# NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

## NOTICE OF PROPOSED RULEMAKING

### TITLE 9. HEALTH SERVICES

### CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINSTRATION

### PREAMBLE

**1. Sections Affected** — **Rulemaking Action**

| | |
|---|---|
| R9-22-101 | Amend |
| R9-22-102 | Amend |
| R9-22-201 | Amend |
| R9-22-204 | Amend |
| R9-22-205 | Amend |
| R9-22-207 | Amend |
| R9-22-208 | Amend |
| R9-22-209 | Amend |
| R9-22-210 | Amend |
| R9-22-211 | Amend |
| R9-22-212 | Amend |
| R9-22-213 | Amend |
| R9-22-215 | Amend |
| R9-22-216 | Amend |

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

Authorizing statute: A.R.S. § 36-2903.01(E)

Implementing statutes: A.R.S. §§ 36-2903(C) and (Q), 36-2903.01(L) and (O), 36-2907, 36-2908, and 36-2909

**3. A list of all previous notices appearing in the Register addressing the proposed rule:**

Notice of Rulemaking Docket Opening: 7 A.A.R. 5261, November 23, 2001

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

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

**5. An explanation of the rule, including the agency's reasons for initiating the rule:**

The Administration made changes to 9 A.A.C. 22 to conform to state statute, federal law, and to provide additional clarity and conciseness to existing rule language. These changes impact two Articles:

Article 1, Definitions (R9-22-101and R9-22-102) to add and amend definitions, and

Article 2, Scope of Services (R9-22-201 through R9-22-205; R9-22-207 through 216).

Following is an explanation of the changes:

9 A.A.C. 22, Article 1, Definitions

The Administration modified, added, or deleted definitions to improve the clarity and conciseness of the rule language.

9 A.A.C. 22, Article 2, Scope of Services

R9-22-201. The Administration amended the content of this Section to improve the clarity and conciseness of the rule language and conform to state statute (subsection L).

R9-22-204. The Administration amended the content of this Section to improve the clarity and conciseness of the rule language and conform to federal law (subsection B).

R9-22-205. The Administration made minor changes to improve clarity.

R9-22-207. The Administration clarified the language to more clearly identify dental services for members over age 21 and members under age 21.

R9-22-208. The Administration made minor changes to improve clarity and deleted subsection 4 as its contents are reflected in R9-22-201.

R9-22-209. The Administration made minor changes to improve clarity and deleted subsection (D)(4) and (5) as these areas are covered under A.R.S. Title 32.

R9-22-210. The Administration made minor changes to conform to federal law.

R9-22-211. The Administration amended the content of this Section to improve the clarity and conciseness of the rule language.

R9-22-212. The Administration made minor changes to improve clarity and deleted subsection (G). The deletion will allow the Administration to work with fee for service (FFS) providers in raising the threshold point at which prior authorization (PA) is needed for medical supplies and durable medical equipment. This makes the PA process less burdensome for the FFS providers.

R9-22-213. The Administration added Hospice, which has been part of the EPSDT service package but was not in rule and added references to 42 CFR 441 Subpart B and A.A.C. R9-7-301 for content.

R9-22-215. The Administration made minor changes to improve clarity.

R9-22-216. The Administration made minor changes to improve clarity.

**6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:**

Not applicable

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

Not applicable

**8. The preliminary summary of the economic, small business, and consumer impact:**

The contractors, members, providers, and AHCCCS are nominally impacted by the changes to the rule language. These rules define the scope of services for AHCCCS' acute care program. The Administration is amending these rules to make the rules more clear, concise, and understandable by:

- grouping like concepts to provide clarity and conciseness to the rule language,
- clarifying language that does not clearly present policies or procedures, and
- updating citations to documents incorporated in the rule, as needed.

It is anticipated that the private sector, including small businesses or political subdivisions will not be impacted since the proposed rule language changes are intended to streamline and clarify the existing rules. The Administration, con-

tractors and providers will benefit because the changes provide greater flexibility and clarification of the rule language.

**9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us on January 11, 2002. Please send written comments to the above address by 5:00 p.m., February 12, 2002. E-mail will not be accepted.

**10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**

Date: February 12, 2002

Time: 1:00 p.m.

Location: AHCCCS
701 East Jefferson
Phoenix, AZ 85034
Gold Room

Nature: Public Hearing

Date: February 12, 2002

Time: 1:00 p.m.

Location: ALTCS: Arizona Long-term Care System
110 South Church, Suite 3250
Tucson, AZ 85701

Nature: Video Conference Oral Proceeding

Date: February 12, 2002

Time: 1:00 p.m.

Location: ALTCS: Arizona Long-term Care System
3480 East Route 66
Flagstaff, AZ 86004

Nature: Video Conference Oral Proceeding

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

Not applicable

**12. Incorporations by reference and their location in the rules:**

| Description | Date | Location |
|---|---|---|
| 42 CFR 418.202 | December 20, 1994 | R9-22-213 |
| 42 CFR 441, Subpart B | January 29, 1985 | R9-22-213 |

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

**TITLE 9. HEALTH SERVICES**

**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION**

**ARTICLE 1. DEFINITIONS**

Section
R9-22-101. Location of Definitions
R9-22-102. Scope of Services Related Definitions

**ARTICLE 2. SCOPE OF SERVICES**

Section
R9-22-201. General Requirements
R9-22-204. Inpatient General Hospital Services
R9-22-205. ~~Physician and Primary Care Physician and Practitioner Services~~ Physician, Practitioner, and Primary Care Provider Services
R9-22-207. Dental Services
R9-22-208. Laboratory, Radiology and Medical Imaging Services
R9-22-209. Pharmaceutical Services
R9-22-210. Emergency Medical and Behavioral Health Services
R9-22-211. Transportation Services
R9-22-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices
R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)
R9-22-215. Other Medical Professional Services
R9-22-216. NF, Alternative HCBS Setting, or HCBS

**ARTICLE 1. DEFINITIONS**

**R9-22-101. Location of Definitions**

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

| Definition | Section or Citation |
|---|---|
| "Accommodation" | R9-22-107 |
| "Act" | R9-22-114 |
| "Active case" | R9-22-109 |
| "Acute mental health services" | R9-22-112 |
| "ADHS" | R9-22-112 |
| "Administration" | A.R.S. § 36-2901 |
| "Administrative law judge" | R9-22-108 |
| "Administrative review" | R9-22-108 |
| "Adverse action" | R9-22-114 |
| "Affiliate corporate organization" | R9-22-106 |
| "Aged" | 42 U.S.C. 1382c(a)(1)(A) and R9-22-115 |
| "Aggregate" | R9-22-107 |
| "AHCCCS" | R9-22-101 |
| "AHCCCS inpatient hospital day or days of care" | R9-22-107 |
| "AHCCCS registered provider" | R9-22-101 |
| "Ambulance" | R9-22-102 |
| "Ancillary department" | R9-22-107 |
| "Annual assessment period" | R9-22-109 |
| "Annual assessment period report" | R9-22-109 |
| "Annual enrollment choice" | R9-22-117 |
| "Appellant" | R9-22-114 |
| "Applicant" | R9-22-101 |
| "Application" | R9-22-101 |
| "Assignment" | R9-22-101 |
| "Attending physician" | R9-22-101 |

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| "Authorized representative" | R9-22-114 |
| "Auto-assignment algorithm" | R9-22-117 |
| "Baby Arizona" | R9-22-114 |
| "Behavior management services" | R9-22-112 |
| "Behavioral health evaluation" | R9-22-112 |
| "Behavioral health medical practitioner" | R9-22-112 |
| "Behavioral health professional" | R9-22-112 |
| "Behavioral health service" | R9-22-112 |
| "Behavioral health technician" | R9-22-112 |
| "Behavior management services" | R9-22-112 |
| "BHS" | R9-22-114 |
| "Billed charges" | R9-22-107 |
| "Blind" | R9-22-115 |
| "Board-eligible for psychiatry" | R9-22-112 |
| "Burial plot" | R9-22-114 |
| "Capital costs" | R9-22-107 |
| "Capped fee-for-service" | R9-22-101 |
| "Caretaker relative" | R9-22-114 |
| "Case" | R9-22-109 |
| "Case record" | R9-22-101 and R9-22-109 |
| "Case review" | R9-22-109 |
| "Cash assistance" | R9-22-114 |
| "Categorically-eligible" | R9-22-101 |
| "Certified psychiatric nurse practitioner" | R9-22-112 |
| "Clean claim" | A.R.S. § 36-2904 |
| "Clinical supervision" | R9-22-112 |
| "CMDP" | R9-22-117 |
| "CMS" | R9-22-101 |
| "Complainant" | R9-22-108 |
| "Continuous stay" | R9-22-101 |
| "Contract" | R9-22-101 |
| "Contractor" | A.R.S. § 36-2901 |
| "Copayment" | R9-22-107 |
| "Corrective action plan" | R9-22-109 |
| "Cost-to-charge ratio" | R9-22-107 |
| "Covered charges" | R9-22-107 |
| "Covered services" | R9-22-102 |
| "CPT" | R9-22-107 |
| "CRS" | R9-22-114 |
| "Cryotherapy" | R9-22-120 |
| "Date of notice" | R9-22-108 |
| "Day" | R9-22-101 |
| "DCSE" | R9-22-114 |
| "De novo hearing" | R9-22-112 |
| "Dentures" | R9-22-102 |
| "Department" | A.R.S. § 36-2901 |
| "Dependent child" | R9-22-114 |
| "DES" | R9-22-101 |
| "Diagnostic services" | R9-22-102 |
| "Director" | R9-22-101 |
| "Disabled" | R9-22-115 |
| "Discussions" | R9-22-106 |
| "Disenrollment" | R9-22-117 |
| "District" | R9-22-109 |
| "DME" | R9-22-102 |
| "DRI inflation factor" | R9-22-107 |
| "E.P.S.D.T. services" | R9-22-102 |
| "Eligible person" | A.R.S. § 36-2901 |
| "Emergency medical condition" | Section 1903(v) of the Social Security Act |

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| "Emergency medical services" | R9-22-102 |
| "Encounter" | R9-22-107 |
| "Enrollment" | R9-22-117 |
| "Enumeration" | R9-22-101 |
| "Equity" | R9-22-101 |
| "Error" | R9-22-109 |
| "Experimental services" | R9-22-101 |
| "FAA" | R9-22-114 |
| "Facility" | R9-22-101 |
| "Factor" | R9-22-101 |
| "FBR" | R9-22-101 |
| "FESP" | R9-22-101 |
| "Finding" | R9-22-109 |
| "First-party liability" | R9-22-110 |
| "Foster care maintenance payment" | 41 U.S.C. 675(4)(A) |
| "FPL" | A.R.S. § 1-215 |
| "FQHC" | R9-22-101 |
| "Grievance" | R9-22-108 |
| "GSA" | R9-22-101 |
| "Health care practitioner" | R9-22-112 |
| "Hearing" | R9-22-108 |
| "Hearing aid" | R9-22-102 |
| "Home health services" | R9-22-102 |
| "Homebound" | R9-22-114 |
| "Hospital" | R9-22-101 |
| "ICU" | R9-22-107 |
| "IHS" | R9-22-117 |
| "IMD" | R9-22-112 |
| "Income" | R9-22-114 |
| "Inmate of a public institution" | 42 CFR 435.1009 |
| "Interested party" | R9-22-106 |
| "License" or "licensure" | R9-22-101 |
| "Mailing date" | R9-22-114 |
| "Management evaluation review" | R9-22-109 |
| "Medical education costs" | R9-22-107 |
| "Medical expense deduction" | R9-22-114 |
| "Medical record" | R9-22-101 |
| "Medical review" | R9-22-107 |
| "Medical services" | R9-22-101 |
| "Medical supplies" | R9-22-102 |
| "Medical support" | R9-22-114 |
| "Medically necessary" | R9-22-101 |
| "Medicare claim" | R9-22-107 |
| "Medicare HMO" | R9-22-101 |
| "Member" | R9-22-101 |
| "Mental disorder" | R9-22-112 |
| "New hospital" | R9-22-107 |
| "NF" | R9-22-101 |
| "NICU" | R9-22-107 |
| "Noncontracting provider" | A.R.S. § 36-2901 |
| "Nonparent caretaker relative" | R9-22-114 |
| "Notice of Findings" | R9-22-109 |
| "OAH" | R9-22-108 |
| "Occupational therapy" | R9-22-102 |
| "Offeror" | R9-22-106 |
| "Operating costs" | R9-22-107 |
| "Outlier" | R9-22-107 |
| "Outpatient hospital service" | R9-22-107 |
| "Ownership change" | R9-22-107 |

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| "Partial Care" | R9-22-112 |
| "Party" | R9-22-108 |
| "Peer group" | R9-22-107 |
| "Peer Review Study" | R9-22-120 |
| "Performance measures" | R9-22-109 |
| "Pharmaceutical service" | R9-22-102 |
| "Physical therapy" | R9-22-102 |
| "Physician" | R9-22-102 |
| "Post-stabilization services" | 42 CFR 438.114 |
| "Practitioner" | R9-22-102 |
| "Pre-enrollment process" | R9-22-114 |
| "Preponderance of evidence" | R9-22-109 |
| "Prescription" | R9-22-102 |
| "Primary care provider" ("PCP") | R9-22-102 |
| "Primary care provider services" | R9-22-102 |
| "Prior authorization" | R9-22-102 |
| "Private duty nursing services" | R9-22-102 |
| "Proposal" | R9-22-106 |
| "Prospective rates" | R9-22-107 |
| "Prospective rate year" | R9-22-107 |
| "Provider" | R9-22-101 |
| "Prudent layperson standard" | 42 U.S.C. 1396u-2 |
| "Psychiatrist" | R9-22-112 |
| "Psychologist" | R9-22-112 |
| "Psychosocial rehabilitation services" | R9-22-112 |
| "Qualified Alien" | A.R.S. § 36-2903.03 |
| "Quality management" | R9-22-105 |
| "Radiology services" | R9-22-102 |
| "Random sample" | R9-22-109 |
| "RBHA" | R9-22-112 |
| "Rebasing" | R9-22-107 |
| "Referral" | R9-22-101 |
| "Rehabilitation services" | R9-22-102 |
| "Reinsurance" | R9-22-107 |
| "Resources" | R9-22-114 |
| "Respiratory therapy" | R9-22-102 |
| "Respondent" | R9-22-108 |
| "Responsible offeror" | R9-22-106 |
| "Responsive offeror" | R9-22-106 |
| "Review" | R9-22-114 |
| "Review period" | R9-22-109 |
| "RFP" | R9-22-106 |
| "Scope of services" | R9-22-102 |
| "SDAD" | R9-22-107 |
| "Section 1115 Waiver" | A.R.S. § 36-2901 |
| "Service location" | R9-22-101 |
| "Service site" | R9-22-101 |
| "S.O.B.R.A." | R9-22-101 |
| "SESP" | R9-22-101 |
| "Specialist" | R9-22-102 |
| "Specified relative" | R9-22-114 |
| "Speech therapy" | R9-22-102 |
| "Spendthrift restriction" | R9-22-114 |
| "Spouse" | R9-22-101 |
| "SSA" | P.L. 103-296, Title I |
| "SSI" | R9-22-101 |
| "SSN" | R9-22-101 |
| "Standard of care" | R9-22-101 |
| "Sterilization" | R9-22-102 |

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| "Subcontract" | R9-22-101 |
| "Summary report" | R9-22-109 |
| "SVES" | R9-22-114 |
| "Third-party" | R9-22-110 |
| "Third-party liability" | R9-22-110 |
| "Tier" | R9-22-107 |
| "Tiered per diem" | R9-22-107 |
| "Title IV-D" | R9-22-114 |
| "Title IV-E" | R9-22-114 |
| "Title XIX" | 42 U.S.C. 1396 |
| "Title XXI" | 42 U.S.C. 1397aa |
| "Tolerance level" | R9-22-109 |
| "Total inpatient hospital days" | R9-22-107 |
| "Utilization management" | R9-22-105 |
| "WWHP" | R9-22-120 |

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

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

"AHCCCS registered provider" means a provider who:

Has a provider agreement under A.R.S. § 36-2904,

Meets state and federal requirements, and

Is appropriately licensed or certified to provide AHCCCS covered services.

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

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

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

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a fee-for-service member; or a specialist who, upon referral from a member's PCP, has primary responsibility for treating a member's specific illness, injury, or medical condition.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific AHCCCS-covered service and equipment provided to a member. A payment is made in accordance with an upper, or capped, limit established by the Director.

"Case record" means the file and all documents in the file that are used to establish eligibility.

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

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

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

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

"Day" means a calendar day unless otherwise specified in the text.

"DES" means the Department of Economic Security.

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

"Eligible person" means the person defined in A.R.S. § 36-2901.

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

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

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

"Factor" means an organization, a collection agency, a service bureau, or a person who advances money to a provider for accounts receivable that the provider assigns, sells, or otherwise transfers, including transfers through the use of a power

of attorney, to the organization, the collection agency, the service bureau, or the person that receives an added fee or a deduction of a portion of the face value of the accounts receivable in return for the advanced money. The term "factor" does not include a business representative, such as a bailing agent or an accounting firm described within these rules, or a health care institution.

"Experimental services" means investigational services. Experimental services are associated with a treatment or diagnostic evaluation which:

Is not generally and widely accepted as a standard of care in the practice of medicine in the United States, or

Does not have evidence of safety and effectiveness documented in peer reviewed articles in medical journals published in the United States, or

Lack authoritative evidence by the professional medical community of safety and effectiveness because the services are rarely used, novel, or relatively unknown.

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

"FESP" means federal emergency services program that is designed to provide emergency medical services covered under 42 U.S.C. 1396b(v), to treat an emergency medical condition for a categorically-eligible member who is determined eligible under A.R.S. § 36-2903.03.

"FQHC" means federally qualified health center.

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

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

"Inmate of a public institution" means a person defined by 42 CFR 435.1009.

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

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

"Medical services" means health care services provided to a member by a physician, a practitioner, a dentist, or by a health professional and technical personnel under the direction of a physician, a practitioner, or a dentist.

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

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

"Member" is defined in A.R.S. § 36-2901.

"NF" means a nursing facility defined in 42 U.S.C. 1396r(a).

"Noncontracting provider" is defined in A.R.S. § 36-2901.

"Provider" means a person or entity who subcontracts with a contractor for the delivery of services under this Article.

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

"Service location" means any location at which a member obtains any health care service provided by a contractor of record under the terms of a contract.

"Service site" means a location designated by a contractor of record as the location at which a member is to receive health care services.

"SESP" means state emergency services program covered under R9-22-217 to treat an emergency medical condition for a qualified alien or noncitizen who is determined eligible under A.R.S. § 36-2901.06.

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

"Spouse" means the husband or wife who has entered into a contract of marriage, recognized as valid by Arizona.

"SSA" means Social Security Administration under P.L. 103-296, Title I.

"SSI" means Supplemental Security Income under Title XVI of the Social Security Act, as amended.

"SSN" means social security number.

"Standard of care" means a medical procedure or process that is established as a model for treating a specific illness, injury or medical condition through custom, peer review or an authority that is accepted by the medical community.

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

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

A marketing organization; or

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

**R9-22-102. Scope of Services Related Definitions**

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

~~1.~~ "Ambulance" means a medical transport vehicle that is registered by and part of an ambulance service licensed by the Arizona Department of Health Services according to A.R.S. Title 36, Chapter 21.1, and 19 A.A.C. 13; and includes ground, air, and water ambulances that are staffed and equipped as a basic life support (BLS) vehicle or an advanced life support (ALS) vehicle. Ambulances may be used to provide:
- ~~a.~~ Emergency transportation for eligible persons or members requiring emergency medical services; or
- ~~b.~~ Medically necessary transportation from ~~1~~ one medical facility to another; and
- ~~c.~~ Any necessary emergency medical services that a certified emergency medical technician (EMT), an Intermediate EMT or paramedic, a registered nurse or a physician assistant, provides before, during, or after transportation.

~~2.~~ "Covered services" means the health and medical services described in Articles 2 and 12.

~~3.~~ "Dentures" means a partial or complete set of artificial teeth and services that are determined to be medically necessary, and the primary treatment of choice, or an essential part of an overall treatment plan, designed to alleviate a medical condition as determined by the primary care provider in consultation with the dental service provider.

~~4.~~ "Diagnostic services" means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

~~5.~~ "DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

~~6.~~ "Emergency medical condition" has meaning in 42 U.S.C. 1396b(v).

~~7.~~ "Emergency medical services" means services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
- ~~a.~~ Placing the patient's health in serious jeopardy;
- ~~b.~~ Serious impairment to bodily functions; or
- ~~c.~~ Serious dysfunction of any bodily organ or part.

~~8.~~ "E.P.S.D.T. services" means early and periodic screening, diagnosis, and treatment services for ~~eligible persons or~~ members less than 21 years of age. For the purpose of these rules:
- ~~a.~~ "Early" means, ~~in the case of an eligible person less than 21 years of age,~~ as early as possible in the ~~person's~~ member's life or, in other cases, as soon as the person becomes eligible;
- ~~b.~~ "Periodic" means at appropriate intervals established by the Administration for screening to ensure that a condition, illness, or injury is not incipient or present;
- ~~c.~~ "Screening" means the use of quick, simple procedures carried out among large groups of people to distinguish apparently well persons from those who may have a condition, illness, or injury and the identification of those in need of more definitive study. For the purposes of AHCCCS, screening and diagnosis are not synonymous;
- ~~d.~~ "Diagnosis" means the determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental and psychological examination, laboratory tests, X-rays; and
- ~~e.~~ "Treatment" means any type of health care or service recognized under the state Plan submitted according to Title XIX of the Social Security Act to prevent or ameliorate a condition, illness, or injury or prevent or correct abnormalities detected by screening or diagnostic procedures.

~~9.~~ "Hearing aid" means ~~a wearable~~ an instrument or device designed for, or represented as aiding or compensating for impaired or defective human hearing, and any parts, attachments, or accessories of the instrument or device.

~~10.~~ "Home health services" means the services that are provided by a home health agency that coordinates in-home intermittent services for curative, habilitative care. This includes home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.

~~11~~. "Medical supplies" means consumable items that are designed specifically to meet a medical purpose.
~~12~~. "Occupational therapy" means the medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual's ability to perform tasks required for independent functioning.
~~13.~~ "Pharmaceutical service" means medically necessary medications that are prescribed by a physician, practitioner, or dentist~~, and are dispensed by a licensed pharmacist through a registered pharmacy~~ under R9-22-209.
~~14.~~ "Physical therapy" means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.
~~15.~~ "Physician" means a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17.
~~16.~~ "Practitioner" means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.
~~17.~~ "Prescription" means an order to provide covered services, which is signed or transmitted by a provider authorized to prescribe or order services.
~~18.~~ "Primary care provider" ("PCP") means an individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of a member's or eligible person's health care.
~~19.~~ "Primary care provider services" means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.
~~20.~~ "Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services contingent on their medical necessity.
~~21.~~ "Private duty nursing services" means nursing services provided to a member or eligible person who requires more individual and continuous care than is available from a visiting nurse, or routinely provided by the nursing staff of a nursing facility or ICF-MR, and that are provided by a registered nurse or licensed practical nurse.
~~22.~~ "Radiology services" means professional and technical services rendered to provide medical imaging, radioisotope services, and radiation oncology.
~~23.~~ "Rehabilitation services" means physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level.
~~24.~~ "Respiratory therapy" means treatment services to restore, maintain, or improve respiratory functions and is provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.
~~25.~~ "Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of these rules.
~~26.~~ "Specialist" means a Board eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty.
~~27.~~ "Speech therapy" means medically prescribed diagnostic and treatment services provided by, or under the supervision of, a certified speech therapist.
~~28.~~ "Sterilization" means a medically necessary procedure, not for purpose of family planning, to render an eligible person or member barren in order to:
~~a.~~ Prevent the progression of disease, disability, or adverse health conditions; or
~~b.~~ Prolong life and promote physical health.

