Source of Admission	20	<p>Indicates the source of admission – adults and pediatrics:</p> <p>1 – Physician referral 2 – Clinic referral 3 – HMO / AHC-CCS health plan referral 4 – Transfer from a hospital 5 – Transfer from a SNF 6 – Transfer from another health care facility (other than acute care or SNF) 7 – Emergency room 8 – Court / Law Enforcement 9 – Information not available</p> <p>If Type of Admission = newborn (4) use:</p> <p>1 – Normal Delivery 2 – Premature Delivery 3 – Sick baby 4 – Extramural birth 9 – Information not available</p>	Must be filled in.
6	587-592	Principal Diagnosis Code	67	Enter the ICD code describing the condition chiefly responsible for causing this hospitalization.	Left adjust. Must be filled in, including decimal and applicable letter, such as V or E code. Leave blank if unknown. If code consists of less than six places, including the decimal, do not zero fill the blank(s) on the right.
6	593-598	Second Diagnosis	68	Enter the ICD code describing additional conditions	Leave blank if not applicable. Otherwise, left adjust, and include decimal and applicable letter such as V or E code. If code consists of less than six places, including the decimal, do not zero fill the blank(s) on the right.

Arizona Administrative Register / Secretary of State

Notices of Final Rulemaking

6	599-604	Third Diagnosis Code	69	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	605-610	Fourth Diagnosis Code	70	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	611-616	Fifth Diagnosis Code	71	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	617-622	Sixth Diagnosis Code	72	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	623-628	Seventh Diagnosis Code	73	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	629-634	Eighth Diagnosis Code	74	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	635-640	Ninth Diagnosis Code	75	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	641-646	External Cause of Injury	77	Enter the ICD code describing the external cause of injury.	Leave blank if not applicable. Otherwise, left adjust, include decimal and the letter E.
6	647-652	Second External Cause of Injury	-	Enter the ICD code describing the external cause of injury.	Leave blank if not applicable. Otherwise, left adjust, include decimal and the letter E.
8	653-660	Principal Procedure Date	80	The month, day, and year of the patient's principal procedure MM-DD-YY	All digits must be filled in including dashes.
5	661-665	Principal Procedure Code	80	Enter the ICD code that identifies the principal procedure performed.	Left adjust. Must be filled in, including decimal. Leave blank if unknown. If code consists of less than five places, including the decimal, do not zero fill the blank(s) on the right.
5	666-670	Second Procedure Code	81A	Enter the ICD code describing procedures other than the principal procedure.	Leave blank if not applicable. Otherwise left adjust and include decimal. If code consists of less than five places including the decimal, do not zero fill the blank(s) on the right.
5	671-675	Third Procedure Code	81B	Same as second procedure code.	Same as instructions for the second procedure code.

Notices of Final Rulemaking

5	676-680	Fourth Procedure Code	81C	Same as second procedure code.	Same as second procedure code.
5	681-685	Fifth Procedure Code	81D	Same as second procedure code.	Same as second procedure code.
5	686-690	Sixth Procedure Code	81E	Same as second procedure code.	Same as second procedure code.
4	691-694	Newborn Birth Weight	-	Birth weight in grams.	Must be entered for all newborns.
<p>Data Requirements for Reporting Under A.R.S. § 36-125.05:</p> <p>MEDIUM: 9-TRACK, 1/2-INCH TAPE BPI: 6250 RECL: 694 CHARACTERS BLOCKSIZE: 27,760 LABEL: NO LABELS DATA FORMAT: EBCDIC</p> <p>MAGTAPE.FN2 (2/2/95)</p>					

**ARTICLE 5. OUTPATIENT SERVICES
EMERGENCY DEPARTMENT DISCHARGE REPORTING**

R9-11-501. Definitions

The following definitions apply in this Article:

