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 9. DEPARTMENT OF AGRICULTURE
AGRICULTURAL COUNCILS AND COMMISSIONS

[R05-41]

PREAMBLE

1. Sections Affected **Rulemaking Action**

R3-9-506 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. § 3-468

Implementing statute: A.R.S. § 3-468.02(C)(9)

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 1166, March 26, 2004

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

Name: Rebecca Nichols, Rules Analyst

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

Telephone: (602) 542-0962

Fax: (602) 542-5420

E-mail: rnichols@azda.gov

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

This rulemaking codifies the process under which the Arizona Citrus Research Council (ACRC) will conduct grant-making. This ACRC received an exemption from Chapter 24 of the A.R.S. that applies to the solicitation of grants statute. A.R.S. § 41-2701 et seq.

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

None

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

Not applicable

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

A. *The Arizona Citrus Research Council and the Arizona Department of Agriculture*.

The ACRC and the Department will incur modest expenses related to educating the regulated community on the new Sections.

B. *Political Subdivision*.

Other than the ACRC and the Department, the Office of Administrative Hearings may be affected by this rulemaking if a hearing is requested.

C. *Businesses Directly Affected By the Rulemaking*.

Citrus producers, grower-shippers, handlers, researchers and universities are the beneficiaries of Grants programs developed by the ACRC.

The regulated community the ACRC serves, as well as the ACRC itself, will be beneficially affected by the use of this Grant rule.

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:	Rebecca Nichols, Rules Analyst
Address:	Arizona Department of Agriculture 1688 W. Adams, Room 235 Phoenix, AZ 85007
Telephone:	(602) 542-0962
Fax:	(602) 542-5420
E-mail:	rnichols@azda.gov

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

An oral proceeding is not scheduled for these proposed rules. To request an oral proceeding or to submit comments, please contact the rules analyst listed in item #4 between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday, except legal holidays. If a request for an oral proceeding is not made, the public record for this rulemaking will close April 21, 2005.

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 9. DEPARTMENT OF AGRICULTURE AGRICULTURAL COUNCILS AND COMMISSIONS

ARTICLE 5. ARIZONA CITRUS RESEARCH COUNCIL

Section
R3-9-506. Grants

ARTICLE 5. ARIZONA CITRUS RESEARCH COUNCIL

R3-9-506. Grants

In addition to the definitions in A.R.S. § 3-527, the following terms apply to this Article:

A. Definitions

1. "ACRC" means the Arizona Citrus Research Council.
2. "Applicant" includes an individual, firm, association, partnership, trust or corporation who applies for a grant under this rule.
3. "Grant" means an award of financial support to an applicant for research in accordance with A.R.S. § 3-468.02 (B) and (C)(5).
4. "Authorized signature" means the signature of an individual authorized to receive funds on behalf of the applicant and the person who becomes responsible for the execution of the proposed project responsibilities.
5. "Awardee" means a successful applicant who has been awarded grant funds for research on a specific project.
6. "Grant award agreement" means a document advising the applicant of the amount of money to be awarded following receipt by the ACRC of a signed acceptance by the applicant.

B. Grant Application Process

1. The ACRC shall award any grant in accordance with the competitive grant solicitation requirements of this Article.
2. Public notice of the request for grant applications shall be listed in the Grant Application Manual, which will be available upon request at the Arizona Department of Agriculture at least four weeks prior to the due date for submittal of the applications. In addition, a notice will be posted to the ACRC's web page at that time.
3. Grant Application Manuals shall include the following information:
   a. The statutory provisions for ACRC research A.R.S. § 3-468.02(B) and (C)(5) includes: Research, development and survey programs concerning varietal development; Programs for citrus pest eradication; Programs concerning production, harvesting, handling and hauling from field to market; Any other programs, excluding sales or marketing, that the ACRC deems to be appropriate for the purposes of A.R.S. § 3-468 et seq.; Finance appropriate studies conducted by research agencies or to purchase or acquire equipment and facilities consistent with A.R.S. § 3-468 et seq.
   b. That information contained in an application shall not be confidential.
   c. That the source of funding is primarily from per carton assessments on citrus grown in Arizona.
   d. A sample application form including sections about the description of the grant project, scope of work to be performed by an awardee, an authorized signature line, and a sample budget form.
   e. The criteria by which applications shall be evaluated for award.
   f. The due date and time for submittal of applications and the anticipated date the awards shall be made.
   g. That an application shall be received (and not merely postmarked), by the date and time the applications are due; late applications received by the ACRC shall be returned without review.
   h. A copy of the ACRC grant solicitation rules.
4. In addition to the information required in the Grant Application Manuals listed in Section three above, the ACRC shall have the authority to include the following in the Grant Application Manuals:
   a. The budget for the proposed project shall not include overhead expenses.
   b. Upon acceptance of the ACRC grant, the awardee shall execute a grant award agreement indicating the awardee's intention to complete the proposed tasks and authorizing the ACRC to monitor the progress of the project.
   c. Upon execution of the grant award agreement and an invoice, the ACRC shall pay no more than 50% of the grant in the initial payment.
   d. Awardees shall be required to present an invoice and final research report to the ACRC prior to full payment of the grant.
   e. Research findings and reports resulting from grants awarded by the ACRC shall be made available to Arizona citrus producers through the ACRC.
   f. Any additional information approved by the ACRC.

C. Criteria. The following criteria shall be used by the ACRC for reviewing grant applications and awarding the ACRC funds.
1. The completion and sufficiency of prior research projects by the applicant.
2. The extent to which the proposed project identifies solutions to production issues currently facing the citrus industry. The ACRC shall have the authority to take into account any industry survey conducted within the previous year.
3. The extent to which the proposed project addresses future threats facing the citrus industry.
4. The appropriateness of the budget request in obtaining the project objectives.
5. The appropriateness of the proposal time-frame to the stated project objectives.
6. The qualifications of the applicant.

D. No Confidentiality
1. In order to solicit and consider public comment on the grant applications, information contained in an application shall not be confidential.
2. All applications shall be open for public inspection the next business day after the due date.
3. Prior to the awarding of grants, ACRC members may discuss grant applications or proposed projects with applicants, citrus producers, members of the public or any other person as long as the discussion does not violate open meeting laws in accordance with A.R.S. § 38-431 et seq.

E. Evaluation of Grant Applications
1. The ACRC shall evaluate any grant application at a public meeting in accordance with open meeting laws under A.R.S. § 38-431 et seq.
2. Any ACRC member who has a potential personal financial interest with the award of any grant money shall disclose that interest in the official records of the ACRC and refrain from participating in the award decision. A personal financial interest exists if it is reasonably foreseeable that the award shall have a material financial benefit or detriment either directly or indirectly on the ACRC member, except that no personal financial interest exists if the ACRC member is a member of a class of persons and it reasonably appears that a majority of the total membership of that class shall be affected by the award.
3. The ACRC may allow applicants to make oral or written presentations at the public meeting. The ACRC may require

an applicant to revise the applicant's application to reflect information provided in an oral or written presentation.
4. Public comment on the grant applications may be received by the ACRC at the public meeting.
5. The approved minutes of the meeting shall serve as a written record of the decision on each application.
6. An award may include the ACRC's decision to fund or modify the project budget.
7. All applicants shall be notified in writing of the ACRC's decision to fund, modify or reject the proposed project within ten business days of the ACRC decision. Written notification shall be accomplished by either the US Postal Service, commercial delivery, electronic mail or facsimile.