## ARTICLE 2. SCOPE OF SERVICES

### R9-22-201. General Requirements

~~A.~~ ~~In addition to requirements and limitations specified in this Chapter, the following general requirements apply:~~
~~1. Covered services provided to a member shall be medically necessary and provided by, or under the direction of, a primary care provider or a dentist; specialist services shall be provided under referral from, and in consultation with, the primary care provider.~~
~~a. The role or responsibility of a primary care provider, as defined in these rules, shall not be diminished, by the primary care provider delegating the provision of primary care for a member to a practitioner.~~
~~b. Behavioral health screening and evaluation services may be provided, without referral from a primary care provider. Behavioral health treatment services shall be provided only under referral from and in consultation with the PCP, or upon authorization by the contractor or its designee.~~
~~c. The contractor may waive the referral requirements.~~
~~2. Covered services provided to an eligible person through the AHCCCS Administration shall be medically necessary and provided by, or under the direction of, an attending physician, practitioner, or dentist;~~
~~3. Services shall be rendered in accordance with state and federal laws and regulations, the Arizona Administrative Code and AHCCCS contractual requirements;~~
~~4. Experimental services as determined by the director, or services provided primarily for the purpose of research, shall not be covered;~~

5. AHCCCS services shall be limited to those services that are not covered for a member or eligible person who is a Medicare beneficiary;
6. Services or items, if furnished gratuitously, are not covered and payment shall be denied;
7. Personal care items are not covered and payment shall be denied;
8. AHCCCS covered services shall not be covered if provided to:
   a. An inmate of a public institution;
   b. A person who is in residence at an institution for the treatment of tuberculosis; or
   c. A person age 21 through 64 who is in an institution for the treatment of mental diseases, unless provided under Article 12.

**B.** Services shall be provided by AHCCCS registered personnel or facilities that meet state and federal requirements, and are appropriately licensed or certified to provide the services.

**C.** Payment for services or items requiring prior authorization may be denied if prior authorization by the Administration or contractor is not obtained. Services provided during the prior period coverage do not require authorization. Emergency services under A.R.S. § 36-2908 do not require prior authorization.
1. For an eligible person, the AHCCCS Administration shall prior authorize services based on the diagnosis, complexity of procedures, and prognosis, and be commensurate with the diagnostic and treatment procedures requested by the eligible person's attending physician or practitioner.
2. Services for unrelated conditions, requiring additional diagnostic and treatment procedures, require additional prior authorization.
3. In addition to the requirements of Article 7, written documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.

**D.** Covered services rendered to a member shall be provided within the service area of the member's primary contractor except when:
1. A primary care provider refers a member out of the contractor's area for medical specialty care;
2. A covered service that is medically necessary for a member is not available within the contractor's service area;
3. A net savings in service delivery costs can be documented without requiring undue travel time or hardship for a member or the member's family;
4. A member is placed in a nursing facility located out of the contractor's service area;
5. Services provided are during the prior period coverage time-frame authorized under Article 3; and
6. The service is otherwise authorized by the contractor based on medical practice patterns, and cost or scope of service considerations.

**E.** When a member is traveling or temporarily residing out of the service area of the member's contractor, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

**F.** A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in these rules and in contract.

**G.** If a member or eligible person requests the provision of a service that is not covered by AHCCCS or not authorized by the contractor, the service may be rendered to the member or eligible person by an AHCCCS-registered service provider under the following conditions:
1. A document that lists the requested services and the estimated cost of each is prepared by the contractor and provided to the member or eligible person; and
2. The signature of the member or eligible person is obtained in advance of service provision indicating that the services have been explained to the member or eligible person, and that the member or eligible person accepts responsibility for payment.

**H.** The Director shall determine the circumstances under which an eligible person may receive services, other than emergency services, from service providers outside the eligible person's county of residence, or outside the state. Criteria considered by the Director in making this determination shall include availability and accessibility of appropriate care, and cost effectiveness.

**I.** If a member is referred out of the contractor's service area to receive an authorized medically necessary service the contractor shall also provide all other medically necessary covered services for the member during that time.

**J.** The restrictions, limitations, and exclusions in this Article shall not apply to the following groups:
1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27, and wishing to negotiate for extended benefits; and
2. Contractors electing to provide noncovered services.
   a. The costs associated with providing any noncovered service to a member shall not be included in development or negotiation of capitation.
   b. Noncovered services shall be paid from administrative revenue or other contractor funds, unrelated to Title XIX services.

~~**K.** In accordance with A.R.S. § 36-2907 the Director may, upon 30 days advance written notice to contractors and counties, modify the list of services for all members except those members categorically eligible according to Title XIX of the Social Security Act, as amended.~~

**A.** For the purposes of this Article, authorization by:
1. The Administration refers to scope of services for fee for service members, and
2. The contractor refers to scope of services for prepaid capitated members.

**B.** In addition to requirements and limitations specified in this Chapter, the following general requirements apply:
1. A primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services as authorized by the Administration or the contractor:
   a. Covered services are medically necessary, cost effective and federally and state reimbursable;
   b. Covered services for the state and federal emergency services programs are under R9-22-217;
   c. Delegation of the provision of care to a practitioner, shall not diminish the role or responsibility of the primary care provider;
   d. Specialist services shall be provided under referral from, and in consultation with, the primary care provider;
   e. A member may receive behavioral health evaluation services without a referral from a primary care provider. Behavioral health treatment services are provided only under referral from and in consultation with the PCP, or upon authorization by the contractor or its designee.
   f. A female member shall have direct access to gynecology providers within the contractor's network for preventive and routine services without a referral;
   g. The Administration or the contractor may waive the covered services referral requirements noted in this Article.
2. A member may receive a treatment that is considered the standard of care, as determined by the AHCCCS Chief Medical Officer;
3. A member shall receive services according to state and federal laws and regulations, the Arizona Administrative Code and AHCCCS contractual requirements;
4. An AHCCCS registered provider shall provide covered services within the provider's scope of practice;
5. In addition to the specific exclusions and limitations otherwise specified under this Article the following are not included:
   a. A service that is determined by the Chief Medical Officer to be experimental or provided primarily for the purpose of research;
   b. Services or items, if furnished gratuitously; and
   c. Personal care items.
   6. The Administration or a contractor shall not cover medical or behavioral health services if provided to:
   a. An inmate of a public institution;
   b. A person who is in residence at an institution for the treatment of tuberculosis; or
   c. A person age 21 through 64 who is in an institution for the treatment of mental diseases, unless provided under Article 12.

**C.** The Administration or contractor has authority to deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7. Documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.

**D.** Services provided during the prior period coverage or emergency services under A.R.S. § 36-2908 do not require prior authorization. Additional diagnostic and treatment procedures for a condition that is unrelated to the emergent condition require prior authorization by the Administration or contractor.

**E.** Outside the primary contractor service area, a member shall receive covered services only when one of the following apply:
1. A primary care provider refers a member out of the contractor's area for medical specialty care,
2. A covered service that is medically necessary for a member is not available within the contractor's service area,
3. A net savings in service delivery costs can be documented without requiring undue travel time or hardship for a member or the member's family,
4. The contractor authorizes placement in a nursing facility located out of the contractor's service area,
5. Services provided are during the prior period coverage time-frame, or
6. The contractor considers criteria that includes availability and accessibility of appropriate care and cost effectiveness.

**F.** When a member is traveling or temporarily residing out of the member's contractor service area, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

**G.** A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in these rules and in contract.

**H.** The Administration shall determine the circumstances under which a member may receive services, other than emergency services, from service providers outside the member's county of residence, or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care, and cost effectiveness.

**I.** If a member requests the provision of service that is not covered by the Administration or not authorized by a contractor, an AHCCCS registered provider may render the service and request reimbursement from the member under the following conditions:
1. A provider shall prepare and provide the member with a document that lists the requested services and the estimated cost of each service, and
2. A member signs the document prior to the provision of services indicating that the member understands and accepts the responsibility for payment.

**J.** If a member is referred out of the contractor's service area to receive an authorized medically necessary service a contractor shall also provide all other medically necessary covered services for the member during that time.

**K.** The restrictions, limitations, and exclusions in this Article shall not apply to the following groups:
1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27, and wishing to negotiate for extended benefits; and
2. Contractors electing to provide noncovered services.
   a. The costs associated with providing any noncovered service to a member shall not be included in development or negotiation of capitation.
   b. Noncovered services are paid from administrative revenue or other contractor funds, which are unrelated to Title XIX services.

**L.** Under A.R.S. § 36-2907, the Administration may, upon 30 days written notice, modify the list of services for members defined under A.R.S. § 36-2901(6) (a).

**R9-22-204. Inpatient General Hospital Services**

**A.** ~~Inpatient services provided in a general hospital shall be provided by contractors, fee-for-service providers, or noncontracting providers and shall include:~~ Contractors, fee-for-service providers or non-contracting providers shall render inpatient general hospital services including:
1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
   a. Maternity care, including labor, delivery, and recovery room, birthing center, and newborn nursery;
   b. Neonatal intensive care unit (NICU);
   c. Intensive care unit (ICU);
   d. Surgery, including surgery room and recovery room;
   e. Nursery and related services;
   f. Routine care; and
   g. Emergency behavioral health services are provided under Article 12 of this Chapter for a member eligible under A.R.S. §§ 36-2901(6)(a)~~, 36-2901.01, and 36-2901.04 provided under 9 A.A.C. 22, Article 12.~~
2. Ancillary services as specified by the Director and included in contract:
   a. Laboratory services;
   b. Radiological and medical imaging services;
   c. Anesthesiology services;
   d. Rehabilitation services;
   e. Pharmaceutical services and prescribed drugs;
   f. Respiratory therapy;
   g. Blood and blood derivatives; and
   h. Central supply items, appliances, and equipment not ordinarily furnished to all patients and customarily reimbursed as ancillary services.

**B.** The following limitations apply to general inpatient hospital services that are provided by fee-for-service providers and for which the Administration is financially responsible:
~~1. The cost of inpatient hospital accommodation for a member shall be incorporated into the rate paid for the level of care as specified in subsection (A)(1).~~
~~2. Prior authorization shall be obtained from the Administration for the following inpatient hospital services provided to a member:~~
   ~~a. Nonemergency and elective admission, including psychiatric hospitalization;~~
   ~~b. Elective surgery, with the exception of voluntary sterilization procedures, shall be authorized before the surgery;~~
   ~~c. An emergency hospitalization that exceeds three days or an intensive care unit admission that exceeds one day;~~
   ~~d. Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through AHCCCS Administration concurrent team review; and~~
   ~~e. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury before service delivery.~~
1. Providers shall obtain prior authorization from the Administration for the following inpatient hospital services:
   a. Nonemergency and elective admission, including psychiatric hospitalization;
   b. Elective surgery, excluding voluntary sterilization procedures; and

c. Services or items provided to reconstruct or improve personal appearance after an illness or injury.

2. Concurrent review:
   a. The Administration has the authority to perform concurrent review for hospitalizations to establish medical necessity.
   b. Providers shall notify the Administration no later than the fourth day of hospitalization after an emergency admission or no later than the second day after an intensive care unit admission so that the Administration may initiate concurrent review of the hospitalization.
   c. The Administration has the authority to deny claims for failure to provide timely notification as specified in this Article.

**R9-22-205. ~~Physician and Primary Care Physician and Practitioner Services~~ Physician, and Practitioner, and Primary Care Provider Services**

**A.** ~~Primary care provider services shall be furnished by a physician or practitioner and shall be covered for members when rendered within the provider's scope of practice under A.R.S. Title 32. A member may receive these services through an attending physician or practitioner. Primary care provider services may be provided in an inpatient or outpatient setting and shall include at a minimum:~~ The primary care provider, attending physician or practitioner shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member is eligible to receive primary care provider services in an inpatient or outpatient setting including at a minimum:

1. Periodic health examination and assessment;
2. Evaluation and diagnostic workup;
3. Medically necessary treatment;
4. Prescriptions for medication and medically necessary supplies and equipment;
5. Referral to a specialist or other health care professional when medically necessary;
6. Patient education;
7. Home visits when medically necessary;
8. Covered immunizations; and
9. Covered preventive health services.

**B.** The following limitations and exclusions apply to physician and practitioner services and primary care provider services:

1. Specialty care and other services provided to a member upon referral from a primary care provider or to a member upon referral from the attending physician or practitioner ~~shall be~~ are limited to the service or condition for which the referral is made, or for which authorization is given~~, unless referral is waived by the Administration;~~
2. ~~If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), the physical examination shall be covered by the member's contractor, or the Administration, except if an additional or alternative objective to satisfy the requirement of an outside public or private agency. Alternative objectives may include physical examination and resulting documentation for:~~ The Administration or a contractor shall not cover a member's physical examination when the sole purpose results in documentation for:
   a. Qualification for insurance;
   b. Pre-employment physical evaluation;
   c. Qualification for sports or physical exercise activities;
   d. Pilot's examination (FAA);
   e. Disability certification for establishing any kind of periodic payments;
   f. Evaluation for establishing 3rd-party liabilities; or
   g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A).
3. Orthognathic surgery ~~shall be~~ is covered only for members who are less than 21 years of age;
4. The following services ~~shall be~~ are excluded from AHCCCS coverage:
   a. Infertility services, reversal of surgically induced infertility (sterilization), and ~~sex-change operations~~ gender reassignment surgeries;
   b. Abortion counseling services;
   c. ~~Abortions, unless authorized under federal or state law~~ Abortions, unless authorized under federal law, with the exception of abortions performed under the State Emergency Services Program;
   d. Services or items furnished solely for cosmetic purposes; and
   e. Hysterectomies unless determined medically necessary.
5. ~~Prior authorization from the Administration shall be~~ is required for fee-for-service providers to render the following services to members:
   a. ~~Elective or scheduled surgeries with the exception of voluntary sterilization procedures;~~
   b. ~~Services or items provided to reconstruct or improve personal appearance after an illness or injury.~~

**R9-22-207. Dental Services**

**A.** ~~Emergency dental care, which encompasses the following services, shall be covered:~~ The Administration or a contractor shall cover dental services for members less than 21 years of age under R9-22-213.

~~1. Emergency oral diagnostic examination including laboratory and radiographs when necessary to determine an emergent condition;~~

~~2. Immediate palliative treatment, including extractions when professionally indicated, for relief of severe pain associated with an oral or maxillofacial condition;~~

~~3. Initial treatment for acute infection;~~

~~4. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone, or soft tissue;~~

~~5. Reoperative procedures; and~~

~~6. Anesthesia appropriate for optimal patient management~~

~~**B.** The following limitations shall apply to emergency dental services provided by the Administration's fee-for-service providers:~~

~~1. Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection. Root canals are limited to treatment for acute infection or to eliminate pain;~~

~~2. Routine restorative procedures and routine root canal therapy are not emergency services;~~

~~3. Radiographs are limited to symptomatic teeth for use as a diagnostic tool preceding treatment and to support the need for, and provision of, dentures;~~

~~4. Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxillae and mandible; and~~

~~5. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.~~

**B.** The Administration or a contractor shall cover the following emergency dental care services.

1. Emergency oral diagnostic examination including laboratory and radiographs when necessary to determine an emergent condition;
2. Immediate palliative treatment, including extractions when professionally indicated, for relief of severe pain associated with an oral or maxillofacial condition;
3. Initial treatment for acute infection;
4. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone, or soft tissue;
5. Preoperative procedures; and
6. Anesthesia appropriate for optimal patient management.

**C.** Covered denture services include medically necessary dental services and procedures associated with, and including, the provision of dentures.

**D.** The following limitations shall apply to dentures: ~~provided by the Administration's fee-for-service providers:~~

1. Provision of dentures for cosmetic purposes is not a covered service;
2. Extractions of asymptomatic teeth are not covered unless their removal constitutes the most cost-effective dental procedure for the provision of dentures;
3. Radiographs are limited to use as a diagnostic tool preceding treatment of symptomatic teeth and to support the need for, and provision of, dentures.~~; and~~

~~4. Prior authorization of dental services for an eligible person is required from the Administration for the following:~~

~~a. Provision of medically necessary dentures;~~

~~b. Replacement, repair, or adjustment to dentures; and~~

~~c. Provision of obturators or other prosthetic appliances for restoration or rehabilitation~~.

**E.** The following limitations shall apply to emergency dental services provided by the Administration's fee-for-service providers for members age 21 or older:

1. Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection. Root canals are limited to treatment for active infection or to eliminate pain; restorative procedures and routine root canal therapy are not emergency services;
3. Radiographs are limited to symptomatic teeth for use as a diagnostic tool preceding treatment and to support the need for, and provision of, dentures;
4. Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxillae and mandible; and
5. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.

**F.** Prior authorization of dental services for a member is required from the Administration for the following:

1. Provision of medically necessary dentures;
2. Replacement, repair, or adjustment to dentures; and

3. Provision of obturators or other prosthetic appliances for restoration or rehabilitation.

**R9-22-208. Laboratory, Radiology, and Medical Imaging Services**

Laboratory, radiology, and medical imaging services ~~shall be~~ are covered services if:

1. Prescribed ~~for~~ by the ~~members~~ member's ~~by a~~ attending physician, practitioner, primary care provider or a dentist, or ~~if~~ prescribed by a physician or practitioner upon referral from the primary care provider or dentist.~~, unless referral is waived by the Administration;~~
2. ~~Provided for an eligible person by a fee-for-service provider and the services are prescribed by the attending physician, practitioner, or dentist of the eligible person;~~ Provided by licensed health care providers in:
   a. Hospitals
   b. Clinics
   c. Physician offices, or
   d. Other health care facilities.
3. ~~Provided in hospitals, clinics, physician offices, or other health care facilities by licensed health care providers; and~~
4. ~~Provided by a provider that meets all applicable state and federal license and certification requirements and provides only services that are within the scope of practice stated in the provider's license or certification.~~

**R9-22-209. Pharmaceutical Services**

**A.** ~~Pharmaceutical services may be provided by an inpatient or outpatient provider including hospitals, clinics, or appropriately licensed health care facilities and pharmacies.~~ An inpatient or outpatient provider, including hospitals, clinics, or other appropriately licensed health care facilities and pharmacies may provide pharmaceutical services.

**B.** The Administration or ~~its~~ a contractor ~~shall make~~ require pharmaceutical services to be:

1. ~~available~~ Available during customary business hours, and ~~shall be~~
2. ~~located~~ Located within reasonable travel distance of a member's residence.

**C.** ~~Pharmaceutical services shall be covered if prescribed for a member by the member's primary care provider or dentist, or if prescribed by a specialist upon referral from the primary care provider unless referral is waived by the Administration or upon authorization by the contractor or its designee. Pharmaceutical services provided for an eligible person shall be covered if prescribed by the attending physician, practitioner, or dentist.~~ Pharmaceutical services are covered if:

1. Prescribed for a member by the member's primary care provider, attending physician, practitioner, or dentist; or
2. If prescribed by a specialist upon referral from the primary care provider or attending physician; or
3. If the contractor or its designee authorizes the service.

**D.** The following limitations shall apply to pharmaceutical services:

1. A medication personally dispensed by a physician or dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. A prescription or refill in excess of a 30-day supply or a 100-unit dose is not covered unless:
   a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is greater.
   b. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is greater.
   c. The medication is prescribed for ~~birth control~~ contraception and the prescription is limited to no more than a 100-day supply.
3. ~~An over the counter medication may be covered as an alternative to prescription medication only if it is available and less costly than a prescription medication.~~ An over the counter medication, in lieu of a covered prescription medication, is covered only when an appropriate, equally effective, and safe, alternative is available and is less costly than a covered prescription medication.
4. ~~A prescription is not covered if filled or refilled in excess of the number specified, or if the initial prescription or refill is dispensed more than 1 year from the original prescribed order.~~
5. ~~Approval by the authorized prescriber is required for all changes in, or additions to, an original prescription. The date of a prescription change shall be clearly indicated and initialed by the dispensing pharmacist.~~

**E.** ~~A contractor shall monitor and ensure that a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.~~

A contractor shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being.

**R9-22-210. Emergency Medical and Behavioral Health Services**

**A.** ~~Provision of and payment for emergency services. An emergency medical or behavioral health service is provided based on the prudent layperson standard to a member enrolled with a contractor by a licensed provider, registered with AHCCCS to provide the services. Emergency services shall be provided under 42 U.S.C. 1396u-2.~~

Provision of and payment for emergency services. An AHCCCS registered provider shall render an emergency medical or behavioral health service based on the prudent layperson standard to a member enrolled with a contractor. Emergency services shall be provided under 42 U.S.C. 1396u-2.

**B.** Verification. A provider of emergency services shall verify a member's eligibility and enrollment status through the Administration ~~to determine the need for notification to a contractor for a member, or the Administration for an eligible person, and to determine the party responsible for payment of services rendered.~~ to determine the party responsible for the payment of services rendered, and to determine the need for notification to a contractor for a member.

**C.** Access. Access to an emergency room, emergency medical, or behavioral health services shall be available 24 hours per day, 7 days per week in each contractor's service area. The use of an examining or a treatment room shall be available when required by a physician or a practitioner for the provision of emergency services.

**D.** Behavioral health evaluation. A behavioral health evaluation provided by a psychiatrist or a psychologist shall be covered as an emergency service as under this Section if required to evaluate or stabilize an acute episode of mental disorder or substance abuse.

**E.** Prior authorization. An emergency service does not require prior authorization; however, a provider shall comply with the following notification requirements:

1. A provider and a noncontracting provider furnishing emergency services to a member shall notify a member's contractor within 12 hours from the time a member presents for services;
2. A provider of emergency services ~~for an eligible person~~ is not required to notify the Administration for a fee for service member; and
3. If a member's medical condition is determined not to be an emergency medical condition as defined in Article 1 of this Chapter, a provider shall:
   a. Notify a member's contractor before initiation of treatment;
   b. Follow the prior authorization requirements and protocol of a contractor regarding treatment of a member's nonemergent condition. Failure to provide timely notice or comply with prior authorization requirements of a contractor constitutes cause for denial of payment.

**F.** Post-stabilization services. After a member's emergent condition has been stabilized, a provider and a noncontracting provider shall request authorization from a contractor for post-stabilization under 42 U.S.C. 1396u-2.

**R9-22-211. Transportation Services**

**A.** Emergency ambulance services.

1. ~~Emergency ambulance transportation shall be is a covered service for a member or eligible person. Payment shall be limited to the cost of transporting the member or eligible person in a ground or air ambulance:~~ A member shall receive medically necessary emergency transportation in a ground or air ambulance:
   a. To the nearest appropriate provider or medical facility capable of meeting the member's ~~or eligible person's~~ medical needs; and
   b. When no other means of transportation is both appropriate and available.
2. ~~A ground or air ambulance transport that originates in response to a 911 call or other emergency response system shall be reimbursed by the member's contractor, or the Administration for eligible persons, if the medical condition at the time of transport justified a medically necessary ambulance transport. No prior authorization is required for reimbursement of these transports.~~ The Administration or a member's contractor shall reimburse a ground or air ambulance transport that originates in response to a 911 call or other emergency response system:
   a. If the member's medical condition justifies the medical necessity of the type of ambulance transportation received,
   b. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs,
   c. No prior authorization is required for reimbursement of these transports.
3. ~~Determination of whether transport is medically necessary shall be based upon the medical condition of the member or eligible person at the time of transport.~~ The member's medical condition at the time of transport determines whether the transport is medically necessary.
4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure to notify the contractor may constitute cause for denial of claims.
5. Notification to the Administration of emergency transportation provided to ~~an eligible person~~ a member is not required, but the provider shall submit documentation with the claim which justifies the service.

~~**B.** Medically necessary nonemergency transportation.~~

~~1. As specified in contract, contractors shall arrange or provide medically necessary nonemergency transportation services for a member who is unable to arrange or pay for the member's own transportation to a service site or location if free transportation services are not available.~~

~~2. If an eligible person requires medically necessary non-emergency transportation due to an inability to arrange or pay for the services, or the services are not available at no cost, the attending physician or practitioner shall order those services.~~

**B.** The Administration or a contractor covers air ambulance services only if:
1. The air ambulance transport is initiated upon the request of:
   a. An emergency response unit, or
   b. A law enforcement official, or
   c. A clinic or hospital medical staff member, or
   d. A physician, or a practitioner; and
2. The point of pickup:
   a. Is inaccessible by ground ambulance, or
   b. Is a great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition, or
3. The medical condition of the member requires immediate:
   a. Intervention from emergency ambulance personnel, or
   b. Intervention from providers with the appropriate facilities to treat the member's condition, and
   c. Ground ambulance service will not suffice.

