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 3. AGRICULTURE

CHAPTER 1. DEPARTMENT OF AGRICULTURE – ADMINISTRATION

PREAMBLE

1. Sections Affected / Rulemaking Action

Sections Affected	Rulemaking Action
R3-1-101	Amend
Article 2	Amend
R3-1-201	Repeal
R3-1-201	New Section
R3-1-202	Repeal
R3-1-203	Repeal
R3-1-204	Repeal
R3-1-205	Repeal
R3-1-206	Repeal
R3-1-207	Repeal
R3-1-208	Repeal
R3-1-209	Repeal
R3-1-210	Repeal
R3-1-211	Repeal
R3-1-212	Repeal
R3-1-213	Repeal
R3-1-214	Repeal
R3-1-215	Repeal
R3-1-216	Repeal
R3-1-217	Repeal
R3-1-218	Amend
R3-1-219	Repeal

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. § 3-107

Implementing statutes: A.R.S. §§ 3-107, 41-1001, 41-1092

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

Notice of Rulemaking Docket Opening: 7 A.A.R. 2013, May 4, 2001

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

Name: Sherry D. Blatner, Rules Specialist

Address: Arizona Department of Agriculture
1688 West Adams, Room 235
Phoenix, AZ 85007

Telephone: (602) 542-0962

Fax: (602) 542-5420

E-mail: sherry.blatner@agric.state.az.us

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

This rulemaking updates the Department of Agriculture's rules regarding administrative hearing practices, conforming agency practices to those of the Office of Administrative Hearings. The Department is adding the definition of "administrative law judge," deleting the definition of "hearing officer," and modifying the reasons under which the Director will grant a rehearing or review of an administrative law judge's decision. The title of Article 2 is expanded to include both contested cases and appealable agency actions. This rulemaking is undertaken in response to commitments made by the Department in a Five-year Review of rules.

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:

Adoption of this rule will have an impact on the following groups:

A. *The Arizona Department of Agriculture*.

The Department will use the rules of the Office of Administrative Hearings when holding a hearing at the Department, with the Director acting as an Administrative Law Judge. An internal proceeding will require the time of the Director, where in the past the option existed to appoint a hearing officer.

The Department will be responsible for the costs incurred for hearings held through the Office of Administrative Hearings.

B. *Political Subdivisions.*

The implementation of this rulemaking will directly affect the caseload of the Office of Administrative Hearings.

C. *Businesses Directly Affected By the Rulemaking.*

The regulated community the Department serves, and their attorneys, will be beneficially affected by the use of the uniform administrative procedures of the Office of Administrative Hearings.

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: Sherry D. Blatner, Rules Specialist

Address: Arizona Department of Agriculture
1688 West Adams, Room 235
Phoenix, AZ 85007

Telephone: (602) 542-0962

Fax: (602) 542-5420

E-mail: sherry.blatner@agric.state.az.us

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 of Agriculture will schedule a public hearing if a written request for a public hearing is made to the person in item #4.

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

None

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

None

13. The full text of the rules follows:

TITLE 3. AGRICULTURE

CHAPTER 1. DEPARTMENT OF AGRICULTURE - ADMINISTRATION

ARTICLE 1. GENERAL PROVISIONS

Section
R3-1-101. Definitions

ARTICLE 2. PRACTICE AND PROCEDURE - CONTESTED CASES AND APPEALABLE AGENCY ACTIONS

Section
R3-1-201. ~~Contested Cases: Hearings~~ Adjudicative Proceedings Before the Department
R3-1-202. ~~Initiation of Hearing~~ Repealed
R3-1-203. ~~Hearing Officer; Disqualification; Substitution~~ Repealed
R3-1-204. ~~Communications Regarding Matters Related to a Contested Hearing~~ Repealed
R3-1-205. ~~Notice of Hearing~~ Repealed
R3-1-206. ~~Responses; Motions for More Definite Statement; Negotiated Settlement~~ Repealed
R3-1-207. ~~Prehearing Conference; Procedure and Prehearing Order~~ Repealed
R3-1-208. ~~Procedures for Motions~~ Repealed
R3-1-209. ~~Filing; Computation of Time; Extension of Time~~ Repealed
R3-1-210. ~~Record of Hearings~~ Repealed
R3-1-211. ~~Service; Proof of Service~~ Repealed
R3-1-212. ~~Default~~ Repealed
R3-1-213. ~~Intervention~~ Repealed
R3-1-214. ~~Subpoenas~~ Repealed
R3-1-215. ~~Procedure at Hearings~~ Repealed
R3-1-216. ~~Evidence~~ Repealed
R3-1-217. ~~Recommended Decision; Objections to Proposed Draft of Recommended Decision; Director's Decision~~ Repealed
R3-1-218. Rehearing or Review of Decision; Basis
R3-1-219. ~~Effectiveness of Orders~~ Repealed

ARTICLE 1. GENERAL PROVISIONS

R3-1-101. Definitions

In addition to the definitions provided in A.R.S. § 41-1001, the following shall apply to this Chapter, unless the context otherwise requires:

"Administrative Law Judge" means an individual, or the Director of the Department, that sits as an administrative law judge, conducts administrative hearings in a contested case or an appealable agency action, and makes decisions regarding the contested case or appealable agency action. A.R.S. § 41-1092.

~~1.~~ "Applicant" means any person who applies for a permit, license, or certification, or a permit, license, or certification renewal from the Department and is denied that permit, license, or certification.

~~2.~~ "Attorney General" means the Attorney General of the state of Arizona and the Attorney General's designees.

~~3.~~ "Department" means the Arizona Department of Agriculture.

~~4.~~ "Director" means the Director of the Arizona Department of Agriculture.

~~5. "Hearing officer" means the Director, unless otherwise provided by law, or an individual appointed by the Director to conduct hearings.~~

~~6.~~ "Oral proceeding" means a proceeding held during the rulemaking process, as described by A.R.S. § 41-1023.

ARTICLE 2. PRACTICE AND PROCEDURE - CONTESTED CASES AND APPEALABLE AGENCY ACTIONS

R3-1-201. ~~Contested Cases: Hearings~~ Adjudicative Proceedings Before the Department

~~Unless otherwise provided by statute, this Article shall govern contested cases, referenced hereinafter as hearings, held before the Department in all proceedings in which the legal rights, duties, or privileges of a party or applicant are required by A.R.S. Title 3, A.R.S. Title 41, Chapter 6, Article 6, or by rule, to be determined after an opportunity for a hearing. These rules are not applicable to:~~

1. ~~Oral proceedings.~~
2. ~~Any person applying for license or permit unless the license or permit is denied.~~
3. ~~Personnel matters, or resolution of disputes involving contracts, held before the Department of Administration.~~

The Department shall use the uniform administrative procedures of A.R.S. Title 41, Chapter 6, Article 10 to govern the initiation and conduct of formal adjudicative proceedings before the Department.

R3-1-202. ~~Initiation of Hearing~~ Repealed

~~A.~~ ~~A hearing may be initiated only by the Department or by a party or applicant pursuant to statute, rule, or as otherwise provided by law.~~

~~B.~~ ~~If requested by a party or applicant other than the Department, the party or applicant shall, within 30 days of the date of the decision of the Department, file a written request for hearing with the Department and shall clearly state:~~
1. ~~The specific actions of the Department which are the bases of the hearing request; and~~
2. ~~The statute or rule entitling the party or applicant to a hearing.~~

~~C.~~ ~~Within 15 days of the receipt of a written request for hearing, the Department shall provide written notice to the party or applicant of its decision for the hearing.~~
1. ~~If the Department accepts the request for hearing, the Department shall give the party or applicant notice of the hearing date.~~
2. ~~If the Department denies the request for hearing, the Department shall state the reasons for denial.~~

R3-1-203. ~~Hearing Officer; Disqualification; Substitution~~ Repealed

~~A.~~ ~~In any action pending before a hearing officer, the hearing officer is subject to disqualification for good cause shown. Any party may petition the hearing officer for the hearing officer's disqualification within five days of receipt of notice of hearing indicating the hearing officer's identity or within 20 days of discovering facts indicating grounds for disqualification or else the right to change a hearing officer is deemed waived. The petition for disqualification shall state the facts giving rise to the disqualification.~~

~~B.~~ ~~The Director shall appoint a hearing officer or any substitute hearing officer to replace a disqualified or unavailable hearing officer.~~

~~C.~~ ~~If a substitute hearing officer is appointed, the substitute hearing officer shall use any existing record and may conduct further appropriate proceedings as the hearing officer deems to be in the interests of justice.~~

R3-1-204. ~~Communications Regarding Matters Related to a Contested Hearing~~ Repealed

~~A.~~ ~~Except for negotiated settlements with the Director pursuant to A.R.S. § 3-368(D)(4), neither the parties nor their legal counsel shall communicate with the Director or the hearing officer concerning any matter related to a hearing pending before the Director or the hearing officer. Communication with the Director or the hearing officer is prohibited from the date a hearing is initiated until a final order is issued unless the communication takes place in the presence of all parties or their counsel or, if the communication is in writing, the party provides copies to all other parties.~~

~~B.~~ ~~Any party directly involved in a hearing who receives a prohibited communication shall file, within 48 hours, a copy of the written communication or summary of the oral communication with the Director or hearing officer and serve copies of the same on each party or their counsel.~~

~~C.~~ ~~Upon receipt of a notice described in subsection (B), the Director or hearing officer shall give all other parties reasonable opportunity to respond to the communication.~~

R3-1-205. ~~Notice of Hearing~~ Repealed

~~A.~~ ~~Unless otherwise provided by law, the hearing officer shall set the time and place of the hearing and serve written notice to all parties not less than 30 days prior to the hearing.~~

~~B.~~ ~~The notice shall contain the following:~~
1. ~~The Department file number, the caption or title of the proceeding, and a general description of the subject matter;~~
2. ~~The time, place, and nature of the hearing;~~
3. ~~A statement of the legal authority and jurisdiction under which the hearing is to be held;~~
4. ~~A short statement from the moving party relating the factual basis for the allegation;~~
5. ~~A reference to the particular Sections of the statutes and rules involved;~~
6. ~~The name, official title, mailing address, and telephone number of the hearing officer for the hearing;~~
7. ~~A statement that a party who, after notice has been given pursuant to Article 2 of this Chapter, fails to attend or participate in a hearing or prehearing proceeding is considered to have waived the right to appear and the party may be held in default or the agency may proceed without the presence of the party;~~
8. ~~The names and mailing addresses of persons to whom notice is being given, including any counsel or employee who has been designated to appear for the Department;~~
9. ~~A statement that any party desiring to negotiate a settlement shall contact the Department to expressly request a negotiated settlement conference.~~

~~C.~~ ~~The notice may include any other matters that the hearing officer considers desirable to expedite the proceedings.~~

R3-1-206. ~~Responses; Motions for More Definite Statement; Negotiated Settlement~~ Repealed

~~A. Any party who receives a notice of hearing shall file a response to the action. The written response, to be considered, shall be filed within 15 days after receipt of the notice of hearing.~~

~~B. A response shall specifically admit, deny, or state that the party does not have or is unable to obtain sufficient information to admit or deny each allegation in the notice of hearing. When a party intends in good faith to deny only a part of an allegation, the party shall admit so much of it as is true and shall deny the remainder.~~

~~C. Within 15 days after service of the notice of hearing, any party may file a motion for a more definite statement. Such motion shall state the respects in which and the reasons why each such matter of fact should be required to be made more definite. If the motion is granted by the hearing officer, the order granting such motion shall set the time periods in which the more definite statement, and any response thereto, shall be filed.~~

~~D. Any party requesting a negotiated settlement conference shall contact the Department either orally or in writing. If the conference is granted, the party shall be afforded the opportunity to participate or to be represented by counsel. Unless otherwise provided by law, no negotiated settlement conference or request for negotiated settlement conference shall operate as a waiver of the party's duty to respond to the notice of hearing, to request a hearing, to raise a defense, or to stay any scheduled hearing.~~

R3-1-207. ~~Prehearing Conference; Procedure and Prehearing Order~~ Repealed

~~A. Upon a motion of the hearing officer or any party, the hearing officer may schedule a prehearing conference at least ten days prior to the hearing date. Within five days of completion of the filing of said motion, the hearing officer shall notify the parties of the decision to hold a prehearing conference and the date, time, and place where it will be held.~~

~~B. The hearing officer may conduct the prehearing conference to deal with:~~

~~1. Negotiated settlement, stipulations, clarification of issues, admissions, amendments of pleadings, prehearing briefs, pretrial statements, rulings on identity and limitation of the number of witnesses, objections to proffers of evidence, use of written presentation for direct evidence, rebuttal evidence, or cross-examination;~~

~~2. Whether appearing at the hearing by way of telephone, television, or other electronic means will substitute for appearing at the proceedings in person;~~

~~3. The order of presentation of evidence and cross-examination, rulings on admissibility or exclusion of evidence, rulings regarding issuance of subpoenas, discovery orders, and protective orders; and~~

~~4. Such other matters as will promote the orderly and prompt conduct of the hearing.~~

~~C. The hearing officer may conduct all or part of the prehearing conference by telephone, television, or other electronic means so long as each party in the prehearing conference can hear and has and opportunity to participate during the entire proceeding.~~

~~D. After any prehearing conference, an order will be either entered verbally on the record or issued in writing, prior to the hearing, reciting stipulations and admissions made, actions taken, and other matters resolved. This order shall only be modified to prevent manifest injustice, as determined by the hearing officer.~~

~~E. The hearing officer may issue orders to regulate the conduct of the proceedings and limiting the issues to those raised in the pleadings whether or not a prehearing conference is held.~~

R3-1-208. ~~Procedures for Motions~~ Repealed

~~A. Motions calling for determination of any matter of law shall be filed with the hearing officer in writing.~~

~~B. Any non-moving party may file a response to a motion, pursuant to R3-1-209(B) and shall serve the response upon the moving party within ten days after service of such motion.~~

~~C. The moving party shall have ten days after service of a response to file a replay to that response.~~

~~D. The time limits for motions, responses, and replies may be shortened or extended by the hearing officer.~~

~~E. Motions shall be considered on the written materials submitted by the parties. No written pleading shall exceed 15 pages in length unless permitted by the hearing officer. No oral argument shall be heard on such motions unless requested by a party and the hearing officer so directs.~~

~~F. Except as provided in subsection (A), motions and objections made during the course of the hearing may be made orally. Objections to the admission or exclusion of evidence shall be made on the record, shall be brief, and shall state the ground for the objection.~~

R3-1-209. ~~Filing; Computation of Time; Extension of Time~~ Repealed

~~A. Upon initiation of a hearing, the Director shall assign each proceeding a number and shall maintain a docket of all proceedings.~~

~~B. Unless otherwise specifically provided in the rules or by an order of the Director, an original of all pleadings shall be filed with the Director and one copy to the hearing officer within the time limits set forth in R3-1-205, R3-1-206, R3-1-207, and R3-1-208.~~

~~C. All documents required to be filed may be transmitted by regular or express mail, or otherwise delivered to the Director. Service thereof shall be made simultaneously on all parties to the proceeding, pursuant to R3-1-211. A document shall be~~

~~considered to be filed on the date received by the Director. When a pleading is mailed, any limitation on the time in which a response may be made thereto shall be increased by five days.~~

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

~~**E.**~~ ~~For good cause shown, the hearing officer may grant continuances and extensions of time.~~

R3-1-210. ~~Record of Hearings~~ Repealed

~~The Director shall maintain the record in a hearing as prescribed in A.R.S. § 41-1061(E). Upon completion of the hearing, the Director shall maintain the docket and the records for three years.~~

R3-1-211. ~~Service; Proof of Service~~ Repealed

~~**A.**~~ ~~Service of process by the party responsible for filing shall be required with respect to notices of hearing issued under this Article. The original shall be filed with and retained by the Director, pursuant to R3-1-210.~~

~~**B.**~~ ~~Unless otherwise provided by law, service of process for notices of hearing shall be sufficient if made by personal service or by certified mail to the last known address of record of the person being served or, if served on a corporation, partnership, or association, the personnel service is made upon the statutory agent, corporate officer, partner, owner, co-owner, or agent.~~

~~**C.**~~ ~~All other pleadings, notices, decisions, and orders subsequent to the notice of hearing shall be served on each of the parties. Service shall be made by personal service or by regular mail to the last known address of record of the party or the party's counsel. Service by regular mail is complete upon mailing.~~

~~**D.**~~ ~~The following shall establish proof of service:~~

~~1.~~ ~~If transmitted by certified mail, the return of the signed return receipt; or~~

~~2.~~ ~~If by regular mail or personally served, filing with the pleading or separately with the Director a written statement that the service has been made, setting forth the date and manner of service signed by the party serving the pleading.~~

R3-1-212. ~~Default~~ Repealed

~~**A.**~~ ~~If a party fails to attend or participate in a prehearing conference, prehearing proceeding, or hearing, any party may file a motion to default the nonparticipating party. The motion to default shall state the grounds upon which the nonparticipating party is to be defaulted together with a proposed form of default order. The party against whom the motion was filed may respond as set forth in R3-1-208(B). The hearing officer may order a default upon the hearing officer's own motion.~~

~~**B.**~~ ~~The hearing officer may conduct a hearing on the motion for default order after notice to all parties.~~

~~**C.**~~ ~~The hearing officer shall rule on the motion for default before commending the hearing.~~

~~**D.**~~ ~~After issuing a default order, the hearing officer shall conduct any further proceedings necessary to complete the adjudication without the defaulting party and shall determine all issues, including those affecting that party.~~