F. Awards and Project Monitoring
1. Upon acceptance of the ACRC grant and prior to the release of grant funds, an awardee shall execute a grant award agreement with the ACRC indicating the awardee's intention to accept the grant's legal requirements and grant conditions, complete the proposed tasks and authorize the ACRC to monitor the progress of the project.
2. Awards shall not include the funding for overhead expenses.
3. Upon execution of the grant award agreement between the awardee and the ACRC and an invoice to the ACRC, no more than 50% of the grant shall be provided in the initial payment to the awardee.
4. During the term of the project, an awardee shall inform the ACRC of changes to any of the awardee's address, telephone number or other contact information.
5. The ACRC shall have the authority to require an interim written report or oral presentation prior to completion of the project.
6. Awardees shall be required to present a final research report and invoice to the ACRC prior to full payment of the grant.
7. Research findings and reports resulting from any grant awarded by the ACRC shall be made available to Arizona citrus producers through the ACRC.

G. Repayment. All unexpended funds shall be returned to the ACRC upon completion of the project. In the event the project is not completed, unexpended funds shall be returned within 30 days after receipt of the ACRC's written request.

NOTICE OF PROPOSED RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 8. ACUPUNCTURE BOARD OF EXAMINERS

[R05-52]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R4-8-101	Amend
R4-8-105	Amend
R4-8-303	Amend
R4-8-304	Amend
R4-8-307	Amend
R4-8-311	New Section
R4-8-312	New Section
R4-8-401	Amend
R4-8-402	Amend

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

Authorizing statute: A.R.S. § 32-3903 (A)(1)

Implementing statute: A.R.S. § 32-3903 (A)(6)

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

Notice of Rulemaking Docket Opening: 11 A.A.R. 411, January 14, 2005

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

Name: Allen Imig, Executive Director

Address: 1400 W. Washington, Suite 230
Phoenix, AZ 85007

Telephone: (602) 542-3095

Fax: (602) 542-3093

5. An explanation of the rule, including the Agency's reasons for initiating the rule:
This rulemaking will establish guidelines for Preceptorship training pursuant to A.R.S. § 32-3903 (A)(6).

6. A reference to any study relevant to the rules that the agency reviewed and either proposes to rely on or not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, any analysis of each 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 economic impact to other state agencies will be minor and limited mainly to the processing of this rule package and publications. The economic impact is minor for the agency. The applicant will incur some economic impact in the form of copy expense to document program qualifications for Board approval. The public will not experience an economic impact.

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:	Allen Imig, Executive Director
Address:	1400 W. Washington, Suite 230 Phoenix, AZ 85007
Telephone:	(602) 542-3095
Fax:	(602) 542-3093

10. The time, place and nature of the proceedings for adoption, amendment, or repeal of the rule or, if no proceeding is scheduled when, where, or how persons may request an oral proceeding on the proposed rule:
Written comment will be accepted at the Board office, 1400 W. Washington, Suite 230, Phoenix, AZ 85007 on a business day between the hours of 8:00 a.m. and 5:00 p.m. until 5:00 p.m. on March 28, 2005. An oral proceeding is not scheduled but may be requested.

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. Incorporation by reference and their location in the rules:
Not applicable

13. The full text of the rules as follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 8. ACUPUNCTURE BOARD OF EXAMINERS

ARTICLE 1. GENERAL PROVISIONS

Section
R4-8-101. Definitions
R4-8-102. Certification of Documentation; Translation; Verification
R4-8-103. Filing of Address and Telephone Number
R4-8-104. Board Meetings
R4-8-105. Time-frames for Licensure, Certification, and Approvals
Table 1. Time-frames (in days)
R4-8-106. Completion of Applications; Nonrefundable Fees

ARTICLE 3. TRAINING PROGRAMS AND CONTINUING EDUCATION

Section
R4-8-301. Auricular Acupuncture Training Program Approval
R4-8-302. Clean Needle Technique Course Approval
R4-8-303. Approval of Program of Acupuncture; Clinical Training; Preceptorship Training

ARTICLE 4. REGULATORY PROVISIONS

ARTICLE 1. GENERAL PROVISIONS

R4-8-101. Definitions

For purposes of this Chapter:

1. "ACAOM" means the Accreditation Commission for Acupuncture and Oriental Medicine.
2. "Acupuncturist" means a person licensed or certified by the Board to practice acupuncture in this state ~~the State of Arizona~~.
3. "Administrative completeness review" means the Board's process for determining that a person has provided all of the information and documents required by this Chapter for an application.
4. "Applicant" means a person requesting a certificate or license from the Board.
5. "Application packet" means the fees, forms, documents, and additional information the Board requires to be submitted by an applicant or on an applicant's behalf.
6. "Clean needle technique" means a manner of needle sterilization and use that avoids the spread of disease and infection, protects the public and the patient, and complies with state and federal law~~, regulation, and rule~~.
7. "Course" means a systematic learning experience, at least 1 hour in length, that assists a participant to acquire knowledge, skills, and information relevant to the practice of acupuncture.
8. "Day" means calendar day.
9. "Hour" means at least 50 minutes of course participation.
10. "NADA" means the National Acupuncture Detoxification Association.
11. "NCCAOM" means the National Commission for the Certification of Acupuncture and Oriental Medicine.
12. "Successful completion of a clean needle technique course" means a course participant has:
    a. Attended the course, and
    b. Received a passing score on an examination or other confirmation from the course provider that evidences that the participant mastered the course content.
13. "Supervisor" means an acupuncturist licensed by the Board who is responsible for the oversight and direction of an acupuncture student.
14. "Clinical hours" means actual clock hours that a student spends providing patient care under a Board-approved supervisor.
15. "Preceptorship training" is a program that a student completes under a Board-approved supervisor who assumes the responsibility for the didactic and clinical training of a student.
16. "Program of acupuncture" means a Board-approved method of training designed to prepare a student for the NCCAOM exam and licensure.
17. "Acupuncture student" means a person enrolled in a program of acupuncture or a preceptorship training program.

R4-8-105. Time-frames for Licensure, Certification, and Approval

A. The overall time-frame described in A.R.S. § 41-1072(2) for each type of license, certificate, and approval granted by the Board is listed in Table 1. An applicant and the Executive Director of the Board may agree in writing to extend the overall time-frame. The overall time-frame and the substantive time-frame may not be extended by more than 25% of the overall time-frame.

B. The administrative completeness review time-frame begins:

~~1. For approval or denial of an acupuncture license by grandfathered rights, when the Board receives an application packet;~~

~~2~~1. For approval or denial of an application for licensure or other certification, when the Board receives an application packet; and

~~3~~2. For approval or denial of an application for approval of a training program, clean needle course, or continuing education course, when the Board receives a request for approval.

C. If a time-frame's last day falls on a Saturday, Sunday or official state holiday, the next business day is the time-frame's last day.