~~**C.** Air ambulance services shall be covered only if:~~
~~1. The air ambulance transport is initiated upon the request of: an emergency response unit, a law enforcement official, a hospital or clinic medical staff member, a physician, or a practitioner;~~
~~2. The point of pickup: is: inaccessible by ground ambulance, or great distances, or other obstacles are involved in getting emergency services to the member or eligible person or transporting the member or eligible person to the nearest hospital or other provider with appropriate facilities; and~~
~~3. The medical condition of the member or eligible person requires timely ambulance service and ground ambulance service will not suffice.~~

**C.** Medically necessary nonemergency transportation.
1. Transportation is limited to the cost of transporting the member to an appropriate provider capable meeting the member's medical needs.
2. As specified in contract, contractors shall arrange or provide medically necessary nonemergency services for a member who is unable to arrange transportation to a service site or location.
3. For a fee for service member, the Administration shall authorize medically necessary nonemergency transportation for a member who is unable to arrange transportation to a service site or location.

~~**D.** Meals, lodging, and escort services.~~
~~1. Expenses for meals, lodging, and transportation for a member or eligible person while en route to, returning from, an approved and prior authorized health care service site out of the member's or person's service area or county of residence shall be an AHCCCS covered service.;~~
~~2. Meals, lodging, and transportation expenses of an escort, who may be a family household member an eligible person or a member out of the eligible person's or member's service area, be covered if the services of the escort are ordered in writing by the member's primary care or the eligible person's attending physician or practitioner. A salary for an escort shall be covered if the escort is not a part of the eligible person's or member's family household.~~

**D.** The Administration or a contractor shall cover expenses for transportation en route to and returning from an approved and prior authorized health care service site for a member provided by a family or household member, friend or neighbor when:
1. The transportation services are authorized by the Administration or the member's contractor or designee; and
2. The family household member, friend, or neighbor is an AHCCCS registered provider; and
3. No other means of appropriate transportation is available.

~~**E.** Limitations.~~
~~1. Family, household members, friends, and neighbors shall be reimbursed for providing transportation services only if:~~
~~a. The services are ordered in writing by the member's PCP or the eligible person's attending physician or practitioner; or~~
~~b. The services are authorized by the member's contractor or designee; and~~
~~c. Appropriate free transportation or public transportation is not available.~~
~~2. A charitable organization routinely providing transportation services at no cost to ambulatory or chairbound persons shall not charge or seek reimbursement from the Administration or contractors for the provision of these services to a member or eligible person but may enter into subcontractual agreements with AHCCCS contractors for medically necessary transportation services provided to their members.~~
~~3. Payment for meals, lodging, and transportation of an escort and a salary not to exceed the federal minimum wage shall be allowed only when the member or eligible person requires covered services that are not available in the service area. If the member or eligible person is admitted to an inpatient facility, meals, lodging, and a salary for the~~

~~escort shall be covered only when accompanying the member or eligible person en route to, and returning from, the inpatient facility.~~

**E.** The Administration or a contractor shall cover expenses for meals, lodging, and transportation for a member en route to or returning from an approved and prior authorized health care service site out of the member's service area or county of residence.

**F.** The Administration or a contractor shall cover the expense of meals, lodging, and transportation for:

1. A family household person accompanying a member when:
   a. The member is en route to or returning from an approved and prior authorized health care service site out of the member's service area or county of residence; and
   b. The meals, lodging, and transportation services are authorized by the Administration or the member's contractor or designee.
2. An escort who is not a family member when:
   a. The member is en route to or returning from an approved and prior authorized health care service site, including en route to and from an inpatient facility, out of the member's service or county of residence; and
   b. The escort services are authorized by the Administration or the member's contractor or designee.
   c. The escort salary shall not exceed the federal minimum wage**.**

**~~F.~~G.** ~~Subject to A.R.S. § 36-2908(E) prior~~ Prior authorization from the Administration for transportation services provided for ~~eligible persons~~ a member is required for the following:

1. Medically necessary nonemergency transportation services not originated through a 911 call or other emergency response system; and
2. All meals, lodging, and services of an escort accompanying the ~~eligible person~~ member under ~~subsection (D)(2)~~ this Section.

**H.** A charitable organization routinely providing transportation services at no cost to ambulatory or persons shall not charge or seek reimbursement from the Administration or contractors for provision of these services to a member ~~or eligible person~~ but may enter into subcontractual with AHCCCS contractors for medically necessary transportation services provided to their members.

**R9-22-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices**

**A.** Medical supplies, durable equipment, and orthotic and prosthetic devices ~~shall be~~ are covered services if:

~~1. Prescribed for a member by the member's primary care provider or if prescribed by a physician or practitioner upon referral from the primary care provider unless referral is waived by the Administration; or~~
~~2. Prescribed by the attending physician or practitioner of an eligible person~~ the member~~; and~~
~~3. Provided in compliance with requirements of this Chapter.~~

1. Prescribed by the primary care provider, attending physician, practitioner, or dentist;
2. Prescribed by a specialist, upon referral from the primary care provider
3. Authorized as required by the Administration, contractor, or contractor's designee.
4. Provided in compliance with requirements of this Chapter.

**B.** ~~Medical supplies include consumable items covered under Medicare that are provided to a member or eligible person and that are not reusable.~~ Medical supplies include consumable items that are disposable and are essential for the member's health.

**C.** Medical equipment includes any durable item, appliance, or piece of equipment that is designed for a medical purpose, is generally reusable by others, and is purchased or rented for a member ~~or eligible person~~.

**D.** Prosthetic and orthotic devices include only those items that are essential for the habilitation or rehabilitation of a member ~~or eligible person~~.

**~~E.~~** ~~Prescriptive lenses are covered if they are the sole prosthetic device after a cataract extraction;~~

**~~F.~~E.** The following limitations apply:

1. ~~If medical equipment cannot be reasonably obtained from alternative resources at no cost, the~~ The medical equipment ~~shall be~~ is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment shall not exceed the cost of the equipment if purchased.
2. Reasonable repair or adjustment of purchased medical equipment ~~shall be~~ is covered if necessary to make the equipment serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
3. ~~Changes~~ A change in, or ~~additions~~ addition to, an original order for medical equipment ~~shall be~~ is covered if approved by the member's primary care provider or authorized prescriber, or prior authorized by the Administration or contractor ~~for eligible persons~~, and ~~shall be~~ is indicated clearly and initialed by the vendor. No change or addition to the original order for medical equipment may be made after a claim for services ~~has been~~ is submitted to the member's contractor, or the Administration ~~for eligible persons~~, without prior written notification of the change or addition.
4. Rental fees shall terminate:
   a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member ~~or eligible person~~ no longer needs the medical equipment;

b. When the member ~~or eligible person~~ is no longer eligible for AHCCCS services; or
c. When the member is no longer enrolled with a contractor, with the exception of transitions of care as specified by the ~~Director.~~ Administration.

5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming ~~shall not be~~ are not covered unless needed to treat a medical condition and ~~provided in accordance with a prescription.~~ are prescribed by the member's primary care provider, an attending physician or practitioner, or if prescribed by a specialist upon referral from the primary care provider, attending physician, or contractor or its designee authorizes the service.
6. First aid supplies ~~shall not be~~ are not covered unless ~~when~~ they are provided in accordance with a prescription.
7. Hearing aids ~~and prescriptive lenses shall not be~~ are not covered for members ~~or eligible persons~~ who are age 21 ~~years of age and~~ or older~~, unless authorized under subsection (E)~~.
8. Prescriptive lenses are not covered for members who are age 21 or older unless they are the sole prosthetic device after a cataract extraction.

~~G.~~ ~~Fee-for-service providers shall obtain prior authorization from the Administration before providing:~~
~~1. Consumable medical supplies exceeding $50.00 per month; or~~
~~2. Durable medical equipment or prosthetic or orthotic devices for an eligible person for all rentals or if the cost to purchase the equipment or device exceeds $200.00.~~

~~H.~~**F.** Liability and ownership.

1. Purchased durable medical equipment provided to members but which is no longer needed may be disposed of in accordance with each contractor's policy.
2. The ~~state~~ Administration shall retain title to purchased durable medical equipment supplied to ~~eligible persons~~ members who become ineligible or no longer require its use.
3. If customized durable medical equipment is purchased by the Administration or contractor ~~for an eligible person, or~~ for a member ~~by the contractor~~, the equipment will remain with the person during times of transition, or upon loss of eligibility.
   a. For purposes of this Section, customized durable medical equipment refers to equipment that has been altered or built to specifications unique to a member's ~~or eligible person's~~ medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.
   ~~b. Customized equipment obtained fraudulently by a member or an eligible person shall be returned for disposal to the member's contractor, or to the Administration. if the customized equipment was purchased for an eligible person.~~
   b. A member shall return customized equipment obtained fraudulently to the Administration or the contractor.

**R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)**

**A.** The following E.P.S.D.T. services ~~shall be~~ are covered for a member less than 21 years of age:

1. Screening services including:
   a. Comprehensive health and developmental history;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history;
   d. Laboratory tests; and
   e. Health education, including anticipatory guidance;
2. Vision services including:
   a. Diagnosis and treatment for defects in vision;
   b. Eye examinations for the provision of prescriptive lenses; and
   c. Provision of prescriptive lenses;
3. Hearing services including:
   a. Diagnosis and treatment for defects in hearing;
   b. Testing to determine hearing impairment; and
   c. Provision of hearing aids;
4. Dental services including:
   a. Emergency dental services as specified in R9-22-207;
   b. Preventive services including screening, diagnosis, and treatment of dental disease; and
   c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
5. Orthognathic surgery;
6. Nutritional assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;
7. Behavioral health services under 9 A.A.C. 22, Article 12;
8. Hospice
   a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within 6 months;

b. Services available to a member receiving hospice care are limited to those allowable under 42 CFR 418.202, December 20, 1994, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no further editions or amendments; and
c. Hospice services are inclusive as stated in subsection (b) except for:
i. Medical services provided that are not related to the terminal illness;
ii. Home delivered meals; and
iii. Hospice services that are provided and covered through Medicare.

~~8.~~9. Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5~~), April 1, 1990, incorporated by reference and on file with the Administration and the Office of Secretary of State. This incorporation by reference contains no future editions or amendments~~.

**B.** ~~All providers~~ Providers of E.P.S.D.T. services shall meet the following standards:
1. Provide services by or under the direction of the member's primary care provider, attending physician, practitioner, or dentist.
2. Perform tests and examinations ~~in accordance with the AHCCCS Administration Periodicity Schedule.~~ under 42 CFR 441 Subpart B, January 29, 1985, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments:
a. Refer members as necessary for dental diagnosis and treatment, and necessary specialty care.
b. Refer members as necessary for behavioral health evaluation and treatment services.

**C.** Contractors shall meet the following additional conditions for E.P.S.D.T. members as specified in contract:
1. Provide information to a member, parent, or guardian concerning E.P.S.D.T. services;
2. Notify a member, parent, or guardian regarding the initiation of E.P.S.D.T. screening and subsequent appointments according to the AHCCCS Administration Periodicity Schedule; and
3. ~~If~~ When requested, offer and provide necessary assistance with scheduling appointments for services and transportation to and from providers under R9-22-211.

**D.** ~~Members with special health care needs shall be referred to CRS.~~ A primary care provider, attending physician, or practitioner shall refer a member with special health care needs under R9-7-301 to CRS.

**R9-22-215. Other Medical Professional Services**

**A.** The following medical professional services ~~provided to a member by a contractor, or an eligible person through the Administration, shall be~~ are covered services when ~~provided~~ a member receives these services in an inpatient, outpatient, or office setting within limitations specified below:
1. Dialysis;
2. Family planning services, including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:
a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
b. Sterilization; and
c. Natural family planning education or referral;
3. Certified nurse midwife services provided by a certified nurse practitioner in midwifery;
4. Licensed midwife service for prenatal care and home births in low-risk pregnancies;
5. Podiatry services when ordered by a member's primary care provider, ~~or an eligible person's~~ attending physician, or practitioner;
6. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services under A.R.S. § 36-2907(D);
9. Private or special duty nursing services when medically necessary and prior authorized;
10. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy within limitations in this Article;
11. Total parenteral nutrition services; and
12. Inpatient Chemotherapy~~.~~;
13. Outpatient Chemotherapy.

**B.** Prior authorization from the Administration for ~~eligible persons~~ members is required for services listed in subsections (A)(4) through ~~(11)~~ (12).

**C.** The following services ~~shall be~~ are excluded as ~~AHCCCS~~ covered services:
1. Occupational and speech therapies provided on an outpatient basis for members ~~and eligible persons~~ age 21 ~~years of age and~~ or older;
2. Physical therapy provided only as a maintenance regimen;
3. Abortion counseling; or

4. Services or items furnished solely for cosmetic purposes.

**R9-22-216. NF, Alternative HCBS Setting, or HCBS**

**A.** NF, alternative HCBS setting, or HCBS as defined in 9 A.A.C. 28, Article 2 ~~shall be~~ are covered for a maximum of 90 days per contract year ~~if a medical condition of a member requires hospitalization. of the member.~~ when the member's medical condition would otherwise require hospitalization.

**B.** Except as otherwise provided in 9 A.A.C. 28, the following services ~~shall be~~ are excluded for purpose of separate billing if provided in a NF, alternative HCBS setting, or HCBS:

1. Nursing services including:
   a. Administration of medication,
   b. Tube feedings,
   c. Personal care services (assistance with bathing and grooming),
   d. Routine testing of vital signs, and
   e. Maintenance of catheters;
2. Basic patient care equipment and sickroom supplies including:
   a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
   b. Bathing and grooming supplies;
   c. Identification devices;
   d. Skin lotions;
   e. Medication cups;
   f. Alcohol wipes, cotton balls, and cotton rolls;
   g. Rubber gloves (nonsterile);
   h. Laxatives;
   i. Beds and accessories;
   j. Thermometers;
   k. Ice bags;
   l. Rubber sheeting;
   m. Passive restraints;
   n. Glycerin swabs;
   o. Facial tissue;
   p. Enemas;
   q. Heating pads;
   r. Diapers; and
   s. Alcoholic beverages;
3. Dietary services including preparation and administration of special diets, and adaptive tools for eating;
4. Services that are included in a nursing facility's room and board charge or services that are required of the nursing facility to meet federal mandates, state licensure standards, or county certification requirements;
5. Administrative physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
6. Physical therapy prescribed only as a maintenance regimen; and
7. Assistive devices and non-customized durable medical equipment.

**C.** ~~Each admission shall be prior authorized by the Administration.~~ The Administration shall prior authorize each NF admission.

# NOTICE OF PROPOSED RULEMAKING

## TITLE 9. HEALTH SERVICES

## CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ARIZONA LONG-TERM CARE SYSTEM

## PREAMBLE

| 1. Sections Affected | Rulemaking Action |
|---|---|
| R9-28-101 | Amend |
| R9-28-102 | Amend |
| R9-28-201 | Amend |
| R9-28-202 | Amend |

| | |
|---|---|
| R9-28-204 | Amend |
| R9-28-205 | Amend |
| R9-28-206 | Amend |

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

Authorizing statute: A.R.S. § 36-2932

Implementing statutes: A.R.S. §§ 36-29-07, 36-2932, 36-2939, 36-2947

**3. A list of all previous notices appearing in the Register addressing the proposed rule:**

Notice of Rulemaking Docket Opening: 7 A.A.R. 5262, November 23, 2001

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

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

**5. An explanation of the rule, including the agency's reasons for initiating the rule:**

The Administration made changes to 9 A.A.C. 28 to provide additional clarity and conciseness to existing rule language. These changes impact two Articles:

• Article 1. Definitions (R9-28-101and R9-28-102), and

• Article 2. Scope of Services (R9-28-201 through R9-22-206).

Following is an explanation of the changes:

9 A.A.C. 28. Article 1. Definitions

The Administration modified, added, or deleted definitions to improve the clarity and conciseness of the rule language.

9 A.A.C. 28. Article 2. Scope of Services

R9-28-201. The Administration made minor changes to improve clarity.

R9-28-202. The Administration made minor changes to improve clarity.

R9-28-204. The Administration amended the content of this Section to improve the clarity and conciseness of the rule language and clarify where institutional services may be provided as well as the limitations.

R9-28-205. The Administration defined "private duty nursing services".

R9-28-206. The Administration amended "ventilator dependent services" by striking "private duty nursing services", as this is a service available to other HCBS members.

**6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:**

Not applicable

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

Not applicable

**8. The preliminary summary of the economic, small business, and consumer impact:**

The contractors, members, providers, and AHCCCS are nominally impacted by the changes to the rule language. These rules define the scope of services for AHCCCS' long-term care program. The Administration is amending these rules to make the rules more clear, concise, and understandable by:

• grouping like concepts to provide clarity and conciseness to the rule language,

• clarifying language that does not clearly present policies or procedures, and

• updating citations to documents incorporated in the rule, as needed.

It is anticipated that the private sector, including small businesses or political subdivisions will not be impacted since the proposed rule language changes are intended to streamline and clarify the existing rules. The Administration, contractors and providers will benefit because the changes provide greater flexibility and clarification of the rule language.

**9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

Proposed rule language will be available on the AHCCCS web site, www.ahcccs.state.az.us. on January 11, 2002. Please send written comments to the above address by 5:00 p.m., February 12, 2002. E-mail will not be accepted.

**10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**

Date: February 12, 2002

Time: 1:00 p.m.

Location: AHCCCS
701 East Jefferson
Phoenix, AZ 85034
Gold Room

Nature: Public Hearing

Date: February 12, 2002

Time: 1:00 p.m.

Location: ALTCS: Arizona Long-term Care System
110 South Church, Suite 3250
Tucson, AZ 85701

Nature: Video Conference Oral Proceeding

Date: February 12, 2002

Time: 1:00 p.m.

Location: ALTCS: Arizona Long-term Care System
3480 East Route 66
Flagstaff, AZ 86004

Nature: Video Conference Oral Proceeding

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

Not applicable

**12. Incorporations by reference and their location in the rules:**

| Description | Date | Location |
|---|---|---|
| 42 CFR Part 418.202 | December 20, 1994 | R9-28-206 |

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

**TITLE 9. HEALTH SERVICES**

**CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**
**ARIZONA LONG-TERM CARE SYSTEM**

**ARTICLE 1. DEFINITIONS**

Section
R9-28-101. General Definitions
R9-28-102. Covered Services Related Definitions

**ARTICLE 2. COVERED SERVICES**

Section
R9-28-201. General Requirements
R9-28-202. Medical Services
R9-28-204. Institutional Services
R9-28-205. Home and Community Based Services (HCBS)
R9-28-206. ALTCS Services that may be Provided to Members ~~or Eligible Persons~~ Residing in either Institutional or HCBS Settings

**ARTICLE 1. DEFINITIONS**

**R9-28-101. General Definitions**

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

| Definition | Section or Citation |
|---|---|
| "217" | 42 CFR 435.217 |
| "236" | 42 CFR 435.236 |
| "Administration" | A.R.S. § 36-2931 |
| "ADHS" | R9-28-111 |
| "Aggregate" | R9-22-107 |
| "AHCCCS" | R9-22-101 |
| "Algorithm" | R9-28-104 |
| "ALTCS" | A.R.S. § 36-2932 |
| "ALTCS acute care services" | R9-28-104 |
| "Alternative HCBS setting" | R9-28-101 |
| "Ambulance" | R9-22-102 |
| "Bed hold" | R9-28-102 |
| "Behavior intervention" | R9-28-102 |
| "Behavior management service" | R9-28-111 |
| "Behavioral health evaluation" | R9-28-111 |
| "Behavioral health medical practitioner" | R9-28-111 |
| "Behavioral health professional" | R9-28-111 |
| "Behavioral health service" | R9-28-111 |
| "Behavioral health technician" | R9-28-111 |
| "Billed charges" | R9-22-107 |
| "Board-eligible for psychiatry" | R9-28-111 |
| "Capped fee-for-service" | R9-22-101 |
| "Case management plan" | R9-28-101 |
| "Case manager" | R9-28-101 |
| "Case record" | R9-22-101 |
| "Categorically-eligible" | A.R.S. § 36-2934 |
| "Certification" | R9-28-105 |
| "Certified psychiatric nurse practitioner" | R9-28-111 |
| "CFR" | R9-28-101 |
| "Clean claim" | A.R.S. § 36-2904 |
| "Clinical supervision" | R9-28-111 |
| "CMS" | R9-22-101 |

| | |
|---|---|
| "Community Spouse" | R9-28-104 |
| "Contract" | R9-22-101 |
| "Contractor" | A.R.S. § 36-2901 |
| "County of fiscal responsibility" | R9-28-107 |
| "Covered services" | R9-22-102 |
| "CPT" | R9-22-107 |
| "CSRD" | R9-28-104 |
| "Day" | R9-22-101 |
| "DES Division of Developmental Disabilities" | A.R.S. § 36-551 |
| "De novo hearing" | R9-28-111 |
| "Developmental disability" | A.R.S. § 36-551 |
| "Diagnostic services" | R9-22-102 |
| "Director" | R9-22-101 |
| "Disenrollment" | R9-22-117 |
| "DME" | R9-22-102 |
| "Eligible person" | A.R.S. § 36-2931 |
| "Emergency medical services" | R9-22-102 |
| "Encounter" | R9-22-107 |
| "Enrollment" | R9-22-117 |
| "Estate" | A.R.S. § 14-1201 |
| "Facility" | R9-22-101 |
| "Factor" | R9-22-101 |
| "Fair consideration" | R9-28-104 |
| "FBR" | R9-22-101 |
| "Grievance" | R9-22-108 |
| "GSA" | R9-22-101 |
| "Guardian" | R9-22-116 |
| "HCBS" | A.R.S. §§ 36-2931 and 36-2939 |
| "Health care practitioner" | R9-28-111 |
| "Hearing" | R9-22-108 |
| "Home" | R9-28-101 |
| "Home health services" | R9-22-102 |
| "Hospital" | R9-22-101 |
| "ICF-MR" | 42 CFR 435.1009 and 440.150 |
| "IHS" | R9-28-101 |
| "IMD" | 42 CFR 435.1009 and R9-28-111 |
| "Indian" | P.L. 94-437 |
| "Institutionalized" | R9-28-104 |
| "Interested Party" | R9-28-106 |
| "JCAHO" | R9-28-101 |
| "License" or "licensure" | R9-22-101 |
| "Medical record" | R9-22-101 |
| "Medical services" | R9-22-101 |
| "Medical supplies" | R9-22-102 |
| "Medically eligible" | R9-28-104 |
| "Medically necessary" | R9-22-101 |
| "Member" | A.R.S. § 36-2931 |
| "Mental disorder" | R9-28-111 |
| "MMMNA" | R9-28-104 |
| "NF" | 42 U.S.C. 1396r(a) |
| "Noncontracting provider" | A.R.S. § 36-2931 |
| "Occupational therapy" | R9-22-102 |
| "Partial care" | R9-28-111 |
| "PAS" | R9-28-103 |
| "PASARR" | R9-28-103 |
| "Pharmaceutical service" | R9-22-102 |
| "Physical therapy" | R9-22-102 |
| "Physician" | R9-22-102 |
| "Post-stabilization services" | 42 CFR 438.114 |

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|---|---|
| "Practitioner" | R9-22-102 |
| "Primary care provider" (PCP) | R9-22-102 |
| "Primary care provider services" | R9-22-102 |
| "Prior authorization" | R9-22-102 |
| "Prior period coverage" | R9-28-101 |
| "Private duty nursing services" | R9-22-102 |
| "Program contractor" | A.R.S. § 36-2931 |
| "Provider" | A.R.S. § 36-2931 |
| "Prudent layperson standard" | 42 U.S.C. 1396u-2 |
| "Psychiatrist" | R9-28-111 |
| "Psychologist" | R9-28-111 |
| "Psychosocial rehabilitation" | R9-28-111 |
| "Quality management" | R9-22-105 |
| "RBHA" | R9-28-111 |
| "Radiology" | R9-22-102 |
| "Reassessment" | R9-28-103 |
| "Redetermination" | R9-28-104 |
| "Referral" | R9-22-101 |
| "Reinsurance" | R9-22-107 |
| "Representative" | R9-28-104 |
| "Respiratory therapy" | R9-22-102 |
| "Respite care" | R9-28-102 |
| "RFP" | R9-22-106 |
| "Room and board" | R9-28-102 |
| "Scope of services" | R9-22-102 |
| "Section 1115 Waiver" | A.R.S. § 36-2901 |
| "Speech therapy" | R9-22-102 |
| "Spouse" | R9-28-104 |
| "SSA" | P.L. 103-296, Title I |
| "SSI" | R9-22-101 |
| "Subcontract" | R9-22-101 |
| "Utilization management" | R9-22-105 |
| "Ventilator dependent" | R9-28-102 |

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

"AHCCCS" is defined in 9 A.A.C. 22, Article 1.