R3-1-213. ~~Intervention~~ Repealed

~~**A.**~~ ~~A person seeking to intervene in a proceeding shall do so at least 25 days prior to a hearing. A person seeking to intervene in any hearing shall file a written petition for intervention with the hearing officer and serve the petition on each party. A petition shall state facts demonstrating that the petitioner's legal rights, duties, privileges, immunities, or other legal interests may be substantially affected by the proceeding.~~

~~**B.**~~ ~~Any party may file a response to the petition for intervention within five days of service of the petition upon the party. A copy of the response shall be served upon each party and on each petitioner.~~

~~**C.**~~ ~~A petition for intervention may be granted upon a determination that the petition complies with the requirements in subsection (A) and that the intervention sought is in the interests of justice, will not unduly broaden the scope of the inquiry, and will not impair the orderly and prompt conduct of the proceedings.~~

~~**D.**~~ ~~The hearing officer shall rule on the petition for intervention and shall notify the petitioner and all parties of the decision at least 15 days prior to the hearing date.~~

~~**E.**~~ ~~The hearing officer may continue the hearing, provide for a prehearing conference, or both, to give a party a specific amount of time to file a response to the petition for intervention or prepare for the hearing.~~

R3-1-214. ~~Subpoenas~~ Repealed

~~**A.**~~ ~~Unless otherwise required by law, a request for subpoena shall be in writing, filed with the Director, and served on each party at least seven days prior to the date of hearing. The request shall state the following:~~

~~1.~~ ~~The identification of the person or document requested;~~

~~2.~~ ~~The facts expected to be established by the person or document subpoenaed, as needed to determine relevancy and materiality of the testimony or document sought.~~

~~**B.**~~ ~~If more than two subpoenas are requested to establish a single fact in dispute, the request for subpoena shall state the reason why the additional subpoena is not repetitive.~~

~~**C.** The person to whom a subpoena is directed shall comply with its provisions unless, prior to the date set for hearing, the hearing officer quashes or modifies the subpoena. Any request to quash or modify the subpoena shall be submitted in writing and shall briefly, but thoroughly, state the reasons therefor. The hearing officer shall grant or deny such request by order.~~

~~**D.** The party requesting the subpoena shall serve it, as prescribed in R3-1-211, upon the person to whom it is directed and that person shall be compensated as prescribed in A.R.S. § 12-303.~~

R3-1-215. ~~Procedure at Hearings~~ Repealed

~~**A.** The hearing officer shall regulate the course of the proceedings and shall conform with any prehearing order.~~

~~**B.** To enable disclosure of relevant facts and issues, the hearing officer shall give all parties the opportunity to testify, respond, present evidence and argument, conduct examination and cross-examination of witnesses, and submit rebuttal evidence, except as restricted by an order of the hearing officer.~~

~~**C.** The hearing officer may conduct all or part of the hearing by telephone, television, or other electronic means, so long as each party has an opportunity to participate in the entire proceeding as it takes place.~~

~~**D.** All hearings are open to public observation, except where closed pursuant to an express provision of law. Upon motion of any party, the hearing officer may exclude any witness from the hearing until after that witness has testified.~~

~~**E.** All hearings shall be recorded or transcribed by a court reporter. Transcripts of the hearing shall be arranged and paid for by the person seeking the transcripts.~~

R3-1-216. ~~Evidence~~ Repealed

~~**A.** All witnesses at a hearing shall testify under oath or affirmation. All parties shall have the right to present such oral or documentary evidence and to conduct such cross-examination as may be required for a full and true disclosure of the facts. The hearing officer shall receive relevant, probative, and material evidence, rule upon offers of proof, and exclude all evidence the hearing officer has determined to be irrelevant, immaterial, or unduly repetitious. Unless otherwise prohibited by statute, the hearing officer may admit oral or written testimony regarding a statement made by another person, even if it would be inadmissible in a civil court trial.~~

~~**B.** Unless otherwise ordered by the hearing officer, documentary evidence shall be limited in size when folded to 8 1/2 x 11 inches. The submitting party shall furnish a copy of each documentary exhibit to each party of record present, and the original document plus one additional copy shall be furnished to the Director, unless the Director or hearing officer otherwise directs. When a relevant and material matter offered in evidence by any party appears in a larger work containing other information, the party shall plainly designate the offered matter. If the offered matter is in such volume as would unnecessarily encumber the record, such book, paper, or document shall not be received in evidence but may be marked for identification and, if properly authenticated, the relevant and material matter may be read into or photocopied for the record.~~

~~**C.** All documentary evidence offered shall be subject to appropriate and timely objection or by any order of the hearing officer.~~

~~**D.** When ordered by the hearing officer, the parties shall exchange copies of exhibits prior to or at the hearing.~~

R3-1-217. ~~Recommended Decision; Objections to Proposed Draft of Recommended Decision; Director's Decision~~ Repealed

~~**A.** The hearing officer may draft the findings of fact and conclusions of law or allow each party the opportunity to submit proposed findings of fact and conclusions of law within ten days after the conclusion of the hearing.~~

~~**B.** The hearing officer shall render a decision which separately states findings of fact and conclusions of law based on evidence presented at the hearing. Experience, technical competence, or specialized knowledge of the hearing officer may be utilized in evaluating evidence.~~

~~**C.** The hearing officer shall render a decision, or recommended decision, within 30 days after conclusion of the hearing. If the hearing officer is not the Director, the Director shall render a decision within 15 days after receipt of a recommended decision of the hearing officer.~~

R3-1-218. Rehearing or Review of Decision; Basis

~~**A.** Unless as otherwise provided by law or rule, any party to a hearing before the Department who is aggrieved by a decision rendered in such case may file with the Director a written request for rehearing or review of the decision within 15 days after the date of the decision. The request shall specify the particular grounds for rehearing or review. The requesting party shall serve copies upon all other parties in compliance with Section R3-1-211. A request for rehearing or review under this rule may be amended at any time before it is ruled upon by the Director.~~

~~**B.** Any party may file a response to the request for rehearing.~~

~~**C.** Any party may request oral argument on the request for rehearing.~~

~~**D.** A rehearing or review of the decision may be granted for any of the following causes which materially affect the requesting party's rights:~~

~~1. Irregularity in the proceedings or any abuse of discretion whereby the requesting party was deprived of a fair hearing;~~

2. ~~Misconduct of the Department, the hearing officer, or the prevailing party;~~
3. ~~Accident or surprise which could not have been prevented by ordinary prudence;~~
4. ~~Newly discovered material evidence which could not, with reasonable diligence, have been discovered and produced at the original hearing;~~
5. ~~Excessive or insufficient penalties;~~
6. ~~Error in the admission or rejection of evidence or other errors of law occurring during the proceedings;~~
7. ~~That the decision is the result of passion or prejudice; or~~
8. ~~That the decision is not supported by the evidence or is contrary to law.~~

~~E. Upon review of a request for rehearing and any response thereto, the Director may affirm or modify the decision or grant a rehearing. An order granting a rehearing shall specify with particularity the grounds on which the rehearing is granted, and the rehearing shall cover only those matters specified. All parties to the hearing may participate as parties at any rehearing.~~

~~D. Within 15 days after a decision is rendered, the Director may, on the Director's own initiative, order a rehearing or review of a decision for any reason for which a rehearing on motion of a party might have been granted. The order granting such a rehearing shall specify the grounds for the review of the decision.~~

The Director shall grant a rehearing or review of an administrative law judge's decision for any of the following reasons, and shall specify the reasons:

1. The decision is not justified by the evidence or is contrary to law.
2. There is newly discovered material evidence which could not with reasonable diligence have been discovered and produced at the original proceeding.
3. One or more of the following has deprived the party of a fair hearing:
   a. Irregularity or abuse of discretion in the conduct of the proceeding.
   b. Misconduct of the Department, the administrative law judge, or the prevailing party.
   c. Accident or surprise which could not have been prevented by ordinary prudence.

R3-1-219. ~~Effectiveness of Orders~~ Repealed

~~A. In accordance with R3-1-218, a decision becomes a final order 15 days after the decision is issued by the Director or the hearing officer, unless a party has filed a petition for review or reconsideration or unless otherwise stated.~~

~~B. If, in a particular decision, the Director or the hearing officer makes specific findings that the immediate effectiveness of such decision is necessary for the immediate preservation of the public peace, health, and safety, the decision may be issued as a final decision without an opportunity for a reconsideration. If a decision is issued as a final decision without an opportunity for reconsideration, any application for judicial review of the decision shall be made within the time limits permitted for application for judicial review of the final decision.~~

NOTICE OF PROPOSED RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 28. STATE REAL ESTATE DEPARTMENT

PREAMBLE

1. Sections Affected / **Rulemaking Action**

Sections Affected	Rulemaking Action
R4-28-101	Amend
R4-28-701	Amend
R4-28-802	Amend
R4-28-1101	Amend
R4-28-1103	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. § 32-2107(E)

Implementing statutes: A.R.S. §§ 32-2101 through 32-2176

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

Notice of Rulemaking Docket Opening: 7 A.A.R. 3487, August 10, 2001

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

Name: Cindy Wilkinson, Policy Officer

Address: Arizona Real Estate Department
2910 N. 44th St., Suite 100
Phoenix, AZ 85018

Telephone: (602) 468-1414, ext. 345

Fax: (602) 955-6284

E-mail: cwilkinson@re.state.az.us

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

Two definitions are added for clarity. Grammar, style, and formatting changes are made to existing rules. New rules describe a licensee's standard of care and disclosures that may be required.

A new Section provides guidance as to a broker's "reasonable supervision" of licensees and others under his employ. Based on statutory requirements found throughout A.R.S. Title 32, Chapter 20, the rule distills the various areas a broker must address to demonstrate that the broker is fulfilling the broker's statutory obligation to supervise licensees and unlicensed employees.

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:

The economic impact of the proposed rulemaking is expected to be minimal on each broker and the Department. Many of the changes are made to clarify the rule's meaning and remove uncertainty or ambiguity and thus make it easier to understand. The new rule, R4-28-1103, provides in one place the areas a broker is to address with licensed and unlicensed persons in the broker's employ in order to demonstrate that the broker has taken or is taking reasonable steps to supervise these persons in the course of their employment with the broker. The responsibility to supervise is not new. What is new is setting out in one rule the areas over which the broker is expected to supervise licensees and other employees, and the requirement that office policies and procedure be established *in writing*.

A broker may be able to convey the policy and procedure for each of the items in a sentence, or may take several pages, depending on the size and complexity of the brokerage. Establishment of a system that will allow the broker to monitor and review may cost approximately $400. The costs will vary depending on the involvement of legal counsel in the development of the policies or procedures, the complexity or simplicity of the system developed, the staff time needed, as well as the number of copies needed and cost of materials used. Assuming the broker earns $50 per hour, if a broker spent one 8-hour day and prepares one page for each of the nine areas, has copies made at the local copy shop (9 x $.10 each), and places the statements in an inexpensive 1" binder ($3), the cost is estimated at $403.90. For the "one-person" brokerages the costs may be even less.

It is also anticipated that most, if not all, of the larger brokerage firms (those employing 100 or more licensees) already have these procedures, policies and systems in place. On December 18, 2001, we looked at how many brokerages were "small businesses" (with less than 100 licensed employees), how many were one-person firms, and how many employed 100 or more licensees. The breakdown was:

4,078 One licensed employee (self and perhaps unlicensed employees, not tracked)

6,180 More than 1 and less than 100 (licensed) employees

152 More than 100 (licensed) employees

The areas identified in the rule are areas with which the real estate statutes charge the broker with responsibility. The rule merely identifies the areas in which a policy is required under the license laws and requires that it be in writing. Besides providing guidance for brokers, it provides a bar for the Department's use in evaluating complaints of negligence or lack of supervision by a broker. The Department will deem establishment and enforcement of policies, procedures, rules and systems to provide appropriate oversight over the identified areas being "reasonable supervision" by the broker.

Applicable statutory requirements distilled here include A.R.S. §§ 32-2122(B), (C), and (D), 32-2155(A), (B), and (C) (license required to act as broker or receive compensation for licensed acts); A.R.S. §§ 32-2101.46 (definition of "real estate broker" as one who is acting for another as agent); A.R.S. Title 32, Chapter 20, Articles 3 and 3.1; A.R.S. § 32-2153(A)(2) (acting for more than one party in a transaction without knowledge or consent is grounds for disciplinary action), and A.R.S. § 32-2153(A)(21), failure to exercise reasonable supervision or licensees or others under the broker's control and over control of the licensed entity for which the designated broker is responsible, if any, is grounds for disciplinary action).

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: Cindy Wilkinson, Policy Officer

Address: Arizona Real Estate Department
2910 N. 44th St., Suite 100
Phoenix, AZ 85018

Telephone: (602) 468-1414, ext. 345

Fax: (602) 955-6284

E-mail: cwilkinson@re.state.az.us

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:

Written comments will be accepted at the location listed in item #4 between 8:00 a.m. and 5:00 p.m., Monday through Friday (excluding state holidays). An oral proceeding will be held as follows:

Date: Thursday, May 30, 2002

Time: 10:00 a.m.

Location: Arizona Department of Real Estate
2910 North 44th Street, First Floor Conference Room
Phoenix, AZ 85018

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

None

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

None

13. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 28. STATE REAL ESTATE DEPARTMENT

ARTICLE 1. GENERAL PROVISIONS

Section
R4-28-101. Definitions

ARTICLE 7. COMPENSATION

Section
R4-28-701. Compensation Sharing Disclosure

ARTICLE 8. DOCUMENTS

Section
R4-28-802. Conveyance Documents

ARTICLE 11. PROFESSIONAL CONDUCT

Section
R4-28-1101. Duties to Client

R4-28-1103. Broker Supervision and Control

ARTICLE 1. GENERAL PROVISIONS

R4-28-101. Definitions

In addition to the definitions listed in A.R.S. § 32-2101 the following terms apply to this Chapter:

1. No change
2. No change
3. "Closing" means the final steps of a real estate transaction, such as the when the consideration is paid, the mortgage is secured, or the deed is delivered or placed in escrow.

~~3.~~4. "Credit hour" means 50 minutes of instruction.

~~4.~~5. "Course" means a class, seminar, or presentation.

~~5.~~6. "D.b.a." means "doing business as."

~~6.~~7. "Distance learning" means a course of instruction outside a traditional classroom situation consisting of interactive instructional material, such as computer-based or audio-visual, requiring completion in the course hours specified. A course that requires a student to read text, listen to audio tapes, or view video material without student participation, feedback, and remedial instruction is not a distance learning course.

~~7.~~8. "Fictitious name" means any name used to conduct business other than a person's legal name, and includes a d.b.a. name or trade name.

~~8.~~9. "Franchise" means a contract or agreement, either express or implied, oral or written, between 2 or more persons by which:

   a. A franchisee is granted the right to engage in the business of offering, selling, and distributing goods or services under a marketing plan or system prescribed in substantial part by a franchiser; and
   b. The operation of the franchisee's business pursuant to the plan or system is substantially associated with the franchiser's trademark, service mark, trade name, logotype, advertising, or other commercial symbol designating the franchiser or its affiliate; and
   c. The franchisee is required to pay, directly or indirectly, a franchise fee.

10. "Immediate family" means the licensee's spouse, and the siblings, parents, grandparents, children and grandchildren of the licensee or spouse.

~~9.~~11. "Individual" means a natural person.

~~10.~~12. "Material change" means any significant change in the size or character of the development, development plan, or interest being offered, or a change that has a significant effect on the rights, duties, or obligations of the developer or purchaser, or use and enjoyment of the property by the purchaser.

~~11.~~13. "Property interest" means a person's ownership or control of a lot, parcel, unit, share, use in a development, including any right in a subdivided or unsubdivided land, a cemetery plot, a condominium, a time-share interval, a membership camping contract, or a stock cooperative.

ARTICLE 7. COMPENSATION

R4-28-701. Compensation Sharing Disclosure

A real estate broker shall disclose to all the parties in the transaction, in writing before ~~close of escrow~~ closing, the name of each employing broker who represents a party to the transaction and who will receive ~~receiving~~ compensation from the transaction.

ARTICLE 8. DOCUMENTS

R4-28-802. Conveyance Documents

A. Upon execution of any transaction document ~~prescribed pursuant to A.R.S. Title 32, Chapter 20,~~ a salesperson or broker shall, as soon as practical, deliver a legible copy of the signed document and final agreement to each party signing the document.

B. ~~In addition to any other obligation imposed by law or contract during the term of a listing agreement,~~ During the term of a listing agreement, a salesperson or broker shall promptly submit all offers to purchase or lease the listed property to the client. Upon receiving permission of the seller or lessor, a salesperson or broker acting on behalf of a seller or lessor is permitted to disclose to all prospective buyers or their agents the existence and terms of any additional offers on the listed property. The salesperson or broker shall submit all offers until the sale or lease is final ~~or close of escrow~~ and is not released from this duty by the client's acceptance of an offer unless the client instructs the salesperson or broker to cease submitting offers or unless otherwise provided in the listing agreement, lease or purchase contract. The salesperson or broker may voluntarily advise the seller or lessor of offers notwithstanding any limitations contained in the listing agreement and may submit offers after the listing agreement has terminated.

C. No change

ARTICLE 11. PROFESSIONAL CONDUCT

R4-28-1101. Duties to Client

A. No change

B. No change

C. No change

D. No change

E. A salesperson or broker shall not act ~~as a principal,~~ directly or indirectly, in a transaction without informing the other parties in the transaction, in writing and before any binding agreement, that the salesperson or broker has a present, prospective or contemplated interest or conflict in the transaction, including that the:

1. ~~salesperson~~ Salesperson or broker has a license and is acting as a principal.
2. Purchaser or seller is a member of the licensee's or designated broker's immediate family.
3. Purchaser or seller is the licensee's employing broker, owns or is employed by the licensee's employing broker.
4. Salesperson or broker may have a financial interest in the transaction in addition to the receipt of compensation for the salesperson's or broker's real estate related services.