Table 1. Time-frames (in days)

Type of Applicant	Type of Approval	Statutory Authority	Overall Time-frame	Administrative Completeness Time-frame	Substantive Review Time-frame
~~Acupuncture License by Grandfathered Rights~~	~~Approval for Licensure~~	~~Laws 1998, Ch. 239, § 3~~	~~60~~	~~20~~	~~40~~
Acupuncture License	Approval for Licensure	A.R.S. § 32-3924	60	20	40
Visiting Professor Certificate	Approval for Certification	A.R.S. § 32-3926	60	20	40
Auricular Acupuncture Certificate	Approval for Certification	A.R.S. § 32-3922	60	20	40
Auricular Acupuncture Training Program	Approval of training program	A.R.S. § 32-3922	60	20	40
Program of Acupuncture	Approval of training program	A.R.S. § 32-3924(2)	60	20	40
Clinical Training Program	Approval of training program	A.R.S. § 32-3924(2)	60	20	40
Clean Needle Technique Course	Approval of course	A.R.S. § 32-3924	60	20	40
Continuing education program	Approval for Continuing Education	A.R.S. § 32- 3925	90	40	50
Exemption from continuing education	Approval of exemption	A.R.S. § 32-3925	30	10	20
License or certificate renewal	Approval of renewal	A.R.S. § 32-3925	60	20	40
License or certificate reinstatement	Approval of reinstatement of license	A.R.S. § 32-3925(D)	60	20	40
Preceptorship training program	Preceptorship training program	A.R.S. § 32-3903(6)	60	20	40

ARTICLE 3. TRAINING PROGRAMS AND CONTINUING EDUCATION

R4-8-303. Approval of Program of Acupuncture; Clinical Training; Preceptorship Training

A. To obtain approval from the Board, an acupuncture program shall either:
1. Submit documentation that the acupuncture program is a candidate for accreditation or has accreditation through the ACAOM and provides a minimum of 1850 hours of training, including not less than 800 hours of clinical training; or
2. Submit documentation of compliance with R4-8-304.

B. To obtain approval from the Board, an acupuncture clinical training program shall either:
1. Submit documentation that the clinical training program is part of an acupuncture program that is a candidate for accreditation or has accreditation through the ACAOM, or is itself a candidate for accreditation or has accreditation through ACAOM; or
2. Submit documentation of compliance with R4-8-304(B).

C. To obtain approval from the Board, a preceptorship training program shall submit documentation of compliance with R4-8-311.

R4-8-304. Program of Acupuncture Standards

A. The Board shall approve a program of acupuncture that does not meet the standard at R4-8-303(A)(1) only if the program is for a minimum of ~~3~~ three years and provides the following course content and hours:
1. 690 hours in Oriental medical theory, diagnosis, and treatment techniques in acupuncture and related studies;
2. 800 hours in clinical training; and

3. 360 hours in biomedical clinical sciences.

B. The Board shall approve an acupuncture clinical training program that does not meet the standard of R4-8-303(B)(1) only if the clinical training program owns and operates an acupuncture clinic, provides at least 75% of clinical instruction in its clinic, and provides direct patient contact in the following:
1. Supervised observation of the clinical practice of acupuncture with case presentations and discussions;
2. Application of Eastern and Western diagnostic procedures in evaluating patients; and
3. Clinical treatment of a patient with acupuncture.

C. To be approved by the Board, an acupuncture program shall comply with the 14 Essential Requirements and their attendant criteria in the "Accreditation Handbook", January 1998 Update, pages 9 through 41, published by the Accreditation Commission for Acupuncture and Oriental Medicine, 1010 Wayne Avenue, Suite 1270, Silver Spring, MD 20910, which is incorporated by reference and on file with the Board and the Secretary of State. This incorporation includes no later edition or amendment.

R4-8-307. Acupuncture Program Monitoring; Records; Reporting

A. Every approved acupuncture program shall submit to the Board, within 60 days after the close of the program's fiscal year, a letter attesting that the program continues to meet the standards of R4-8-303 and R4-8-304, and a course catalog that includes:
1. Course descriptions of the next years' proposed curriculum;
2. The program faculty, administration, or governing body; and
3. A description of the program facility.

B. Representatives of the Board may conduct an onsite visit of an approved program to review and evaluate the status of the program. The approved program shall reimburse the Board for direct costs incurred in conducting this review and evaluation.

C. All student records shall be maintained in English.

D. Each approved program of acupuncture shall, within 30 days, report to the Board any failure to comply with R4-8-303 and R4-8-304.

E. Every approved preceptorship training program shall submit annually, a letter attesting that the training program continues to meet the standards of R4-8-311.

R4-8-311. Preceptorship Training Standards

A. The Board shall approve a preceptorship training program that meets the following criteria:
1. The preceptorship training program shall have a minimum of 4,000 hours in no fewer than three and no more than six consecutive years.
2. The clinical training shall have a minimum of 1,950 clinical hours that includes:
   a. Clinical observation;
   b. History and physical examination;
   c. Therapeutic diagnosis and treatment planning;
   d. Preparation of the patient;
   e. Sterilization, use, and maintenance of equipment;
   f. Moxibustion;
   g. Electro acupuncture (AC and DC voltages);
   h. Acupuncture techniques, auricular acupuncture, acupressure, Tui Na, and other forms of Oriental bodywork;
   i. Treatment of emergencies, including cardiopulmonary resuscitation;
   j. Pre-treatment and post-treatment instruction to the patient;
   k. Contraindications, precautions and clean needle technique; and
   l. Practice management and ethics.
3. The didactic training shall have a minimum of 1,050 hours that includes:
   a. Traditional Oriental medicine;
   b. Acupuncture, Tui Na, Oriental bodywork, and clinical training techniques;
   c. Traditional Oriental exercise, including Qi Gong and Tai Chi;
   d. Western sciences, which may be obtained at a college or university accredited by the U.S. Department of Education, including:
      i. Anatomy;
      ii. Physiology;
      iii. Pathology and pathophysiology;
      iv. Survey of western clinical medicine and sciences;
      v. Psychology and counseling;
      vi. Nutrition;
      vii. General sciences (biology, chemistry and physics);

viii. Medical terminology;
ix. First aid and cardiopulmonary resuscitation.

4. The Preceptorship training program shall not enroll more than two students per approved supervisor.
5. The Preceptorship training program shall only enroll students who:
   a. Are at least 18 years old, and
   b. Have official transcripts documenting at least 60 semester hours or 90 quarter hours of credit from a college or university accredited by the U.S. Department of Education.
6. The Preceptorship training program requires each student, before admission to sign a statement disclosing receipt of the following:
   a. Preceptorship training requirements.
   b. A current copy of the Acupuncture Board's statutes and rules, and
   c. A current copy of NCCAOM requirements for apprenticeship training programs.

R4-8-312. Approval of Preceptorship Training Program Supervisor

A. The Board shall approve each supervisor for a preceptorship training program who is a licensed acupuncturist and submits an application on a form provided by the Board that includes:
   a. Name, date of birth, and social security number;
   b. Current license number and expiration date;
   c. Whether the licensed acupuncturist has ever had a licensing authority of any state, district, or territory of the United States, or any other country or subdivision of any country, deny the applicant a license or certificate to practice acupuncture, or revoke, suspend, limit, restrict, or take any other action regarding the applicant's license or certificate to practice acupuncture, and if so, a written explanation;
   d. Documentation of a minimum of 10 years experience in the practice of acupuncture and a current practice that includes a minimum of 500 acupuncture patient visits by no fewer than 100 different patients during each year. Patient visits shall be in a general health care practice, excluding specialized limited practice such as substance abuse or addiction.
   e. The address where the preceptorship training program will be provided.

B. The licensed acupuncturist shall certify to the Board that the acupuncturist shall be solely responsible for the supervision of an enrolled student assigned to the acupuncturist for supervision.

ARTICLE 4. REGULATORY PROVISIONS

R4-8-401. Treatment of Patients by Acupuncture Students; Supervision

A. For an acupuncture student to treat a patient, the student and the student's supervisor shall ~~comply with the following~~:
   1. Obtain written evidence of informed consent in writing from the patient before treatment by an acupuncture student, indicating that the patient knows a student will be treating the patient;
   2. Have a supervisor physically present in the clinic during any treatment of the patient performed by an acupuncture student;
   3. Consult each other before and after each treatment; and
   4. Maintain records for each patient treated in accordance with R4-8-402.