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

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

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

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

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

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

Family foster home under 6 A.A.C. 5, Article 58;

Group foster home defined in 6 A.A.C. 5, Article 59;

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

Adult Therapeutic Foster Home defined in 9 A.A.C 20, Articles 1 and 15; and

Behavioral health service agency specified in A.R.S. § 36-2939(C) and 9 A.A.C. 20, Articles 1, 4, 5, and 6 for Levels I, II, or III; and 9 A.A.C. 20, Articles 1 and 14 for Rural Substance Abuse Transitional Agency.

For a person who is elderly or physically disabled (EPD), and the facility, setting, or institution is registered with AHCCCS:

Adult foster care homes defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939; an assisted living home or residential unit, as defined in A.R.S. § 36-401, and as authorized in A.R.S. § 36-2939.

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

Adult Therapeutic Foster Home defined in 9 A.A.C. 20, Articles 1 and 15; and

Behavioral health service agency specified in A.R.S. § 36-2939(C) and 9 A.A.C. 20, Articles 1, 4, 5, and 6 for Levels I, II, or III; and 9 A.A.C. 20, Articles 1 and 14 for Rural Substance Abuse Transitional Agency; and

Alzheimer's treatment assistive living facility demonstration pilot project as specified in Laws 1999, Ch. 313, § 35.

"Capped fee-for-service" is defined in 9 A.A.C. 22, Article 1.
"Case management plan" means a service plan developed by a case manager that involves the overall management of a member's care, and the continued monitoring and reassessment of the member's need for services.
"Case manager" means a person who is either a degreed social worker, a licensed registered nurse, or a person with a minimum of ~~2~~ two years of experience in providing case management services to a person who is elderly and physically disabled or has developmental disabilities.
"Case record" is defined in 9 A.A.C. 22, Article 1.
"CFR" means Code of Federal Regulations, unless otherwise specified in this Chapter.
"Contract" is defined in 9 A.A.C. 22, Article 1.
"Day" is defined in 9 A.A.C. 22, Article 1.
"DES Division of Developmental Disabilities" is defined in A.R.S. § 36-551.
"Director" is defined in 9 A.A.C. 22, Article 1.
"Disenrollment" is defined in 9 A.A.C. 22, Article 1.
"Eligible person" is defined in A.R.S. § 36-2931.
"Enrollment" is defined in 9 A.A.C. 22, Article 1.
"Facility" is defined in 9 A.A.C. 22, Article 1.
"Factor" is defined in 9 A.A.C. 22, Article 1.
"FBR" means Federal Benefit Rate and is defined in 9 A.A.C. 22, Article 1.
"GSA" is defined in 9 A.A.C. 22, Article 1.
"HCBS" means home and community based services defined in A.R.S. §§ 36-2931 and 36-2939.
"Home" means a residential dwelling that is owned, rented, leased, or occupied at no cost to a member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion and any of these, licensed or certified by a regulatory agency of the state as a:
Health care institution defined in A.R.S. § 36-401;
Residential care institution defined in A.R.S. § 36-401;
Community residential facility defined in A.R.S. § 36-551; or
Behavioral health service facility defined in 9 A.A.C. 20, Articles 1, 4, 5, and 6.
"Hospital" is defined in 9 A.A.C. 22, Article 1.
"ICF-MR" means an intermediate care facility for the mentally retarded and is defined in 42 CFR 435.1009 and 440.150.
"IHS" means the Indian Health Service.
"Indian" is defined in P.L. 94-437.
"JCAHO" means the Joint Commission on Accreditation of Healthcare Organizations.
"License" or "licensure" is defined in 9 A.A.C. 22, Article 1.
"Medical record" is defined in 9 A.A.C. 22, Article 1.
"Medical services" is defined in 9 A.A.C. 22, Article 1.
"Medically necessary" is defined in 9 A.A.C. 22, Article 1.
"Member" is defined in A.R.S. § 36-2931.
"NF" means nursing facility and is defined in 42 U.S.C. 1396r(a).
"Noncontracting provider" is defined in A.R.S. § 36-2931.
"Prior period coverage" means the period of time from the first day of the month of application or the first eligible month whichever is later to the day a member is enrolled with the program contractor. The program contractor receives notification from the Administration of the member's enrollment.
"Program contractor" is defined in A.R.S. § 36-2931.
"Provider" is defined in A.R.S. § 36-2931.
"Referral" is defined in 9 A.A.C. 22, Article 1.
"Reinsurance" is defined in 9 A.A.C. 22, Article 1.
"SSA" means Social Security Administration defined in P.L. 103-296, Title I.
"SSI" is defined in 9 A.A.C. 22, Article 1.
"Subcontract" is defined in 9 A.A.C. 22, Article 1.

**R9-28-102. Covered Services Related Definitions**

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

~~"Ambulance" is defined in 9 A.A.C. 22, Article 1.~~
"Bed hold" means a 24 hour per day unit of service that is authorized by an ALTCS case manager or designee during a period of short-term hospitalization or therapeutic leave that meets the requirement specified in 42 CFR 483.12 and the CMS 1115 Waiver.

"Behavior intervention" means the planned interruption of a member's inappropriate behavior using techniques such as reinforcement, training, behavior modification, and other systematic procedures intended to result in more acceptable behavior.
~~"Covered services" is defined in 9 A.A.C. 22, Article 1.~~
~~"Diagnostic services is defined in 9 A.A.C. 22, Article 1.~~
~~"DME" means durable medical equipment and is defined in 9 A.A.C. 22, Article 1.~~
~~"Emergency medical services" is defined in 9 A.A.C. 22, Article 1.~~
~~"Home health services" is defined in 9 A.A.C. 22, Article 1.~~
~~"Medical supplies" is defined in 9 A.A.C. 22, Article 1.~~
~~"Occupational therapy" is defined in 9 A.A.C. 22, Article 1.~~
~~"Pharmaceutical service" is defined in 9 A.A.C. 22, Article 1.~~
~~"Physical therapy" is defined in 9 A.A.C. 22, Article 1.~~
~~"Physician" is defined in 9 A.A.C. 22, Article 1.~~
~~"Practitioner" is defined in 9 A.A.C. 22, Article 1.~~
~~"Primary care provider" is defined in 9 A.A.C. 22, Article 1.~~
~~"Primary care provider services" is defined in 9 A.A.C. 22, Article 1.~~
~~"Prior authorization" is defined in 9 A.A.C. 22, Article 1.~~
~~"Private duty nursing services" is defined in 9 A.A.C. 22, Article 1.~~
~~"Radiology" is defined in 9 A.A.C. 22, Article 1.~~
~~"Respiratory therapy" is defined in 9 A.A.C. 22, Article 1.~~
"Respite care" means a short-term service provided in a NF or a home and community based service setting to an individual when necessary to relieve a family member or other person caring for the individual.
"Room and board" means lodging and meals.
~~"Scope of services" is defined in 9 A.A.C. 22, Article 1.~~
~~"Speech therapy" is defined in 9 A.A.C. 22, Article 1.~~
"Ventilator dependent", for purposes of ALTCS eligibility, means an individual is medically dependent on a ventilator for life support at least 6 hours per day and has been dependent on ventilator support as an inpatient in a hospital, NF, or ICF-MR for 30 consecutive days.

## ARTICLE 2. COVERED SERVICES

### R9-28-201. General Requirements

In addition to the exclusions and limitations specified in this Article, ALTCS services ~~shall be~~ are:

1. Medically necessary, cost effective, and federally reimbursable;
2. Coordinated by a case manager in accordance with requirements specified in R9-28-510;
3. Prior authorized as required by ~~an eligible person or~~ a member's program contractor or by the Administration~~, when this authorization is required~~:
    a. Services may be denied if required prior authorization is not obtained.
    b. Services provided during ~~a retroactive period of eligibility~~ prior period coverage are exempt from prior authorization requirements~~.~~;
4. Provided in facilities or areas of facilities, licensed or certified according to Article 5, or meet other requirements described in Article 5;
5. ~~Rendered by providers registered with the Administration as authorized to provide the service~~ Rendered by AHCCCS registered providers as authorized and within their scope of practice; and
6. Provided at an appropriate level of care, as determined by the case manager or the primary care provider.

### R9-28-202. Medical Services

The Administration and ~~its contractors~~ a contractor shall cover medical services and provisions specified in 9 A.A.C. 22, Article 2 and Article 12 for ALTCS members ~~and eligible persons~~, subject to the limitations and exclusions specified in those Articles, unless otherwise specified in this Chapter.

### R9-28-204. Institutional Services

**A.** Institutional services ~~shall be~~ are provided in:
1. A ~~nursing facility~~ NF under R9-28-101;
2. An "ICF-MR" under R9-28-101; or
~~3. An "IMD" under R9-28-101.~~
3. Facilities under R9-28-1105(A)(1)(b), (B), (C).

**B.** The Administration and ~~its contractors~~ a contractor shall include the following services in the per diem rate for these facilities:
1. Nursing care services;

2. Rehabilitative services;
3. Restorative services;
4. Social services;
5. Nutritional and dietary services;
6. Recreational therapies and activities;
7. Medical supplies and non-customized durable medical equipment under 9 A.A.C. 22, Article 2;
8. Overall management and evaluation of a member's ~~or eligible person's~~ care plan;
9. Observation and assessment of a member's ~~or eligible person's~~ changing condition;
10. Room and board services, including~~, but not limited to,~~ supporting services such as food and food preparation, personal laundry, and housekeeping;
11. Non-prescription~~,~~ and stock pharmaceuticals; and
12. Respite services not to exceed 30 days per contract year.

**C.** Each facility ~~shall be~~ is responsible for coordinating the delivery of at least the following auxiliary services:

1. Under 9 A.A.C. 22, Article 2:
   a. ~~Medical services~~ Attending physician, practitioner, and primary care provider services;
   b. Pharmaceutical services;
   c. Diagnostic services under R9-22-208;
   d. Emergency services; and
   e. Emergency and medically necessary transportation services.
2. Therapy services, under R9-28-206.

**D.** Limitations. The following limitations apply:

1. A ~~nursing facility~~ NF, ICF-MR, or ~~IMD~~ facilities under R9-28-1105(A)(1)(b), (B), (C) shall place a member ~~or eligible person~~ in a private room only if:
   a. The member or eligible person has a medical condition that requires isolation, and
   b. The member's ~~or eligible person's~~ primary care provider or attending physician ~~gives~~ provides written authorization.
2. Each ICF-MR shall meet the standards in A.R.S. § 36-2939(B)(1), and in 42 CFR, Part 483, Subpart I, February 28, 1992.
3. ~~Convalescent care shall be excluded as a covered service for members and eligible persons specified in A.R.S. Title 36, Chapter 29, Article 1;~~
4.3. Bed hold days ~~for the Administration's~~ as authorized by the Administration or its designee for fee-for-service members and providers shall meet the following criteria:
   a. Short-term hospitalization leave for a member age 21 and over is limited to 12 days per AHCCCS contract year, and is available when ~~an eligible person~~ a member is admitted to a hospital for a short stay. After the short-term hospitalization, the ~~eligible person~~ member is returned to the institutional facility from which leave was taken, and the same bed if the level of care required can be provided in that facility bed; and
   b. Therapeutic leave for a member age 21 and older is limited to 9 days per AHCCCS contract year. A physician order is required for leave from the facility for ~~1~~ one or more overnight stays to enhance psycho-social interaction, or as a trial basis for discharge planning. After the therapeutic leave, the ~~eligible person~~ member is returned to the same bed within the institutional facility;
   c. ~~A combination of therapeutic leave and bedhold days, totaling no more than 21 days per contract year, may be taken by a member under 21 years of age.~~ Therapeutic leave and short-term hospitalization days are limited to a combined total of 21 days for a member under age 21.
5. The Administration or ~~its contractors~~ a contractor shall cover services that are not part of a per diem rate but are ALTCS covered services included in this Article, and deemed necessary by a member's ~~or eligible person's~~ case manager or the case manager's designee if:
   a. The services are ordered by the member's ~~or eligible person's~~ primary care provider; and
   b. The services are specified in a case management plan under R9-28-510.
6. A member age 21 through 64 as defined in 42 CFR 441.150 is eligible for behavioral health services provided in a facility under subsection (A)(3) which has more than 16 beds, for up to 30 days per admission and no more than 60 days per contract year as allowed under the Administration's Section 1115 Waiver with CMS and except as specified in 42 CFR 441.151.
7. The limitations in subsection 6 do not apply to a member:
   a. Under age 21 and age 65 or over, or
   b. In a facility with 16 beds or less.

**R9-28-205. Home and Community Based Services (HCBS)**

**A.** Subject to the availability of federal funds, HCBS are covered services when provided to a member ~~or eligible person~~ residing in a HCBS setting. Room and board services are not covered in a HCBS setting.

**B.** The case manager shall authorize and specify in a case management plan any additions, deletions, or changes in home and community based services provided to a member or eligible person in accordance with R9-28-510.

**C.** Home and community based services shall include the following:

1. Home health services provided on a part-time or intermittent basis. These services include:
   a. Nursing care;
   b. Home health aide;
   c. Medical supplies, equipment, and appliances;
   d. Physical therapy;
   e. Occupational therapy;
   f. Respiratory therapy; and
   g. Speech and audiology services;
2. Private duty skilled nursing services provided on a continuous basis as an alternative to hospitalization or institutionalization when care cannot be safely managed within the scope and standards of intermittent nursing care and when determined to be cost effective.
~~2.~~3. Medical supplies and durable medical equipment, including customized DME, as described in 9 A.A.C. 22, Article 2;
~~3.~~4. Transportation services to obtain ALTCS covered medically necessary services;
~~4.~~5. Adult day health services provided to a member ~~or eligible person who is not developmentally disabled as defined by A.R.S. § 36-551,~~ in an adult day health care facility licensed according to 9 A.A.C. 10, Article 5, including:
   a. Planned care supervision and activities;
   b. Personal care;
   c. Personal living skills training;
   d. Meals and health monitoring;
   e. Preventive, therapeutic, and restorative health related services; and
   f. Behavioral health services, provided either directly or through referral, if medically necessary;
~~5.~~6. Personal care services;
~~6.~~7. Homemaker services;
~~7.~~8. Home delivered meals, which provide at least 1/3 of the recommended dietary allowance, for a member ~~or eligible person~~ who is not developmentally disabled ~~as defined in~~ under A.R.S. § 36-551;
~~8.~~9. Respite care services for no more than 720 hours per contract year;
~~9.~~10. Habilitation services including:
   a. Physical therapy;
   b. Occupational therapy;
   c. Speech and audiology services;
   d. Training in independent living;
   e. Special development skills;
   f. Sensory-motor development;
   g. Behavior intervention; and
   h. Orientation and mobility training;
~~10.~~11. Developmentally disabled day care for ~~an eligible person or~~ a member who is developmentally disabled, ~~as defined by~~ under A.R.S. § 36-551, provided in a group setting during a portion of a 24-hour period, ~~and to include~~ including:
   a. Planned care supervision and activities;
   b. Personal care;
   c. Activities of daily living skills training; and
   d. Habilitation services; and
~~11.~~12. Supported employment services provided to a member or eligible person who is an ALTCS transitional developmentally disabled HCBS person ~~as defined by~~ under A.R.S. § 36-551 and in R9-28-306.

**R9-28-206. ALTCS Services that may be Provided to Members ~~or Eligible Persons~~ Residing in either Institutional or HCBS Settings**

The Administration shall cover the following ALTCS services when the services are provided to a member or eligible person within the limitations listed:

1. Occupational and physical therapies, speech and audiology services, and respiratory therapy:
   a. The duration, scope, and frequency of each therapeutic modality or service is prescribed by the member's ~~or eligible person's~~ primary care provider or attending physician;

b. These therapies and services are authorized by the member's ~~program~~ contractor or the Administration ~~for an eligible person~~; and
c. These therapies and services are included in the member's ~~or eligible person's~~ case management plan.

2. Medical supplies, durable medical equipment, and customized durable medical equipment:
   a. These supplies or equipment conform with the requirements and limitations of 9 A.A.C. 22, Article 2; and
   b. For billing purposes, supplies and equipment are limited to items not included by the Administration under the rates in Article 7 of this Chapter for the providers of the services.

~~3. Ventilator dependent services:~~
   ~~a. Inpatient or institutional services for a ventilator dependent member are limited to services provided in a general hospital, special hospital, nursing facility, or ICF-MR. Services provided in a general or special hospital are included in the hospital's unit tier rate; or~~
   ~~b. In addition to authorized home and community based services specified in this Section, private duty nursing services are covered only for a ventilator dependent member or eligible person residing in a HCBS setting.~~

3. Ventilator dependent inpatient or institutional services are limited to services provided in a general hospital, special hospital, NF, or ICF-MR. Services provided in a general or special hospital are included in the hospital's unit tier rate. Ventilator dependent members are entitled to all authorized home and community based services.

4. Hospice services:
   a. Hospice services are covered only for a member ~~or eligible person~~ who is in the final stages of a terminal illness and has a prognosis of death within 6 months;
   b. Services available to a member ~~or eligible person~~ receiving hospice care are limited to those allowable under ~~42 CFR Part 418~~ 42 CFR 418.202, December 20, 1994, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no further editions or amendments; and
   c. Hospice services are inclusive as stated in subsection (b) except for:
      i. Medical services provided that are not related to the terminal illness;
      ii. Home delivered meals; and
      iii. Hospice services that are provided and covered through Medicare.

# NOTICE OF PROPOSED RULEMAKING

## TITLE 9. HEALTH SERVICES

## CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) CHILDREN'S HEALTH INSURANCE PROGRAM

### PREAMBLE

| 1. Sections Affected | Rulemaking Action |
|---|---|
| R9-31-101 | Amend |
| R9-31-201 | Amend |
| R9-31-204 | Amend |
| R9-31-205 | Amend |
| R9-31-207 | Amend |
| R9-31-208 | Amend |
| R9-31-209 | Amend |
| R9-31-212 | Amend |
| R9-31-215 | Amend |
| R9-31-216 | Amend |
| R9-31-1603 | Amend |
| R9-31-1608 | Amend |
| R9-31-1611 | Amend |
| R9-31-1612 | Amend |
| R9-31-1613 | Amend |
| R9-31-1614 | Amend |
| R9-31-1617 | Amend |

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

Authorizing statutes: A.R.S. §§ 36-2982, 36-2986 and 36-2989

Implementing statutes: A.R.S. §§ 36-2982, 36-2986, 36-2988, and 36-2989

**3. A list of all previous notices appearing in the Register addressing the proposed rule:**

Notice of Rulemaking Docket Opening: 7 A.A.R. 5264, November 23, 2001

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

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

**5. An explanation of the rule, including the agency's reasons for initiating the rule:**

The Administration made changes to 9 A.A.C. 31 to conform to state statute, federal law to provide additional clarity and conciseness to existing rule language. These changes impact three Articles:

• Article 1, Definitions (R9-31-101),

• Article 2, Scope of Services (R9-22-201 through R9-31-205; R9-31-207 through R9-31-209; and R9-31-211 through R9-31-216), and

• Article 16, Services for Native Americans (R9-31-1603, R9-31-1608, and R9-31-1611 through 1617)

Following is an explanation of the changes:

9 A.A.C. 31. Article 1. Definitions

The Administration modified, added, or deleted definitions to improve the clarity and conciseness of the rule language.

R9 A.A.C. 31. Article 2. Scope of Services

R9-31-201 The Administration amended the content of this Section to improve the clarity and conciseness of the rule language.

R9-31-204 The Administration made minor changes to improve clarity.

R9-31-205 The Administration made minor changes to improve clarity.

R9-31-207 The Administration made minor changes to improve clarity.

R9-31-208 The Administration struck the language and refers to R9-22-208 and A.R.S. § 36-2989 for content.

R9-31-209 Administration struck the language and refers to R9-22-209 for content.

R9-31-212 The Administration made minor changes to improve clarity.

R9-31-215 The Administration deleted chiropractic services in subsection (B)(3).

R9-31-216 The Administration made minor changes to improve clarity.

9 A.A.C. 31 Article 16, Services for Native Americans

R9-31-1603 The administration amended the content of this Section to improve the clarity and conciseness of the rule language and conform to federal law (subsection B).

R9-31-1608 The Administration made minor changes to improve clarity and deleted subsection (C)(4) and (5) as these areas are covered under A.R.S. Title 32.

R9-31-1611 The Administration made minor changes to improve clarity and deleted subsection (G). The deletion will allow the Administration to work with fee for service (FFS) providers in raising the

threshold point at which prior authorization (PA) is needed for medical supplies and durable medical equipment. This makes the PA process less burdensome for the FFS providers.

R9-31-1612 The Administration amended vision services to conform to state statute (A)(2) and added the following references: 42 CFR 441 Subpart B and A.A.C. R9-7-301 for content.

R9-31-1613 The Administration added exclusions to Title XXI covered services to mirror R9-31-215.

R9-31-1614 The Administration made minor changes to improve clarity.

R9-31-1617 The Administration struck language, which was duplicative of R9-31-1603.

**6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:**

Not applicable

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

Not applicable

**8. The preliminary summary of the economic, small business, and consumer impact:**

The contractors, members, providers, and AHCCCS are nominally impacted by the changes to the rule language. These rules define the scope of services for AHCCCS' KidsCare program. The Administration is amending these rules to make the rules more clear, concise, and understandable by:

• grouping like concepts to provide clarity and conciseness to the rule language,

• clarifying language that does not clearly present policies or procedures, and

• updating citations to documents incorporated in the rule, as needed.

It is anticipated that the private sector, including small businesses or political subdivisions will not be impacted since the proposed rule language changes are intended to streamline and clarify the existing rules. The Administration, contractors and providers will benefit because the changes provide greater flexibility and clarification of the rule language.

**9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us on January 11, 2002. Please send written comments to the above address by 5:00 p.m., February 12, 2002. E-mail will not be accepted.

**10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**

Date: February 12, 2002

Time: 1:00 p.m.