F. A licensee shall not accept compensation from or represent both parties to a transaction without the prior written consent of both parties.

G. A licensee shall not accept any compensation~~, rebates, or profit for transactions made on behalf of a client~~ including rebates or other consideration, directly or indirectly, for any goods or services provided to a person that are related to or resulting from a current or prospective real estate transaction, without ~~the~~ that person's prior written consent or acknowledgement. ~~of the client.~~ This requirement does not apply to compensation paid to a real estate broker by a real estate broker who represents a party in the transaction.

H. The services that a licensee provides to clients and customers shall conform to the standards of practice and competence that are reasonably expected in the specific real estate discipline in which the licensee engages. A licensee shall not undertake to provide specialized professional services concerning a type of property or service that is outside the licensee's field of competence unless the licensee engages the assistance of a person who is competent on such type of property or service, or unless the licensee's lack of expertise is first disclosed to the client in writing.

I. An agent does not have the obligation to have expertise in subject areas other than those required by the holding of a license. However, a licensee shall be obligated to exercise reasonable care in obtaining and communicating information that is material to the client's interests and relevant to the contemplated transaction.

J. A licensee shall not:

1. Permit occupancy in a person's real property to a third party without written authorization by the person.
2. Deliver possession of a property prior to the closing unless expressly so instructed by the owner of the interest being transferred.

K. A licensee shall recommend to a client that the client seek appropriate counsel regarding the risks of pre- or post-possession of the property.

R4-28-1103. Broker Supervision and Control

A. The employing and designated brokers shall exercise reasonable supervision and control over the activities of real estate licensees and others in the employ of the broker. Reasonable supervision and control includes, as appropriate, the establishment and enforcement of written policies, rules, procedures and systems to review, oversee, inspect and manage:

1. Transactions requiring a real estate license.
2. Documents that may have a material effect upon the rights or obligations of a party to the transaction.
3. Filing, storage and maintenance of such documents.
4. The handling of trust funds.
5. Advertising and marketing by the broker and the broker's agents.
6. Familiarizing salespersons and associate brokers with the requirements of federal and state laws relating to the practice of real estate.
7. The use of employment agreements, disclosure forms and contracts.
8. The delegation of authority to others to act on behalf of the broker.
9. The use of unlicensed assistants by the agents of the broker.

B. A broker shall establish a system for monitoring compliance with the broker's policies, rules, procedures and systems. A broker may use the services of employees to assist in administering the provisions of this Section but shall not relinquish overall responsibility for supervision and control of the acts of employees of the broker.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

PREAMBLE

1. Sections Affected / **Rulemaking Action**

Sections Affected	Rulemaking Action
R9-22-101	Amend
R9-22-107	Amend
R9-22-503	Repeal
R9-22-702	Amend
R9-22-703	Amend
R9-22-704	Amend
R9-22-707	Amend
R9-22-711	Amend
R9-22-713	Amend
R9-22-719	New Section

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

Authorizing statute: A.R.S. § 36-2903.01

Implementing statutes: A.R.S. §§ 36-2903, 36-2904, 36-2906

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 East 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 three Articles:

Article 1, Definitions (R9-22-101and R9-22-107) to add and amend definitions,

Article 5, General Provision And Standards (R9-22-503, Reinsurance) to repeal a Section, and

Article 7, Standards For Payments (R9-22-702 through R9-22-704; R9-22-707, R9-22-713 and R9-22-719) to add and amend language.

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 5, General Provision And Standards

R9-22-503 -- The Administration repealed the language and relocated "Reinsurance" to Article 7, R9-22-719. Language that more appropriately exists in contract is deleted according to A.R.S. § 41-1005(A)(16). New language conforms to statutory requirements.

9 A.A.C. 22, Article 7, Standards For Payments

R9-22-702 -- The Administration amended the language to improve the clarity and conciseness of the rule.

R9-22-703 -- The Administration amended the language to comply with statutory changes (A.R.S. § 36-2904) and added language to make the rule more clear and understandable.

R9-22-704 -- The Administration amended the language to improve the clarity and conciseness of the rule.

R9-22-707 -- The Administration amended the language to comply with statutory changes and to make the rule more clear, concise and understandable.

R9-22-711 -- The Administration amended the language to comply with statutory changes and to make the rule more clear, concise and understandable.

R9-22-713 -- The Administration amended the language to conform to federal law (subsection (A)); make the language more clear and understandable and deleted subsection (B) as it is covered in subsection (C) and in contract.

R9-22-719 -- The Administration repealed the language and relocated "Reinsurance" to Article 7, R9-22-719. Language that more appropriately exists in contract is deleted according to A.R.S. § 41-1005(A)(16). New language conforms to statutory requirements.

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 specific facets of Standard for Payment for the AHCCCS acute care program. The Administration is amending these rules to conform to state statute and federal law and make the rules more clear, concise, and understandable by:

- Grouping like concepts to provide clarity and conciseness to the rule language, and
- Clarifying language that does not clearly present policies or procedures.

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 East Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

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: April 25, 2002

Time: 1:00 p.m.

Location: AHCCCS
701 East Jefferson
Phoenix, AZ 85034

	Salmon Room
Nature:	Public Hearing
Date:	April 25, 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:	April 25, 2002
Time:	1:00 p.m.
Location:	ALTCS: Arizona Long-term Care System 3480 East Route 66 Flagstaff, AZ 86004

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:

Not applicable

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
R9-22-107. Standards for Payments Related Definitions

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section
R9-22-503. ~~Reinsurance~~ Repealed

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-702. Prohibitions Against Charges to Members ~~or Eligible Persons~~
R9-22-703. Claims Submission to the Administration
R9-22-704. Transfer of payments
R9-22-707. Payments for Newborns
R9-22-711. Copayments
R9-22-713. Payments made on behalf of a contractor; recovery of indebtedness
R9-22-719. Reinsurance

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
"AHCCCS registered provider"	R9-22-101
"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
"Affiliated 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
"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
"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"	R9-20-101
"Behavioral health service"	R9-22-112
"Behavioral health technician"	R9-20-101
"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

Term	Section
“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
“Date of eligibility posting	R9-22-107
“DCSE”	R9-22-114
“De novo hearing”	42 CFR 431.201
“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
“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
“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”	42 U.S.C. 675(4)(A)
“Federal poverty level” (“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”	42 CFR 435.1009 and R9-22-112
“Income”	R9-22-114
“Inmate of a public institution”	42 CFR 435.1009
“Interested party”	R9-22-106
“LEEP”	R9-22-120
“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”	A.R.S. § 36-401
“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”	A.R.S. § 36-2901
“Mental disorder”	A.R.S. § 36-501
“New hospital”	R9-22-107
“Nursing facility” (“NF”)	42 U.S.C. 1396r(a)
“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
“Ownership interest”	42 CFR 455.101
“Operating costs”	R9-22-107
“Outlier”	R9-22-107
“Outpatient hospital service”	R9-22-107
“Ownership change”	R9-22-107
“Partial Care”	R9-22-112
“Party”	R9-22-108
“Peer group”	R9-22-107
“Performance measures”	R9-22-109
“Pharmaceutical service”	R9-22-102
“Physical therapy”	R9-22-102
“Physician”	R9-22-102
“PPC”	R9-22-107
“Post-stabilization care services”	42 CFR 422.113
“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
“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
“Remittance advice”	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
"SESP"	R9-22-101
"S.O.B.R.A."	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"	42 CFR 1000.10
"SSI"	42 CFR 435.4
"SSN"	R9-22-101
"Sterilization"	R9-22-102
"Subcontract"	R9-22-101
"Submitted"	A.R.S. § 36-2904
"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
"Tolerance level"	R9-22-109
"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 or noncontracting 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.

"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 an applicant's or member's 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 this Chapter.
"Day" means a calendar day unless otherwise specified.
"DES" means the Department of Economic Security.
"Director" means the Director of the Administration or the Director's designee.
"Eligible person" means a person as 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 service.
"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~~ billing agent or an accounting firm described in this Chapter, or a health care institution.
"FBR" means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.
"FESP" means a federal emergency services program covered under R9-22-217, to treat an emergency medical condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).
"FQHC" means federally qualified health center.
"GSA" means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with 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, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.
"License" or "licensure" means a nontransferable authorization that is awarded 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 lawfully render a health care service.
"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.
"Medically necessary" means a covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or 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).
"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 a location at which a member obtains a covered health care service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.
"Service site" means a location designated by a contractor as the location at which a member is to receive covered 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 a person who has entered into a contract of marriage, recognized as valid by Arizona.
"SSN" means social security number.
"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member;
A marketing organization; or
Any other organization or person who agrees to perform any administrative function or service for a contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

R9-22-107. Standard for Payments 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:

"Accommodation" means bed and board services provided to a patient during an inpatient hospital stay and includes the cost of all staffing, supplies, and equipment. The accommodation is semi-private except when the member must be isolated for medical reasons. Other types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which bed and board are provided.

"Aggregate" means the combined amount of hospital payments for covered services provided within and outside the service area.

"AHCCCS inpatient hospital day or days of care" means the period of time beginning with the day of admission and includes each day of an inpatient stay for ~~an eligible person~~ a member, including the day of death, but excluding the day of discharge, provided that all medical necessity and medical review requirements are met.

"Ancillary department" means the department of a hospital that provides ancillary services and outpatient services, which are defined in the Medicare provider Reimbursement Manual.

"Billed charges" means charges that a hospital includes on a claim for providing hospital services to ~~an eligible person or~~ a member consistent with the rates and charges filed by the hospital with the Arizona Department of Health Services.

"Capital costs" means capital-related costs, which are defined in the Medicare provider Reimbursement Manual, Chapter 28, such as building and fixtures, and movable equipment.

"Copayment" means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.

"Cost-to-charge ratio" means a hospital's costs for providing covered services divided by the hospital's covered charges for the same services.

"Covered charges" means billed charges that represent medically necessary, reasonable, and customary items of expense for AHCCCS-covered services that meet medical review criteria of the Administration or contractor.

"CPT" means current procedural terminology, the manual published and updated by the American Medical Association, which is a nationally accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and provides a uniform language to accurately designate medical, surgical, and diagnostic services.

"Date of eligibility posting" means the date the member information is entered into the AHCCCS pre-paid medical management information system (PMMIS).

"DRI inflation factor" means the Data Resources Inc., Health Care Financing Administration hospital input price index for prospective hospital reimbursement, which is published by DRI/McGraw-Hill.

"Encounter" means a record of medical service, submitted by a contractor and processed by AHCCCS, that is rendered by a provider registered with AHCCCS to a member who is enrolled with the contractor on the date of service, and for which the contractor incurs any financial liability.

"ICU" means the intensive care unit of a hospital.

"Medical education costs" means direct hospital costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, which are defined in the Medicare provider Reimbursement Manual, Chapter 28.

"Medical review" means a review involving clinical judgment of a claim or a request for a service before or after it is paid or rendered to ensure that services provided to ~~an eligible person or~~ a member are medically necessary covered services and that required authorizations are obtained by the provider. The criteria for medical review are established by the Administration or contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

"Medicare claim" means a claim for Medicare covered services for ~~an eligible person or~~ a member with Medicare coverage.

"New hospital" means a hospital for which Medicare Cost Report (Health Care Finance Administration form-2552) data and claim and encounter data are not available for hospital rate development from any owner or operator of the hospital, during either the initial prospective rate year or rebasing.

"NICU" means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

"Operating costs" means an AHCCCS allowable accommodation and ancillary department hospital costs excluding capital and medical education costs.

"Outlier" means a hospital claim or encounter in which the AHCCCS inpatient hospital days of care have operating costs per day that meet the criteria described in R9-22-712.

"Outpatient hospital service" means a service provided in an outpatient hospital setting that does not result in an admission.

"Ownership change" means a change in a hospital's owner, lessor, or operator as defined in 42 CFR 489.18(A).

"Peer group" means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services.

"PPC" means prior period coverage. PPC is the period of time, prior to the member's enrollment, during which a member is eligible for covered services. The time-frame is the first day of the month of application or the first eligible month, whichever is later to the day a member is enrolled with a contractor.

"Prospective rates" means inpatient or outpatient hospital rates defined by the Administration in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, ~~non-categorical discounts,~~ and first-and third-party payments regardless of billed charges or individual hospital costs.

"Prospective rate year" means the period from October 1 of each year to September 30 of the following year, except for the initial prospective rate year, which is between March 1, 1993, and September 30, 1994.

"Rebasing" means the process by which new Medicare Cost Report data (HCFA-2552),and AHCCCS claim and encounter data are collected and analyzed to reset periodically the inpatient hospital tiered per diem rates or the outpatient hospital cost-to-charge ratios.

"Reinsurance" means a risk-sharing program provided by the Administration to contractors for the reimbursement of certain contract service costs incurred by a member ~~or eligible person~~ beyond a certain monetary threshold.

"Remittance advice means an electronic or paper document submitted to an AHCCCS registered provider by the Administration, to explain:

- How submitted claims were paid,
- Why submitted claims were denied or adjusted,
- Why submitted claims were pended and,
- How to grieve the Administration's adverse action according to Article 8 of this Chapter.

"SDAD" means same day admit and discharge, which is a hospital stay with the admit and discharge occurring on the same calendar day.

"Tier" means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure or revenue codes, peer group, or NICU classification level, or any combination of these items.

"Tiered per diem" means a payment structure in which payment is made on a per-day basis depending upon the tier into which an AHCCCS inpatient hospital day of care is assigned.

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-22-503. ~~Reinsurance~~ Repealed

~~A. Contractor-acquired reinsurance. A contractor may obtain reinsurance for coverage of prepaid capitated members. A contractor shall not obtain reinsurance to reduce liability below 25% of the applicable deductible level during any AHCCCS contract year. This limitation does not apply to reinsurance obtained by a contractor to cover the cost of services provided by noncontracting providers and non providers to members under emergency circumstances.~~

~~B. Administration reinsurance. For purposes of the Administration's reinsurance program, the insured entity shall be a prepaid plan with which the Administration contracts. Only costs incurred during the contract year in which a member is enrolled with a contractor qualify for reinsurance. Any movement of a member from membership with 1 contractor to membership with another contractor shall be cause for resetting the deductible level unless resetting is waived by the Administration.~~

~~C. Coinsurance and deductibles for members.~~

~~1. Coinsurance. As stated in the contract, the Administration shall pay a percentage of costs in excess of the deductible level incurred in paying for covered inpatient hospital services and when applicable, nursing facilities and acute medical and psychiatric services approved by the Director.~~

~~2. Deductible. A contractor shall pay the deductible for members.~~

~~D. Computation of the deductible level. The deductible level shall be determined by the costs paid by the contractor, or the AHCCCS fee schedule, if the costs are paid under a subcapitated arrangement.~~

~~E. Amounts in excess of the deductible level shall be paid based upon costs paid by the contractor, minus the coinsurance unless the costs are paid under a subcapitated arrangement. In subcapitated cases, the Administration shall base reimbursement of reinsurance encounters on the calculated AHCCCS allowed amount minus Medicare/TPL payments and applicable quick pay discounts.~~

~~1. The contractor shall maintain evidence that costs incurred have been paid by the contractor before submitting reinsurance encounters. This information is subject to AHCCCS Administration review.~~

~~2. First- and 3rd-party collections shall be reflected by the contractor as reductions in the encounters submitted on a dollar-for dollar-basis.~~

~~3. Payments made by contractor-purchased reinsurance are not considered 1st- and 3rd- party collections for the purpose of Administration reinsurance.~~

~~F. Encounter submission. A contractor shall prepare, review, verify, certify, and submit, encounters for consideration to the Administration.~~

~~1. The contractor shall certify that the services listed were actually rendered, medically necessary, and within the scope of AHCCCS benefits.~~

~~2. The contractor shall submit encounters in the format prescribed by the Administration.~~

~~3. The contractor shall initiate and evaluate an encounter for probable 1st- and 3rd- party liability before submitting the encounter for reinsurance consideration to the Administration, unless the encounter involves underinsured or uninsured motorist liability insurance, 1st- and 3rd- party liability insurance, or a tort-feasor.~~

~~G. Encounter processing. The Administration shall process reinsurance associated or related encounters submitted by a contractor.~~

~~1. The Administration shall accept for processing only those encounters that are submitted directly by an AHCCCS contractor and that comply with the conditions in subsections (B), (C), (E), and (F).~~

~~2. The Administration shall establish and maintain separate records of all reinsurance cases established and all payments and case reviews made to the contractor as a result of these cases.~~

~~3. The Administration shall subject a contractor to utilization of services and other evaluative reviews of care provided to a member that result in a reinsurance case.~~

~~H. Payment of reinsurance cases. The Administration shall reimburse a contractor for costs incurred in excess of the applicable deductible level calculated according to the provisions of subsection (E) and R9-22-703(B)(2).~~

~~I. The Administration may limit reinsurance reimbursement to a lower or alternative level of care if the Director or designee determines that the less costly alternative could and should have been used by the contractor. A contractor whose reinsurance case is reduced or denied shall be notified in writing by the Administration. The notification shall include the cause for reduction or denial and describe the applicable grievance and appeal process available under Article 8 of this Chapter.~~

~~J. The Administration or its contractors may arrange special contractual reinsurance terms for catastrophic cases. Catastrophic cases include, but are not limited to organ and bone marrow transplants (excluding kidney and cornea transplants which are covered under regular reinsurance), and hemophiliac cases. The contractor shall notify the AHCCCS Administration when a member is identified for possible reimbursement of AHCCCS-approved catastrophic cases. The determination of whether a case or type of case is catastrophic shall be made by the Director based on the following criteria:~~

~~1. Severity of medical condition, including prognosis; and~~

~~2. Average cost or average length of hospitalization and medical care, or both, in Arizona for the type of case under consideration.~~

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-702. Prohibitions Against Charges to Members ~~or Eligible Persons~~

~~A. A contractor, subcontractor, or other provider of care or services shall not charge, submit a claim, demand, or otherwise collect payment from a member or eligible person, or a person acting on behalf of a member or eligible person, for any covered service except to collect an authorized co-payment or payment for additional services. A prepaid capitated contractor shall have the right to recover from a member that portion of payment made by a 3rd party to the member when the payment duplicates AHCCCS paid benefits and has not been assigned to the prepaid contractor. A prepaid capitated contractor who makes a claim under this provision shall not charge more than the actual, reasonable cost of providing the covered services.~~

~~B. A provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from an individual claiming to be AHCCCS eligible without 1st receiving verification from the Administration that the individual was ineligible for AHCCCS on the date of service or that the services provided were not covered by AHCCCS.~~

~~C. A provider, including a noncontracting provider, may bill an eligible person for medical expenses incurred during a period of time when the eligible person willfully withheld material information from the provider or gave false information to the provider pertaining to the eligible person's AHCCCS eligibility or enrollment status that caused payment to be denied.~~

A. Except as provided in subsection (B), under A.R.S. § 36-2903.01, an AHCCCS registered provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from a person claiming to be AHCCCS eligible without first receiving verification from the Administration that the person was ineligible for AHCCCS on the date of service or that the services provided were not covered by AHCCCS.