B. The supervisor shall assign only patient treatments that can safely and effectively be performed by the student given the student's level of training.

R4-8-402. Recordkeeping

A. An acupuncturist shall maintain legible and accurate records on each patient who is given acupuncture treatment, including the name of the patient, dates of treatment, history, treatment given, and progress made during acupuncture treatments.

B. Acupuncture programs, clinical training programs, and preceptorship training programs shall safeguard, and maintain accurate and complete records that include:
   1. Permanent program and student academic records that document all of the program requirements according to Article 3 of this Chapter, and
   2. Programs shall award a certificate, diploma or degree in compliance with state and federal law to each student successfully completing a program.

NOTICE OF PROPOSED RULEMAKING

TITLE 6. ECONOMIC SECURITY

CHAPTER 7. DEPARTMENT OF ECONOMIC SECURITY
CHILD SUPPORT ENFORCEMENT

[R05-42]

PREAMBLE

1. Sections Affected **Rulemaking Action**

Article 4	New Article
R6-7-401	New Section
R6-7-402	New Section
R6-7-403	New Section
R6-7-404	New Section
R6-7-405	New Section
R6-7-406	New Section

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

Authorizing statute: A.R.S. §§ 41-1954(A)(3), 41-1954 (A)(1)(c)

Implementing statute: 42 U.S.C. § 652 (k)(1), 42 U.S.C. § 654 (31)

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

None

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

Name: Beth Broeker

Address: 1789 West Jefferson
Site Code 837A
Phoenix, AZ 85007

Telephone: (602) 542-6555

Fax: (602) 542-6000

E-mail: bbroeker@azdes.gov

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

This rule establishes the procedures and criteria for the passport denial process for an obligor who has a child support arrearage over the amount specified in federal law. Title IV-D agencies, which operate child support programs, are required by 42 U.S.C. § 652 (k)(1) to have a procedure for certifying an obligor with a child support arrearage exceeding the amount set by federal law to the United States Secretary of Health and Human Services for passport denial. The United States Secretary of Health and Human Services sends the certification to the United States Secretary of State, who has authority to refuse to issue a passport, or revoke, restrict, or limit a passport that was previously issued. The rule conforms to federal requirements. Passport denial is another mechanism that Title IV-D agencies can use to enforce collection of child support arrearages.

All Title IV-D cases in which the obligor has a child support arrearage over the federally-set level that are submitted for federal income tax refund offset and federal administrative offset are automatically submitted for passport denial. The Title IV-D Agency must provide notice to an obligor who has child support arrearages over the federally-set level that the obligor will be submitted for passport denial. The notice informs the obligor of the right to request an administrative review**.** The rule provides the conditions under which an obligor may be withdrawn from passport denial status and indicates how an obligor may appeal the Title IV-D Agency's determination at the administrative review.

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

The agency did not review any studies relating to this rule.

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:

This economic, small business and consumer impact statement for the passport denial rule analyzes the costs and benefits of this rulemaking on the Title IV-D Agency, the Division of Child Support Enforcement, and its contracting entities, child support obligees and obligors, and the business community. The economic impact of adoption of this proposed rule on the Title IV-D Agency is minimal.

The rule benefits obligors in Title IV-D child support cases by providing clear procedures regarding the operation of the passport denial process, indicates how an obligor may file for an administrative review, how passport denial may be withdrawn, and how to appeal a Department action. The proposed rule's impact on the procedures, operation, and costs of the Division of Child Support Enforcement is minimal. No costs are imposed by the federal government on Title IV-D agencies for submittal and certification of obligees for the passport denial process. Internal procedures have been established on this process.

The Department incurs minimal costs to operate the passport denial process, including the certification process to submit the names of obligors for passport denial. Because the process leads to the collection of a substantial amount of past due support in Title IV-D cases, the process has a beneficial impact on families. In some cases the state also collects assigned arrearages through the passport denial process, providing financial support for the Title IV-D program. For this reason, the process also has a beneficial impact on the state.

The passport denial process requires a Title IV-D Agency to certify an obligor's arrearages to the United States Secretary of Health and Human Services if the arrearages exceed the federal threshold. This certification is submitted to the United States Secretary of State, who has authority to withdraw a passport. If the arrearages exceed the federal threshold, the obligor in most cases is required to make payments to the Title IV-D Agency in order for the passport denial to be withdrawn.

This rule will not impose additional costs or requirements on small businesses and consumers. In Title IV-D cases in which an obligor has a child support arrearage over the federally-set level, and is unwilling to enter into a payment plan or pay the arrearage in full, small travel-related businesses could be negatively impacted due to an obligor's inability to obtain a passport to travel.

Support monies received by obligees as a result of the passport denial process may be spent in the business sector for various services or products. The economic impact of the expenditure of Title IV-D support monies received, on the private sector may be substantial, but cannot be quantified.

The Department of Economic Security has incurred minimal costs to write policies and procedures on passport denial and to operate a passport denial process. This rule will not impose additional costs or requirements on small businesses and consumers. In Title IV-D cases in which an obligor has a child support arrearage over the federally set level, and is unwilling to enter into a payment plan or pay the arrearage in full, small travel-related businesses could be negatively impacted due to an obligor's inability to obtain a passport to travel.

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:	**Annmarie Mena**
Address:	P. O. Box 40458 Site Code 021A Phoenix, AZ 85067
Telephone:	(602) 274-7703
Fax:	(602) 277-0517
E-mail:	amena@azdes.gov

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 will conduct an oral proceeding on the proposed rule if a written request is submitted within 30 days after the date this notice is published to the person named in item #4. The Department will accept written comments on the proposed rule for at least 30 days following publication of this notice.

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 rules follows:

TITLE 6. ECONOMIC SECURITY

CHAPTER 7. DEPARTMENT OF ECONOMIC SECURITY
CHILD SUPPORT ENFORCEMENT

ARTICLE 4. PASSPORT DENIAL

Section
R6-7-401. Definitions
R6-7-402. Certification and Criteria
R6-7-403. Notice
R6-7-404. Administrative Review
R6-7-405. Withdrawal of Passport Denial
R6-7-406. Appeal from Administrative Review

ARTICLE 4. PASSPORT DENIAL

R6-7-401. Definitions
The following definitions apply in this Chapter unless otherwise provided in a specific Article of this Chapter:
1. "Certification" means to furnish to OCSE the name, identification, and amount of arrearages of an individual owing a delinquent support obligation.
2. "Passport denial" means the authority of the United States Secretary of State to refuse to issue a passport or to revoke, restrict, or limit a passport that was previously issued, because the obligor in a Title IV-D case has an arrearage in an amount governed by federal statute for certification.
3. "Secretary" means the United States Secretary of State.
4. "Title IV-D case" means a proceeding for support managed by the Title IV-D Agency as required by Title IV-D of the Social Security Act, 42 U.S.C. 651 et seq.

R6-7-402. Certification and Criteria
A. The Title IV-D Agency shall:
1. Automatically submit and certify to OCSE for passport denial all Title IV-D cases with arrearages in an amount governed by federal statute for certification.
2. Refer these cases to OCSE for federal income tax refund offset and federal administrative offset under federal statute.

B. The Title IV-D Agency shall submit and certify a case for passport denial if it meets the following criteria:
1. A support obligation is established under a court order or an administrative process; and
2. The arrearages are in an amount governed by federal statute for certification.