1. "Charge" means the same as "rate or charge" in R9-11-101.
2. "Diagnosis" means a determination of an individual's disease, illness, or injury, made by a health care provider authorized by law to make the determination.
3. "Diagnostic related group code" means a numeric or alpha-numeric identifier that is assigned by the Center for Medicare and Medicaid Services to two or more outpatient services that are provided to an individual with a specific diagnosis.
4. "Governing authority" has the same meaning as in A.R.S. § 36-401.
5. "Hospital" has the same meaning as in A.A.C. R9-10-201.
6. "Hospital identification number" has the same meaning as in R9-11-401.
7. "Outpatient" has the same meaning as in A.A.C. R9-10-201.
8. "Outpatient services" means:
 - a. Hospital services as defined in A.A.C. R9-10-201 provided to an outpatient by a hospital; and
 - b. Outpatient surgical services as defined in A.A.C. R9-10-1701 provided to an individual by an outpatient surgical center.
9. "Outpatient surgical center" has the same meaning as in A.R.S. § 36-401.
10. "Patient certificate or social security number" has the same meaning as "patient certificate/social security number" in R9-11-401.
11. "Patient control number" has the same meaning as in R9-11-401.
12. "Payer code" has the same meaning as in R9-11-401.
13. "Procedure" means a surgical operation or technique.
14. "Tax ID number" means the numeric identifier that a person uses to report financial information to the United States Internal Revenue Service.
15. "Total patient charges" has the same meaning as in R9-11-401.

In this Article, unless otherwise specified:

Notices of Final Rulemaking

1. “CPT code” means a code from Current Procedural Terminology, a HCPCS coding system used primarily to identify medical services and procedures provided by medical practitioners.
2. “Emergency department discharge report” means a document that meets the requirements of A.R.S. § 36-125.05 and contains the information required in R9-11-502.
3. “HCPCS” means the Healthcare Common Procedure Coding System used by a hospital for billing for hospital services or commodities provided to an outpatient as defined in A.A.C. R9-10-201.

R9-11-502. Reporting Requirements

A governing authority of a hospital or an outpatient surgical center shall submit the following information for each outpatient according to the schedule and format requirements in R9-11-402:

1. An identification number as follows:
 - a. For a hospital, the hospital identification number; or
 - b. For an outpatient surgical center, the outpatient surgical center’s tax ID number;
2. The patient control number;
3. The patient certificate or social security number;
4. The patient’s address including city, state, and zip code;
5. The patient’s date of birth;
6. The patient’s sex;
7. The date outpatient services were initiated;
8. The date outpatient services were terminated;
9. The diagnostic related group code;
10. The total patient charges;
11. The payer code;
12. The principal diagnosis;
13. The second diagnosis;
14. The third diagnosis;
15. The fourth diagnosis;
16. The fifth diagnosis;
17. The sixth diagnosis;
18. The seventh diagnosis;
19. The eighth diagnosis;
20. The ninth diagnosis;
21. External cause of injury;
22. Second external cause of injury;
23. The date of the principal procedure;
24. The principal procedure;
25. The second procedure;
26. The third procedure;
27. The fourth procedure;
28. The fifth procedure; and
29. The sixth procedure.

A. A hospital administrator shall ensure that the following information, in a format specified by the Department, is submitted to the Department as part of the emergency department discharge report required in subsection (C):

1. The name of the hospital;
2. The hospital’s Arizona facility ID and national provider identifier;
3. The name, mailing address, telephone number, and e-mail address of the individual at the hospital whom the Department may contact about the emergency department discharge report;
4. If the entity submitting the emergency department discharge report to the Department is different from the hospital:
 - a. The name of the entity submitting the emergency department discharge report to the Department; and
 - b. The name, mailing address, telephone number, and e-mail address of the individual at the entity specified in subsection (A)(4)(a) who prepared the emergency department discharge report;
5. The reporting period; and
6. The name of the electronic file containing the emergency department discharge report specified in subsection (C).