B. An AHCCCS registered provider shall not charge, submit a claim, demand, or otherwise collect payment, directly or through a collection agency, from a member, or a person acting on behalf of a member, for any service except as described:

1. To collect an authorized copayment;
2. To pay for non-covered services;
3. To recover from a member that portion of payment made by a third party to the member when the payment duplicates AHCCCS paid benefits and has not been assigned to a contractor. A contractor who makes a claim under this provision shall not charge more than the actual, reasonable cost of providing the covered service;

4. To bill a member for medical expenses incurred during a period of time when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused payment to be reduced or denied.

R9-22-703. Claims Submission to the Administration

~~**A.** Claims submission to contractors. A provider shall submit to a capitated contractor all claims for services rendered to a member enrolled with the capitated contractor, including services rendered during a prior period for which the capitated contractor is responsible.~~

~~**B.** Claims submission to the AHCCCS Administration.~~

~~1. A provider, noncontracting provider, or non-provider shall ensure that a claim for covered services provided to an AHCCCS-eligible person is initially received by the AHCCCS Claims Administration not later than 9 months from the date of service or 9 months from the date of eligibility posting, whichever is later. The Administration shall deny a claim not received within the 9 month period from the date of service or 9 months from the date of eligibility posting, whichever is later. If a claim meets the 9 month limitation, the provider, noncontracting provider, or nonprovider shall file a clean claim which is received by the AHCCCS Claims Administration not later than 12 months from the date of service or 12 months from the date of eligibility posting, whichever is later.~~

~~2. Exceptions to the 9-month and 12-month rules are:~~

~~a. The Administration shall not consider a reinsurance claim for payment unless the claim is received by the AHCCCS Claims Administration not later than 9 months from the close of the contract year in which the claim is incurred or 9 months after the date of eligibility posting, whichever is later. If a claim meets the 9-month limitation, the contractor shall file a clean claim which is received by the AHCCCS Claims Administration not later than 12 months from the close of the contract year in which the claim is incurred or 12 months after the date of eligibility posting, whichever is later.~~

~~b. The 9 month deadline for an inpatient hospital claim begins on the date of discharge for each claim.~~

~~**C.** Claims processing.~~

~~1. If a claim contains erroneous or conflicting information, exceeds parameters, fails to process correctly, does not match the AHCCCS files, or requires manual review to be resolved, the Administration shall report the claim to the provider with a remittance advice.~~

~~2. The Administration shall process a hospital claim in accordance with R9-22-712.~~

~~**D.** Overpayments for AHCCCS services. When an AHCCCS overpayment is made to a provider, noncontracting provider, nonprovider, or contractor, the provider, noncontracting provider, nonprovider, or contractor shall notify AHCCCS that an overpayment was made. The Administration shall recoup an overpayment from a future claim cycle, or, at the discretion of the Director, require the provider, noncontracting provider, nonprovider, or contractor to return the incorrect payment to AHCCCS.~~

A. Timely Submission of Claims

1. The Administration regards the claim as submitted on the date that it is received by the Administration as evidenced by the date stamp on the face of the claim, the claim reference number or the date-specific number system assigned by the Administration.
2. Except as provided in subsection (A)(6), an AHCCCS registered provider shall initially submit a claim for covered services to the Administration not later than:
   a. Six months from the date of service or
   b. Six months from the date of eligibility posting, whichever is later.
3. The Administration shall deny the claim if the claim is not initially submitted within:
   a. The six-month period from the date of service,
   b. Or six months from the date of eligibility posting, whichever is later.
4. Except as provided in subsection (A)(6), if an AHCCCS registered provider submits an initial claim within the six-month period noted in subsection (A)(2), the AHCCCS registered provider shall submit a clean claim to the Administration not later than:
   a. Twelve months from the date of service; or
   b. Twelve months from the date of eligibility posting, whichever is later.
5. The claim is clean when all supporting documentation or information that is required to process the claim has been submitted. A claim pending for additional documentation is not a clean claim.
6. Under A.R.S. § 36-2904, an AHCCCS registered provider shall:
   a. Initially submit a claim for inpatient hospital services not later than six months from the date of member discharge for each claim and
   b. Submit a clean claim for inpatient hospital services not later than 12 months from the date of discharge for each claim.
7. A Contractor shall submit a reinsurance claim for payment as specified in the contract.

B. Claims Processing

1. The Administration shall notify the AHCCCS registered provider with a remittance advice when the claim is processed for payment.
2. The Administration shall pay valid clean claims in a timely manner according to 42 USC 1396u-2, as of August 5, 1997, which states:
   a. 90 per cent of valid clean claims shall be paid within 30 days of the date of receipt of a claim;
   b. 99 per cent of valid clean claims shall be paid within 90 days of the date of receipt of a claim; and
   c. The remaining one percent of valid clean claims shall be paid within 12 months of the date of receipt of a claim.
3. For purposes of determining timely claims processing, a claim pending for additional documentation is not a clean claim.
4. A claim is paid on the date indicated on the disbursement check.
5. A claim is denied as of the date of the remittance advice.
6. The Administration shall process a hospital claim according to R9-22-712.

C. Overpayments for AHCCCS Services
1. An AHCCCS registered provider shall notify the Administration when an overpayment was made by the Administration.
2. The Administration shall recoup an overpayment from a future claim cycle, or
3. An AHCCCS registered provider shall return the incorrect payment amount to the Administration.

D. Postpayment Claims Review
1. The Administration shall conduct postpayment review of claims paid by the Administration if monies have been erroneously paid to an AHCCCS registered provider.
   a. The Administration shall recoup an overpayment from a future claim cycle, or
   b. An AHCCCS registered provider shall return the incorrect payment amount to the Administration.
2. An AHCCCS registered provider may file a grievance or request for hearing under Article 8 of this Chapter if the AHCCCS registered provider disagrees with the recoupment action.

E. Claims Review
1. An AHCCCS registered provider shall:
   a. Obtain prior authorization from the Administration for non-emergency hospital admissions and covered services as specified in Articles 2 and 12 of this Chapter,
   b. Notify the Administration of emergency admissions under Article 2 and this Article, and
   c. Make records available for review.
2. Failure by an AHCCCS registered provider to obtain prior authorization from the Administration or to notify the Administration under Article 2 and this Article shall result in reduced payment, or denial of a claim.
3. All hospital claims, including outlier claims, are subject to prepayment medical review and post-payment review by the Administration.
4. Erroneously paid claims are subject to recoupment or submission by the AHCCCS registered provider of the incorrect payment amount under subsection (D).
5. If the Administration issues prior authorization for a specific level of care but subsequent medical review indicates that a different level of care was medically appropriate, the claim shall be paid, or adjusted to pay, at the appropriate level of care.
6. Post-payment reviews shall comply with A.R.S. § 36-2903.01.

R9-22-704. Transfer of payments

A. Business agent. For purposes of this sub-section a business agent is a firm such as a billing service or accounting firm who renders statements and receives payment in behalf of the contractor or AHCCCS registered provider.

~~**A.**~~**B.**~~Payments permitted.~~ Allowable transfer of payments. ~~Payments may be made~~ The Administration makes payments to other than the contractor~~, noncontracting provider or non provider~~ or an AHCCCS registered provider as follows:
1. When ~~payment is made in accordance with~~ there is an assignment to a government agency or there is an assignment ~~made pursuant to~~ under a court order; or
2. ~~When payment is made to a business agent, such as a billing service or accounting firm, who renders statements and receives payment in the name of the contractor, noncontracting provider or nonprovider, providing that the agent's compensation for this service is:~~ When a business agent receives payment in the name of the contractor or AHCCCS registered provider, and the agent's compensation for this service is:
   a. Reasonably related to the cost of processing the statements; and
   b. Not dependent upon the actual collection of payment.

~~**B.**~~**C.**Payment to physicians, dentists or other health professionals. Payment to physicians, dentists or other health professionals may be made as follows:
1. To the employer of the physician, dentist or other health professional, if such person is required, as a condition of employment, to ~~turn over~~ relinquish fees to ~~his or her~~ the employer;

2. To a foundation, plan, consortium or other similar organization, including a health care service organization, which furnishes health care through an organized health care delivery system, if there is a contractual arrangement between the organization and the person furnishing the services under which the organization bills or receives payment for such services.

~~C.~~**D.**~~Payments prohibited.~~ Prohibition of transfer of payments for contractors or AHCCCS registered providers. ~~Contractors, noncontracting providers or nonproviders~~ AHCCCS registered providers are prohibited from assigning all or part of AHCCCS payments for covered services furnished to a member to any party other than the provider except as specified in this Section.

~~D.~~**E.**Prohibition of transfer of payments to factors. Payment for covered services furnished to a member by ~~a contractor, noncontracting provider or nonprovider~~ an AHCCCS registered provider shall not be made to, or through a factor, either directly, or by virtue of a power of attorney given to the factor.

R9-22-707. Payments for Newborns

~~If a mother is enrolled on the date of her newborn baby's birth, a contractor shall be financially liable under the mother's capitation to provide all AHCCCS-covered services to the newborn baby from the date of birth to the date of the mother's disenrollment or the date of the baby's enrollment, whichever occurs 1st. However, if the mother is eligible for AHCCCS as an indigent or medically needy individual, the contractor shall have a maximum liability of 60 days under the mother's capitation.~~
If a mother is enrolled on the date of her newborn baby's birth, a contractor shall be financially liable under the mother's capitation to provide all Title XIX-covered services to the newborn baby from the date of birth until the Administration is notified of the birth.

R9-22-711. Copayments

~~A.~~ ~~Contractors are responsible for collecting copayments from members. The following are excluded from copayment requirements:~~
1. ~~Prenatal care including all obstetrical visits;~~
2. ~~Well-baby and E.P.S.D.T. care;~~
3. ~~Care in nursing facilities and intermediate care facilities for the mentally retarded;~~
4. ~~Visits scheduled by a primary care physician or practitioner, and not at the request of a member;~~
5. ~~Drugs and medications beginning October 1, 1985; and~~
6. ~~Family planning services as specified in 42 U.S.C. 1396o, July 16, 1998, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~

~~B.~~ ~~Except as provided in subsection (A), contractors and members shall comply with the following copayment schedules:~~
1. ~~Categorically eligible members:~~

~~*Covered Services*~~	~~*Copayment*~~
~~Doctor's office or home visit and all diagnostic and rehabilitative x-ray and laboratory services associated with the visit.~~	~~$1.00 per visit~~
~~Nonemergency surgery~~	~~$5.00 per procedure~~
~~Nonemergency use of the emergency room~~	~~$5.00 per visit~~

2. ~~MI/MN, EAC, and ELIC members:~~

~~*Covered Services*~~	~~*Copayment*~~
~~Doctor's office or home visit and all diagnostic and laboratory services associated with the visit.~~	~~$5.00 per visit~~
~~Nonemergency surgery~~	~~$5.00 per procedure~~
~~Nonemergency use of the emergency room~~	~~$5.00 per visit~~

A. Except as provided in subsection (B), contractors and members shall comply with the following copayment schedule:

Covered Services	**Copayment**
Doctor's office or home visit and all diagnostic and rehabilitative x-ray and laboratory services associated with the visit.	$1.00 per visit

Nonemergency surgery.	$5.00 per procedure
Nonemergency use of the emergency room.	$5.00 per visit

B. AHCCCS registered providers are responsible for collecting copayments from members. The following are excluded from copayment requirements:
1. Prenatal care including all obstetrical visits;
2. Well-baby and E.P.S.D.T. care;
3. Care in a nursing facility and ICF/MR;
4. Visits scheduled by a primary care physician, attending physician, or practitioner, and not at the request of the member;
5. Drugs and medications beginning October 1, 1985; and
6. Family planning services as specified in 42 U.S.C. 1396o.

C. A contractor or the Administration shall ensure that a member is not denied services because of the member's inability to pay a copayment.

R9-22-713. Payments made on behalf of a contractor; recovery of indebtedness

A. The Administration may make payments on behalf of a contractor in order to prevent a suspension or termination of AHCCCS services when ~~either~~:
~~1. No payment period is specified by subcontract and a valid accrued claim is not paid within 60 days of receipt by such contractor, or~~
~~2. A valid accrued claim is not paid within the period set forth under subcontract.~~
1. A contractor does not adjudicate a valid accrued claim within the period set forth under subcontract, or
2. A contractor does not adjudicate a valid accrued claim within 90 days of receipt from the AHCCCS registered provider whichever time-frame is longer.

~~**B.** In the event a payment is made by the Administration pursuant to this Article, the Administration shall reduce the capitation payment due a contractor by the amount of payment made, plus a 10% administrative fee for each claim that is paid.~~

~~**C.**~~**B.** If a contractor or a subcontracting provider receives an overpayment or otherwise becomes indebted to the Administration, the contractor or subcontracting provider shall immediately remit such funds to the Administration for deposit in the AHCCCS fund.

~~**D.** The action of the Administration to recover amounts from contractors or subcontracting providers may include the following:~~
~~1. Negotiation of a repayment agreement executed with the Administration.~~
~~2. Withholding or offsetting against current or future prepayments or other payments to be paid to the contractor or subcontracting provider.~~
~~3. Enforcement of, or collection against, the performance bond or withhold described in R9-22-701, subsection (C).~~

C. The Administration may recover monies from a contractor or a subcontracting provider in circumstances including the following:
1. Negotiation of a repayment agreement executed with the Administration,
2. Withholding or offsetting against current or future prepayments or other payments to be paid to the contractor or subcontracting provider, or
3. Enforcement of, or collection against, the performance bond or withhold under A.R.S. § 36-2903.

~~**E.**~~**D.** Except as specifically provided for in these rules, the Administration shall not be liable for payment for medical expenses incurred by enrolled members of prepaid capitated contractors.

R9-22-719. Reinsurance

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

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

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**

Sections Affected	Rulemaking Action
R9-28-101	Amend
R9-28-702	Amend
R9-28-703	Amend
R9-28-704	Amend
R9-28-709	Amend
R9-28-711	Amend
R9-28-712	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. §§ 36-2945, 36-2932, and 36-2913

Implementing statutes: A.R.S. §§ 36-2932, 36-2944, 36-2937, and 36-2945

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

Notice of Rulemaking Docket Opening: 7 A.A.R. 5263, 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 East 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 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 (R9-28-101) to add and amend definitions, and

Article 7, Standards For Payments (R9-28-702 through R9-28-704; R9-28-709, R9-28-711 and R9-28-712) to add and amend language.

Following is an explanation of the changes:

<u>9 A.A.C. 28, Article 1, Definitions</u>

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

<u>9 A.A.C. 28, Article 7, Standards For Payments</u>

R9-28-702 -- The Administration amended the language to improve the clarity and conciseness of the rule.

R9-28-703 -- The Administration amended the language to comply with statutory changes and to make the rule more clear and understandable.

R9-28-704 -- The Administration amended the language to improve the clarity and conciseness of the rule.

R9-28-709 -- The Administration amended the language to comply with state statute and references R9-22-719.

R9-28-711 -- The Administration made minor language changes.

R9-28-712 -- The Administration amended the language to improve the clarity and conciseness of the rule.

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 specific facets of Standard for Payment for the AHCCCS' long term care program. The Administration is amending these rules to conform to state statute and federal law and make the rules more clear, concise, and understandable by:

- Grouping like concepts to provide clarity and conciseness to the rule language, and
- Clarifying language that does not clearly present policies or procedures.

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 East Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

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: April 25, 2002

Time: 1:00 p.m.

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

Nature: Public Hearing

Date: April 25, 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: April 25, 2002

Time: 1:00 p.m.