C. The Title IV-D Agency shall not submit the following cases for passport denial:
1. Interstate cases in which the obligee receives temporary assistance for needy families and the state of Arizona does not have an assignment of rights.
2. Cases in which federal statute or regulations preclude action.

R6-7-403. Notice
A. The Title IV-D Agency shall provide written notice to an obligor that the obligor has support arrearages in an amount governed by federal statute for certification, and that the obligor has been referred for federal administrative offset, federal income tax refund offset, and to the Secretary for passport denial.

B. The Title IV-D Agency shall send an obligor the notice by first class mail. The mailing of this notice to an obligor's last address known to the Title IV-D Agency constitutes proper and sufficient notice.

C. The notice shall also inform the obligor of the right to contest the enforcement action.

R6-7-404. Administrative Review
A. An obligor may file a written request for administrative review by the Title IV-D Agency within thirty business days after the date on the notice mailed by the Title IV-D Agency provided for in R6-7-403.

B. An obligor shall have the burden of proof as to any issues raised in the administrative review.

C. The issues at the administrative review are limited to:
1. Whether there has been a mistake regarding the identity of the obligor;
2. The amount of the obligor's arrearages, if any;
3. Whether the obligor has the ability to pay any of the arrearages owed.

D. If an obligor alleges that there has been a mistake regarding the identity of the obligor, the Title IV-D Agency shall issue a final written determination by first class mail to all parties within two business days after receipt of the request.

E. In all circumstances other than a mistake regarding the identity of the obligor, the Title IV-D Agency shall issue a final

written determination within forty-five business days after the date when the Title IV-D Agency receives the request for administrative review, or if additional information is required and provided, forty-five business days after receipt of this information.

F. In an interstate case, only the certifying state has the authority to withdraw an obligor from the passport denial, revocation, or restriction process.

G. If an obligor does not request an administrative review within the required time-frame, the Title IV-D Agency's certification for purposes of passport denial remains in effect.

H. If an obligor requests an administrative review within the required time-frame and meets the requirements for withdrawal of passport denial in R6-7-405, the Title IV-D Agency shall notify OCSE to withdraw the passport denial in accordance with OCSE requirements.

R6-7-405. Withdrawal of Passport Denial

A. The Title IV-D Agency shall notify OCSE to withdraw passport denial for an obligor if one or more of the following applies:
1. The Title IV-D Agency makes a final determination during an administrative review that:
   a. The case does not meet the criteria for passport denial; or
   b. There has been a mistake regarding the identity of the obligor;
2. The obligor has paid the arrearages down to:
   a. An amount less than that governed by federal statute, and has entered into a payment agreement with the Title IV-D Agency; or
   b. Zero; or
   c. An amount agreed to by the Title IV-D Agency, if the arrearages are owed to both the state and the obligee, provided the obligor agrees to and abides by any other terms required by the Title IV-D Agency, and the provisions of R6-7-405(B).

B. The Title IV-D Agency shall also notify OCSE to withdraw passport denial for an obligor if all of the following apply:
1. The obligee agrees to accept partial payment of the total arrearages owed by the obligor to the obligee even though the payment does not comply with the requirements of R6-7-405(A)(2) to pay arrearages down to zero or an amount less than that governed by federal statute;
2. The obligor and obligee agree to the amount of the partial payment in writing, signed by both parties and submitted to the Title IV-D Agency;
3. The obligee is advised that the Title IV-D Agency may not have the opportunity to request passport denial for another ten years;
4. The obligee provides the Title IV-D Agency a signed, notarized statement acknowledging receipt of the advisement in subsection (B)(3) prior to the notification to OCSE to withdraw the passport denial;
5. The obligor enters into a payment agreement with the Title IV-D Agency for the remainder of the arrearages owed;
6. The Title IV-D Agency consents to the agreement between the obligor and the obligee.

C. The Title IV-D Agency shall notify OCSE by facsimile, computer, or other electronic or non-electronic means to withdraw the passport denial, in accordance with OCSE requirements.

D. If the obligor fails to comply with the terms of any payment agreement with the Title IV-D Agency, and the arrearage meets the amount governed by federal statute for certification, the Title IV-D Agency shall re-certify the obligor to OCSE for passport denial.

R6-7-406. Appeal from Administrative Review

A Title IV-D Agency determination made under this rule is subject to judicial review under Title 12, Chapter 7, Article 6 of the Arizona Revised Statutes (Judicial Review of Administrative Decisions), or other applicable law.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 6. DEPARTMENT OF HEALTH SERVICES
COMMUNICABLE DISEASES

[R05-53]

PREAMBLE

1. Sections Affected	Rulemaking Action
R9-6-701	Amend
R9-6-702	Amend

R9-6-704	Amend
R9-6-706	Amend
Table 1	Amend
Table 2	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. §§ 36-136(A)(7) and 36-136(F)

Implementing statutes: A.R.S. §§ 15-872, 15-873, 36-136(H)(1), 36-672, and 36-883(C)

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

Notice of Rulemaking Docket Opening: 10 AAR 3021, July 30, 2004

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

Name:	Andie Denious, M.S., R.N., Manager, Immunization Services
Address:	Arizona Department of Health Services Arizona Immunization Program Office 150 N. 18th Ave, Suite 120 Phoenix, AZ 85007-3233
Telephone:	(602) 364-3626
Fax:	(602) 364-3285
E-mail:	denioue@azdhs.gov
	Or
Name:	Kathleen Phillips, Rules Administrator
Address:	Arizona Department of Health Services 1740 W. Adams St., Room 202 Phoenix, AZ 85007-3233
Telephone:	(602) 542-1264
Fax:	(602) 364-1150
E-mail:	phillik@azdhs.gov

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

The purpose of this rulemaking is to add the varicella vaccine (VAR) to the list of required immunizations for child care or school entry. The Department is also making changes to the Article to provide for the additional vaccine requirement and clarify the rules. The rules for required immunizations for child care or school entry are in Title 9, Chapter 6, Article 7 of the *Arizona Administrative Code*. The Department is amending the definitions in R9-6-701 to reflect the changes made to the Article. R9-6-702 and Tables 1 and 2 will be amended to provide for the VAR requirement. In R9-6-704, the Department will clarify the rule and add to the list of those individuals who may sign an electronic version of a child's immunization record. R9-6-706 will be amended to provide exemptions for the VAR requirement. The amended rules will conform to current statutory authority, rulemaking format and style requirements, industry practice, and departmental policy.

Currently, the varicella vaccine is given on a voluntary basis although since 1999, the Advisory Committee on Immunization Practices (ACIP) for the Centers for Disease Control and Prevention (CDC) has recommended that VAR be added to the list of vaccinations required for child care or school entry. Since 1999, 41 states have made the varicella vaccine a requirement for child care or school entry. Arizona is one of the remaining states that has not made the VAR a requirement for child care or school entry. The Arizona Immunization Program Office (AIPO) manages the federal Vaccines for Children Program (VFC) for the state of Arizona. Through the VFC, the Department provides free vaccines to VFC eligible children. VFC eligible children include children enrolled in the Arizona Health Care Cost Containment System (AHCCS), uninsured children, Native American or Alaskan native children, and some underinsured children. VFC children compose approximately 55% of the number of children in Arizona between birth and age 18.

The Department plans to phase in the VAR requirement in an incremental implementation process. During the first year of implementation, 3 grades will be required to have received the VAR before entry into a child care or school. For each year after implementation, 2 more grades will be required to have received the VAR before entry into a child care or school. Through this incremental implementation process, the Department intends to have all children entering child care or school to be have received the VAR by September 1, 2011.