B. A hospital administrator or designee shall:

1. On a form provided by the Department:
 - a. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C) is accurate and complete; or
 - b. If the hospital administrator or designee has personal knowledge that the information submitted according to subsection (C) is not accurate or not complete:
 - i. Identify the information that is not accurate or not complete;

Notices of Final Rulemaking

- ii. Describe the circumstances that make the information not accurate or not complete;
- iii. State what actions the hospital is taking to correct the inaccurate information or make the information complete; and
- iv. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C), except the information identified in subsection (B)(1)(b)(i), is accurate and complete.

C. A hospital administrator shall ensure that an emergency department discharge report:

- 1. Is prepared and named in a format specified by the Department;
- 2. Uses codes and a coding format specified by the Department for data items specified in subsection (C)(3) that require codes; and
- 3. Contains the following information for each emergency department discharge that occurred during the reporting period specified in subsection (A)(5):
 - a. The Arizona facility ID and national provider identifier for the hospital;
 - b. A code indicating that the information submitted about the patient is for an emergency department episode of care;
 - c. The patient's medical record number;
 - d. The patient's control number;
 - e. The patient's name;
 - f. The patient's mailing address;
 - g. If the patient is not a resident of the United States, a code indicating the country in which the patient resides;
 - h. A code indicating that the patient is homeless, if applicable;
 - i. The patient's date of birth and last four digits of the patient's Social Security number;
 - j. Codes indicating the patient's gender, race, ethnicity, and marital status;
 - k. The date and a code indicating the hour the episode of care began;
 - l. A code indicating the priority of visit;
 - m. A code indicating the referral source;
 - n. The date and a code indicating the hour the patient was discharged from the emergency department;
 - o. A code indicating the patient's discharge status;
 - p. Whether the patient has a DNR known to the hospital;
 - q. The date the patient's bill was created;
 - r. The total charges billed for the episode of care;
 - s. A code indicating the expected payer source;
 - t. For each unit of service billed for the episode of care, the:
 - i. Revenue code;
 - ii. Charge billed; and
 - iii. HCPCS code, if applicable;
 - u. The code designating the version of the set of International Classification of Diseases codes used to prepare the bill for the episode of care;
 - v. The International Classification of Diseases code designating the reason for the patient initiating the episode of care;
 - w. The International Classification of Diseases codes for the patient's principal and, if applicable, secondary diagnoses;
 - x. If applicable, the E-codes associated with the episode of care;
 - y. If applicable, the state in which an accident leading to the episode of care occurred;
 - z. If applicable, the date of the onset of symptoms leading to the episode of care;
 - aa. For each procedure performed during the episode of care:
 - i. The applicable International Classification of Diseases, HCPCS/CPT codes for the principal procedure and any other procedures performed during the episode of care; and
 - ii. The dates the principal procedure and any other procedures were performed;
 - bb. The name, state license number, and, if applicable, national provider identifier of the patient's attending provider;
 - cc. The code for the state licensing board that issued the license for the patient's attending provider;
 - dd. The name, state license number, and, if applicable, national provider identifier of the medical practitioner who performed the patient's principal procedure, if applicable;
 - ee. The code for the state licensing board that issued the license for the medical practitioner who performed the patient's principal procedure, if applicable;
 - ff. The name, state license number, and, if applicable, national provider identifier of any other medical practitioner associated with the patient's episode of care; and
 - gg. The code for the state licensing board that issued the license for each of the individuals specified in subsection (C)(3)(ff).

Notices of Final Rulemaking

- D.** A hospital administrator shall ensure that the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) are submitted to the Department twice each calendar year, according to the following schedule:
1. For each emergency department discharge between January 1 and June 30, the report, information, and attestation statement shall be submitted after June 30 and no later than August 15; and
 2. For each emergency department discharge between July 1 and December 31, the report, information, and attestation statement shall be submitted after December 31 and no later than February 15.
- E.** A hospital administrator who receives a request from the Department for revision of an emergency department discharge report not prepared according to subsections (A), (B), and (C) shall ensure that the revised report is submitted to the Department:
1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
 2. Within seven calendar days after the date on the Department's letter requesting a second revision.
- F.** If a hospital administrator or designee does not submit the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.