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

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:

Not applicable

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. Location of Definitions

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-28-702. Prohibition Against Charges to Members ~~or Eligible Persons~~
R9-28-703. Claims
R9-28-704. Transfer of Payments
R9-28-709. Reinsurance
R9-28-711. Payments Made on Behalf of a Program contractor; Recovery of Funds; Postpayment Reviews
R9-28-712. County of Fiscal Responsibility

ARTICLE 1. DEFINITIONS

R9-28-101. Location of Definitions

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

Definition	Section or Citation
"AHCCCS registered provider"	R9-22-101
"Administration"	A.R.S. § 36-2931
"ADHS"	R9-22-112
"Aggregate"	R9-22-107
"AHCCCS"	R9-22-101
"Algorithm"	R9-28-104
"ALTCS"	R9-28-101
"ALTCS acute care services"	R9-28-104
"Alternative HCBS setting"	R9-28-101
"Ambulance"	R9-22-102
"Applicant"	R9-22-101
"Bed hold"	R9-28-102
"Behavior intervention"	R9-28-102
"Behavior management services"	R9-20-101
"Behavioral health evaluation"	R9-22-112
"Behavioral health medical practitioner"	R9-22-112
"Behavioral health professional"	R9-20-101
"Behavioral health service"	R9-20-101
"Behavioral health technician"	R9-20-101
"Billed charges"	R9-22-107
"Board-eligible for psychiatry"	9-22-112
"Capped fee-for-service"	R9-22-101

"Case management plan"	R9-28-101
"Case manager"	R9-28-101
"Case record"	R9-22-101
"Categorically-eligible"	R9-22-101
"Certification"	R9-28-105
"Certified psychiatric nurse practitioner"	R9-22-112
"CFR"	R9-28-101
"Clean claim"	R9-20-101
"Clinical supervision"	9-22-112
"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
"Department"	A.R.S. § 36-2901
"De novo hearing"	42 CFR 431.201
"Developmental disability"	A.R.S. § 36-551
"Diagnostic services"	R9-22-102
"Director"	R9-22-101
"Disenrollment"	R9-22-117
"DME"	R9-22-102
"EPD"	R9-28-301
"Eligible person"	A.R.S. § 36-2931
"Emergency medical services"	R9-22-102
"Encounter"	R9-22-107
"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
"Home and community based services" ("HCBS")	A.R.S. §§ 36-2931 and 36-2939
"Health care practitioner"	R9-22-112
"Hearing"	R9-22-108
"Home"	R9-28-101
"Home health services"	R9-22-102
"Hospital"	R9-22-101
"Intermediate care facility for the mentally retarded" ("ICF-MR")	42 CFR 440.150
"IHS"	R9-28-101
"IMD"	42 CFR 435.1009 and R9-28-111
"Indian"	42 CFR 36.1
"Institutionalized"	R9-28-104
"Interested Party"	R9-28-106
"JCAHO"	R9-28-101
"License" or "licensure"	R9-22-101
"Medical record"	R9-22-101
"Medical services"	R9-22-101
"Medical supplies"	R9-22-102
"Medically eligible"	R9-28-104
"Medically necessary"	R9-22-101

"Member"	A.R.S. § 36-2931
"Mental disorder"	A.R.S. § 36-501
"MMMNA"	R9-28-104
"Nursing facility" ("NF")	42 U.S.C. 1396r(a)
"Noncontracting provider"	A.R.S. § 36-2931
"Occupational therapy"	R9-22-102
"Partial care"	R9-22-112
"PAS"	R9-28-103
"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
"Practitioner"	R9-22-102
"Primary care provider"	R9-22-102
"Primary care provider services"	R9-22-102
"Prior authorization"	R9-22-102
"Prior period coverage" ("PPC")	R9-22-107
"Private duty nursing services"	R9-22-102
"Program contractor"	A.R.S. § 36-2931
"Provider"	A.R.S. § 36-2931
"Psychiatrist"	R9-22-112
"Psychologist"	R9-22-112
"Psychosocial rehabilitation"	R9-20-101
"Quality management"	R9-22-105
"Regional behavioral health authority" ("RBHA")	A.R.S. § 36-3401
"Radiology"	R9-22-102
"Reassessment"	R9-28-103
"Redetermination"	R9-28-104
"Referral"	R9-22-101
"Reinsurance"	R9-22-107
"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"	42 CFR 1000.10
"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:

"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 under A.R.S. § 36-591;

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

Group foster home under R6-5-5903;

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

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

Level I and Level II behavioral health agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6 Rural substance abuse transitional agencies under 9 A.A.C. 20, Articles 1 and 14.

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

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

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

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

Level I and Level II behavioral health agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6 Rural substance abuse transitional agencies under 9 A.A.C. 20, Articles 1 and 14.

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

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

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

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

"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 under A.R.S. § 36-401;

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

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

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

"IHS" means the Indian Health Service.

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

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-28-702. Prohibition Against Charges to Members ~~or Eligible Persons~~

~~**A.** A program contractor, provider, or noncontracting provider shall not charge, submit a claim, demand, or otherwise collect payment from a member or eligible person or a person acting on behalf of a member or eligible person for any covered service other than for a member's or eligible person's share of cost, authorized copayment, or payment for noncovered services. A program contractor shall have the right to recover from a member that portion of payment made by a 1st or 3rd party to the member when the payment duplicates ALTCS-paid benefits.~~

~~**B.** A program contractor, provider, or noncontracting provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from an individual claiming to be ALTCS eligible without 1st receiving verification from the Administration that the individual was ineligible for ALTCS on the date of service, or that service provided was not covered by ALTCS, except as specified in subsection (A).~~

~~**C.** A program contractor, provider, or noncontracting provider may bill an eligible person or member for medical expenses incurred during a period of time when the individual willfully withheld material information pertaining to the individual's ALTCS eligibility or enrollment.~~

A. Except as provided in Section B, an AHCCCS registered provider, under A.R.S. § 36-2932, shall not bill or make any attempt to collect payment, directly or through a collection agency, from a person claiming to be AHCCCS eligible without first receiving verification from the Administration that the person was ineligible for AHCCCS on the date of service or that the services provided were not covered by AHCCCS.

B. An AHCCCS registered provider shall not charge, submit a claim, demand, or otherwise collect payment, directly or through a collection agency, from a member, or a person acting on behalf of a member, for any service except as described:

1. To collect an authorized copayment;
2. To collect a member's share of cost;
3. To pay for additional services under Article 2 of this Chapter;
4. To recover from a member that portion of payment made by a third party to the member when the payment duplicates AHCCCS paid benefits and has not been assigned to a contractor. A contractor who makes a claim under this provision shall not charge more than the actual, reasonable cost of providing the covered service;

5. To bill a member for medical expenses incurred during a period of time when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused payment to be reduced or denied.

R9-28-703. Claims

~~**A.** Program contractors. All claims for covered services rendered to a member enrolled with a prepaid program contractor, shall be submitted to the program contractor.~~

~~**B.** Providers and noncontracting providers. A provider or noncontracting provider, shall submit all claims for covered services rendered to an eligible person to the Administration for payment in accordance with A.A.C. R9-22-703 and this Article.~~

~~**C.** Timeliness. A program contractor, provider, or noncontracting provider shall ensure that a claim for covered services provided to a member or eligible person is initially received by the Administration no later than 9 months after the last date of service shown on the claim, or 9 months after the date of eligibility posting, whichever is later. The Administration shall not consider a claim for payment unless the claim is received by the Administration as a clean claim no later than 12 months after the last date of service shown originally on the claim, or 12 months after the date of eligibility posting, whichever is later.~~

~~1. Reinsurance claims shall be submitted to the Administration in accordance with A.A.C. R9-22-703.~~
~~2. The date of receipt of a claim is the date the Administration receives the claim. The Administration shall consider for payment only claims received in accordance with the provisions of this Section.~~

A. Program contractor. All claims for covered services rendered to a member enrolled with a contractor, shall be submitted to the contractor under A.A.C. R9-22-705.

B. AHCCCS registered providers. An AHCCCS registered provider shall submit all claims for covered services rendered to a FFS member to the Administration for payment under A.A.C. R9-22-703 and this Article.

R9-28-704. Transfer of Payments

~~**A.** Payments permitted. In the following circumstances and when in the best interests of the state, the Administration or its contractors shall make payments to other than a program contractor, provider, or noncontracting provider~~

~~1. When payment is in accordance with an assignment to a government agency or an assignment made under a court order; or~~
~~2. When payment is to a business agent, such as a billing service or accounting firm, that renders statements and receives payment in the name of the program contractor, noncontracting provider, or provider, providing that the agent's compensation for this service is:~~
   ~~a. Reasonably related to the cost of processing the statements; and~~
   ~~b. Not dependent upon the actual collection of payment.~~

~~**B.** When in the best interests of the state, the Administration or its contractors shall make payment to a primary care provider, dentist, or other health care professional as follows:~~

~~1. To the employer of the primary care provider, dentist, or other health professional, if the health care professional is required, as a condition of employment, to turn over fees to the employer;~~
~~2. To a foundation, plan, consortium, or other similar organization, including a health care service organization, that furnishes health care through an organized health care delivery system, if there is a contractual arrangement between the organization and the health care professional furnishing the services under which the organization bills or receives payment for the services.~~

~~**C.** Payments prohibited. A program contractor, provider, or noncontracting provider shall not assign all or part of ALTCS payments for covered services furnished to a member or eligible person to any party other than the program contractor, provider, or noncontracting provider except as specified in this Section.~~

~~**D.** Prohibition of payments to factors. A program contractor, provider, or noncontracting provider shall not make payment for covered services furnished to a member or eligible person to or through a factor, either directly, or by virtue of a power of attorney given to the factor.~~

A. Business agent. For purposes of this Section a business agent is a firm such as a billing service or accounting firm who renders statements and receives payment in behalf of the contractor or AHCCCS registered provider.

B. Allowable transfer of payments. The Administration makes payments to other than the contractor or AHCCCS registered provider as follows:

1. When there is an assignment to a government agency or an assignment under a court order; or
2. When a business agent renders statements and receives payment in the name of the contractor or AHCCCS registered provider, and the agent's compensation for this service is:
   a. Reasonably related to the cost of processing the statements; and
   b. Not dependent upon the actual collection of payment.

C. Payment to physicians, dentists or other health professionals. Payment to physicians, dentists or other health professionals may be made as follows:

1. To the employer of the physician, dentist or other health professional, if such person is required, as a condition of employment, to relinquish fees to the employer;
2. To a foundation, plan, consortium or other similar organization, including a health care service organization, which furnishes health care through an organized health care delivery system, if there is a contractual arrangement between the organization and the person furnishing the services under which the organization bills or receives payment for such services.

D. Prohibition of transfer of payments for contractors or AHCCCS registered providers. Contractors or AHCCCS registered providers are prohibited from assigning all or part of AHCCCS payments for covered services furnished to a member to any party other than the provider except as specified in this Section.

E. Prohibition of transfer of payments to factors. Payment for covered services furnished to a member by a contractor or AHCCCS registered provider shall not be made to, or through a factor, either directly, or by virtue of a power of attorney given to the factor.

R9-28-709. Reinsurance

~~**A.** Program contractor acquired reinsurance. A program contractor may obtain reinsurance for coverage of services provided to members enrolled with the program contractor.~~

~~**B.** Administration reinsurance. For purposes of the Administration's reinsurance program, the insured entity shall be a program contractor.~~

~~1. Reimbursement of covered services shall be subject to a deductible as specified in contract. The deductible shall be reset at the beginning of each contract year and when a member changes program contractors. Allowable costs in excess of the deductible amount shall have a reinsurance percentage as specified in contract applied to calculate the reimbursement amount. Medicare and other 1st -and 3rd -party payments shall be deducted from allowable costs before calculating the reimbursement amount.~~
~~2. Acute inpatient and psychiatric facility services provided while a member is enrolled with a program contractor are covered services for purposes of reinsurance reimbursement.~~
~~3. Services reimbursed under the reinsurance benefit are subject to medical review by the Administration. Reimbursement may be denied, payment levels reduced, or financial sanctions imposed upon a program contractor when medical review results in identification of services that could have been provided in a less costly, medically appropriate manner. Medical review and resulting adjustments to reimbursement shall be in accordance with contract.~~
~~4. Inpatient encounter data submitted by a program contractor shall be used by the Administration to identify reinsurance cases that exceed the deductible amounts and are subject to reimbursement.~~
~~5. A program contractor shall make available to the Administration upon request documentation to support:~~
   ~~a. The services provided;~~
   ~~b. The reimbursement for those services; and~~
   ~~c. Attempts to recover the cost of those services from other payors.~~
~~6. The Administration may require contractual terms that prescribe special reinsurance requirements for catastrophic cases. The requirements may include:~~
   ~~a. Conditions under which a case is considered catastrophic;~~
   ~~b. Claim and documentation requirements; and~~
   ~~c. The method and amount of reimbursement for catastrophic cases.~~

A contractor shall submit to the Administration all reinsurance claims for services rendered to a member enrolled with the contractor as specified in R9-22-719.

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

A. The Administration may make payments on behalf of a program contractor and may recover funds from a program contractor or AHCCCS registered provider ~~in accordance with standards in~~ according to standards under A.A.C. R9-22-713. For purposes of this Section, the term "contractor" as it appears in A.A.C. R9-22-713 means "program contractor".

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

R9-28-712. County of Fiscal Responsibility

A. General requirements.

1. ~~The Administration shall determine the county of fiscal responsibility to determine which program contractor is responsible for an elderly or physically disabled applicant (applicant) or an elderly or physically disabled member (member).~~ Under A.R.S. § 36-2913, the Administration shall determine the county of fiscal responsibility for an elderly or physically disabled applicant or an elderly or physically disabled member.
2. A program contractor shall cover services and provisions specified in 9 A.A.C. 22, Articles 2 and 7 and Article 11 of this Chapter.

~~**B.** Criteria for determining county of fiscal responsibility for an applicant.~~

~~1. The county of fiscal responsibility is the county where the applicant resides if:~~
~~a. The applicant resides in the applicant's own home as specified in R9-28-101(B)(16),~~
~~b. The applicant moved from another state within the last 30 days, or~~
~~c. The applicant has continuously resided in the current county 30 days immediately before entering:~~
~~i. An alternative HCBS setting as specified in R9-28-101(B)(3),~~
~~ii. A NF as specified in A.A.C. R9-22-101(B)(27), or~~
~~iii. An intermediate care facility for the mentally retarded as specified in R9-28-101(B)(18).~~
~~2. The county of fiscal responsibility is the county where the applicant resides, whether in an alternative HCBS setting, or a NF, or an intermediate care facility for the mentally retarded, 30 days immediately before moving to another county.~~

B. Criteria for determining county of fiscal responsibility for an applicant.
1. If the applicant resides in the applicant's own home as specified in R9-28-101, the county of fiscal responsibility is the county where the applicant currently resides.
2. If the applicant is residing in a NF or alternative HCBS setting, the county of fiscal responsibility is the county in which the applicant last resided in the applicant's own home.
3. If the applicant has moved from another state directly into a NF or alternative HCBS setting in Arizona, the county of fiscal responsibility is the county in which the person currently resides.
4. If the applicant moves from ASH or is an inmate of a public institution moving from the public institution into a NF or alternative HCBS setting, the county of fiscal responsibility is the county in which the applicant resided in their own home prior to admission in ASH or the public institution.

C. Criteria for determining if there is a change in county of fiscal responsibility for a member moving from one county to another county.
1. No change in the county of fiscal responsibility. ~~The county of fiscal responsibility for a member shall remain the same if:~~ There will be no change in the county of fiscal responsibility for a member when:
~~1.~~ a. The member moves from a NF to another NF in a different county,
~~2.~~ b. The member moves from a NF to an alternative HCBS setting in a different county,
~~3.~~ c. The member moves from an alternative HCBS setting to another alternative HCBS setting in a different county,
~~4.~~ d. The member moves from an alternative HCBS setting to a NF in a different county,
~~5.~~ e. The member moves from the member's own home to an alternative HCBS setting in a different county, ~~or~~
~~6.~~ f. The member moves from the member's own home to a NF in a different county~~.~~,
g. The member moves from a NF or alternative HCBS setting into ASH, or
h. The member moves from ASH to a NF or alternative HCBS setting.

~~**D.**~~ 2. Change in the county of fiscal responsibility. If the member moves from ~~1~~ one county to another, the county of fiscal of responsibility shall change to the new county if the member moves from:
~~1.~~ a. An alternative HCBS setting to the member's own home in a different county,
~~2.~~ b. A NF to the member's own home in a different county,
~~3. An intermediate care facility for the mentally retarded to the member's own home in a different county, or~~
~~4.~~ c. The member's own home to the member's own home in a different county~~.~~ ,
d. The member moves from ASH to the member's own home.

~~**E.**~~ 3. Transfers between program contractors. The county of fiscal responsibility may change when ~~The~~ the Administration ~~may transfer~~ transfers a member from ~~1~~ one program contractor to a different program contractor if:
~~1.~~ a. Both program contractors agree, or
~~2.~~ b. The Administration determines it is in the best interest of the member.