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

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

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

Not applicable

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

Annual costs/revenues changes are designated as minimal when less than $1,000, moderate when between $1,000 and $10,000, and substantial when $10,000 or greater in additional costs or revenues.

This economic, small business, and consumer impact statement analyzes the costs and benefits of adding VAR to the list of required immunizations for child care or school entry for the following parties: local county health departments, the Department of Education, the federal Vaccines for Children (VFC) program, private health care physicians and clinics, vaccine manufacturers, health insurance companies, child care facilities, schools, children entering child care or school, parents of a child entering child care or school, the public, and the Department.

The estimated cost to local county health departments is minimal to none. The local county health departments are already immunizing VFC eligible children with VAR.

The estimated cost to the Arizona Department of Education (ADOE) is minimal to moderate. ADOE will incur costs for school nurses spending additional time reporting compliance with the new requirement and if the nurses are already providing VAR immunizations, the cost of the additional doses of VAR due to the new VAR requirement.

The estimated cost to the Federal government is moderate to substantial with the federal VFC and "317" programs bearing the cost of providing funding for the VAR doses for the new VAR requirement.

The Department will incur substantial cost for purchasing the VAR for the majority of underinsured children who receive immunizations.

A small businesses, such as a private health care provider, will incur a minimal to moderate cost for additional supplies and staff time needed for the increase in the number of VAR immunizations administered to the children entering child care or school. The actual cost to a private health care provider will depend on the number of children requesting a VAR dose.

AHCCCS contracted health plans will incur a minimal to moderate cost to pay the contracted physicians for the administration of VAR to AHCCCS covered children.

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:	Andie Denious, M.S., R.N., Manager, Immunization Services
Address:	Arizona Department of Health Services Arizona Immunization Program Office 150 N. 18th Ave, Suite 120 Phoenix, AZ 85007-3233
Telephone:	(602) 364-3626
Fax:	(602) 364-3285
E-mail:	denioue@azdhs.gov
	Or
Name:	Kathleen Phillips, Rules Administrator
Address:	Arizona Department of Health Services 1740 W. Adams St., Room 202 Phoenix, AZ 85007-3233
Telephone:	(602) 542-1264
Fax:	(602) 364-1150
E-mail:	phillik@azdhs.gov

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

Date:	March 30, 2005
Time:	10:00 a.m.
Location:	1740 W. Adams St., Room 411 Phoenix, AZ 85007-3233

A person may submit written comments on the proposed rules no later than 5:00 p.m., March 30, 2005 to the individuals listed in questions #4 and #9. Persons with disability may request reasonable accommodations by contacting Maria Herbert at herberm@azdhs.gov or (602) 364-0912. Requests should be made as early as possible to allow sufficient time to arrange for the accommodation.

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. Incorporation by reference and their location in the rules:

Not applicable

13. The full text of the rule follows:

TITLE 9. HEALTH SERVICES

CHAPTER 6. DEPARTMENT OF HEALTH SERVICES
COMMUNICABLE DISEASES

ARTICLE 7. VACCINE-PREVENTABLE DISEASES

Section

ARTICLE 7. VACCINE-PREVENTABLE DISEASES

R9-6-701. Definitions

In this Article, unless otherwise specified:

1. "AHCCCS" means the Arizona Health Care Cost Containment System.
2. "Administration of vaccine" means the inoculation of a child with an immunizing agent by an individual authorized by federal or state law.
3. "ASIIS" means the Arizona State Immunization Information System, an immunization reporting system that collects, stores, analyzes, releases, and reports immunization data.
4. "Case" has the same meaning as in R9-6-101.
5. "Catch-up immunization schedule" means the times established in Table 2 for the immunization of a child who has not completed the vaccine series required in Table 1 before entry into a child care or school.
6. "CDC" means the Centers for Disease Control and Prevention.
7. "Charter school" has the same meaning as in A.R.S. § 15-101.
8. "Child" means:
   a. An individual 18 years of age or less, or
   b. An individual more than 18 years of age attending school.
9. "Child care" means:
   a. A child care facility as defined in A.R.S. § 36-881; or
   b. A child care group home as defined in A.R.S. § 36-897.
10. "Child care administrator" means an individual, or the individual's designee, having daily control and supervision of a child care.
11. "Communicable period" means the time during which an individual is capable of infecting another individual with a communicable disease.
12. "Contact person" means an individual who, on behalf of a school or child care and upon request of the Department, provides information to the Department.
13. "Day" means a calendar day, and excludes the:
    a. Day of the act, or event, from which a designated period of time begins to run, and
    b. Last day of the period if a Saturday, Sunday, or official state holiday.
14. ~~"DtaP"~~ "DTaP" means diphtheria, tetanus, and acellular pertussis vaccine.

15. "DTP" means diphtheria, tetanus, and pertussis vaccine.
16. "Enroll" means to accept into a school by the school or into a child care by the child care.
17. "Entry" means the first day of attendance at a child care or at a specific grade level in a school.
~~18. "Guardian" means an individual appointed by a court of competent jurisdiction to care for a child or the child's property.~~
~~19.~~ 18. "Head Start program" means a federally funded program administered under 42 U.S.C. 9831.
~~20.~~ 19. "Hep A" means hepatitis A vaccine.
~~21.~~ 20. "Hep B" means hepatitis B vaccine.
~~22.~~ 21. "Hib" means *Haemophilus influenzae* type b vaccine.
~~23.~~ 22. "Immunization" has the same meaning as in A.R.S. § 36-671.
~~24.~~ 23. "Immunization registry" means a storage of immunization data for vaccines.
~~25.~~ 24. "Immunization registry administrator" means an individual, or the individual's designee, having daily control and supervision of an immunization registry.
~~26.~~ 25. "IRMS number" means a numeric identifier that the Department issues to a person in ASIIS.
~~27.~~ 26. "KidsCare" means a federally funded program administered by AHCCCS under A.R.S. § 36-2982.
~~28.~~ 27. "Kindergarten" means the grade level in a school that precedes first grade.
~~29.~~ 28. "Laboratory evidence of immunity" has the same meaning as in A.R.S. § 36-671.
~~30.~~ 29. "Local health agency" has the same meaning as "health agency" in A.R.S. § 36-671.
~~31.~~ 30. "Local health officer" means an individual or the individual's designee having daily control and supervision of a local health agency.
~~32.~~ 31. "Medical exemption" means to excuse a child from immunization against a specified disease if the required immunization may be detrimental to the child's health, as determined by a physician.
~~33.~~ 32. "Medical services" has the same meaning as in A.R.S. § 36-401.
~~34.~~ 33. "MMR" means measles, mumps, and rubella vaccine.
~~35.~~ 34. "Outbreak" means an unexpected increase in the incidence of a disease as determined by the Department or local health agency.
~~36. "Parent" means a biological or legally adoptive mother or father of a child.~~
~~37. "Person in loco parentis" means an individual acting in the place of a parent or guardian and exercising the duties, rights, or responsibilities of a parent or guardian.~~
~~38.~~ 35. "Physician" has the same meaning as in A.R.S. § 15-871.
~~39.~~ 36. "Polio" means poliomyelitis vaccine.
37. "Practical nurse" has the same meaning as in A.R.S. § 32-1601.
~~40.~~ 38. "Private school" has the same meaning as in A.R.S. § 15-101.
~~41.~~ 39. "Provider" means an individual who administers a vaccine, or an entity that is responsible for administering a vaccine.
~~42.~~ 40. "Public school" has the same meaning as "school" in A.R.S. § 15-101.
~~43.~~ 41. "Registered nurse ~~practitioner~~" has the same meaning as in A.R.S. § 32-1601.
~~44.~~ 42. "Responsible person" ~~means a parent, guardian, or person in loco parentis to a child~~ has the same meaning as "parent" in A.A.C. R9-5-101.
~~45.~~ 43. "Route of administration" means a method of inoculation with a vaccine.
~~46.~~ 44. "School" has the same meaning as in A.R.S. § 36-671.
~~47.~~ 45. "School administrator" has the same meaning as in A.R.S. § 36-671.
~~48.~~ 46. "Suspect case" has the same meaning as in R9-6-101.
47. "Temporary" means lasting for a limited time.
~~49.~~ 48. "Td" means tetanus and diphtheria vaccine.
~~50.~~ 49. "Underinsured" means having medical insurance that does not cover all or part of the cost of a vaccination.
~~51.~~ 50. "Uninsured" means not having medical insurance.
~~52.~~ 51. "Vaccine" has the same meaning as "biological product" defined in 21 CFR 600.3h (April 1, 2000).
52. "VAR" means varicella vaccine.
53. "VFC" means Vaccines for Children, a federal program administered by the Department.
54. "VFC PIN number" means a numeric identifier that the VFC issues to a person participating in the VFC.
55. "WIC" means Women, Infants, and Children, a federal program administered by the Department.
56. "WIC administrator" means an individual, or the individual's designee, having daily control and supervision of a WIC.