Location: AHCCCS
701 East Jefferson
Phoenix, AZ 85034
Gold Room

Nature: Public Hearing

Date: February 12, 2002

| | |
|---|---|
| Time: | 1:00 p.m. |
| Location: | ALTCS: Arizona Long-term Care System<br>3480 East Route 66<br>Tucson, AZ 85701 |
| Nature: | Video Conference Oral Proceeding |

| | |
|---|---|
| Date: | February 12, 2002 |
| Time: | 1:00 p.m. |
| Location: | ALTCS: Arizona Long-term Care System<br>3480 East Route 66<br>Flagstaff, AZ 86004 |
| Nature: | Video Conference Oral Proceeding |

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

Not applicable

**12. Incorporations by reference and their location in the rules:**

42 CFR 441 Subpart B, January 29, 1985, in R9-31-1612

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

**TITLE 9. HEALTH SERVICES**

**CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**
**CHILDREN'S HEALTH INSURANCE PROGRAM**

**ARTICLE 1. DEFINITIONS**

Section
R9-31-101. Location of Definitions

**ARTICLE 2. SCOPE OF SERVICES**

Section
R9-31-201. General Requirements
R9-31-204. Inpatient General Hospital Services
R9-31-205. ~~Physician and Primary Care Physician and Practitioner Services~~ Physician, Practitioner, and Primary Care Provider Services
R9-31-207. Dental Services
R9-31-208. Laboratory, Radiology, and Medical Imaging Services
R9-31-209. Pharmaceutical Services
R9-31-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices
R9-31-215. Other Medical Professional Services
R9-31-216. ~~Nursing Facility Services~~ NF, Alternative HCBS Setting, or HCBS

**ARTICLE 16. SERVICES FOR NATIVE AMERICANS**

Section
R9-31-1603. Inpatient General Hospital Services
R9-31-1608. Pharmaceutical Services
R9-31-1611. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices
R9-31-1612. Health Risk Assessment and Screening Services
R9-31-1613. Other Medical Professional Services
R9-31-1614. ~~Nursing Facility Services~~ NF, Alternative HCBS Setting, or HCBS
R9-31-1617. Prior Authorization

## ARTICLE 1. DEFINITIONS

**R9-31-101. Location of Definitions**

**A**. Location of definitions. Definitions applicable to 9 A.A.C. 31 are found in the following.

| Definition | Section or Citation |
|---|---|
| "Accommodation" | R9-31-113 |
| "Acute mental health services" | R9-22-112 |
| "ADHS" | R9-31-112 |
| "Administration" | A.R.S. § 36-2901 |
| "Adverse action" | R9-31-108 |
| "Aggregate" | R9-22-107 |
| "AHCCCS" | R9-31-101 |
| "AHCCCS registered provider" | R9-31-101 |
| "Ambulance" | R9-22-102 |
| "Ancillary department" | R9-22-107 |
| "Applicant" | R9-31-101 |
| "Application" | R9-31-101 |
| "Behavior management service" | R9-31-112 |
| "Behavioral health professional" | R9-31-112 |
| "Behavioral health evaluation" | R9-31-112 |
| "Behavioral health medical practitioner" | R9-31-112 |
| "Behavioral health service" | R9-31-112 |
| "Behavioral health technician" | R9-31-112 |
| "Billed charges" | R9-22-107 |
| "Board-eligible for psychiatry" | R9-31-112 |
| "Capital costs" | R9-22-107 |
| "Certified nurse practitioner" | R9-31-102 |
| "Certified psychiatric nurse practitioner" | R9-31-112 |
| "Child" | 42 U.S.C. 1397jj |
| "Chronically ill" | A.R.S. § 36-2983 |
| "Clean claim" | A.R.S. § 36-2904 |
| "Clinical supervision" | R9-31-112 |
| "CMDP" | R9-31-103 |
| "Continuous stay" | R9-22-101 |
| "Contract" | R9-22-101 |
| "Contractor" | A.R.S. § 36-2901 |
| "Contract year" | R9-31-101 |
| "Copayment" | R9-22-107 |
| "Cost avoidance" | R9-31-110 |
| "Cost-to-charge ratio" | R9-22-107 |
| "Covered charges" | R9-31-107 |
| "Covered services" | R9-22-102 |
| "CPT" | R9-22-107 |
| "CRS" | R9-31-103 |
| "Date of action" | R9-31-113 |
| "Day" | R9-22-101 |
| "Denial" | R9-31-113 |
| "De novo hearing" | R9-31-112 |
| "Dentures" | R9-22-102 |
| "DES" | R9-31-103 |
| "Determination" | R9-31-103 |
| "Diagnostic services" | R9-22-102 |
| "Director" | A.R.S. § 36-2981 |
| "DME" | R9-22-102 |
| "DRI inflation factor" | R9-22-107 |
| "Emergency medical condition" | 42 U.S.C. 1396b(v) |
| "Emergency medical services" | R9-22-102 |
| "Encounter" | R9-22-107 |
| "Enrollment" | R9-31-103 |

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|---|---|
| "Evaluation" | R9-31-112 |
| "Experimental services" | R9-22-101 |
| "Facility" | R9-22-101 |
| "Factor" | R9-22-101 |
| "First-party liability" | R9-22-110 |
| "FPL" | A.R.S. § 36-2981 |
| "Grievance" | R9-22-108 |
| "Group Health Plan" | 42 U.S.C. 1397jj |
| "GSA" | R9-22-101 |
| "Guardian" | R9-22-103 |
| "Head of Household" | R9-31-103 |
| "Health care practitioner" | R9-31-112 |
| "Hearing" | R9-22-108 |
| "Hearing aid" | R9-22-102 |
| "Home health services" | R9-22-102 |
| "Household income" | R9-31-103 |
| "Hospital" | R9-31-103 |
| "ICU" | R9-22-107 |
| "IGA" | R9-31-116 |
| "IHS" | R9-31-116 |
| "IHS" or "Tribal Facility Provider" | R9-31-116 |
| "Information" | R9-31-103 |
| "IMD" | R9-31-112 |
| "Inmate of a public institution" | 42 CFR 435.1009 |
| "Inpatient hospital services" | R9-31-101 |
| "License" or "licensure" | R9-22-101 |
| "Medical record" | R9-22-101 |
| "Medical review" | R9-31-107 |
| "Medical services" | R9-22-101 |
| "Medical supplies" | R9-22-101 |
| "Member" | A.R.S. § 36-2981 |
| "Mental disorder" | R9-31-112 |
| "Native American" | R9-31-101 |
| "New hospital" | R9-22-107 |
| "NF" | 42 U.S.C. 1396r(a) |
| "NICU" | R9-22-107 |
| "Noncontracting provider" | A.R.S. § 36-2981 |
| "Occupational therapy" | R9-22-102 |
| "Offeror" | R9-31-106 |
| "Operating costs" | R9-22-107 |
| "Outlier" | R9-31-107 |
| "Outpatient hospital service" | R9-22-107 |
| "Ownership change" | R9-22-107 |
| "Partial care" | R9-31-112 |
| "Peer group" | R9-22-107 |
| "Pharmaceutical service" | R9-22-102 |
| "Physical therapy" | R9-22-102 |
| "Physician" | A.R.S. § 36-2981 |
| "Post stabilization services" | 42 CFR 438.114 |
| "Practitioner" | R9-22-102 |
| "Pre-existing condition" | R9-31-105 |
| "Prepaid capitated" | A.R.S. § 36-2981 |
| "Prescription" | R9-22-102 |
| "Primary care physician" | A.R.S. § 36-2981 |
| "Primary care practitioner" | A.R.S. § 36-2981 |
| "Primary care provider" | R9-22-102 |
| "Primary care provider services" | R9-22-102 |
| "Prior authorization" | R9-22-102 |
| "Private duty nursing services" | R9-22-102 |

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|---|---|
| "Program" | A.R.S. § 36-2981 |
| "Proposal" | R9-31-106 |
| "Prospective rates" | R9-22-107 |
| "Provider" | A.R.S. § 36-2901 |
| "Prudent layperson standard" | 42 U.S.C. 1396u-2 |
| "PSP" | R9-31-103 |
| "Psychiatrist" | R9-31-112 |
| "Psychologist" | R9-31-112 |
| "Psychosocial rehabilitation" | R9-31-112 |
| "Qualified alien" | P.L. 104-193 |
| "Qualifying plan" | A.R.S. § 36-2981 |
| "Quality management" | R9-22-105 |
| "Radiology services" | R9-22-102 |
| "RBHA" | R9-31-112 |
| "Rebasing" | R9-22-107 |
| "Redetermination" | R9-31-103 |
| "Referral" | R9-22-101 |
| "Registered nurse" | R9-31-112 |
| "Rehabilitation services" | R9-22-102 |
| "Reinsurance" | R9-22-107 |
| "RFP" | R9-31-106 |
| "Respiratory therapy" | R9-22-102 |
| "Respondent" | R9-22-108 |
| "Scope of services" | R9-22-102 |
| "SDAD" | R9-22-107 |
| "Seriously ill" | R9-31-101 |
| "Service location" | R9-22-101 |
| "Service site" | R9-22-101 |
| "SMI" | A.R.S. § 36-550 |
| "Specialist" | R9-22-102 |
| "Speech therapy" | R9-22-102 |
| "Spouse" | R9-31-103 |
| "SSI-MAO" | R9-31-103 |
| "Standard of care" | R9-22-101 |
| "Sterilization" | R9-22-102 |
| "Subcontract" | R9-22-101 |
| "Subcontractor" | R9-31-101 |
| "Third-party" | R9-22-110 |
| "Third-party liability" | R9-22-110 |
| "Tier" | R9-22-107 |
| "Tiered per diem" | R9-31-107 |
| "Title XIX" | 42 U.S.C. 1396 |
| "Title XXI" | 42 U.S.C. 1397aa |
| "TRBHA" | R9-31-116 |
| "Tribal facility" | A.R.S. § 36-2981 |
| "Utilization management" | R9-22-105 |

**B.** General definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

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

"AHCCCS registered provider" means a provider who:

Has a provider agreement under A.R.S. § 36-2904,

Meets state and federal requirements, and

Is appropriately licensed or certified to provide AHCCCS covered services.

"Applicant" means a person who submits, or whose representative submits, a written, signed, and dated application for Title XXI benefits which has not been approved or denied.

"Application" means an official request for Title XXI benefits made in accordance with Article 3.

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

"Inpatient hospital services" means medically necessary services that require an inpatient stay in an acute hospital. Inpatient hospital services are provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

"Native American" means Indian as specified in 42 CFR 36.1.

"Seriously ill" means a medical or psychiatric condition manifesting itself by acute symptoms that left untreated may result in:

Death,

Disability,

Disfigurement, or

Dysfunction.

"Subcontractor" means a person, agency or organization who enters into an agreement with a contractor or subcontractor.

## ARTICLE 2. SCOPE OF SERVICES

**R9-31-201. General Requirements**

**A.** The Administration shall administer the program under A.R.S. § 36-2982.

**B.** The Director has full operational authority to adopt rules or to use the appropriate rules adopted under A.R.S. § 36-2986.

**C.** Scope of Services for fee for service members are under Article 16 of this Chapter.

~~**C.**~~**D.** Behavioral health services ~~shall be~~ are provided under 9 A.A.C. 31, Article 12.

~~**D.** In addition to requirements and limitations specified in this Chapter, the following general requirements apply:~~

~~1. Under, covered services provided to a member shall be medically necessary and provided by, or under the direction of, a primary care provider or a dentist; specialist services shall be provided under referral from, and in consultation with, the primary care provider.~~

~~a. The role or responsibility of a primary care provider, as defined in these rules, shall not be diminished by the primary care provider delegating the provision of primary care for a member to a practitioner, and~~

~~b. The contractor may waive the referral requirements.~~

~~2. Services shall be rendered in accordance with state and federal laws and regulations, the Arizona Administrative Code, and AHCCCS contractual requirements.~~

~~3. Experimental services as determined by the Director, or services provided primarily for the purpose of research, shall not be covered.~~

~~4. Services or items, if furnished gratuitously, are not covered and payment shall be denied.~~

~~5. Personal care items are not covered and payment shall be denied.~~

**E.** In addition to requirements and limitations specified in this Chapter, the following general requirements apply:

1. Covered services are medically necessary, cost effective and federally or state reimbursable;
2. A primary care provider, or a dentist shall provide or direct the member's covered services:
   a. Specialist services are provided under referral from and in consultation with the primary care provider;
   b. Delegation of the provision of the care to a practitioner shall not diminish the role or responsibility of the primary care provider;
   c. A member may receive behavioral health evaluation services without a referral from a primary care provider. Behavioral health treatment services are provided only under referral from and in consultation with the PCP, or upon authorization by the contractor or its designee;
   d. A female member shall have direct access to gynecology providers within the contractor's network for preventive and routine services without a referral;
   e. The contractor may waive the covered services referral requirements noted in this Article;
3. A member shall receive a treatment as determined by the AHCCCS Chief Medical Officer, that is considered the standard of care;
4. A member shall receive services according to state and federal laws and regulations, the Arizona Administrative Code, and AHCCCS contractual requirements;
5. In addition to the specific exclusions and limitations otherwise specified under this Article the following are not included:
   a. A service when the Director determines the service to be experimental or provided primarily for the purpose of research;
   b. Services or items, if furnished gratuitously;
   c. Personal care items;
6. ~~Services shall not be covered if provided to:~~ The contractor shall not cover medical or behavioral health services if provided to:

a. An inmate of a public institution,
b. A person who is a resident of an institution for the treatment of tuberculosis, or
c. A person who is in an institution for the treatment of mental diseases at the time of application.

~~**E.** Services shall be provided by AHCCCS registered personnel or facilities, that meet state and federal requirements, and are appropriately licensed or certified to provide the services~~.

**F.** An AHCCCS registered provider shall provide covered services within the provider's scope of practice.

~~**F.** Payment for services or items requiring prior authorization may be denied if prior authorization by the contractor is not obtained. Emergency services do not require prior authorization.~~

~~1. Services for unrelated conditions, requiring additional diagnostic and treatment procedures, require additional prior authorization~~.

~~2. In addition to the requirements of 9 A.A.C. 31, Article 7, written documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.~~

**G.** The contractor has authority to deny payment of non-emergency services if prior authorization is not obtained under this Article and Article 7. Documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.

**H.** Emergency services do not require prior authorization. Additional diagnostic and treatment procedures for a condition that is unrelated to the emergent condition requires prior authorization by the contractor.

~~**G.I.** As specified in~~ Under A.R.S. § 36-2989, ~~covered services rendered to a member shall be provided within the service area of the member's primary contractor except when:~~ a member shall receive covered services outside the primary contractor service area only when one of the following apply:

1. A primary care provider refers a member out of the contractor's area for medical specialty care;
2. A covered service that is medically necessary for a member is not available within the contractor's service area;
3. A net savings in service delivery costs can be documented without requiring undue travel time or hardship for a member or the member's family;
4. A member is placed in an NF located out of the contractor's service area; and
5. The service is otherwise authorized by the contractor based on medical practice patterns, and cost or scope of service considerations.

~~**H.J.** When a member is traveling or temporarily residing out of the~~ member's contractor service area, ~~of the member's contractor,~~ covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

~~**I.K.** A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in these rules and in contract.

~~**J.** If a member requests the provision of a service that is not covered by a contractor or not authorized by a contractor, the service may be rendered to a member by an AHCCCS-registered service provider under the following conditions:~~

~~1. A document that lists the requested services and the itemized cost of each is prepared by the contractor and provided to the member; and~~

~~2. The signature of the member is obtained in advance of service provision indicating that the services have been explained to the member and that the member accepts responsibility for payment.~~

**L.** If a member requests the provision of a service that is not covered by a contractor or not authorized by a contractor, an AHCCCS-registered service provider may render the service and request reimbursement from the member under the following conditions:

1. A provider shall prepare, and provide the member with, a document that lists the requested services and the estimated cost of each service; and
2. The member signs a document prior to the provision of services indicating that the member understands the services and accepts the responsibility for payment.

~~**K.M.** If a member is referred out of a contractor's service area to receive an authorized medically necessary service a contractor shall also provide all other medically necessary covered services for a member during that time.~~

~~**L.N.** The restrictions, limitations, and exclusions in this Article shall not apply to contractors when electing to provide noncovered services.~~ :

1. The costs associated with providing any noncovered service to a member shall not be included in development or negotiation of capitation.~~:~~;
2. ~~Noncovered services shall be paid from administrative revenue or other contractor funds, unrelated to Title XXI services.~~ Non-covered services are paid from administrative revenue or other contractors funds which are unrelated to Title XXI services.

**R9-31-204. Inpatient General Hospital Services**

~~Inpatient services provided in a general hospital shall be covered by contractors or noncontracting providers and shall include:~~ Contractors, or non-contracting providers shall render inpatient general hospital services including:

1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
   a. Maternity care, including labor, delivery, and recovery room, birthing center, and newborn nursery;

b. Neonatal intensive care unit (NICU)~~,~~;
c. Intensive care unit (ICU)~~,~~;
d. Surgery, including surgery room and recovery room;
e. Nursery and related services;
f. Routine care~~,~~; and
g. ~~Behavioral health (psychiatric) care as specified in A.R.S. § 36-2989 and~~ Emergency behavioral health services under 9 A.A.C. 31, Article 12.

2. Ancillary services as specified by the ~~Director~~ Administration:
~~a. Labor, delivery and recovery rooms, and birthing centers;~~
~~b. Surgery and recovery rooms;~~
~~c.~~a. Laboratory services;
~~d.~~b. Radiological and medical imaging services;
~~e.~~c. Anesthesiology services;
~~f.~~d. Rehabilitation services;
~~g.~~e. Pharmaceutical services and prescribed drugs;
~~h.~~f. Respiratory therapy;
~~i.~~g. Blood and blood derivatives; and
~~j.~~h. Central supply items, appliances, and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary services~~;~~ .
~~k. Maternity services; and~~
~~l. Nursery and related services.~~

**R9-31-205. ~~Physician and Primary Care Physician and Practitioner Services~~ Physician, Practitioner, and Primary Care Provider Services**

**A.** ~~Primary care provider services shall be furnished by a physician or practitioner and shall be covered for members when rendered within the provider's scope of practice under A.R.S. § 36-2981. Primary care provider services may be provided in an inpatient or outpatient setting and shall include at a minimum:~~ The primary care provider shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member is eligible to receive primary care provider services in an inpatient or outpatient setting including at a minimum:
1. Periodic health examinations and assessments,
2. Evaluations and diagnostic workups,
3. Medically necessary treatment,
4. Prescriptions for medications and medically necessary supplies and equipment,
5. Referrals to specialists or other health care professionals when medically necessary as specified in A.R.S. § 36-2989,
6. Patient education,
7. Home visits when determined medically necessary,
8. Covered immunizations, and
9. Covered preventive health services.

**B.** As specified in A.R.S. § 36-2989, a ~~2nd~~ second opinion procedure may be required to determine coverage for surgeries. Under this procedure, documentation must be provided by at least ~~2~~ two physicians as to the need for the proposed surgery.

**C.** The following limitations and exclusions apply to physician and practitioner services and primary care provider services:
1. Specialty care and other services provided to a member upon referral from a primary care provider ~~shall be~~ are limited to the services or conditions for which the referral is made, or for which authorization is given~~,~~ ; ~~unless referral is waived by the contractor.~~
~~2. If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), it shall be covered by the member's contractor except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:~~
2. The contractor shall not cover a member's physical examination when the physical examination has resulting documentation for:
   a. Qualification for insurance,
   b. Pre-employment physical evaluation,
   c. Qualification for sports or physical exercise activities,
   d. Pilot's examination (FAA),
   e. Disability certification for establishing any kind of periodic payments,
   f. Evaluation for establishing 3rd party liabilities, or
   g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A).
3. The following services ~~shall be~~ are excluded from Title XXI coverage:

a. Infertility services, reversal of surgically induced infertility (sterilization), and ~~sex change operations~~ gender reassignment surgeries;
b. Abortion counseling services;
c. Abortions, unless authorized under federal law;
d. Services or items furnished solely for cosmetic purposes; and
e. Hysterectomies, unless determined to be medically necessary.

**R9-31-207. Dental Services**

Medically necessary dental services ~~shall be~~ are provided for children under age 19 ~~as specified in~~ under A.R.S. § 36-2989 and R9-22-213.

**R9-31-208. Laboratory, Radiology, and Medical Imaging Services**

~~As specified in A.R.S. § 36-2989, laboratory, radiology, and medical imaging services shall be covered services if:~~

~~1. Prescribed for members by a primary care provider or a dentist, or if prescribed by a physician or practitioner upon referral from the primary care provider or dentist, unless referral is waived by the contractor;~~
~~2. Provided in hospitals, clinics, physician offices, or other health care facilities by licensed health care providers; and~~
~~3. Provided by a provider that meets all applicable state and federal license and certification requirements and provides only services that are within the scope of practice stated in the provider's license or certification.~~

Laboratory, radiology, and medical imaging services are provided for children under age 19, under A.R.S. § 36-2989 and R9-22-208.

**R9-31-209. Pharmaceutical Services**

~~**A.** Pharmaceutical services may be provided by an inpatient or outpatient provider including hospitals, clinics, or appropriately licensed health care facilities and pharmacies.~~
~~**B.** The contractor shall make pharmaceutical services available during customary business hours and shall be located within reasonable travel distance of a member's residence.~~
~~**C.** As specified in A.R.S. § 36-2989, pharmaceutical services shall be covered if prescribed for a member by the member's primary care provider or dentist, or if prescribed by a specialist upon referral from the primary care provider, unless referral is waived by the contractor or its designee.~~
~~**D.** The following limitations shall apply to pharmaceutical services:~~
~~1. A medication personally dispensed by a physician or dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.~~
~~2. A prescription in excess of a 30 day supply or a 100-unit dose is not covered unless:~~
~~a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is more.~~
~~b. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.~~
~~c. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is more.~~
~~3. A nonprescription medication is not covered unless an appropriate alternative over the counter medication is available and less costly than a prescription medication.~~
~~4. A prescription is not covered if filled or refilled in excess of the number specified, or if an initial prescription or refill as dispensed after 1 year from the original prescribed order.~~
~~5. Approval by the authorized prescriber is required for all changes in, or additions to, an original prescription. The date of a prescription change is to be clearly indicated and initialed by the dispensing pharmacist.~~
~~**E.** A contractor shall monitor and take necessary actions to ensure that a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.~~

Pharmaceutical services are provided for children under age 19 under R9-22-209.

**R9-31-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices**

**A.** As specified in A.R.S. § 36-2989, medical supplies, durable equipment, and orthotic and prosthetic devices ~~shall be~~ are covered services if:
1. Prescribed ~~for a member~~ by the member's primary care provider or if prescribed by a physician or practitioner upon referral from the primary care provider~~, referral is waived by the contractor,~~
2. Authorized by the contractor or the contractor's designee, or
~~2.~~3. Provided in compliance with requirements of this Chapter.

**B.** Medical supplies include consumable ~~items covered under Medicare~~ items that are disposable and are essential to a member's health. ~~that are provided to a member~~.

**C.** Medical equipment includes any durable item, appliance, or piece of equipment that is designed for a medical purpose, is generally reusable by others, and is purchased or rented for a member.

**D.** Prosthetic and orthotic devices include only those items that are essential for the habilitation or rehabilitation of a member.

**E.** The following limitations apply:

1. ~~If medical equipment cannot be obtained from alternative resources at no cost, the~~ The medical equipment ~~shall be~~ is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment shall not exceed the cost of the equipment if purchased~~.~~;
2. Reasonable repair or adjustment of purchased medical equipment ~~shall be~~ is covered if necessary to make the equipment serviceable and if the cost of repair is less than the cost of renting or purchasing another unit~~.~~;
3. ~~Changes~~ A change in, or ~~additions~~ addition to, an original order for medical equipment ~~shall be~~ is covered if approved by the member's primary care provider or authorized prescriber, or prior authorized by the contractor for members, and ~~shall be~~ is indicated clearly and initialed by the vendor. No change or addition to the original order for medical equipment shall be made after a claim for services ~~has been~~ is submitted to a member's contractor, without prior written notification of the change or addition~~.~~;
4. Rental fees shall terminate:
   a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member no longer needs the medical equipment;
   b. When the member is no longer eligible for Title XXI services; or
   c. When the member is no longer enrolled with a contractor, with the exception of transitions of care as specified by the Director.
5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming ~~shall not be~~ are not covered unless needed to treat a medical condition and ~~provided in accordance with a prescription.~~ are prescribed by the member's primary care provider or practitioner, or if prescribed by a specialist upon referral from the primary care provider or contractor or its designee authorizes the service;
6. First aid supplies ~~shall not be~~ are not covered unless they are provided in accordance with a prescription.

**F.** Liability and ownership.

1. Purchased durable medical equipment provided to a member but which is no longer needed may be disposed of in accordance with each contractor's policy.
2. If customized durable medical equipment is purchased by the contractor for a member, the equipment will remain with the member during times of transition, or upon loss of eligibility.
   a. For purposes of this Section, customized durable medical equipment refers to equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.
   b. Customized equipment obtained fraudulently by a member shall be returned for disposal to the member's contractor.

**R9-31-215. Other Medical Professional Services**

**A.** The following medical professional services ~~provided to a member by a contractor shall be covered services when provided~~ are covered services when a member receives these services in an inpatient, outpatient, or office setting within limitations specified below:

1. Dialysis;
2. Family planning services as specified in A.R.S. § 36-2989 including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:
   a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
   b. Natural family planning education or referral;
3. Certified nurse midwife services provided by a certified nurse practitioner in midwifery;
4. Podiatry services when ordered by a member's primary care provider as specified in A.R.S. § 36-2989;
5. Respiratory therapy;
6. Ambulatory and outpatient surgery facilities services;
7. Home health services in A.R.S. § 36-2989;
8. Private or special duty nursing services when medically necessary and prior authorized;
9. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy within limitations in this Article;
10. Total parenteral nutrition services;
11. Chemotherapy; and
12. Hospice under R9-22-213.

**B.** The following shall be excluded as Title XXI covered services:

1. Abortion counseling,

2. Services or items furnished solely for cosmetic purposes, and
~~3. Chiropractic services, and~~
~~4. Licensed midwife service for prenatal care and home births.~~

**R9-31-216. ~~Nursing Facility Services~~ NF, Alternative HCBS Setting, or HCBS**

**A.** NF, including room and board, alternative HCBS setting, or HCBS as defined in 9 A.A.C. 28, Article 2 ~~services shall be~~ are covered for a maximum of 90 days per contract year ~~if the medical condition of a member is such that, if NF services are not provided, hospitalization of the individual would result.~~ when the member's medical condition would otherwise require hospitalization.