~~**F.** No program contractor. If there is no authorized program contractor within the member's service area, the member shall receive services according to A.R.S. § 36-2945.~~

~~**G.** Arizona State Hospital (ASH). If the member moves from ASH to an approved ALTCS setting, the Administration shall assign the member to a program contractor in the county that the member resided in prior to admission in ASH. This subsection does not apply when a member moves from ASH to a member's own home.~~

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**

Sections Affected	Rulemaking Action
R9-31-101	Amend
R9-31-107	Amend
R9-31-116	Amend
R9-31-503	Repeal
R9-31-702	Amend
R9-31-703	Amend
R9-31-707	Amend
R9-31-711	Amend
R9-31-713	Amend
R9-31-719	New Section
R9-31-1618	Amend
R9-31-1620	Amend
R9-31-1621	Amend
R9-31-1623	Repeal

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 and 36-2986

Implementing statutes: A.R.S. §§ 36-2982, 36-2986 and 36-2987

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

Notice of Rulemaking Docket Opening: 7 A.A.R. 5263, 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 East 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, and to provide additional clarity and conciseness to existing rule language. These changes impact four Articles:

Article 1, Definitions (R9-31-101, R9-31-107 and R9-31-116) to add and amend definitions,

Article 5, General Provision And Standards (R9-22-503, Reinsurance) to repeal a Section,

Article 7, Standards For Payments (R9-31-702 through R9-31-704; R9-31-711, R9-31-713 and R9-31-719) to add and amend language,

Article 16, Services For Native Americans (R9-31-16-18, R9-31-1620, R9-31-21, and R9-31-1623) to add, amend, and repeal language.

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.

9 A.A.C. 31, Article 5, General Provision And Standards

R9-31-503 -- The Administration repealed the language and relocated "Reinsurance" to R9-31-719. Language that more appropriately exists in contract is deleted according to A.R.S. § 41-1005(A)(16). New language references R9-22-713.

9 A.A.C. 31, Article 7, Standards For Payments

R9-22-702 -- The Administration amended the language to improve the clarity and conciseness of the rule.

R9-22-703 -- The Administration made minor changes to improve clarity.

R9-22-704 -- The Administration made minor changes to improve clarity.

R9-22-711 -- The Administration made minor changes to improve clarity.

R9-22-713 -- The Administration amended the language to conform to federal law (Section A); make the language more clear and understandable and deleted Section B as it is covered in Section C and in contract.

R9-22-719 -- The Administration relocated "Reinsurance" from R9-31-503 to R9-31-719. Language that more appropriately exists in contract is deleted according to A.R.S. § 41-1005(A)(16). New language references R9-22-719.

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

R9-31-1618 -- The Administration amended the language to comply with statutory changes and added language to make the rule more clear and understandable.

R9-31-1620 -- The Administration amended the language to improve the clarity and conciseness of the rule.

R9-31-1621 -- The Administration amended the language to improve the clarity and conciseness of the rule.

R9-31-1623 -- The Administration repealed this Section to conform to federal law that prohibits copayments and premiums for Native Americans.

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 specific facets of Standard for Payment for the AHCCCS' KidsCare program. The Administration is amending these rules to conform to state statute and federal law and make the rules more clear, concise, and understandable by:

- Grouping like concepts to provide clarity and conciseness to the rule language, and
- Clarifying language that does not clearly present policies or procedures.

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 East Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

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: April 25, 2002

Time: 1:00 p.m.

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

Nature: Public Hearing

Date: April 25, 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: April 25, 2002

Time: 1:00 p.m.

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

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:

Not applicable

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
R9-31-107. Standard for Payments Related Definitions
R9-31-116. Services for Native Americans Related Definitions

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section
R9-31-503. ~~Reinsurance~~ Repealed

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-31-702. Prohibitions Against Charges to Members
R9-31-703. Claims

R9-31-704. Transfer of Payments
R9-31-711. Copayments and Premiums
R9-31-713. Payments Made on Behalf of a Contractor; Recovery of Indebtedness
R9-31-719. Reinsurance

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

Section
R9-31-1618. Claims Submission to the Administration
R9-31-1620. Prohibitions Against Charges to Members
R9-31-1621. The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care
R9-31-1623. ~~Copayments and Premiums~~ Repealed

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"	R9-22-107
"Action"	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

“Date of eligibility posting	R9-22-107
“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
“Evaluation”	R9-31-112
“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”	42CFR 435.1009 and 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~~ 42 CFR 36.1
“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 (PCP)"	R9-22-102
"Primary care provider services"	R9-22-102
"Prior authorization"	R9-22-102
"Private duty nursing services"	R9-22-102
"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
"Remittance advice"	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
"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 or noncontracting 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~~ Title XXI 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.~~ medical coverage made under this Chapter.

"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.

R9-31-107. Standards for Payments Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

~~1.~~ "Covered charges" means billed charges that represent medically necessary, reasonable, and customary items of expense for Title XXI covered services that meet medical review criteria of the Administration or contractor.

~~2.~~ "Medical review" means a review involving clinical judgment of a claim or a request for a service before or after it is paid or rendered to ensure that services provided to a member are medically necessary and covered services and that required authorizations are obtained by the provider. The criteria for medical review are established by the contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

~~3.~~ "Outlier" means a hospital claim or encounter in which the Title XXI inpatient hospital days of care have operating costs per day that meet the criteria described in A.A.C. R9-22-712.

~~4.~~ "Tiered per diem" means a payment structure in which payment is made on a per-day basis depending upon the tier into which the Title XXI inpatient hospital day of care is assigned.

R9-31-116. Services for Native Americans Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

~~1.~~ "IGA" means Intergovernmental Agreement.

~~2.~~ "IHS" means Indian Health Service.

~~3.~~ "IHS or Tribal Facility Provider" means a person who is authorized by the IHS or Tribal Facility and registered as an AHCCCS provider to provide covered services to members. The IHS or Tribal Facility by authorizing the person to provide covered services, shall certify that the person meets all applicable federal and state requirements.

~~4.~~ "TRBHA" means the Tribal Regional Behavioral Health Authority. Tribal governments, through an IGA with ADHS may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to a Native American member residing on reservation.

R9-31-503. ~~Reinsurance~~ Repealed

~~**A.** Contractor-acquired reinsurance. As specified in A.R.S. § 36-2988, a contractor may obtain reinsurance for coverage of prepaid capitated members. A contractor shall not obtain reinsurance to reduce liability below 25% of the applicable deductible level during any Title XXI contract year. This limitation does not apply to reinsurance obtained by a contractor to cover the cost of services provided by noncontracting providers and nonproviders to a member under emergency circumstances.~~

~~**B.** Administration reinsurance. For purposes of the Administration's reinsurance program, the insured entity shall be a prepaid plan with which the Administration contracts. Only costs incurred during the contract year in which a member is~~

~~enrolled with a contractor qualify for reinsurance. Any movement of a member from membership with 1 contractor to membership with another contractor shall be cause for resetting the deductible level unless resetting is waived by the Administration.~~

~~C.~~ ~~Encounter submission. A contractor shall prepare, review, verify, certify, and submit, encounters for consideration to the Administration.~~
  ~~1.~~ ~~The contractor shall certify that the services listed were actually rendered, medically necessary, and within the scope of Title XXI benefits.~~
  ~~2.~~ ~~The contractor shall submit encounters in the format prescribed by the Administration.~~
  ~~3.~~ ~~The contractor shall initiate and evaluate an encounter for probable 1st- and 3rd-party liability before submitting the encounter for reinsurance consideration to the Administration, unless the encounter involves underinsured or uninsured motorist liability insurance, 1st- and 3rd-party liability insurance, or a tort-feasor.~~
  ~~4.~~ ~~The Administration shall not consider a reinsurance claim for payment unless the claim is received by the AHCCCS Claims Administration not later than 12 months after the date of service.~~

~~D.~~ ~~Encounter processing. The Administration shall process reinsurance associated or related encounters submitted by a contractor.~~
  ~~1.~~ ~~The Administration shall accept for processing only those encounters that are submitted directly by a Title XXI contractor and that comply with the conditions in subsections (B), (C), (E), and (F).~~
  ~~2.~~ ~~The Administration shall establish and maintain separate records of all reinsurance cases established and all payments and case reviews made to the contractor as a result of these cases.~~
  ~~3.~~ ~~The Administration shall subject a contractor to utilization of services and other evaluative reviews of care provided to a member that result in a reinsurance case.~~

~~E.~~ ~~Payment of reinsurance cases. The Administration shall reimburse a contractor for costs incurred in excess of the applicable deductible level calculated according to the provisions of A.A.C. R9-22-703.~~

~~F.~~ ~~The Administration may limit reinsurance reimbursement to a lower or alternative level of care if the Director or designee determines that the less costly alternative could and should have been used by the contractor. A contractor whose reinsurance case is reduced or denied shall be notified in writing by the Administration. The notification shall include the cause for reduction or denial and describe the applicable grievance and appeal process available under 9 A.A.C. 31, Article 8.~~

~~G.~~ ~~The Administration or its contractors may arrange special contractual reinsurance terms for catastrophic cases. Catastrophic cases include, but are not limited to organ and bone marrow transplants (excluding kidney and cornea transplants which are covered under regular reinsurance), and hemophiliac cases. The contractor shall notify the Administration when a member is identified for possible reimbursement of Title XXI-approved catastrophic cases. The determination of whether a case or type of case is catastrophic shall be made by the Director based on the following criteria:~~
  ~~1.~~ ~~Severity of medical condition, including prognosis; and~~
  ~~2.~~ ~~Average cost or average length of hospitalization and medical care, or both, in Arizona for the type of case under consideration.~~

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-31-702. Prohibitions Against Charges to Members

~~A.~~ ~~A contractor, subcontractor, or other provider of care or services shall not charge, submit a claim, demand, or otherwise collect payment from a member or a person acting on behalf of a member for any covered service except to collect an authorized co-payment or payment for additional services. A contractor shall have the right to recover from a member that portion of payment made by a 3rd party to the member when the payment duplicates Title XXI paid benefits and has not been assigned to the contractor. A contractor who makes a claim under this provision shall not charge more than the actual, reasonable cost of providing the covered services.~~

~~B.~~ ~~A provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from an individual claiming to be Title XXI eligible without 1st receiving verification from the Administration that the individual was ineligible for Title XXI on the date of service or that the services provided were not covered by Title XXI as specified in A.R.S. § 36-2987.~~

~~C.~~ ~~A provider, including a noncontracting provider, may bill a member for medical expenses incurred during a period of time when the member willfully withheld material information from the provider or gave false information to the provider pertaining to the member's Title XXI eligibility or enrollment status that caused payment to be denied.~~

A. Except as provided in subsection (B), under A.R.S. § 36-2987, an AHCCCS registered provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from a person claiming to be Title XXI eligible without first receiving verification from the Administration that the person was ineligible for Title XXI benefits on the date of service or that the services provided were not covered by AHCCCS.

B. An AHCCCS registered provider shall not charge, submit a claim, demand, or otherwise collect payment, directly or through a collection agency, from a member, or a person acting on behalf of a member, for any service except as described:

1. To collect an authorized copayment;
2. To pay for non-covered services;
3. To recover from a member that portion of payment made by a third party to the member when the payment duplicates Title XXI paid benefits and has not been assigned to a contractor. A contractor who makes a claim under this provision shall not charge more than the actual, reasonable cost of providing the covered service;
4. To bill a member for medical expenses incurred during a period of time when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's Title XXI eligibility or enrollment that caused payment to be reduced or denied.

R9-31-703. Claims

A. Claims submission to contractors. ~~A provider~~ An AHCCCS registered provider shall submit to a contractor all claims for services rendered to a member enrolled with the contractor as specified in R9-31-705.

B. Overpayments for Title XXI services. When a Title XXI overpayment is made to a contractor, the contractor shall notify the Administration that an overpayment was made. The Administration shall recoup an overpayment from a future claim cycle, or, at the discretion of the ~~Director~~, Administration require the contractor to return the incorrect payment to the Children's Health Insurance Program Fund.

R9-31-704. Transfer of Payments

~~**A.** Payments permitted. Payments may be made to other than the contractor as follows:~~
1. ~~When payment is made in accordance with an assignment to a government agency or an assignment made according to a court order; or~~
2. ~~When payment is made to a business agent, such as a billing service or accounting firm, who renders statements and receives payment in the name of a contractor providing that the agent's compensation for this service is:~~
   a. ~~Reasonably related to the cost of processing the statements,~~
   b. ~~Not dependent upon the actual collection of payment.~~

~~**B.** Prohibition of payments to factors. Payment for covered services furnished to a member by a contractor shall not be made to, or through a factor, either directly, or by virtue of a power of attorney given to the factor.~~

A. Billing agent. For purposes of this Section a business agent is a firm such as a billing service or accounting firm who renders statements and receives payment in behalf of the contractor or AHCCCS registered provider.

B. Allowable transfer of payments. The Administration makes payments to other than the contractor or AHCCCS registered provider as follows:
1. When there is an assignment to a government agency or an assignment under a court order; or
2. When a business agent renders statements and receives payment in the name of the contractor, and the agent's compensation for this service is:
   a. Reasonably related to the cost of processing the statements; and
   b. Not dependent upon the actual collection of payment.

C. Prohibition of transfer of payments to factors. Payment for covered services furnished to a member by an AHCCCS registered provider shall not be made to, or through a factor, either directly, or by virtue of a power of attorney given to the factor.

R9-31-711. Copayments and Premiums

A. Contractors ~~shall be~~ are responsible for collecting a $5.00 copayment from a member for non-emergency use of the emergency room.

B. A contractor shall ensure that a member is not denied services because of the member's inability to pay a copayment.

C. The Administration shall establish standards for premiums as discussed in 9 A.A.C. 31, Article 14.

R9-31-713. Payments Made on Behalf of a Contractor; Recovery of Indebtedness

A. The Administration may make payments on behalf of a contractor in order to prevent a suspension or termination of Title XXI services when ~~either~~:
1. ~~No payment period is specified by subcontract and a valid accrued claim is not paid within 30 days of receipt by the contractor, or~~
2. ~~A valid accrued claim is not paid within the period under subcontract.~~
1. A contractor does not adjudicate a valid accrued claim within the period set forth under subcontract, or
2. A contractor does not adjudicate a valid accrued claim within 90 days of receipt from the AHCCCS registered provider whichever time-frame is longer.

~~**B.** In the event a payment is made by the Administration according to this Article, the Administration shall reduce the capitation payment due a contractor by the amount of payment made, plus a 10% administrative fee for each claim that is paid.~~

~~**C.**~~**B.** If a contractor or a subcontracting provider receives an overpayment or otherwise becomes indebted to the Administration, the contractor or subcontracting provider shall immediately remit such funds to the Administration for deposit in the Children's Health Insurance Program Fund.

~~D.~~ ~~The action of the Administration to recover amounts from contractors or subcontracting providers may include the following:~~
 ~~1.~~ ~~Negotiation of a repayment agreement executed with the Administration.~~
 ~~2.~~ ~~Withholding or offsetting against current or future prepayments or other payments to be paid to the contractor or subcontracting provider.~~
 ~~3.~~ ~~Enforcement of, or collection against, the performance bond or withhold as specified in A.R.S. § 36-2986.~~

C. The Administration may recover monies from a contractor or a subcontracting provider in circumstances including the following:
 1. Negotiation of a repayment agreement executed with the Administration, or
 2. Withholding or offsetting against current or future prepayments or other payments to be paid to the contractor or subcontracting provider.
 3. Enforcement of, or collection against, the performance bond or withhold under A.R.S. § 36-2986.

~~E.~~**D.** Except as specifically provided for in these rules, the Administration shall not be liable for payment for medical expenses incurred by members enrolled with contractors.

R9-31-719. Reinsurance

A contractor shall submit to the Administration all reinsurance claims for services rendered to a member enrolled with the contractor as specified in R9-22-719.

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1618. Claims Submission to the Administration

~~A.~~ ~~Claims submission to the Administration.~~
 ~~1.~~ ~~The IHS, a Tribal Facility, a TRBHA, or a provider under referral shall ensure that a claim for covered services provided to a member is initially received by the Administration not later than six months from the date of service. The Administration shall deny a claim not received within the six month period from the date of service. If a claim meets the six-month limitation, the IHS, a Tribal Facility, a TRBHA, or a provider under referral shall file a clean claim which is received by the Administration not later than 12 months from the date of service.~~
 ~~2.~~ ~~The six and twelve-month deadlines for an inpatient hospital claim begin on the date of discharge for each claim.~~

~~B.~~ ~~Claims processing.~~
 ~~1.~~ ~~If a claim contains erroneous or conflicting information, exceeds parameters, fails to process correctly, does not match the Administration's files, or requires manual review to be resolved, the Administration shall report the claim to a provider with a remittance explanation.~~
 ~~2.~~ ~~The Administration shall process a hospital claim in accordance with A.A.C. R9-22-712.~~

~~C.~~ ~~Overpayments for Title XXI services. An IHS or a Tribal Facility provider, a noncontracting provider, or a Tribal Facility, shall notify the Administration if an overpayment is made. The Administration shall recoup an overpayment from a future claim cycle, or, at the discretion of the Director, require the IHS or a Tribal Facility provider or a noncontracting provider, to return the incorrect payment to the Administration.~~

A. Timely Submission of Claims
 1. The Administration regards the claim as submitted on the date that it is received by the Administration as evidenced by the date stamp on the face of the claim, the claim reference number or the date-specific number system assigned by the Administration.
 2. Except as provided in subsection (A)(6), the IHS, a Tribal Facility, a TRBHA, or a provider under referral shall initially submit a claim for covered services to the Administration not later than:
  a. Six months from the date of service or
  b. Six months from the date of eligibility posting, whichever is later.
 3. The Administration shall deny the claim if the claim is not initially submitted within:
  a. The six-month period from the date of service, or
  b. Six months from the date of eligibility posting, whichever is later.
 4. Except as provided in subsection (A)(6), if the IHS, a Tribal Facility, a TRBHA, or a provider under referral submits an initial claim within the six-month period noted in subsection (A)(2), the AHCCCS registered provider shall:
  a. Submit a clean claim to the Administration not later than 12 months from the date of service; or
  b. Twelve months from the date of eligibility posting, whichever is later.
 5. The Administration considers the claim clean when all supporting documentation or information required to process the claim has been submitted. A claim pending for additional documentation is not a clean claim.
 6. Under A.R.S. § 36-2987, the IHS, a Tribal Facility, a TRBHA, or a provider under referral shall:
  a. Initially submit a claim for inpatient hospital services not later than six months from the date of member discharge for each claim, and
  b. Submit a clean claim for inpatient hospital services not later than 12 months from the date of discharge for each claim.