R9-6-702. Required Immunizations for Child Care or School Entry

A. Except as provided in R9-6-706, a school administrator or child care administrator shall:
1. Ensure that a child attending a school or child care has been immunized against each of the following diseases according to Table 1 or Table 2:

a. Diphtheria;
b. Tetanus;
c. Hepatitis A, for a child 2 through 5 years of age in child care in Maricopa County;
d. Hepatitis B;
e. Pertussis;
f. Poliomyelitis;
g. Measles (rubeola);
h. Mumps;
i. Rubella (German Measles); and
j. *Haemophilus influenzae* type b; and
k. Varicella

2. If a child does not have proof of immunization according to Table 1 or Table 2, exclude the child from:
   a. School entry; or
   b. Child care, unless the child is immunized against the diseases listed in subsection (A)(1) within 15 days following entry.

B. Unless exempt according to R9-6-706, a child who has received a first dose of MMR but has not received a second dose of MMR shall:
1. Receive the second dose according to Table 2 and the following:
   a. By September 1, 2002 for a child attending kindergarten through 4th grade or 7th through 9th grade;
   b. By September 1, 2003 for a child attending kindergarten through 5th grade or 7th through 10th grade;
   c. By September 1, 2004 for a child attending kindergarten through 11th grade; and
   d. By September 1, 2005 for a child attending kindergarten through 12th grade; and
2. Be excluded from school entry by a school administrator until the requirements in Table 2 are met.

C. Unless exempt according to R9-6-706, a child who has not completed the three-dose Hep B series specified in Table 1 or 2 shall:
1. Receive the remaining doses according to Table 2 and the schedule in subsection (B)(1)(a) through (B)(1)(d), and
2. Be excluded from school entry by a school administrator until the requirements in Table 2 are met.

D. Unless exempt according to R9-6-706, a child who has not received the VAR specified in Table 1 or Table 2 shall:
1. Receive the VAR dose according to Table 2 and the following:
   a. By September 1, 2005 for a child attending kindergarten, 1st grade, and 7th grade; and
   b. By September 1, 2006 for a child attending kindergarten through 2nd grade, 7th grade, and 8th grade; and
   c. By September 1, 2007 for a child attending kindergarten through 3rd grade, and 7th grade through 9th grade; and
   d. By September 1, 2008 for a child attending kindergarten through 4th grade, and 7th grade through 10th grade; and
   e. By September 1, 2009 for a child attending kindergarten through 5th grade, and 7th grade through 11th grade; and
   f. By September 1, 2010 for a child attending kindergarten through 12th grade; and
2. Be excluded from school entry by a school administrator until the requirements in Table 2 are met.

~~D~~**E.** If the Department receives written notification from the CDC that there is a shortage of a vaccine for a disease listed in subsection (A)(1), or that the CDC is limiting the amount of a vaccine for a disease listed in subsection (A)(1), the Department shall:
1. Provide written notification to each school and child care in this state of the shortage or limitation of the vaccine;
2. Suspend compliance with subsections (A), (B), ~~and~~ (C) and (D); and
3. Upon receiving written notification from the CDC that the vaccine is available, notify each school and child care in this state:
   a. That the vaccine is available, and
   b. Of the time by which an individual is required to comply with subsections (A), (B), ~~and~~ (C) and (D).

~~E~~**F.** The Department shall notify each school and child care in this state that the Department no longer requires compliance with subsections (A), (B), ~~and~~ (C) and (D) for a disease listed in subsection (A)(1) if:
1. The disease is declared eradicated by:
   a. The World Health Organization, and
   b. The Advisory Committee on Immunization Practices; and
2. The Department no longer recommends immunization against the disease.

R9-6-704. Standards for Documentary Proof of Immunity

A. An individual may establish proof of immunity to a disease listed in R9-6-702(A)(1) by one of the following:
1. An immunization record that contains:
   a. A child's name;
   b. The child's date of birth;

c. The type of vaccine administered;
d. The month and year of each immunization, other than MMR, for a child ~~born~~ who received an immunization before January 1, 2003;
e. The month, day, and year of MMR immunization for a child ~~born~~ who received an immunization before January 1, 2003;
f. The month, day, and year of each immunization for a child ~~born~~ who received an immunization on or after January 1, 2003; and
g. The name of the individual administering the vaccine or the name of the entity that the individual administering the vaccine represents;

2. Laboratory evidence of immunity;
3. An Arizona school immunization record that includes:
   a. The child's name;
   b. The child's date of birth;
   c. The grade of the child on the date of enrollment;
   d. Whether the child is male or female;
   e. The type of vaccine administered;
   f. The month and year of each immunization, other than MMR, for a child born before January 1, 2003;
   g. The month, day, and year of MMR immunization for a child born before January 1, 2003;
   h. The month, day, and year of each immunization for a child born on or after January 1, 2003;
4. A school immunization record from another state;
5. An electronic version of the child's immunization record containing the information in subsection (A)(1)(a) through (f) generated by an immunization registry, and signed and dated by any of the following:
   a. A local health officer,
   b. A school administrator,
   c. A child care administrator,
   d. A WIC administrator, ~~or~~
   e. An immunization registry administrator or immunization registry administrator's designee; or
   f. A physician, physician's designee, practical nurse, or registered nurse;
6. An electronic version of the child's immunization record generated by a school, signed and dated by the school administrator or the school administrator's designee, and containing the information in subsection (A)(1)(a) through (f); or
7. A statement of immunity as described in subsection (B).

B. A physician, the physician's designee, practical nurse or ~~a~~ registered nurse ~~practitioner~~ may sign a statement of immunity stating that a child is immune to a disease, but shall not sign a statement of immunity to measles or rubella without obtaining serologic evidence of immunity.

R9-6-706. Exemptions to Immunizations

A. A child who has reached a 5th birthday is exempt from the Hib immunization requirement.
B. A child who has reached a 7th birthday is exempt from the pertussis immunization requirement.
C. A child:
1. Until September 1, 2011, is exempt from the VAR immunization requirement if the child's responsible person states, verbally or in writing, that the child has had varicella, and
2. After September 1, 2011, is not exempt from the VAR immunization requirement unless the child provides laboratory evidence of immunity to varicella.