**B.** Except as otherwise provided in 9 A.A.C. 28, the following services shall be excluded for purpose of separate billing if provided in an NF:
1. Nursing services including but not limited to:
   a. Administration of medication,
   b. Tube feedings,
   c. Personal care services (assistance with bathing and grooming),
   d. Routine testing of vital signs, and
   e. Maintenance of catheters.
2. Basic patient care equipment and sickroom supplies, including, but not limited to:
   a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over the counter remedies;
   b. Bathing and grooming supplies;
   c. Identification devices;
   d. Skin lotions;
   e. Medication cups;
   f. Alcohol wipes, cotton balls, and cotton rolls;
   g. Rubber gloves (non sterile);
   h. Laxatives;
   i. Beds and accessories;
   j. Thermometers;
   k. Ice bags;
   l. Rubber sheeting;
   m. Passive restraints;
   n. Glycerin swabs;
   o. Facial tissue;
   p. Enemas;
   q. Heating pads; and
   r. Diapers.
3. Dietary services including~~, but not limited to,~~ preparation and administration of special diets, and adaptive tools for eating;
4. Any services that are included in an NF's room and board charge or services that are required of the NF to meet federal mandates, state licensure standards, or county certification requirements;
5. Administrative physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
6. Physical therapy; and
7. Assistive devices and non-customized durable medical equipment.

## ARTICLE 16. SERVICES FOR NATIVE AMERICANS

**R9-31-1603. Inpatient General Hospital Services**

**A.** ~~Inpatient services provided in a general hospital may include:~~ Fee-for-service providers or non-contracting providers shall render inpatient general hospital services including:
1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
   a. Maternity care, including labor, delivery, and recovery room, birthing center, and newborn nursery;
   b. Neonatal intensive care (NICU)~~,~~;
   c. Intensive care (ICU)~~,~~;
   d. Surgery, including surgery room and recovery room;
   e. Nursery~~,~~;
   f. Routine care~~,~~; and
   g. ~~Behavioral health (psychiatric) care as specified in A.R.S. § 36-2989 and~~ Emergency behavioral services under 9 A.A.C. 31, Article 12~~,~~;
2. Ancillary services as specified by the ~~Director~~ Administration:

~~a. Labor, delivery and recovery rooms, and birthing centers;~~
~~b. Surgery and recovery rooms;~~
~~c.~~a. Laboratory services;
~~d.~~b. Radiological and medical imaging services;
~~e.~~c. Anesthesiology services;
~~f.~~d. Rehabilitation services;
~~g.~~e. Pharmaceutical services and prescribed drugs;
~~h.~~f. Respiratory therapy;
~~i.~~g. Blood and blood derivatives; and
~~j.~~h. Central supply items, appliances, and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary services~~;~~ .
~~k. Maternity services; and~~
~~l. Nursery and related services.~~

**B.** The following limitations apply to general inpatient hospital services that are provided by a fee-for-service provider and for which the Administration is financially responsible:

~~1. The cost of an inpatient hospital accommodation for a member shall be incorporated into the rate paid for the level of care in subsection (A)(1).~~
~~2. Prior authorization shall be obtained from the Administration for a member referred out of the IHS or a Tribal Facility for the following inpatient hospital services provided to a member:~~
~~a. Non-emergency and elective admission, prior to the scheduled admission;~~
~~b. Elective surgery prior to the surgery;~~
~~c. An emergency hospitalization that exceeds 3 days or an intensive care unit admission that exceeds 1 day;~~
~~d. Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through the Administration's concurrent team review; or~~
~~e. A service or an item furnished to cosmetically reconstruct appearance after the on-set of trauma or serious injury shall be authorized prior to service delivery.~~

1. Providers shall obtain prior authorization from the Administration for the following inpatient hospital services:
   a. Nonemergency and elective admission, including psychiatric hospitalization;
   b. Elective surgery, excluding voluntary sterilization procedures.
   c. Services or items provided to reconstruct or improve personal appearance after an illness or injury.
2. Concurrent review:
   a. The Administration has the authority to perform concurrent review for hospitalizations to establish medical necessity.
   b. Providers shall notify the Administration no later than the fourth day of hospitalization after an emergency admission or no later than the second day after an intensive care unit admission so that the Administration may initiate concurrent review of the hospitalization.
   c. The Administration has the authority to deny claims for failure to provide timely notification as specified in this Article.

**R9-31-1608. Pharmaceutical Services**

**A.** Pharmaceutical services may be provided by the IHS, a Tribal Facility, or under referral from an IHS or a Tribal Facility provider.

**B.** As specified in A.R.S. § 36-2989, pharmaceutical services ~~shall be~~ are covered if prescribed for a member by the IHS, a Tribal Facility provider or a dentist, or if prescribed by a specialist upon referral from the IHS or a Tribal Facility provider.

**C.** The following limitations shall apply to pharmaceutical services:

1. A medication personally dispensed by a physician or a dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. A prescription or refill in excess of a 30-day supply or a 100-unit dose is not covered unless:
   a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is more.
   b. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.
   c. A member lives in an area not readily accessible to a pharmacy and the prescription is limited to 100-days or 100-unit dose, whichever is more.
3. ~~A nonprescription medication is not covered unless an appropriate alternative over the counter medication is available and less costly than a prescription medication.~~ An over the counter medication in lieu of a covered prescription medication is covered only when an appropriate, equally effective, and safe alternative is available and is less costly than a covered prescription medication.
4. ~~A prescription is not covered if filled or refilled in excess of the number specified, or if an initial prescription or refill as dispensed after 1 year from the original prescribed order.~~

~~5. Approval by an authorized prescriber is required for all changes in, or additions to, an original prescription. The date of a prescription change is to be clearly indicated and initialed by a dispensing pharmacist.~~

~~**D.** The IHS or a Tribal Facility shall monitor and take necessary actions to ensure that a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.~~

**D.** The IHS or a Tribal Facility shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being.

**R9-31-1611. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices**

**A.** ~~As specified in A.R.S. § 36-2989, medical supplies, durable equipment, and orthotic and prosthetic devices shall be covered services if prescribed for a member by the IHS or a Tribal Facility provider or if prescribed by a physician or a practitioner upon referral from the IHS or a Tribal Facility provider unless referral is waived by a contractor.~~ Medical supplies, durable equipment, and orthotic and prosthetic devices are covered when:

1. Authorized by the Administration,
2. Prescribed by the IHS or Tribal Facility provider, or
3. Prescribed by a physician or a practitioner upon referral from the IHS or a Tribal Facility unless the referral is waived by the Administration.

**B.** Medical supplies include consumable ~~items covered under Medicare~~ items that are disposable and are essential to a member's health. ~~that are provided to a member~~.

**C.** Medical equipment includes any durable item, an appliance, or a piece of equipment that is designed for a medical purpose, is generally reusable by others, and is purchased or rented for a member.

**D.** Prosthetic and orthotic devices include only those items that are essential for the habilitation or rehabilitation of a member.

**E.** The following limitations apply:

1. ~~If medical equipment cannot be reasonably obtained from alternative resources at no cost, the~~ The medical equipment shall be furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment shall not exceed the cost of the equipment if purchased~~.~~;
2. Reasonable repair or adjustment of purchased medical equipment ~~shall be~~ is covered if necessary to make the equipment serviceable and if the cost of repair is less than the cost of renting or purchasing another unit~~.~~;
3. Changes in, or additions to, an original order for medical equipment ~~shall be~~ is approved by a member's IHS or a Tribal Facility provider or an authorized prescriber and ~~shall be~~ is indicated clearly and initialed by a vendor~~.~~;
4. Rental fees shall terminate:
   a. No later than the end of the month in which the IHS or a Tribal Facility provider or an authorized prescriber certifies that a member no longer needs the medical equipment,
   b. When a member is no longer eligible for Title XXI service, or
   c. When a member is no longer enrolled with the IHS with the exception of transitions of care as specified by the ~~Director~~ Administration.
5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming ~~shall not be~~ are not covered unless needed to treat a medical condition and ~~provided in accordance with a prescription.~~ prescribed by the member's primary care provider or practitioner, or if prescribed by a specialist upon referral from the primary care provider or contractor or its designee authorizes the service;
6. First aid supplies ~~shall not be~~ are not covered unless they are provided according to a prescription.

**F**. Liability and ownership.

1. Purchased durable medical equipment provided to a member but which is no longer needed may be disposed of as specified in the policy of the IHS or a Tribal Facility.
2. If customized durable medical equipment is purchased for a member, the equipment will remain with the member during times of transition, or upon loss of eligibility.
   a. For purposes of this Section, customized durable medical equipment refers to equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.
   b. ~~Customized~~ A member shall return customized equipment obtained fraudulently to the Administration. ~~by a member shall be returned for disposal to the Administration.~~

~~**G.** A provider shall obtain prior authorization from the Administration before providing the following services to a member referred out of the IHS or a Tribal Facility:~~

~~1. Consumable medical supplies exceeding $50.00 per month.~~
~~2. Durable medical equipment, prosthetic or orthotic devices for a member for all rentals if the cost to purchase the equipment or devise exceeds $200.00.~~

**R9-31-1612. Health Risk Assessment and Screening Services**

**A.** As specified in A.R.S. § 36-2989, the following services shall be covered for a member less than 19 years of age:
1. Screening services, including:
   a. Comprehensive health, behavioral health and developmental histories;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history; ~~and~~
   d. Health education, including anticipatory guidance~~.~~ ; and
   e. Laboratory tests.
2. Vision services ~~as specified in A.R.S. § 36-2989~~ including:
   ~~a.~~ ~~Treatment for medical conditions of the eye,~~ Diagnosis and treatment for defects in vision.
   ~~b.~~ ~~1 eye examination per contract year, and~~ Eye examinations for the provision of prescriptive lenses, and
   ~~c.~~ Provision of ~~1 pair of~~ prescriptive lenses ~~per contract year.~~
3. Hearing services, including:
   a. Diagnosis and treatment for defects in hearing,
   b. Testing to determine hearing impairment, and
   c. Provision of hearing aids.

**B.** ~~All providers~~ Providers of services shall meet the following standards:
1. Provide services by or under the direction of a member's IHS or a Tribal Facility provider or a dentist.
2. Perform tests and examinations ~~in accordance with the Administration's Periodicity Schedule~~ under 42 CFR 441 Subpart B, January 29, 1985, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments.
   a. Refer a member as necessary for dental diagnosis and treatment, and necessary specialty care;
   b. Refer a member as necessary for behavioral health evaluation and treatment services as specified in this Article.

**C.** The IHS or a Tribal Facility shall meet the following additional conditions for a member:
1. Provide information to a member and a member's parent or guardian concerning services, and
2. Notify a member and a member's parent or guardian regarding the initiation of screening and subsequent appointments according to the Administration's Periodicity Schedule.

**D.** ~~A member with special health care needs may be referred to the Children's Rehabilitative Service program~~ The IHS or a Tribal Facility provider shall refer a member with special health care needs under A.A.C. R9-7-301 to CRS.

**R9-31-1613. Other Medical Professional Services**

**A.** The following medical professional services ~~provided to a member by the IHS or a Tribal Facility or for a member referred out of the IHS or a Tribal Facility shall be~~ are covered services as specified in A.R.S. § 36-2989 when ~~provided~~ a member receives these services in an inpatient, an outpatient, or an office setting within limitations specified below:
1. Dialysis;
2. Family planning services including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:
   a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service; and
   b. Natural family planning education or referral.
3. Midwife services provided by a certified nurse practitioner;
4. Podiatry services when ordered by an IHS or a Tribal Facility provider;
5. Respiratory therapy;
6. Ambulatory and outpatient surgery facilities services;
7. Home health services;
8. Private or special duty nursing services when medically necessary and prior authorized;
9. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy within limitations in this Article;
10. Total parenteral nutrition services; ~~and~~
11. Out-patient ~~Chemotherapy.~~ chemotherapy; and
12. Hospice under R9-22-213.

**B.** The Administration shall prior authorize services in subsections (A)(4) through (~~10~~ 11) for a member referred out of the IHS or a Tribal Facility.

**C.** The following shall be excluded as Title XXI covered services:
1. Abortion counseling,
2. Services or items furnished solely for cosmetic purposes, and

**R9-31-1614. ~~Nursing Facility Services~~ NF, Alternative HCBS Setting, or HCBS**

**A.** NF services including room and board, alternative HCBS setting, or HCBS as defined in 9 A.A.C. 28, Article 2 ~~shall be~~ are covered for a maximum of 90 days per contract year ~~if the medical condition of a member is such that, if NF services are not provided, hospitalization of an individual would result.~~ when the member's medical condition would otherwise require hospitalization.

**B.** Except as otherwise provided in 9 A.A.C. 28, the following services ~~shall be~~ are excluded for purpose of separate billing if provided in an NF:

1. Nursing services including but not limited to:
   a. Administration of medication,
   b. Tube feedings,
   c. Personal care services (assistance with bathing and grooming),
   d. Routine testing of vital signs, and
   e. Maintenance of catheters.
2. Basic patient care equipment and sickroom supplies, including, but not limited to:
   a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over the counter remedies;
   b. Bathing and grooming supplies;
   c. Identification devices;
   d. Skin lotions;
   e. Medication cups;
   f. Alcohol wipes, cotton balls, and cotton rolls;
   g. Rubber gloves (non sterile);
   h. Laxatives;
   i. Beds and accessories;
   j. Thermometers;
   k. Ice bags;
   l. Rubber sheeting;
   m. Passive restraints;
   n. Glycerin swabs;
   o. Facial tissue;
   p. Enemas;
   q. Heating pads; and
   r. Diapers.
3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating;
4. Any services that are included in an NF's room and board charge or services that are required of an NF to meet federal mandates, state licensure standards, or county certification requirements;
5. Physical therapy; and
6. Assistive devices and non-customized durable medical equipment.

**C.** ~~Each NF admission out of the IHS or a Tribal Facility's service area shall be prior authorized by the Administration.~~ The Administration shall prior authorize each NF admission outside the IHS or a Tribal Facility's service area.

**R9-31-1617. Prior Authorization**

A provider and a ~~nonprovider~~ noncontracting provider shall request prior authorization from the Administration according to this Article. ~~The following inpatient hospital services provided to a member enrolled with the IHS out of the IHS or a Tribal Facility require prior authorization from the Administration:~~

~~1. Nonemergency and elective admission, shall be authorized prior to admission;~~
~~2. Elective surgery, excluding voluntary sterilization, shall be authorized prior to the surgery;~~
~~3. An emergency hospitalization that exceeds three days or an intensive care admission that exceeds one day;~~
~~4. Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through the Administration's concurrent team review; and~~
~~5. Services or items furnished to cosmetically reconstruct appearance after the on-set of trauma or serious injury shall be authorized prior to service delivery.~~

# NOTICE OF PROPOSED RULEMAKING

## TITLE 18. ENVIRONMENTAL QUALITY

## CHAPTER 2. DEPARTMENT OF ENVIRONMENTAL QUALITY

## AIR POLLUTION CONTROL

## PREAMBLE

**1. Sections Affected** | **Rulemaking Action**

| | |
|---|---|
| R18-2-101 | Amend |
| R18-2-210 | Amend |
| R18-2-333 | Amend |
| R18-2-901 | Amend |
| R18-2-1101 | Amend |
| Appendix 2 | Amend |

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

Authorizing and implementing statutes: A.R.S. §§ 49-104(A)(11), 49-404(A) and 49-425(A)

**3. List of all previous notices appearing in the Register addressing the proposed rule:**

Notice of Rulemaking Docket Opening: 7 A.A.R. 5139, November 9, 2001

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

Name: Mark Lewandowski, Air Quality Division

Address: ADEQ
3033 N. Central Ave.
Phoenix, AZ 85012-2809

Telephone: (602) 207-2230 (Any ADEQ number may be reached in-state by dialing 1-800-234-5677, and asking for that extension.)

Fax: (602) 207-2366

**5. An explanation of the rule, including the agency's reasons for initiating the rule:**

The Arizona Department of Environmental Quality (ADEQ) is proposing new and updated incorporations by reference of the following federal regulations in state rules: New Source Performance Standards (NSPS), National Emission Standards for Hazardous Air Pollutants (NESHAP), Acid Rain, and other parts of 40 CFR. The federal regulations would be incorporated as of July 1, 2001.

In addition, ADEQ is proposing to amend the definition of "major source" by deleting the phrase "but only with respect to those air pollutants that have been regulated for that category" in R18-2-101(64)(c)(xxvii). This change will ensure that the definition of "major source" fully meets 40 CFR 70. Once final, the rule change will be submitted to EPA as a revision to Arizona's Title V Program, as explained in EPA's approval of ADEQ's Title V Program (66 FR 63177, 12/5/01) EPA.

**NSPS and NESHAP regulations.** Federal regulations already incorporated by reference from 40 CFR Parts 60, 61, and 63 are proposed to be updated from July 1, 1999, to July 1, 2001, in R18-2-901 and R18-2-1101. As explained further below, ADEQ is also proposing to incorporate by reference new subparts in Parts 60 and 63, adopted as of July 1, 2001.

**Acid Rain.** Federal regulations already incorporated by reference from 40 CFR Part 72, 74, 75, and 76 are proposed to be updated from July 1, 1999, to July 1, 2001, in R18-2-333. ADEQ is obligated under state and federal law to incorporate federal acid rain requirements in the permits issued by ADEQ (R18-2-306(A)(2); 40 CFR 70.6(a)(1)) ADEQ further discusses two of these revisions below.

**Miscellaneous Incorporations by Reference in R18-2-210 and Appendix 2.** The provisions in Appendix 2 are proposed to be updated from July 1, 1999, to July 1, 2001. These provisions are cited throughout 18 A.A.C. 2, but are incorporated by reference once in Appendix 2 for convenience. R18-2-210 incorporates by reference area attainment status designations for Arizona approved or designated by EPA pursuant to section 107 of the Clean Air Act (CAA). These Arizona designations, at 40 CFR 81.303, were amended at 65 FR 36358, June 8, 2000; 65 FR 50652, Aug. 21, 2000; and 65 FR 45182, July 20, 2000, to reflect the redesignating of the Tucson carbon monoxide nonattainment area to attainment.

ADEQ's intention in updating all of the incorporations by reference is to continue its delegated authority from EPA to implement and enforce the NSPS, NESHAP, and acid rain programs in Arizona.

Below are descriptions of federal subparts proposed to be newly incorporated into Arizona's rules, taken from EPA's Notices of Final Rulemakings.

NEW SOURCE PERFORMANCE STANDARDS (NSPS), PART 60:

Subparts Added:

**Part 60, Subparts: CCCC - Standards of Performance for Commercial and Industrial Solid Waste Incineration Units for Which Construction Is Commenced after November 30, 1999, or for Which Modification or Reconstruction Is Commenced on or after June 1, 2001;** [Added at 65 FR 75338, 12/1/00] EPA promulgated standards for new and existing commercial and industrial solid waste incineration (CISWI) units. These standards fulfill the requirements of sections 111 and 129 of the Clean Air Act (CAA), which require EPA to promulgate standards for CISWI units. The final standards will protect public health by reducing exposure to air pollution, including several hazardous air pollutants (HAP) that can cause toxic effects such as eye, nose, throat, and skin irritation; reproductive effects; and cancer. These standards apply only to CISWI units burning nonhazardous wastes.

**Part 60, Subpart AAAA - Standards of Performance for Small Municipal Waste Combustion Units for Which Construction Is Commenced after August 30, 1999, or for Which Modification or Reconstruction Is Commenced after June 6, 2001** [Added at 65 FR 76350, 12/6/00] This action reestablished new source performance standards (NSPS) for new small municipal waste combustion (MWC) units. The NSPS for small MWC units contain stringent emission limits for organics (dioxins/furans), metals (cadmium, lead, mercury, and particulate matter), and acid gases (hydrogen chloride, sulfur dioxide, and nitrogen oxides). Some of those pollutants can cause toxic effects such as eye, nose, throat, and skin irritation, and blood cell, heart, liver, and kidney damage. The NSPS for small MWC units were originally promulgated in December, 1995, but were vacated by the U.S. Court of Appeals for the District of Columbia Circuit in March, 1997. In response to the 1997 vacature, on August 30, 1999, EPA proposed to reestablish NSPS for small MWC units. The NSPS contained in this final rule are equivalent to the 1995 NSPS for small MWC units.

EPA also promulgated emission guidelines and compliance times for existing sources that would otherwise be regulated under Subparts AAAA and CCCC. ADEQ is not proposing any rulemaking action related to these existing source categories because ADEQ believes that there are no such sources in Arizona. ADEQ plans to send a "negative declaration" letter to EPA regarding these source categories. Prior to such action, ADEQ requests comment on this conclusion. If ADEQ concludes that one or more of these sources exist in Arizona, it may propose a rule implementing the federal emission guidelines and compliance times for these sources similar to R18-2-731 and R18-2-732.

Subparts Significantly Revised:

**Part 60, Appendices A and B** [Amended at 64 FR 52828, 9/30/99; Part 63 clarified and corrected at 65 FR 67268, 11/9/00] EPA promulgated new Test Method 5I and Performance Specifications 4B and 8A when it revised standards for hazardous waste incinerators, hazardous waste burning cement kilns, and hazardous waste burning lightweight aggregate kilns. These standards were promulgated under joint authority of the Clean Air Act (CAA) and Resource Conservation and Recovery Act (RCRA). The standards limit emissions of chlorinated dioxins and furans, other toxic organic compounds, toxic metals, hydrochloric acid, chlorine gas, and particulate matter. These standards reflect the performance of Maximum Achievable Control Technologies (MACT) as specified by the CAA. These MACT standards also will result in increased protection to human health and the environment over existing RCRA standards.

**Part 60, Appendix A to Part 60 - Method 5I, Determination of Low Level Particulate Matter Emissions from Stationary Sources,** [Amended at 65 FR 42292, 7/10/00] On September 30, 1999, EPA published the Hazardous Waste Combustors NESHAP Final Rule. On November 19, 1999, EPA published the first technical correction of that rule to address a time sensitive situation. The subject rule corrects numerous typographical errors and clarifies several issues from the September 30, 1999, rule, one issue from a closely-related June 19, 1998, rule, and makes one adjustment to the November 19, 1999, technical correction. These corrections and clarifications will make the NESHAP final rule easier to understand and implement.

**Part 60, Subpart A - General Provisions; Appendix B - Performance Specification 1 - Specifications and Test Procedures for Opacity Continuous Emissions Monitoring Systems in Stationary Sources** [Amended at 65 FR 48914, 8/10/00] EPA issued revisions to the monitoring requirements to Performance Specification 1 (PS-1) of appendix B to part 60. The revisions clarified and updated requirements for source owners and operators who must install and use continuous stack or duct opacity monitoring equipment. The revisions also updated design and performance validation requirements for continuous opacity monitoring system (COMS) equipment in appendix B, PS-1. These revisions did not change an affected facility's applicable emission standards or requirements to monitor opacity. However, the revisions clarified the obligations of owners, operators, and opacity monitor vendors and reaffirmed

and updated COMS design and performance requirements by incorporating by reference American Society for Testing and Materials (ASTM) D 6216-98.

**Part 60, Subparts: A; D; Da; Db; Dc; E; Ea; Eb; Ec; F; J; K; Ka; Kb; L; M; Na; O; P; S; T; U; V; W; X; Y; Aa; AAa; BB; DD; EE; HH; LL; MM; NN; PP; QQ; RR; SS; TT; UU; VV; WW; XX; AAA; BBB; DDD; FFF; GGG; HHH; JJJ; KKK; LLL; NNN; OOO; PPP; QQQ; RRR; TTT; UUU; WWW; Appendix A to Part 60; Appendix B to Part 60** [Amended at 65 FR 61744, 10/17/00] In this rule, EPA made final minor amendments to its stationary source testing and monitoring rules. These amendments included miscellaneous editorial changes and technical corrections that were needed. EPA also promulgated Performance Specification 15, which contains the criteria for certifying continuous emission monitoring systems (CEMS) that use fourier transform infrared spectroscopy (FTIR). In addition, EPA also changed the outline of the test methods and CEMS performance specifications already listed in Parts 60, 61, and 63 to fit a new format recommended by the Environmental Monitoring Management Council (EMMC). The editorial changes and technical corrections updated the rules and endeavored to preserve their original intent. Performance Specification 15 will provide the needed acceptance criteria for FTIR CEMS as they emerge as a new technology. EPA reformatted the test methods and performance specifications to make them more uniform in content and interchangeable with other Agency methods. The amendments apply to a large number of industries that are already subject to the current provisions of Parts 60, 61, and 63.