B. Claims Processing
1. The Administration shall notify the IHS, a Tribal Facility, a TRBHA, or a provider under referral with a remittance advice when the claim is processed.
2. The Administration shall pay valid clean claims in a timely manner according to 42 USC 1396u-2, as of August 5, 1997, which states:
   a. 90 per cent of valid clean claims shall be paid within 30 days of the date of receipt of a claim;
   b. 99 per cent of valid clean claims shall be paid within 90 days of the date of receipt of a claim; and
   c. The remaining one percent of valid clean claims shall be paid within 12 months of the date of receipt of a claim.
3. For purposes of determining timely claims processing, a claim pending for additional documentation is not a clean claim.
4. A claim is paid on the date indicated on the disbursement check.
5. A claim is denied as of the date of the remittance advice.
6. The Administration shall process a hospital claim according to R9-22-712.

C. Overpayments for Title XXI Services
1. The IHS, a Tribal Facility, a TRBHA, or a provider under referral shall notify the Administration when an overpayment was made by the Administration.
2. The Administration shall recoup an overpayment from a future claim cycle, or
3. The IHS, a Tribal Facility, a TRBHA, or a provider under referral shall return the incorrect payment amount to the Administration.

D. Postpayment Claims Review
1. The Administration shall conduct postpayment review of claims paid by the Administration if monies have been erroneously paid to the IHS, a Tribal Facility, a TRBHA, or a provider under referral.
   a. The Administration shall recoup an overpayment from a future claim cycle, or
   b. The IHS, a Tribal Facility, a TRBHA, or a provider under referral shall return the incorrect payment amount to the Administration.
2. The IHS, a Tribal Facility, a TRBHA, or a provider under referral may file a grievance or request for hearing under Article 8 of this Chapter if the AHCCCS registered provider disagrees with the recoupment action.

E. Claims Review
1. The IHS, a Tribal Facility, a TRBHA, or a provider under referral shall:
   a. Obtain prior authorization from the Administration for non-emergency hospital admissions and covered services as specified in Articles 2 and 12 of this Chapter,
   b. Notify the Administration of emergency admissions under Article 2 and this Article, and
   c. Make records available for review.
2. Failure by the IHS, a Tribal Facility, a TRBHA, or a provider under referral to obtain prior authorization from the Administration or to notify the Administration under Article 2 and this Article shall result in reduced payment, or denial of a claim.
3. All hospital claims, including outlier claims, are subject to prepayment medical review and post payment review by the Administration.
4. Erroneously paid claims are subject to recoupment or submission by the IHS, a Tribal Facility, a TRBHA, or a provider under referral of the incorrect payment amount under subsection (D).
5. If the Administration issues prior authorization for a specific level of care but subsequent medical review indicates that a different level of care was medically appropriate, the claim shall be paid, or adjusted to pay, at the appropriate level of care.
6. Post-payment reviews shall comply with A.R.S. § 36-2987.

R9-31-1620. Prohibitions Against Charges to Members

~~**A.** The IHS or a Tribal Facility or other provider of care or services shall not charge, submit a claim, demand, or otherwise collect payment from a member or a person acting on behalf of a member for any covered service except to collect an authorized copayment or payment for additional services. The Administration shall have the right to recover from a member that portion of payment made by a 3rd-party to a member when the payment duplicates Title XXI paid benefits and has not been assigned to the IHS or a Tribal Facility. The IHS or a Tribal Facility who makes a claim under this provision shall not charge more than the actual, reasonable cost of providing the covered services.~~

~~**B.** An IHS or a Tribal Facility provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from an individual claiming to be Title XXI eligible without 1st receiving verification from the Administration that the individual was ineligible for Title XXI on the date of service or that the services provided were not covered by Title XXI as specified in A.R.S. § 36-2989.~~

A. Except as provided in subsection (B), under A.R.S. § 36-2989, the IHS, a Tribal Facility, a TRBHA, or a provider under referral shall not bill or make any attempt to collect payment, directly or through a collection agency, from an individual

claiming to be Title XXI eligible without first receiving verification from the Administration that the individual was ineligible for Title XXI services on the date of service or that the services provided were not covered.

B. The IHS, a Tribal Facility, a TRBHA, or a provider under referral shall not charge, submit a claim, demand, or otherwise collect payment, directly or through a collection agency, from a member, or a person acting on behalf of a member, for any service except as described:
1. To collect an authorized copayment;
2. To pay for non-covered services;
3. To recover from a member that portion of payment made by a third party to the member when the payment duplicates Title XXI paid benefits and has not been assigned to a contractor. A contractor who makes a claim under this provision shall not charge more than the actual, reasonable cost of providing the covered service;
4. To bill a member for medical expenses incurred during a period of time when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's Title XXI eligibility or enrollment that caused payment to be reduced or denied.

R9-31-1621. Transfer of Payments

~~Payments permitted. Payments may be made to other than the IHS, a Tribal Facility, or a referral provider as follows:~~
~~1. Payment made in accordance with an assignment to a government agency or an assignment made according to a court order; or~~
~~2. Payment made to a business agent, such as a billing service or accounting firm, who renders statements and receives payment in the name of the IHS, a Tribal Facility, or a provider providing that an agent's compensation for this service is:~~
~~a. Reasonably related to the cost of processing the statements, and~~
~~b. Not dependent upon the actual collection of payment.~~

A. Business agent. For purposes of this Section a business agent is a firm such as a billing service or accounting firm who renders statements and receives payment in behalf of the contractor or AHCCCS registered provider.

B. Allowable transfer of payments. The Administration makes payments to other than the IHS, a Tribal Facility, a TRBHA, or a provider under referral as follows:
1. When there is an assignment to a government agency or there is an assignment under a court order; or
2. When a business agent, who renders statements and receives payment in the name the IHS, a Tribal Facility, a TRBHA, or a provider under referral and the agent's compensation for this service is:
   a. Reasonably related to the cost of processing the statements; and
   b. Not dependent upon the actual collection of payment.

R9-31-1623. ~~Copayments and Premiums~~ Repealed

~~**A.** The IHS or a Tribal Facility shall be responsible for collecting a $5.00 copayment from a member for non-emergency use of the emergency room.~~
~~**B.** The IHS or a Tribal Facility shall ensure that a member is not denied services because of a member's inability to pay a copayment.~~
~~**C.** The Administration shall establish standards for premiums as discussed in 9 A.A.C. 31, Article 14.~~

NOTICE OF PROPOSED RULEMAKING

TITLE 18. ENVIRONMENTAL QUALITY

CHAPTER 2. DEPARTMENT OF ENVIRONMENTAL QUALITY
AIR POLLUTION CONTROL

PREAMBLE

1. Sections Affected | **Rulemaking Action**

Sections Affected	Rulemaking Action
R18-2-715	Amend
R18-2-715.01	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, 49-425, and 49-426

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

Notice of Rulemaking Docket Opening: 8 A.A.R. 1111, March 15, 2002

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

Name: Mark Lewandowski

Address: ADEQ, 3033 North Central Avenue
Phoenix, AZ 85012-2809

Telephone: (602) 207-2230. If you are outside the (602) area code dial 1(800) 234-5677, and ask for the extension.

Fax: (602) 207-2366

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

Summary. The Arizona Department of Environmental Quality is proposing reductions in emission limits applicable to two copper smelters: one located in Hayden, Gila County, and one located in Miami, Gila County.

Because of measured exceedances of the national ambient air quality standards for sulfur dioxide (SO_2), both the Hayden and the Miami areas were designated nonattainment for SO_2 in 1979. The emissions limits contained in R18-2-715 were adopted in 1979 as a means of lowering stack emissions of SO_2 from the smelters. Because the rule will be a control measure for the air quality State Implementation and Maintenance Plans (SIPs) for the Hayden and Miami SO_2 nonattainment areas, updated air quality impact analyses were performed for both smelters. These analyses demonstrate future air quality protection based on current and expected future operation levels. The new limits proposed in R18-2-715 demonstrate that the smelters are not expected to cause or contribute to a violation of the national ambient air quality standards for SO_2.

For the Hayden smelter, the rule incorporates lower SO_2 stack emission limits and adds new limits for fugitive emissions. For the Miami smelter, the rule incorporates lower SO_2 stack emission limits and includes an overall combined limit for stack and fugitive sources. The proposed rule revisions for the Miami smelter correspond to limits already contained in the facility's permit. The new limits for both the Hayden and Miami smelters also require minor changes to the compliance and monitoring provisions in R18-2-715.01.

Additional amendments to R18-2-715 are proposed to update the rule to remove those sections with emissions limits for smelters that are no longer operating. The rule sections proposed for removal are: R18-2-715(F)(3) for the defunct copper smelter of ASARCO, Inc., Ray Mines Division in Hayden, Pinal County; R18-2-715(F)(5) for the defunct copper smelter of Phelps Dodge Corporation, New Cornelia Branch in Ajo, Pima County; and R18-2-715(F)(6) for the defunct copper smelter of Phelps Dodge Corporation, Morenci Branch in Morenci, Greenlee County.

6. 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 the state:

Not applicable

7. A reference to any study that the agency proposes to rely on 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

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

This rule is primarily a source-specific rulemaking pertaining to the smelter located in Hayden, Gila County, and the smelter located in Miami, Gila County. The Hayden smelter is currently owned and operated by ASARCO Incorporated. The Miami smelter is currently owned and operated by Phelps Dodge Corporation. The Hayden and Miami facilities are classified as major sources for sulfur dioxide and both areas are designated as nonattainment for sulfur dioxide. This rule incorporates lower emissions limits for sulfur dioxide applicable to both smelters.

Subsequent to codification of the rule in 1979, numerous improvements have been implemented at the smelters. ASARCO representatives indicated that over $123,000,000 was spent in upgrading and rebuilding the facility since 1983 for various reasons, including replacing outdated and worn out equipment and introducing more efficient technology. The changes include improved emissions collection systems and control technology, as well as implementation of an improved data collection, recordkeeping, and reporting infrastructure. Similar improvements at the Miami facility are reported by Phelps Dodge representatives to have cost more than $100,000,000.

The current rule revisions are not expected to result in significant additional costs to either smelter. As previously explained, expenditures for emissions collection and control technology have already been incurred and are not attributed to the current rulemaking. No additional labor needs will be generated by the rule. The new emission limits may, however, require updates of the existing data collection, recordkeeping, and reporting infrastructure. Representatives of the ASARCO smelter at Hayden report an estimated one-time expenditure of $5,000 to $10,000 for com-

puter software. Similar data collection and reporting upgrades at the Miami smelter are estimated by representatives of Phelps Dodge to also be a one-time expenditure, at a cost of $4,000 to $6,000.

The Arizona Department of Environmental Quality does not anticipate that the rule changes applicable to the closed smelters will have any substantive economic impact. In all cases, the local citizens may benefit because of lower social costs associated with improved air quality.

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, Economist, Rule Development Section

Address: ADEQ
3033 North Central Avenue
Phoenix, AZ 85012-2809

Telephone: (602) 207-2295 (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:

Oral Proceeding: April 23, 2002, 1:00 p.m.

Location: Miami Town Hall, Council Chambers, 500 Sullivan Street, Miami, AZ, 85539

and

Oral Proceeding: April 24, 2002, 1:00 p.m.

Location: Hayden Town Hall, Council Chambers, 520 Velasco Avenue, Hayden, AZ, 85235

(Please call 602-207-4795 for special accommodations pursuant to the Americans with Disabilities Act.)

Nature: Public hearing with opportunity for formal comments on the record regarding the proposed rule and the submittal of the rule to the Environmental Protection Agency as a revision to the State Implementation Plan.

Close of comment: 5:00 p.m., April 25, 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 rules:

None

13. The full text of the rule follows:

TITLE 18. ENVIRONMENTAL QUALITY

CHAPTER 2. DEPARTMENT OF ENVIRONMENTAL QUALITY AIR POLLUTION CONTROL

ARTICLE 7. EXISTING STATIONARY SOURCE PERFORMANCE STANDARDS

Section

R18-2-715. Standards of Performance for Existing Primary Copper Smelters; Site-specific Requirements
R18-2-715.01. Standards of Performance for Existing Primary Copper Smelters; Compliance and Monitoring

ARTICLE 7. EXISTING STATIONARY SOURCE PERFORMANCE STANDARDS

R18-2-715. Standards of Performance for Existing Primary Copper Smelters; Site-specific Requirements

A. No change
B. No change
C. No change
D. No change
E. No change

F. Except as provided in a consent decree or a delayed compliance order, the owner or operator of any primary copper smelter shall not discharge or cause the discharge of sulfur dioxide into the atmosphere from any stack required to be monitored by R18-2-715.01(K) in excess of the following:

1. For the copper smelter located near San Manuel, Arizona at latitude 32° 36' 58" N and longitude 110° 37' 19" W:
   a. Annual average emissions, as calculated under R18-2-715.01(C), shall not exceed 1,742 pounds per hour.
   b. The number of three-hour average emissions, as calculated under R18-2-715.01(C), shall not exceed n cumulative occurrences in excess of E, the emission level, shown in the following table in any compliance period as defined in R18-2-715.01(J):

n, Cumulative Occurrences	E, (lb/hr)
0	9803
1	8253
2	7619
4	6072
7	5660
12	4922
20	4515
32	4272
48	3945
68	3727
94	3568
130	3419
180	3253
245	3101
330	2958
435	2831
560	2712
710	2615
890	2525
1100	2440
1340	2366
1610	2290
1910	2216
2240	2142

2. For the copper smelter ~~of ASARCO Inc., Hayden~~ located near Hayden, Arizona at latitude 33° 0' 29" N and longitude 110° 47' 17" W:
   a. Annual average emissions, as calculated ~~pursuant to~~ under R18-2-715.01(C) ~~through (J)~~, shall not exceed ~~9,521~~ 7066 pounds per hour.
   b. The number of ~~3-hour~~ three-hour average emissions, as calculated ~~pursuant to~~ under R18-2-715.01(C) ~~through (J)~~, shall not exceed n cumulative occurrences in excess of E, the emission level, shown in the following table in any compliance period as defined in R18-2-715.01(J):

n, Cumulative Occurrences	E, (lb/hr)
0	~~38,000~~ 25300
1	~~36,000~~ 23585
2	~~34,000~~ 22285
4	~~32,000~~ 20830
7	~~30,500~~ 19834
12	~~28,800~~ 19177
20	~~27,300~~ 18079
32	~~26,000~~ 17407
48	~~25,000~~ 16752
68	~~23,800~~ 16130
94	~~22,700~~ 15458
130	~~21,500~~ 14803
180	~~20,500~~ 14129
245	~~19,300~~ 13540
330	~~18,500~~ 12987
435	~~17,500~~ 12438
560	~~16,700~~ 11919
710	~~16,000~~ 11457
890	~~15,000~~ 10934
1100	~~14,200~~ 10472
1340	~~13,500~~ 9999
1610	~~12,800~~ 9562
1910	~~12,200~~ 9185
2240	~~11,500~~ 8778

~~3. For the copper smelter of ASARCO, Inc., Ray Mines Division:~~
- ~~a. Annual average emissions, as calculated pursuant to R18-2-715.01(C) through (J), shall not exceed 7,790 pounds per hour.~~
- ~~b. The number of 3-hour average emissions, as calculated pursuant to R18-2-715.01(C) through (J), shall not exceed n cumulative occurrences in excess of E, the emission level, shown in the following table in any compliance period:~~

~~n~~	~~E, (lb/hr)~~
~~0~~	~~34,000~~
~~1~~	~~32,000~~
~~2~~	~~30,000~~
~~4~~	~~28,500~~
~~7~~	~~26,800~~

~~12~~	~~25,300~~
~~20~~	~~24,000~~
~~32~~	~~22,800~~
~~48~~	~~21,700~~
~~68~~	~~20,700~~
~~94~~	~~19,700~~
~~130~~	~~18,700~~
~~180~~	~~17,700~~
~~245~~	~~16,700~~
~~330~~	~~15,700~~
~~435~~	~~15,200~~
~~560~~	~~14,400~~
~~710~~	~~13,500~~
~~890~~	~~12,700~~
~~1100~~	~~12,000~~
~~1340~~	~~11,200~~
~~1610~~	~~10,500~~
~~1910~~	~~10,000~~
~~2240~~	~~9,500~~

~~4.~~3. For the copper smelter ~~of Cyprus Miami Mining Corporation, Miami~~ located near Miami, Arizona at latitude 33° 24' 50" N and longitude 110° 51' 25" W:

a. Annual average emissions, as calculated ~~pursuant to~~ under R18-2-715.01(C) ~~through (J)~~, shall not exceed ~~3,163~~ 604 pounds per hour.

b. The number of ~~3-hour~~ three-hour average emissions, as calculated ~~pursuant to~~ under R18-2-715.01(C) ~~through (J)~~, shall not exceed n cumulative occurrences in excess of E, the emission level, shown in the following table in any compliance period as defined in R18-2-715.01(J):

n, Cumulative Occurrences	E, (lb/hr)
0	~~16,900~~ 8678
1	~~15,800~~ 7158
2	~~14,750~~ 5903
4	~~13,900~~ 4575
7	~~13,100~~ 4074
12	~~12,250~~ 3479
20	~~11,500~~ 3017
32	~~10,800~~ 2573
48	~~10,250~~ 2111
68	~~9,750~~ 1703
94	~~9,250~~ 1461
130	~~8,700~~ 1274
180	~~8,200~~ 1145