**Part 60, Subparts: A - Standards of Performance for New Stationary Sources, General Provisions; Ka; Kb; VV; DDD; III; NNN; RRR** [Amended at 65 FR 78268, 12/14/00] This action promulgated a consolidated Federal air rule for the Synthetic Organic Chemical Manufacturing Industry (SOCMI). In this final rule, EPA consolidated major portions of several NSPS and NESHAP applicable to storage vessels, process vents, transfer operations, and equipment leaks within the SOCMI. The final rule pulls together applicable Federal SOCMI rules into one integrated set of rules in order to simplify, clarify, and improve implementation of the existing rules with which source owners or operators must comply. The consolidated rule is an optional compliance alternative for SOCMI sources; sources may simply continue to comply with existing applicable rules or choose to comply with the final consolidated rule.

**Part 60, Subparts: Da - Standards of Performance for Electric Utility Steam Generating Units for Which Construction Is Commenced after September 18, 1978; Db - Standards of Performance for Industrial-Commercial-Institutional Steam Generating Units** [Amended at 66 FR 18546, 4/10/01; 66 FR 31177, 6/11/01] EPA took direct final action to amend the emissions monitoring and compliance provisions contained in Subpart Da and Subpart Db. This action added monitoring exemptions and alternative compliance requirements for duct burners, as well as amendments to correct errors in subparts Da and Db. EPA adopted these amendments to ensure that all owners or operators of duct burners have similar compliance requirements and exemptions for their monitoring requirements. On June 11, 2001, due to relevant adverse comment, EPA withdrew two provisions from the direct final rule published on April 10, 2001. These provisions dealt with the revised definition of “boiler operating day” and the data substitution requirement for missing data.

NATIONAL EMISSION STANDARDS FOR HAZARDOUS AIR POLLUTANTS (NESHAP) - PART 61:

Subparts Added: None

Suparts Significantly Revised:

**Part 61, Subparts: B; C; D; E; F; H; I; K; L; M; N; O; Q; R; T; V; W; Y; BB; FF; Appendix B to Part 61** [Amended at 65 FR 61744, 10/17/00] See earlier discussion of this rulemaking under Part 60.

**Part 61, Subparts: A - General Provisions; J - National Emission Standard For Equipment Leaks (Fugitive Emission Sources) of Benzene; V - National Emission Standard For Equipment Leaks (Fugitive Emission Sources); Table 1 to Subpart V - Surge Control Vessels_and_Bottoms_Receivers_at_Existing_Sources; Table 2 to Subpart V - _Surge_Control_Vessels_and_Bottoms_Receivers_at_New_Sources;Y - National Emission Standard For Benzene Emissions From Benzene Storage Vessels; BB - National Emission Standard for Benzene Emissions from Benzene Transfer Operations** [Amended at 65 FR 78268, 12/14/00]] See earlier discussion of this rulemaking under Part 60.

NATIONAL EMISSION STANDARDS FOR HAZARDOUS AIR POLLUTANTS (NESHAP) - PART 63:

Subparts Added:

**Part 63, Subpart VVV - National Emission Standards for Hazardous Air Pollutants: Publicly Owned Treatment Works** [Added at 64 FR 57572, 10/26/99, and corrected at 66 FR 16140, 3/23/01] This action promulgated national emission standards for hazardous air pollutants (NESHAP) for new and existing publicly owned treatment works (POTW). The primary hazardous air pollutants (HAP) emitted by these sources include xylenes, methylene chloride, toluene, ethyl benzene, chloroform, tetrachloroethylene, benzene, and naphthalene.

With this final rule, EPA required air pollution controls on new or reconstructed treatment plants at POTWs that are major sources of HAPs. The standards also required that new and existing POTWs treating regulated waste streams from an industrial user, for the purpose of allowing that industrial user to comply with another NESHAP, meet the treatment and control requirements of the NESHAP with which the industrial user must comply.

**Part 63, Subpart OOO - National Emission Standards for Hazardous Air Pollutant Emissions: Manufacture of Amino/Phenolic Resins** [Added at 65 FR 3290, 1/20/00] This action promulgated national emission standards for hazardous air pollutants (NESHAP) to reduce emissions of hazardous air pollutants (HAPs) from existing and new facilities that manufacture amino or phenolic resins. EPA identified these facilities as major sources of HAPs emissions. These final standards are estimated to reduce organic HAP emissions from major existing sources by 361 tons per year, representing a 51 percent reduction from baseline emissions. This estimate is presented for 40 major existing facilities only, since no new facilities are projected to be constructed in the next three years. The major HAPs emitted by sources covered by the final rule include formaldehyde, methanol, phenol, xylene, and toluene.

**Part 63, Subpart RRR - National Emission Standards for Hazardous Air Pollutants for Secondary Aluminum Production** [Added at 65 FR 15690, 3/23/00] This action promulgated national emission standards for hazardous air pollutants (NESHAP) for new and existing sources at secondary aluminum production facilities. Hazardous air pollutants (HAPs) emitted by the facilities that would be regulated by this final rule include organic HAPs, inorganic gaseous HAPs (hydrogen chloride, hydrogen fluoride, and chlorine), and particulate HAP metals. Some of these pollutants, including 2,3,7,8- tetrachlorodibenzo-p-dioxin, are known or suspected carcinogens and all can cause toxic effects in humans following sufficient exposure. Emissions of other pollutants include particulate matter and volatile organic compounds.

**Part 63, Subpart MM - National Emission Standards for Hazardous Air Pollutants for Chemical Recovery Combustion Sources at Kraft, Soda, Sulfite, and Stand-Alone Semichemical Pulp Mills** [Added at 66 FR 3193, 1/12/01] This action promulgated national emission standards for hazardous air pollutants (NESHAP) for new and existing sources used in chemical recovery processes at kraft, soda, sulfite, and stand-alone semichemical pulp mills.

**Part 63, Subpart GGGG - National Emission Standards for Hazardous Air Pollutants: Solvent Extraction for Vegetable Oil Production** [Added at 66 FR 19006, 4/12/01] This action promulgated national emission standards for hazardous air pollutants (NESHAP) for solvent extraction for vegetable oil production. This industry is comprised of facilities that produce crude vegetable oil and meal products by removing oil from listed oilseeds through direct contact with an organic solvent. EPA identified solvent extraction for vegetable oil production processes as major sources of a single hazardous air pollutant (HAP), n-hexane.

**Part 63, Subpart CCCC - National Emission Standards for Hazardous Air Pollutants: Manufacture of Nutritional Yeast** [Amended at 66 FR 27876, 5/21/2001] This action finalized NESHAP for the nutritional yeast manufacturing source category. EPA identified the nutritional yeast manufacturing source category as a major source of hazardous air pollutants (HAP) emissions of acetaldehyde. These standards implement section 112(d) of the Clean Air Act (CAA) by requiring all major sources to meet HAP emission standards reflecting the application of the maximum achievable control technology (MACT).

Subparts Significantly Revised:

**Part 63, Subparts: EEE - National Emission Standards For Hazardous Air Pollutants From Hazardous Waste Combustors; LLL - National Emission Standards for Hazardous Air Pollutants from the Portland Cement Manufacturing Industry** [Amended at 64 FR 52828, 9/30/99;[Clarified/Corrected at 65 FR 67268, 11/9/00]] EPA promulgated revised standards for hazardous waste incinerators, hazardous waste burning cement kilns, and hazardous waste burning lightweight aggregate kilns. These standards were promulgated under joint authority of the Clean Air Act (CAA) and Resource Conservation and Recovery Act (RCRA). The standards limit emissions of chlorinated dioxins and furans, other toxic organic compounds, toxic metals, hydrochloric acid, chlorine gas, and particulate matter. These standards reflect the performance of Maximum Achievable Control Technologies (MACT) as specified by the Clean Air Act.

**Part 63, Subpart T - National Emission Standards for Halogenated Solvent Cleaning** [Amended at 64 FR 67793, 12/3/99; corrected at 65 FR 54419, 9/8/00] This action promulgated amendments to the "National Emission Standards for Hazardous Air Pollutants: Halogenated Solvent Cleaning" originally promulgated on December 2, 1994. These amendments to the rule were proposed on August 19, 1999. The subject action finalized compliance options for continuous web cleaning machines, as well as amendments to the national emission standards for hazardous air pollutants (NESHAP) that apply to steam-heated vapor cleaning machines and to cleaning machines used to clean transformers. EPA approved the subject amendments to ensure that all owners or operators of solvent cleaning machines have appropriate and attainable requirements for their cleaning machines.

**Part 63, Subparts: M - National Perchloroethylene Air Emission Standards For Dry Cleaning Facilities; N - National Emission Standards For Chromium Emissions From Hard And Decorative Chromium Electroplating And Chromium Anodizing Tanks; O - Ethylene Oxide Emissions Standards For Sterilization Facilities; T - National Emission Standards For Halogenated Solvent Cleaning; Y - National Emission Standards For Marine Tank Vessel Tank Loading Operations** [Amended at 64 FR 69637, 12/14/99] This action continued to allow permitting authorities the discretion to defer Clean Air Act (Act) title V operating permit requirements until December 9, 2004, for area sources of air pollution that are subject to five NESHAPs. These amendments continued to relieve industrial sources, state, local, and tribal agencies, and EPA Regional Offices of a regulatory burden during a time when available resources are needed to implement the title V permit program for major sources. Under these amendments, sources must continue to meet all applicable requirements, including all applicable emission control, monitoring, recordkeeping, and reporting requirements established by the respective NESHAP.The title V operating permit deferral is an option at the permitting authority's discretion under EPA-approved State operating permit programs and not an automatic deferral that the source can invoke. Thus, state operating permit authorities are free to require area sources subject to the five NESHAPS to obtain title V permits. In areas where no state operating permit program is in effect, and the federal operating permit program is administered by EPA, EPA will defer the requirement for title V permitting for these area sources until December 9, 2004.

**Part 63, Subparts U and JJJ;** [Amended at 65 FR 38030, 6/19/00] On September 5, 1996 and September 12, 1996, EPA promulgated national emission standards for hazardous air pollutants (NESHAP) for Group I Polymers and Resins and the NESHAP for Group IV Polymers and Resins, respectively. In November 1996, petitions for review of the September 1996 Polymers and Resins I and IV rules were filed in the U.S. Court of Appeals for the District of Columbia Circuit. The petitioners raised numerous technical issues and concerns with these rules. In addition, on January 17, 1997, amendments to the Synthetic Organic Chemical Manufacturing Industry NESHAP (i.e., the Hazardous Organic NESHAP, or HON) were promulgated; the HON is heavily referenced by both of the Polymers and Resins I and IV NESHAP. On March 9, 1999, EPA proposed amendments to the Polymers and Resins I and IV NESHAP to address the issues raised by the petitioners and to update the rules as necessitated by the HON amendments. This document takes final action on those proposed amendments.

**Part 63, Subpart GGG - National Emission Standards for Pharmaceuticals Production; Table 1 to Subpart GGG - General Provisions Applicability to Subpart GGG; Table 5 to Subpart GGG - Control Requirements for Items of Equipment that Meet the Criteria of § 63.1252(f)** [Amended at 65 FR 52588, 8/29/00] On September 21, 1998 (63 FR 50280), EPA promulgated national emission standards for hazardous air pollutants (NESHAP) for Pharmaceuticals Production. On November 17 and 20, 1998, petitions for reconsideration and review of the September 1998 rule were filed in the U.S. Court of Appeals for the District of Columbia Circuit. The petitioners raised over 12 technical issues and concerns with the rule. Additional issues were raised by intervenors on the side of the petitioners. On April 10, 2000, EPA proposed amendments to the Pharmaceuticals Production NESHAP to address the issues raised by the petitioners; this rule resulted from those proposed amendments.

**Part 63, Subparts: A; G; L; GG; II; Appendix A to Subpart II; Appendix A to Part 63** [Amended at 65 FR 61744, 10/17/00] See discussion, pages 5 and 6.

**Part 63, Subpart GGG - National Emission Standards for Aerospace Manufacturing and Rework Facilities** [Amended at 65 FR 76941, 12/8/00] On September 1, 1995, EPA promulgated the National Emission Standards for Aerospace Manufacturing and Rework Facilities. On January 24, 2000, EPA proposed to amend the standards to include a separate emission limit for exterior primers used for large commercial aircraft at existing facilities that produce fully assembled, large commercial aircraft. This action finalized those proposed amendments.In addition, EPA made a minor correction to the monitoring requirements section of the aerospace emission standards. The amendment corrected regulatory language that erroneously made reference to a list of requirements for initial compliance demonstrations when using incinerators and carbon absorbers.

**Part 63, Subpart H - National Emission Standards for Organic Hazardous Air Pollutants for Equipment Leaks; Table 4 to Subpart H - Table 4 to Subpart H--applicable 40 CFR Part 63 General Provisions** [Amended at 78268, 12/14/00] ] See earlier discussion of this rulemaking under Part 60.

**Part 63, Subparts: F - National Emission Standards for Organic Hazardous Air Pollutants from the Synthetic Organic Chemical Manufacturing Industry; G - National Emission Standards For Organic Hazardous Air Pollutants From The Synthetic Organic Chemical Manufacturing Industry For Process Vents, Storage Vessels, Transfer Operations, and Wastewater; H - National Emission Standards for Organic Hazardous Air Pollutants for Equipment Leaks; Appendix C to Part 63 - Determination of the Fraction Biodegraded (F(bio)) in a Biological Treatment Unit** [Amended at 66 FR 6922, 1/22/01] On April 22, 1994 and June 6, 1994, EPA issued the "National Emission Standards for Hazardous Air Pollutants for Source Categories: Organic Hazardous Air Pollutants

from the Synthetic Organic Chemical Manufacturing Industry and Other Processes Subject to the Negotiated Regulation for Equipment Leaks." This rule is commonly known as the Hazardous Organic National Emission Standards for Hazardous Air Pollutants (NESHAP) or the HON. On January 20, 2000, EPA proposed amendments to the definition of the term "process vent" and to add procedures for identifying "process vents" in order to ensure consistent interpretation of the term. EPA also proposed revisions to several provisions of the rule to reflect the terminology used in the revised definition of process vent. These changes were proposed to reduce the burden associated with developing operating permits for facilities subject to the rule. The January 20, 2000, document also proposed to add provisions to allow off-site control of process vent emissions and to add provisions for establishing a new compliance date under certain circumstances. In that action, EPA also proposed to add an alternative procedure for use in determining compliance with wastewater treatment requirements. This rulemaking took final action on those proposed amendments.These amendments to the rule did not change the basic control requirements of the rule or the level of health protection it provides. The rule requires new and existing major sources to control emissions of hazardous air pollutants to the level reflecting application of the maximum achievable control technology.

**Part 63, Subpart EEE - National Emission Standards For Hazardous Air Pollutants From Hazardous Waste Combustors** [Amended at 66 FR 24272, 5/14/01] In Chemical Manufacturers Association v. EPA, 217 F. 3d 861 (D.C. Cir. 2000), the court vacated the Notice of Intent to Comply (NIC) provisions of EPA's rules relating to the standards for hazardous waste combustors. This revision took the ministerial step of removing these provisions from the Code of Federal Regulations (CFR). In addition, at EPA's request, the D.C. Circuit Court vacated certain parameter limits of baghouses and electrostatic precipitators in order for EPA to solicit further comment on these provisions. CKRC v. EPA, no. 99-1457 (Order of April 5, 2001). This action likewise takes the ministerial step of removing these provisions from the CFR.

ACID RAIN REVISIONS, (40 CFR 72, 74, 75, and 76)

ADEQ is incorporating all of the changes to these regulations that EPA made between from July 1, 1999, to July 1, 2001. Two changes were made as a result of lawsuits. In an October 15, 1999, rule, EPA amended the NOx emission limitations for Group 2 coal-fired boilers to recognize the Court of Appeals statement that "that retrofitted cell burners are not the functional equivalent of wall-fired boilers". (64 FR 55834) In a March 1, 2001, rule, EPA removed the industrial utility-units exemption in 40 CFR 72.14, (66 FR 12974).

**6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study, and other supporting material:**

None

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

Not applicable

**8. The preliminary summary of the economic, small business, and consumer impact:**

IDENTIFICATION OF PROPOSED RULEMAKING

NSPS/NESHAP/Acid Rain 2001: A.A.C. Title 18, Chapter 2, Articles 1, 3, 9 and 11; Appendix 2, Sections R18-2-101, R18-2-210, R18-2-333, R18-2-901, R18-2-1101, Appendix 2.

Costs

ADEQ believes that the necessary proposed change to the "major source" definition in R18-2-101 could have an economic effect on some sources by causing them to be classified as major sources when they would not otherwise be. Certain facilities may need to re-estimate their release of fugitive emissions of nonhazardous air pollutants to determine if they are subject to Title V operating requirements. ADEQ requests information from sources under their jurisdiction that this change may affect.

There are no additional costs to the regulated community when a state agency incorporates an already effective federal standard verbatim. The costs of compliance have already occurred, and were considered when the federal regulation was proposed and adopted. These rules impose no additional costs on the regulated community, small businesses, political subdivisions, or members of the public.

Costs to ADEQ are those that may accrue for implementation and enforcement of the new standards. Although there may be some small incremental costs due to this rulemaking, ADEQ does not intend to hire any additional employees to implement or enforce these rules.

Benefits

Benefits accrue to the regulated community when a state agency incorporates a federal regulation in order to become the primary implementer of the regulation, because the state agency is closer to those being regulated and, therefore, is generally easier to contact and to work with to resolve differences, compared with the U.S. EPA, whose regional office for Arizona is in San Francisco. Local implementation also reduces travel and communication costs.

Health benefits accrue to the general public whenever enforcement of environmental laws takes place. Adverse health effects from air pollution result in a number of economic and social consequences, including:

1. Medical costs. These include personal out-of-pocket expenses of the affected individual (or family), plus costs paid by insurance or Medicare, for example.

2. Work loss. This includes lost personal income, plus lost productivity whether the individual is compensated for the time or not. For example, some individuals may perceive no income loss because they receive sick pay, but sick pay is a cost of business and reflects lost productivity.

3. Increased costs for chores and caregiving. These include special caregiving and services that are not reflected in medical costs. These costs may occur because some health effects reduce the affected individual's ability to undertake some or all normal chores, and he or she may require caregiving.

4. Other social and economic costs. These include restrictions on or reduced enjoyment of leisure activities, discomfort or inconvenience, pain and suffering, anxiety about the future, and concern and inconvenience to family members and others.

Conclusion

In conclusion, the incremental costs associated with this rule are generally low, and apply solely to ADEQ, while the air quality benefits are generally high. In addition, there are benefits to industry from being regulated by a geographically nearer government entity. There are no adverse economic impacts on political subdivisions. There are no adverse economic impacts on private businesses, their revenues or expenditures. The fact that no new employment is expected to occur has been discussed above, in the context of the impact on state agencies. There are no adverse economic impacts on small businesses, although some regulatory benefits will accrue to them. There are no economic impacts for consumers; benefits to private persons as members of the general public are discussed above in terms of enforcement. There will be no direct impact on state revenues. There are no other, less costly alternatives for achieving the goals of this rulemaking. The rules are no less stringent and no more stringent than the federal regulations on each subject.

**Rule impact reduction on small businesses.** A.R.S. § 41-1035 requires ADEQ to reduce the impact of a rule on small businesses by using certain methods when they are legal and feasible in meeting the statutory objectives (see below) for the rulemaking. The five listed methods are:

1. Establish less stringent compliance or reporting requirements in the rule for small businesses.

2. Establish less stringent schedules or deadlines in the rule for compliance or reporting requirements for small businesses.

3. Consolidate or simplify the rule's compliance or reporting requirements for small businesses.

4. Establish performance standards for small businesses to replace design or operational standards in the rule.

5. Exempt small businesses from any or all requirements of the rule.

**The statutory objectives which are the basis of the rulemaking.** The general statutory objectives that are the basis of this rulemaking are contained in the statutory authority cited in number 2 of this preamble. The specific objectives are as follows:

1. Implement rules necessary for EPA delegation of Clean Air Act § 111 (NSPS) program to Arizona.

2. Implement rules necessary for EPA § 112(l) program delegation to Arizona (NESHAP).

3. Implement rules necessary for acid rain program delegation to ADEQ.

ADEQ has determined that there is a beneficial impact on small businesses in transferring implementation of these rules to ADEQ. In addition, for all of these objectives, ADEQ is required to adopt the federal rules without reducing stringency. ADEQ, therefore, finds that it is not legal or feasible to adopt any of the five listed methods in ways that reduce the impact of these rules on small businesses. Finally, where federal rules impact small businesses, EPA is required by both the Regulatory Flexibility Act and the Small Business Regulatory Enforcement and Fairness Act to

make certain adjustments in its own rulemakings. Information related to such may be found in the individual rules described in Section 5.

**9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**

Name: David Lillie, Air Quality Division, Planning Section

Address: ADEQ
3033 N. Central Ave.
Phoenix, AZ 85012-2809

Telephone: (602) 207-4461 (Any extension may be reached in-state by dialing 1-800-234-5677, and asking for that extension)

Fax: (602) 207-2366

**10. The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when and how persons may request an oral proceeding on the proposed rule:**

Date: February 19, 2002

Time: 10:00 a.m.

Location: Arizona Department of Environmental Quality, Room 1709, 3033 N. Central, Phoenix, AZ (Please call 602-207-4795 for special accommodations pursuant to the Americans with Disabilities Act.)

Nature: Public hearing on the proposed rules, with opportunity for formal comments on the record. The close of written comment is 5 p.m., February 22, 2002.

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

Not applicable

**12. Incorporations by reference and their locations in the rules:**

| New incorporations by reference (subparts or larger) | Location |
|---|---|
| 40 CFR 60, subparts AAAA and CCCC | R18-2-901 |
| 40 CFR 63, subparts MM, OOO, RRR, VVV, CCCC, and GGGG | R18-2-1101(B) |

| Incorporations by reference updated to 7/1/01 (may include new sections) | Location |
|---|---|
| 40 CFR 81.303 | R18-2-210 |
| 40 CFR 72, 74, 75 and 76 | R18-2-333(A) |
| 40 CFR 60, listed subparts and accompanying appendices | R18-2-901(A) |
| 40 CFR 61, listed subparts and accompanying appendices | R18-2-1101(A) |
| 40 CFR 63, listed subparts and accompanying appendices | R18-2-1101(B) |
| Currently Cited Appendices to 40 CFR Parts 51, 60, 61, 63, 75 | Appendix 2 |
| 40 CFR 50 | Appendix 2 |
| 40 CFR 50, Appendices A through K | Appendix 2 |
| 40 CFR 52, Appendices D and E; | Appendix 2 |
| 40 CFR 58 | Appendix 2 |
| 40 CFR 58, all appendices | Appendix 2 |

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

**TITLE 18. ENVIRONMENTAL QUALITY**

**CHAPTER 2. DEPARTMENT OF ENVIRONMENTAL QUALITY**
**AIR POLLUTION CONTROL**

**ARTICLE 1. GENERAL**

Section
R18-2-101. Definitions

**ARTICLE 2. AMBIENT AIR QUALITY STANDARDS; AREA DESIGNATIONS; CLASSIFICATIONS**

Section
R18-2-210. Attainment, Nonattainment, and Unclassifiable Area Designations

**ARTICLE 3. PERMITS AND PERMIT REVISIONS**

Section
R18-2-333. Acid Rain

**ARTICLE 9. NEW SOURCE PERFORMANCE STANDARDS**

Section
R18-2-901. Standards of Performance for New Stationary Sources

**ARTICLE 11. FEDERAL HAZARDOUS AIR POLLUTANTS**

Section
R18-2-1101. National Emission Standards for Hazardous Air Pollutants (NESHAPs)
Appendix 2. Test Methods and Protocols

**ARTICLE 1. GENERAL**

**R18-2-101. Definitions**
In addition to the definitions prescribed in A.R.S. §§ 49-101, 49-401.01, 49-421, 49-471, and 49-541, in this Chapter, unless otherwise specified:

1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change
8. No change
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58. No change
59. No change
60. No change
61. No change
62. No change
63. No change
64. "Major source" means:
    a. A major source as defined in R18-2-401.
    b. A major source under Section 112 of the Act:
        i. For pollutants other than radionuclides, any stationary source that emits or has the potential to emit, in the aggregate, including fugitive emissions, 10 tons per year (tpy) or more of any hazardous air pollutant which has been listed pursuant to Section 112(b) of the Act, 25 tpy or more of any combination of such hazardous air pollutants, or such lesser quantity as described in Article 11 of this Chapter. Notwithstanding the preceding sentence, emissions from any oil or gas exploration or production well (with its associated equipment) and emissions from any pipeline compressor or pump station shall not be aggregated with emissions from other similar units, whether or not such units are in a contiguous area or under common control, to determine whether such units or stations are major sources; or
        ii. For radionuclides, "major source" shall have the meaning specified by the Administrator by rule.
    c. A major stationary source, as defined in Section 302 of the Act, that directly emits or has the potential to emit, 100 tpy or more of any air pollutant including any major source of fugitive emissions of any such pollutant. The fugitive emissions of a stationary source shall not be considered in determining whether it is a major stationary source for the purposes of Section 302(j) of the Act, unless the source belongs to 1 of the following categories of stationary source:
        i. Coal cleaning plants (with thermal dryers).
        ii. Kraft pulp mills.
        iii. Portland cement plants.
        iv. Primary zinc smelters.

v. Iron and steel mills.
vi. Primary aluminum ore reduction plants.
vii. Primary copper smelters.
viii. Municipal incinerators capable of charging more than 50 tons of refuse per day.
ix. Hydrofluoric, sulfuric, or nitric acid plants.
x. Petroleum refineries
xi. Lime plants.
xii. Phosphate rock processing plants.
xiii. Coke oven batteries.
xiv. Sulfur recovery plants.
xv. Carbon black plants (furnace process).
xvi. Primary lead smelters.
xvii. Fuel conversion plants.
xviii. Sintering plants.
xix. Secondary metal production plants.
xx. Chemical process plants.
xxi. Fossil-fuel boilers (or combination thereof) totaling more than 250 million British thermal units per hour heat input.
xxii. Petroleum storage and transfer units with a total storage capacity exceeding 300,000 barrels.
xxiii. Taconite ore processing plants.
xxiv. Glass fiber processing plants.
xxv. Charcoal production plants.
xxvi. Fossil-fuel-fired steam electric plants of more than 250 million British thermal units per hour heat input.
xxvii. ~~All~~ Any other stationary source ~~categories~~ category, ~~regulated by a standard promulgated~~ which as of August 7, 1980, is being regulated under Section 111 or 112 of the Act~~, but only with respect to those air pollutants that have been regulated for that category~~.

65. No change
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126. No change

## ARTICLE 2. AMBIENT AIR QUALITY STANDARDS; AREA DESIGNATIONS; CLASSIFICATIONS

**R18-2-210. Attainment, Nonattainment, and Unclassifiable Area Designations**

40 CFR 81.303 as amended as of July 1, ~~1998~~ 2001 (and no future editions) is incorporated by reference and is on file with the Department of Environmental Quality and the Office of Secretary of State.

## ARTICLE 3. PERMITS AND PERMIT REVISIONS

**R18-2-333. Acid Rain**

**A.** 40 CFR 72, 74, 75 and 76 and all accompanying appendices, adopted as of July 1, ~~1999~~ 2001, (and no future amendments) are incorporated by reference. These standards are on file with the Office of the Secretary of State and the Department and shall be applied by the Department.

**B.** When used in 40 CFR 72, 74, 75 or 76, "Permitting Authority" means the Arizona Department of Environmental Quality and "Administrator" means the Administrator of the United States Environmental Protection Agency.

**C.** If the provisions or requirements of the regulations incorporated in this Section conflict with any of the remaining portions of this Title, the regulations incorporated in this Section shall apply and take precedence.

## ARTICLE 9. NEW SOURCE PERFORMANCE STANDARDS

**R18-2-901. Standards of Performance for New Stationary Sources**

Except as provided in R18-2-902 through R18-2-905, the following subparts of 40 CFR 60, New Source Performance Standards (NSPS), and all accompanying appendices, adopted as of July 1, ~~1999~~ 2001, and no future editions or amendments, are incorporated by reference. These standards are on file with the Office of the Secretary of State and the Department and shall be applied by the Department.

1. Subpart A - General Provisions.
2. Subpart D - Fossil-Fuel-Fired Steam Generators for Which Construction is Commenced After August 17, 1971.
3. Subpart Da - Electric Utility Steam Generating Units for Which Construction is Commenced After September 18, 1978.
4. Subpart Db - Industrial-Commercial-Institutional Steam Generating Units.
5. Subpart Dc - Small Industrial-Commercial-Institutional Steam Generating Units.
6. Subpart E - Incinerators.

7. Subpart Ea - Municipal Waste Combustors for Which Construction is Commenced after December 20, 1989 and on or Before September 20, 1994.
8. Subpart Eb - Large Municipal Waste Combustors for Which Construction is Commenced after September 20, 1994 or for Which Modification or Reconstruction is Commenced After June 19, 1996.
9. Subpart Ec - Standards of Performance for Hospital/Medical/Infectious Waste Incinerators for Which Construction is Commenced After June 20, 1996~~, adopted September 15, 1997 (62 FR 48348)~~.
10. Subpart F - Portland Cement Plants.
11. Subpart G - Nitric Acid Plants.
12. Subpart H - Sulfuric Acid Plants.
13. Subpart I - Hot Mix Asphalt Facilities.
14. Subpart J - Petroleum Refineries.
15. Subpart K - Storage Vessels for Petroleum Liquids for Which Construction, Reconstruction, or Modification Commenced After June 11, 1973, and Prior to May 19, 1978.
16. Subpart Ka - Storage Vessels for Petroleum Liquids for Which Construction, Reconstruction, or Modification Commenced After May 18, 1978, and Prior to July 23, 1984.
17. Subpart Kb - Volatile Organic Liquid Storage Vessels (Including Petroleum Liquid Storage Vessels) for Which Construction, Reconstruction, or Modification Commenced after July 23, 1984.
18. Subpart L - Secondary Lead Smelters.
19. Subpart M - Secondary Brass and Bronze Production Plants.
20. Subpart N - Primary Emissions from Basic Oxygen Process Furnaces for Which Construction is Commenced After June 11, 1973.
21. Subpart Na - Secondary Emissions from Basic Oxygen Process Steelmaking Facilities for Which Construction is Commenced After January 20, 1983.
22. Subpart O - Sewage Treatment Plants.
23. Subpart P - Primary Copper Smelters.
24. Subpart Q - Primary Zinc Smelters.
25. Subpart R - Primary Lead Smelters.
26. Subpart S - Primary Aluminum Reduction Plants.
27. Subpart T - Phosphate Fertilizer Industry: Wet-Process Phosphoric Acid Plants.
28. Subpart U - Phosphate Fertilizer Industry: Superphosphoric Acid Plants.
29. Subpart V - Phosphate Fertilizer Industry: Diammonium Phosphate Plants.
30. Subpart W - Phosphate Fertilizer Industry: Triple Superphosphate Plants.
31. Subpart X - Phosphate Fertilizer Industry: Granular Triple Superphosphate Storage Facilities.
32. Subpart Y - Coal Preparation Plants.
33. Subpart Z - Ferroalloy Production Facilities.
34. Subpart AA - Steel Plants: Electric Arc Furnaces Constructed After October 21, 1974, and On or Before August 17, 1983.
35. Subpart AAa - Steel Plants: Electric Arc Furnaces and Argon-Oxygen Decarburization Vessels Constructed After August 7, 1983.
36. Subpart BB - Kraft Pulp Mills.
37. Subpart CC - Glass Manufacturing Plants.
38. Subpart DD - Grain Elevators.
39. Subpart EE - Surface Coating of Metal Furniture.
40. Subpart GG - Stationary Gas Turbines.
41. Subpart HH - Lime Manufacturing Plants.
42. Subpart KK - Lead-Acid Battery Manufacturing Plants.
43. Subpart LL - Metallic Mineral Processing Plants.
44. Subpart MM - Automobile and Light Duty Truck Surface Coating Operations.
45. Subpart NN - Phosphate Rock Plants.
46. Subpart PP - Ammonium Sulfate Manufacture.
47. Subpart QQ - Graphic Arts Industry: Publication Rotogravure Printing.
48. Subpart RR - Pressure Sensitive Tape and Label Surface Coating Operations.
49. Subpart SS - Industrial Surface Coating: Large Appliances.
50. Subpart TT - Metal Coil Surface Coating.
51. Subpart UU - Asphalt Processing and Asphalt Roofing Manufacture.
52. Subpart VV - Equipment Leaks of VOC in the Synthetic Organic Chemicals Manufacturing Industry.
53. Subpart WW - Beverage Can Surface Coating Industry.
54. Subpart XX - Bulk Gasoline Terminals.
55. Subpart AAA - New Residential Wood Heaters.

56. Subpart BBB - Rubber Tire Manufacturing Industry.
57. Subpart DDD - Volatile Organic Compound (VOC) Emissions from the Polymer Manufacturing Industry.
58. Subpart FFF - Flexible Vinyl and Urethane Coating and Printing.
59. Subpart GGG - Equipment Leaks of VOC in Petroleum Refineries.
60. Subpart HHH - Synthetic Fiber Production Facilities.
61. Subpart III - Volatile Organic Compound (VOC) Emissions from the Synthetic Organic Chemical Manufacturing Industry (SOCMI) Air Oxidation Unit Processes.
62. Subpart JJJ - Petroleum Dry Cleaners.
63. Subpart KKK - Equipment Leaks of VOC from Onshore Natural Gas Processing Plants.
64. Subpart LLL - Onshore Natural Gas Processing; $SO_2$ Emissions.
65. Subpart NNN - Volatile Organic Compound (VOC) Emissions From Synthetic Organic Chemical Manufacturing Industry (SOCMI) Distillation Operations.
66. Subpart OOO - Nonmetallic Mineral Processing Plants.
67. Subpart PPP - Wool Fiberglass Insulation Manufacturing Plants.
68. Subpart QQQ - VOC Emissions From Petroleum Refinery Wastewater Systems.
69. Subpart RRR - Volatile Organic Compound Emissions From Synthetic Organic Chemical Manufacturing Industry (SOCMI) Reactor Processes.
70. Subpart SSS - Magnetic Tape Coating Facilities.
71. Subpart TTT - Industrial Surface Coating: Surface Coating of Plastic Parts for Business Machines.
72. Subpart UUU - Calciners and Dryers in Mineral Industries.
73. Subpart VVV - Polymeric Coating of Supporting Substrates Facilities.
74. Subpart WWW - Municipal Solid Waste Landfills.
75. Subpart AAAA - Small Municipal Waste Combustion Units for Which Construction Is Commenced after August 30, 1999, or for Which Modification or Reconstruction Is Commenced after June 6, 2001.
76. Subpart CCCC - Commercial and Industrial Solid waste Incineration Units for Which Construction Is Commenced after November 30, 1999, or for Which Modification or Reconstruction Is Commenced on or after June 1, 2001.

## ARTICLE 11. FEDERAL HAZARDOUS AIR POLLUTANTS

### R18-2-1101. National Emission Standards for Hazardous Air Pollutants (NESHAPs)

**A.** Except as provided in R18-2-1102, the following subparts of 40 CFR 61, National Emission Standards for Hazardous Air Pollutants (NESHAPs), and all accompanying appendices, adopted as of July 1, ~~1999~~ 2001, and no future editions or amendments, are incorporated by reference. These standards are on file with the Office of the Secretary of State and the Department and shall be applied by the Department.

1. Subpart A - General Provisions.
2. Subpart C - Beryllium.
3. Subpart D - Beryllium Rocket Motor Firing.
4. Subpart E - Mercury.
5. Subpart F - Vinyl Chloride.
6. Subpart J - Equipment Leaks (Fugitive Emission Sources) of Benzene.
7. Subpart L - Benzene Emissions from Coke By-Product Recovery Plants.
8. Subpart M - Asbestos.
9. Subpart N - Inorganic Arsenic Emissions from Glass Manufacturing Plants.
10. Subpart O - Inorganic Arsenic Emissions from Primary Copper Smelters.
11. Subpart P - Inorganic Arsenic Emissions from Arsenic Trioxide and Metallic Arsenic Production.
12. Subpart V - Equipment Leaks (Fugitive Emission Sources).
13. Subpart Y - Benzene Emissions From Benzene Storage Vessels.
14. Subpart BB - Benzene Emissions from Benzene Transfer Operations.
15. Subpart FF - Benzene Waste Operations.

**B.** Except as provided in R18-2-1102, the following subparts of 40 CFR 63, NESHAPs for Source Categories, and all accompanying appendices, adopted as of July 1, ~~1999~~ 2001, and no future editions or amendments, are incorporated by reference. These standards are on file with the Office of the Secretary of State and the Department and shall be applied by the Department.

1. Subpart A - General Provisions.
2. Subpart B - Requirements for Control Technology Determinations for Major Sources in Accordance with Clean Air Act Sections, Sections 112(g) and 112(j).
3. Subpart D - Regulations Governing Compliance Extensions for Early Reductions of Hazardous Air Pollutants.
4. Subpart F - National Emission Standards for Organic Hazardous Air Pollutants from the Synthetic Organic Chemical Manufacturing Industry.

5. Subpart G - National Emission Standards for Organic Hazardous Air Pollutants from the Synthetic Organic Chemical Manufacturing Industry for Process Vents, Storage Vessels, Transfer Operations, and Wastewater.
6. Subpart H - National Emission Standards for Organic Hazardous Air Pollutants for Equipment Leaks.
7. Subpart I - National Emission Standards for Organic Hazardous Air Pollutants for Certain Processes Subject to the Negotiated Regulation for Equipment Leaks.
8. Subpart L - National Emission Standards for Coke Oven Batteries.
9. Subpart M - National Perchloroethylene Air Emission Standards for Dry Cleaning Facilities.
10. Subpart N - National Emission Standards for Chromium Emissions From Hard and Decorative Chromium Electroplating and Chromium Anodizing Tanks.
11. Subpart O - Ethylene Oxide Emissions Standards for Sterilization Facilities.
12. Subpart Q - National Emission Standards for Hazardous Air Pollutants for Industrial Process Cooling Towers.
13. Subpart R - National Emission Standards for Gasoline Distribution Facilities (Bulk Gasoline Terminals and Pipeline Breakout Stations).
14. Subpart S - National Emission Standards for Hazardous Air Pollutants from the Pulp and Paper Industry.
15. Subpart T - National Emission Standards for Halogenated Solvent Cleaning.
16. Subpart U - National Emission Standards for Hazardous Air Pollutant Emissions: Group I Polymers and Resins.
17. Subpart W - National Emission Standards for Hazardous Air Pollutants for Epoxy Resins Production and Non-Nylon Polyamides Production.
18. Subpart X - National Emission Standards for Hazardous Air Pollutants from Secondary Lead Smelting.
19. Subpart AA - National Emission Standards for Hazardous Air Pollutants From Phosphoric Acid Manufacturing Plants.
20. Subpart BB - National Emission Standards for Hazardous Air Pollutants From Phosphate Fertilizers Production Plants.
21. Subpart CC - National Emission Standards for Hazardous Air Pollutants from Petroleum Refineries.
22. Subpart DD - National Emission Standards for Hazardous Air Pollutants from Off-Site Waste and Recovery Operations.
23. Subpart EE - National Emission Standards for Magnetic Tape Manufacturing Operations.
24. Subpart GG - National Emission Standards for Aerospace Manufacturing and Rework Facilities.
25. Subpart HH - National Emission Standards for Hazardous Air Pollutants From Oil and Natural Gas Production Facilities.
26. Subpart JJ - National Emission Standards for Wood Furniture Manufacturing Operations.
27. Subpart KK - National Emission Standards for the Printing and Publishing Industry.
28. Subpart LL - National Emission Standards for Hazardous Air Pollutants for Primary Aluminum Reduction Plants.
29. Subpart MM - National Emission Standards for Hazardous Air Pollutants for Chemical Recovery Combustion Sources at Kraft, Soda, Sulfite, and Stand-Alone Semichemical Pulp Mills.

~~29.~~30. Subpart OO - National Emission Standards for Tanks--Level 1.

~~30.~~31. Subpart PP - National Emission Standards for Containers.

~~31.~~32. Subpart QQ - National Emission Standards for Surface Impoundments.

~~32.~~33. Subpart RR - National Emission Standards for Individual Drain Systems.

~~33.~~34. Subpart SS - National Emission Standards for Closed Vent Systems, Control Devices, Recovery Devices and Routing to a Fuel Gas System or a Process.

~~34.~~35. Subpart TT - National Emission Standards for Equipment Leaks - Control Level 1.

~~35.~~36. Subpart UU - National Emission Standards for Equipment Leaks - Control Level 2 Standards.

~~36.~~37. Subpart VV - National Emission Standards for Oil-Water Separators and Organic-Water Separators.

~~37.~~38. Subpart WW - National Emission Standards for Storage Vessels (Tanks) - Control Level 2.

~~38.~~39. Subpart YY - National Emission Standards for Hazardous Air Pollutants for Source Categories: Generic Maximum Achievable Control Technology Standards.

~~39.~~40. Subpart CCC - National Emission Standards for Hazardous Air Pollutants for Steel Pickling - HCl Process Facilities and Hydrochloric Acid Regeneration Plants.

~~40.~~41. Subpart DDD - National Emission Standards for Hazardous Air Pollutants for Mineral Wool Production.

~~41.~~42. Subpart EEE - National Emission Standards for Hazardous Air Pollutants From Hazardous Waste Combustors.

~~42.~~43. Subpart GGG - National Emission Standards for Pharmaceuticals Production.

~~43.~~44. Subpart HHH - National Emission Standards for Hazardous Air Pollutants From Natural Gas Transmission and Storage Facilities.

~~44.~~45. Subpart III - National Emission Standards for Hazardous Air Pollutants for Flexible Polyurethane Foam Production.

~~45.~~46. Subpart JJJ - National Emission Standards for Hazardous Air Pollutant Emissions: Group IV Polymers and Resins.

~~46.~~47. Subpart LLL - National Emission Standards for Hazardous Air Pollutants From the Portland Cement Manufacturing Industry.

~~47.~~48. Subpart MMM - National Emission Standards for Hazardous Air Pollutants for Pesticide Active Ingredient Production.
~~48.~~49. Subpart NNN - National Emission Standards for Hazardous Air Pollutants for Wool Fiberglass Manufacturing.
50. Subpart OOO - National Emission Standards for Hazardous Air Pollutant Emissions: Manufacture of Amino/Phenolic Resins.
~~49.~~51. Subpart PPP - National Emission Standards for Hazardous Air Pollutant Emissions for Polyether Polyols Production.
52. Subpart RRR - National Emission Standards for Hazardous Air Pollutants for Secondary Aluminum Production.
~~50.~~53. Subpart TTT - National Emission Standards for Hazardous Air Pollutants for Primary Lead Smelting.
54. Subpart VVV - National Emission Standards for Hazardous Air Pollutants: Publicly Owned Treatment Works.
~~51.~~55. Subpart XXX - National Emission Standards for Hazardous Air Pollutants for Ferroalloys Production: Ferromanganese and Silicomanganese.
56. Subpart CCCC - National Emission Standards for Hazardous Air Pollutants: Manufacture of Nutritional Yeast.
57. Subpart GGGG - National Emission Standards for Hazardous Air Pollutants: Solvent Extraction for Vegetable Oil Production.

**APPENDIX 2. TEST METHODS AND PROTOCOLS**

The following test methods and protocols are approved for use as directed by the Department under this Chapter. These standards are incorporated by reference as of July 1, ~~1999~~ 2001 (and no future editions or amendments), except for incorporation dates specifically provided. These standards are on file with the Department and the Office of the Secretary of State, and are also available from the U.S. Government Printing Office, Superintendent of Documents, Mail Stop SSOP, Washington D.C. 20402-9328.

1. 40 CFR 50;
2. 40 CFR 50, Appendices A through K;
3. 40 CFR Part 51, Appendix M, Appendix S, Section IV, Appendix W;
4. 40 CFR 52, Appendices D and E;
5. 40 CFR 58;
6. 40 CFR 58, all appendices;
7. 40 CFR Part 60, all appendices.
8. 40 CFR Part 61, all appendices.
9. 40 CFR Part 63, all appendices.
10. 40 CFR Part 75, all appendices.
11. The Department's "Arizona Testing Manual for Air Pollutant Emissions," (March, 1992).

# NOTICE OF PROPOSED RULEMAKING

## TITLE 20. COMMERCE, BANKING, AND INSURANCE

## CHAPTER 6. DEPARTMENT OF INSURANCE

## PREAMBLE

**1. Sections Affected** — **Rulemaking Action**

| | |
|---|---|
| Article 20 | New Article |
| R20-6-2001 | New Section |
| R20-6-2002 | New Section |

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

Authorizing statute: A.R.S. § 20-167(H)

Implementing statutes: A.R.S. §§ 20-167(H), 20-1098.01(G), and 20-1098.06

**3. List all previous notices appearing in the register addressing the proposed rules:**

Notice of Rulemaking Docket Opening: 7 A.A.R. 5265, November 23, 2001

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

Name: Vista Thompson Brown or Margaret McClelland

Address: Arizona Department of Insurance
2910 N. 44th Street, 2nd Floor

Phoenix, AZ 85018

Telephone: (602) 912-8456

Fax: (602) 912-8452

**5. An explanation of the rule, including the agency's reasons for initiating the rule:**

Laws 2000, Chapter 327 established a captive insurance program. The legislation requires the Director of the Department of Insurance to establish fees for issuance and renewal of a license for captive insurers. This rule will establish those fees. The rule also sets forth the captive insurer's obligation to pay any examination costs.

Specific Section-By-Section Explanation of This Proposal

R20-6-2001. Reserved

R20-6-2002. Fees; Examination Costs

Establishes a fee of $1000.00 for issuance of a license and a fee of $5500.00 for annual renewal of a license; provides that captive insurer is responsible for the payment of any examination costs.

**6. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:**

Not applicable

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

Not applicable

**8. The preliminary summary of the economic, small business and consumer impact:**

There will be economic impacts to captive insurers as a result of this rule due to the fees being imposed. Given that captive insurers are typically established only by large enterprises that would otherwise be capable of self insuring their risks, and are not subject to any premium taxes like regular insurers, the economic impact is estimated to be minimal.

There will be a minimal economic impact on the Department, the Secretary of State and the Governor's Regulatory Review Council for costs associated with the rulemaking process.

**9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**

Name: Vista Thompson Brown or Margaret McClelland

Address: Arizona Department of Insurance
2910 N. 44th Street, 2nd Floor
Phoenix, AZ 85018

Telephone: (602) 912-8456

Fax: (602) 912-8452

**10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**

The Department has not scheduled an oral proceeding on this rule, but will do so upon request. The Department will accept written comments on the proposed rule from now until the close of record at 5:00 p.m. on Friday, February 15, 2002.

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

Not applicable

**12. Incorporations by reference and their location in the rule:**

None

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

**TITLE 20. COMMERCE, BANKING, AND INSURANCE**

**CHAPTER 6. DEPARTMENT OF INSURANCE**

**ARTICLE 20. CAPTIVE INSURERS**

Section
R20-6-2001. Reserved
R20-6-2002. Fees; Examination Costs

**ARTICLE 20. CAPTIVE INSURERS**

**R20-6-2001. Reserved**

**R20-6-2002. Fees; Examination Costs**

**A.** A corporation applying for a license to do business as a captive insurer shall pay a nonrefundable fee to the Department in the amount of $1000.00 for issuance of the license. The fee is payable in full at the time the applicant submits the application for license to the Department under A.R.S. § 20-1098.01.

**B.** A captive insurer shall pay a nonrefundable annual renewal fee to the Department in the amount of $5500.00 at the time of filing its annual report under A.R.S. § 20-1098.01(G).

**C.** In addition to the fees prescribed in subsections (A) and (B), an applicant for a captive insurer license or a licensed captive insurer shall pay the costs of any examination conducted by the Director, in accordance with A.R.S. § 20-1098.06.