245	~~7,600~~ 1064
330	~~7,200~~ 1015
435	~~6,750~~ 968
560	~~6,300~~ 933
710	~~5,800~~ 896
890	~~5,500~~ 862
1100	~~5,200~~ 828
1340	~~4,800~~ 797
1610	~~4,500~~ 765
1910	~~4,100~~ 739
2240	~~3,800~~ 712

~~5. For the copper smelter of Phelps Dodge Corporation, New Cornelia Branch:~~

~~a. Annual average emissions, as calculated pursuant to R18-2-715.01(C) through (J), shall not exceed 8,900 pounds per hour.~~

~~b. The number of 3-hour average emissions, as calculated pursuant to R18-2-715.01(C) through (J), shall not exceed n cumulative occurrences in excess of E, the emission level, shown in the following table in any compliance period:~~

~~n~~	~~E, (lb/hr)~~
~~0~~	~~37,000~~
~~1~~	~~35,000~~
~~2~~	~~32,500~~
~~4~~	~~31,000~~
~~7~~	~~29,000~~
~~12~~	~~27,500~~
~~20~~	~~26,000~~
~~32~~	~~25,000~~
~~48~~	~~23,500~~
~~68~~	~~22,500~~
~~94~~	~~21,500~~
~~130~~	~~20,500~~
~~180~~	~~19,500~~
~~245~~	~~18,500~~
~~330~~	~~17,500~~
~~435~~	~~17,000~~
~~560~~	~~16,000~~
~~710~~	~~15,000~~
~~890~~	~~14,250~~
~~1100~~	~~13,500~~
~~1340~~	~~12,500~~
~~1610~~	~~12,000~~
~~1910~~	~~11,000~~

~~2240~~	~~10,500~~

~~6. For the copper smelter of Phelps Dodge Corporation, Morenci Branch:~~

~~a. Annual average emissions, as calculated pursuant to R18-2-715.01(C) through (J), shall not exceed 10,505 pounds per hour.~~

~~b. The number of 3-hour average emissions, as calculated pursuant to R18-2-715.01(C) through (J), shall not exceed n cumulative occurrences in excess of E, the emissions level, shown in the following table in any compliance period:~~

~~n~~	~~E, (lb/hr)~~
~~0~~	~~43,500~~
~~1~~	~~41,000~~
~~2~~	~~38,200~~
~~4~~	~~36,200~~
~~7~~	~~34,500~~
~~12~~	~~32,500~~
~~20~~	~~30,500~~
~~32~~	~~29,500~~
~~48~~	~~28,000~~
~~68~~	~~27,000~~
~~94~~	~~26,000~~
~~130~~	~~24,500~~
~~180~~	~~23,000~~
~~245~~	~~22,000~~
~~330~~	~~21,000~~
~~435~~	~~19,500~~
~~560~~	~~18,500~~
~~710~~	~~17,500~~
~~890~~	~~16,500~~
~~1100~~	~~15,500~~
~~1340~~	~~15,000~~
~~1610~~	~~14,000~~
~~1910~~	~~13,000~~
~~2240~~	~~12,000~~

G. Except as provided in a consent decree or a delayed compliance order, the owner or operator of the copper ~~smelter located near San Manuel, Arizona at latitude 32° 36' 58" N and longitude 110° 37' 19" W~~ smelters listed below shall not discharge or cause the discharge of fugitive sulfur dioxide into the atmosphere in excess of the following:

1. For the copper smelter located near San Manuel, Arizona at latitude 32° 36' 58" N and longitude 110° 37' 19" W:

~~1.~~a. Annual average emissions calculated under R18-2-715.01(R) shall not exceed 715 pounds per hour for converter roof fugitive emissions; and

~~2.~~b. The number of three-hour average emissions for converter roof fugitive emissions, calculated under R18-2-715.01(R) shall not exceed n cumulative occurrences in excess of E_f, the emission level, shown in the following table in any compliance period as defined in R18-2-715.01~~(J)~~(R)(8):

n, Cumulative Occurrences	E_f, (lb/hr)
0	4462
1	4299
2	4222
4	4017
7	3867
12	3460
20	3179
32	3000
48	2827
68	2649
94	2523
130	2361
180	2218
245	2072
330	1923
435	1785
560	1644
710	1517
890	1402
1100	1300
1340	1208
1610	1121
1910	1039
2240	957

2. For the copper smelter located near Hayden, Arizona at latitude 33° 0' 29"N and longitude 110° 47' 17"W, annual average fugitive emissions calculated under R18-2-715.01(T) shall not exceed 582 pounds per hour.

H. In addition to the limits in subsection (F)(3), except as provided in a consent decree or a delayed compliance order, the owner or operator of the copper smelter located near Miami, Arizona at latitude 33° 24' 50" N and longitude 110° 51' 25" W shall not discharge or cause the discharge of sulfur dioxide into the atmosphere from combined stack and fugitive emissions units in excess of the 2420 pounds per hour annual average calculated under R18-2-715.01(U).

R18-2-715.01. Standards of Performance for Existing Primary Copper Smelters; Compliance and Monitoring

A. The cumulative occurrence and emission limits in R18-2-715(F) apply to the total of sulfur dioxide emissions from the smelter processing units and sulfur dioxide control and removal equipment, but not uncaptured fugitive emissions ~~and~~ or emissions due solely to the use of fuel for space heating or steam generation.

B. The owner or operator shall include periods of malfunction, startup, shutdown or other upset conditions when determining compliance with the cumulative occurrence or annual average emission limits in R18-2-715(F), ~~or~~ (G), or (H).

C. The owner or operator shall determine compliance with the cumulative occurrence and emission limits contained in R18-2-715(F) as follows:

1. The owner or operator shall calculate annual average emissions at the end of each day by averaging the emissions for all hours measured during the compliance period defined in subsection (J) ending on that day. An annual emissions average in excess of the allowable annual average emission limit is a violation of R18-2-715(F) if either:

a. The annual average is greater than the annual average computed for the preceding day; or
b. The annual averages computed for the five preceding days all exceed the allowable annual average emission limit~~; and~~ .

2. The owner or operator shall calculate a three-hour emissions average at the end of each clock hour by averaging the hourly emissions for the preceding three consecutive hours provided each hour was measured according to the requirements in subsection (K).

D. For purposes of this Section, the compliance date, unless otherwise provided in a consent decree or a delayed compliance order, shall be January 14, 1986, except that:
1. ~~the~~ The compliance date for the cumulative occurrence and emissions limits in R18-2-715(F)(1) and R18-2-715(G)(1) ~~and (2)~~ is January 15, 2002~~.~~, and
2. The compliance date for the cumulative occurrence and emissions limits in R18-2-715(F)(2), (F)(3), (G)(2), and (H) is the effective date of this rule.

E. For purposes of subsection (C), a three-hour emissions average in excess of an emission level E violates the associated cumulative occurrence limit n listed in R18-2-715(F) if:
1. The number of all three-hour emissions averages calculated during the compliance period in excess of that emission level exceeds the cumulative occurrence limit associated with the emission level; and
2. The average is calculated during the last operating day of the compliance period being reported.

F. A three-hour emissions average only violates the cumulative occurrence limit n of an emission level E on the day containing the last hour in the average.

G. Multiple violations of the same cumulative occurrence limit on the same day and violations of different cumulative occurrence limits on the same day constitute a single violation of R18-2-715(F).

H. The violation of any cumulative occurrence limit and an annual average emission limit on the same day constitutes only a single violation of the requirements of R18-2-715(F).

I. Multiple violations of a cumulative occurrence limit by different three-hour emissions averages containing any common hour constitutes a single violation of R18-2-715(F).

J. To determine compliance with subsections (C) through (I), the compliance period consists of the 365 calendar days immediately preceding the end of each day of the month being reported unless that period includes less than 300 operating days, in which case the number of days preceding the last day of the compliance period shall be increased until the compliance period contains 300 operating days. For purposes of this Section, an operating day is any day on which sulfur-containing feed is introduced into the smelting process.

K. To determine compliance with R18-2-715(F) or (H), the owner or operator of any smelter subject to R18-2-715(F) or (H) shall install, calibrate, maintain, and operate a measurement system for continuously monitoring sulfur dioxide concentrations and stack gas volumetric flow rates in each stack that could emit five percent or more of the allowable annual average sulfur dioxide emissions from the smelter.
1. The owner or operator shall continuously monitor sulfur dioxide concentrations and stack gas volumetric flow rates in the outlet of each piece of sulfur dioxide control equipment.
2. The owner or operator shall continuously monitor captured fugitive emissions for sulfur dioxide concentrations and stack gas volumetric flow rates and include these emissions as part of total plant emissions when determining compliance with the cumulative occurrence and emission limits in R18-2-715(F) and (H).
3. If the owner or operator demonstrates to the Director that measurement of stack gas volumetric flow in the outlet of any particular piece of sulfur dioxide control equipment would yield inaccurate results once operational or would be technologically infeasible, then the Director may allow measurement of the flow rate at an alternative sampling point.
4. For purposes of this subsection, continuous monitoring means the taking and recording of at least one measurement of sulfur dioxide concentration and stack gas flow rate reading from the effluent of each affected stack, outlet, or other approved measurement location in each 15-minute period. Fifteen-minute periods start at the beginning of each clock hour, and run consecutively. An hour of smelter emissions is considered continuously monitored if the emissions from all monitored stacks, outlets, or other approved measurement locations are measured for at least 45 minutes of any hour according to the requirements of this subsection.
5. The owner or operator shall demonstrate that the continuous monitoring system meets all of the following requirements:
   a. The sulfur dioxide continuous emission monitoring system installed and operated under this Section meets the requirements of 40 CFR 60, Appendix B, Performance Specification 6.
   b. The sulfur dioxide continuous emission monitoring system installed and operated under this Section meets the quality assurance requirements of 40 CFR 60, Appendix F.
   c. The owner or operator shall notify the Director in writing at least 30 days in advance of the start of ~~quality assurance~~ relative accuracy test audit (RATA) procedures performed on the continuous monitoring system.
   d. The Director shall approve the location of all sampling points for monitoring sulfur dioxide concentrations and stack gas volumetric flow rates in writing before installation and operation of measurement instruments.

e. The measurement system installed and used under this subsection is subject to the manufacturer's recommended zero adjustment and calibration procedures at least once per 24-hour operating period unless the manufacturer specifies or recommends calibration at shorter intervals, in which case specifications or recommendations shall be followed. The owner or operator shall make available a record of these procedures that clearly shows instrument readings before and after zero adjustment and calibration.

L. The owner or operator of a smelter subject to this Section shall measure at least 95 percent of the hours during which emissions occurred in any month.

M. ~~The~~ Failure of the owner or operator of a smelter subject to this Section ~~shall~~ to measure any 12 consecutive hours of emissions according to the requirements of subsection (K) or (S) is a violation of this Section.

N. The owner or operator of any smelter subject to this Section shall maintain on hand and ready for immediate installation sufficient spare parts or duplicate systems for the continuous monitoring equipment required by this Section to allow for the replacement within six hours of any monitoring equipment part that fails or malfunctions during operation.

O. To determine total overall emissions, the owner or operator of any smelter subject to this Section shall perform material balances for sulfur according to the procedures prescribed by Appendix 8 of this Chapter.

P. The owner or operator of any smelter subject to this Section shall maintain a record of all average hourly emissions measurements and all calculated average monthly emissions required by this Section. The record of the emissions shall be retained for at least five years following the date of measurement or calculation. The owner or operator shall record the measurement or calculation results as pounds per hour of sulfur dioxide. The owner or operator shall summarize the following data monthly and submit ~~them~~ the summary to the Director within 20 days after the end of each month:

1. For all periods described in subsection (C) and (R), the annual average emissions as calculated at the end of each day of the month;
2. The total number of hourly periods during the month in which measurements were not taken and the reason for loss of measurement for each period;
3. The number of three-hour emissions averages that exceeded each of the applicable emissions levels listed in R18-2-715(F) and (G)(1)(b) for the compliance periods ending on each day of the month being reported;
4. The date on which a cumulative occurrence limit listed in R18-2-715(F) or (G)(1)(b) was exceeded if the exceedance occurred during the month being reported~~.~~ ; and
5. For all periods described in subsections (T) and (U), the annual average emissions as calculated at the end of the last day of each month.

Q. An owner or operator shall install instrumentation to monitor each point in the smelter facility where a means exists to bypass the sulfur removal equipment, to detect and record all periods that the bypass is in operation. An owner or operator of a copper smelter shall report to the Director, not later than the 15th day of each month, the recorded information required by this Section, including an explanation for the necessity of the use of the bypass.

R. The owner or operator shall determine compliance with the cumulative occurrence and fugitive emission limits contained in R18-2-715(G)(1) ~~and (2)~~ as follows:

1. The owner or operator shall calculate annual average emissions at the end of each day by averaging the emissions for all hours measured during the compliance period, as defined in subsection (R)(8), ending on that day. An annual emissions average in excess of the allowable annual average emission limit is a violation of R18-2-715(G)(1)(a) if either:
   a. The annual average is greater than the annual average computed for the preceding day; or
   b. The annual averages computed for the five preceding days all exceed the allowable annual average emission limit.
2. The owner or operator shall calculate a three-hour emissions average at the end of each clock hour by averaging the hourly emissions for the preceding three consecutive hours provided each hour was measured according to the requirements contained in subsection (S).
3. For purposes of subsection (R)(2), a three-hour emissions average in excess of an emission level E_f violates the associated cumulative occurrence limit n listed in R18-2-715(G)~~(2)~~(1)(b) if:
   a. The number of all three-hour emissions averages calculated during the compliance period in excess of that emission level exceeds the cumulative occurrence limit associated with the emission level; and
   b. The average is calculated during the last operating day of the compliance period being reported.
4. A three-hour emissions average only violates the cumulative occurrence limit n of an emission level E_f on the day containing the last hour in the average.
5. Multiple violations of the same cumulative occurrence limit on the same day and violations of different cumulative occurrence limits on the same day constitute a single violation of R18-2-715(G)~~(2)~~ (1)(b).
6. The violation of any cumulative occurrence limit and an annual average emission limit on the same day constitutes only a single violation of the requirements of R18-2-715(G)(1).
7. Multiple violations of a cumulative occurrence limit by different three-hour emissions averages containing any common hour constitutes a single violation of R18-2-715(G)~~(2)~~(1)(b).

8. To determine compliance with subsections (R)(1) through (R)(7), the compliance period consists of the 365 calendar days immediately preceding the end of each day of the month being reported unless that period includes less than 300 operating days, in which case the number of days preceding the last day of the compliance period shall be increased until the compliance period contains 300 operating days. For purposes of this Section, an operating day is any day on which sulfur-containing feed is introduced into the smelting process.

S. To determine compliance with R18-2-715(G)(1) ~~and (2)~~, the owner or operator of ~~any~~ the smelter subject to R18-2-715(G)(1) ~~and (2)~~ shall install, calibrate, maintain, and operate a measurement system for continuously monitoring sulfur dioxide concentrations of the converter roof fugitive emissions.

1. For purposes of this subsection, continuous monitoring means the taking and recording of at least one measurement of sulfur dioxide concentration from an approved measurement location in each 15-minute period. Fifteen-minute periods start at the beginning of each clock hour, and run consecutively. An hour of smelter emissions is considered continuously monitored if the emissions from all approved measurement locations are measured for at least 45 minutes of any hour according to the requirements of this subsection.
2. The owner or operator of a smelter subject to the requirements of this subsection shall conduct quality assurance procedures on the continuous monitoring system according to the methods in 40 CFR 60, Appendix F, except that an annual relative accuracy test audit (RATA) is not required.

T. The emission limit in R18-2-715(G)(2) applies to the total of uncaptured fugitive sulfur dioxide emissions from the smelter processing units and sulfur dioxide control and removal equipment, but not emissions due solely to the use of fuel for space heating or steam generation. The owner or operator shall determine compliance with the emission limit contained in R18-2-715(G)(2) as follows:

1. The owner or operator shall calculate annual average fugitive emissions at the end of the last day of each month by averaging the monthly emissions for the previous 12-month period ending on that day. As a means of determining monthly fugitive emissions, the owner or operator shall perform material balances for sulfur according to the sulfur balance procedures prescribed in Appendix 8 of this Chapter.
2. An annual emissions average in excess of the allowable annual average emission limit is a violation of R18-2-715(G)(2) if the fugitive annual average computed at the end of each month exceeds the allowable annual average emission limit.

U. The emission limit in R18-2-715(H) applies to the total of stack and uncaptured fugitive sulfur dioxide emissions from the smelter processing units and sulfur dioxide control and removal equipment, but not emissions due solely to the use of fuel for space heating or steam generation. The owner or operator shall determine compliance with the emission limit contained in R18-2-715(H) as follows:

1. The owner or operator shall calculate annual average stack emissions at the end of the last day of each month by averaging the emissions for all hours measured during the previous 12-month period ending on that day according to the requirements contained in subsection (K).
2. The owner or operator shall calculate annual average fugitive emissions at the end of the last day of each month by averaging the monthly emissions for the previous 12-month period ending on that day. As a means of determining monthly fugitive emissions, the owner or operator shall perform material balances for sulfur according to the sulfur balance procedures prescribed in Appendix 8 of this Chapter.
3. An annual emissions average in excess of the allowable annual average emission limit is a violation of R18-2-715(H) if the total of the stack and fugitive annual averages computed at the end of each month exceeds the allowable annual average emission limit.