~~C.~~D. A child who submits laboratory evidence of immunity to a disease to a school or child care is not required to be immunized against ~~that~~ the disease as a condition for school or child care entry.
~~D.~~E. ~~A child attending a school, who submits documentary proof of exemption from immunization for personal beliefs that contains the information in A.R.S. § 15-873(A)(1), is exempt from the immunization requirements in this Article.~~
For a child attending a school, a parent or guardian shall submit a written statement for exemption from immunization for personal beliefs as required in A.R.S. § 15-873(A)(1) or written certification for medical exemption as required in A.R.S. § 15-873(A)(2) on a form provided by the Department that contains:
1. The child's name,
2. The child's date of birth,
3. The type of exemption requested,
4. The vaccinations/immunizations the parent or guardian is requesting an exemption from,
5. Whether the medical exemption is permanent or temporary, if applicable,
6. The date the medical exemption terminates, if applicable,
7. The parent or guardian's signature and the date signed, and
8. The physician's signature and the date signed, if applicable.

~~**E.** A child attending child care, who submits a written document for exemption from immunization that contains the child's name, the child's date of birth, a statement that the exemption is based upon religious beliefs, and the responsible person's signature is exempt from the immunization requirements in this Article.~~

F. ~~If a medical exemption is obtained, a physician shall identify each vaccine that is exempted.~~

~~1. The physician shall designate the exemption as either permanent or temporary.~~

~~2. If designated as a permanent medical exemption, the medical exemption lasts indefinitely.~~

~~3. If designated as a temporary medical exemption, a physician shall specify the date of termination of the temporary medical exemption.~~

~~a. A school or child care shall allow a child with a temporary medical exemption to attend school or child care until the exemption terminates.~~

~~b. A school administrator or a child care administrator shall notify the responsible person in writing of the date by which the child is required to complete all immunizations for which the child has a temporary medical exemption.~~

For a child attending a child care, a responsible person shall submit a written statement for exemption from immunization as required in A.R.S. ß 36- 883(C) on a form provided by the Department that includes:

1. The child's name,
2. The child's date of birth,
3. The type of exemption,
4. The vaccinations/immunizations the responsible person is requesting an exemption from,
5. If a medical exemption, whether the medical exemption is permanent or temporary,
6. If temporary, the date the medical exemption terminates, if applicable,
7. The responsible person's signature and the date signed, and
8. The physician's signature and the date signed, if applicable.

G. ~~A school administrator or child care administrator shall record an exemption on the child's immunization record.~~

A child care administrator or school administrator shall:

1. Record an exemption on a child's immunization record,
2. Allow a child with a temporary medical exemption to attend a child care or school until the date the temporary exemption terminates, and
3. Notify a child's responsible person in writing of the date the child is required to complete all the immunizations before the temporary medical exemption terminates.

Table 1. Immunization Requirements for Child Care or School Entry

Age at Entry	Number of Doses of Vaccine Required	Special Notes and Exceptions
<2 months	1 Hep B	(See Note 1)
2 through 3 months	1 DTP or DTaP 1 Polio 1 Hib 1 Hep B	 (See Note 1)
4 through 5 months	2 DTP or DTaP 2 Polio 2 Hib 2 Hep B	 (See Note 1)
6 through 11 months	3 DTP or DTaP 2 Polio 3 Hib 2 Hep B	 (Hib exception - See Note 2 for a child 7 months through 59 months of age.) (See Note 1)
12 through 14 months	3 DTP or DTaP 3 Polio 1-4 Hib 1 MMR 3 Hep B 1 Varicella	 (See Note 2) (See Note 3) (See Note 1) (See Note 6)

15 through 59 months	4 DTP or DTaP 3 Polio 1-4 Hib 1-2 MMR 3 Hep B 1 Varicella	 (See Note 2) (See Note 3) (See Note 1) (See Note 6)
2 through 5 years (Only required for Maricopa County child care)	2 Hep A	(See Note 4)
Kindergarten or 1st grade entry 4 through 6 years	5 DTP or DTaP 4 Polio 2 MMR 3 Hep B 1 Varicella	Exception - A 5th dose is not required if the 4th dose of diphtheria-tetanus containing vaccine was received after the 4th birthday. Exception - A 4th dose is not required if the 3rd dose of polio was received after the 4th birthday. (See Note 3) A child entering school shall receive a 2nd dose, 1 month or more after the date of the 1st dose. (See Note 6)
7 years or older	5 DTP, DTaP, or any combination of DTP and Td 4 Polio 1-2 MMR Hep B 1 Varicella	Exception - A 5th dose is not required if the 4th dose of diphtheria-tetanus containing vaccine was received after the 4th birthday. Exception - If started on or after the 7th birthday, a minimum of 3 doses of a tetanus-diphtheria containing vaccine is required. A child shall receive a Td dose if 10 years or more have passed since the date of the last dose of tetanus-diphtheria containing vaccine. Exception - A 4th dose is not required if the 3rd dose of polio was received after the 4th birthday. (See Note 5) (See Note 3) A child entering school shall receive the Hep B series according to Note 1. (See Note 6)

1. A child shall receive the 1st dose of Hep B according to R9-6-702(C), or no later than 15 days following child care entry. A child shall receive the 2nd dose of Hep B 4 weeks or more after the date of the 1st dose. A child who is 6 months of age or older shall receive the 3rd dose 2-5 months after the date of the 2nd dose and 4 months or more after the date of the 1st dose. For a child 11-15 years of age who receives the optional Merck Recombivax HB Adult Formulation vaccine, only 2 doses are required 4 or more months apart.
2. The recommended schedule for 4 dose Hib vaccine is 2, 4, and 6 months of age with a booster dose at 12-15 months of age. The optimal schedule for 3 dose Hib vaccine is 2 and 4 months of age with a booster dose at 12 -15 months of age. There shall be a minimum interval of 4 weeks between each of the first 3 doses. A child shall receive a booster dose no earlier than 12 months of age and no earlier than 8 weeks after the previous dose. A child who starts the Hib series after 7 months of age may be required to complete a full 3 or 4 dose series. A child who starts Hib at 15 months of age or older shall receive 1 dose at 15-59 months of age.
3. A child who is 12 months of age or older, shall receive measles, mumps, and rubella vaccines as individual antigens or as a combined MMR vaccine. A child shall receive the 1st dose of MMR before school entry, or no later than 15

days following child care entry. A child who is 4 years of age or older and who is entering school shall receive a 2nd dose of MMR according to R9-6-702(B), and 1 month or more after the date of the 1st dose.

4. A child who is 2 through 5 years of age shall receive the 1st dose of hepatitis A vaccine no later than 15 days following child care entry in Maricopa County. A child shall receive a 2nd dose 6 months following the date of the 1st dose.
5. Polio vaccine is not required for individuals 18 years of age or older.
6. A child shall receive the VAR according to the schedule in R9-6-702(D) no later than 15 days following child care entry.

Table 2. Catch-up Immunization Schedule for Child Care or School Entry

Vaccine	Dose	Time Intervals, Special Notes, and Exceptions
1. Diphtheria, Tetanus, and Pertussis a. For a Child Younger Than 7 Years of Age: DTP or any combination of DTP or DTaP	1st	A child shall receive the 1st dose before school entry, or no later than 15 days following child care entry.
	2nd	If 4 weeks or more have passed since the date of the 1st dose, a child shall receive the 2nd dose before school entry, or no later than 15 days following child care entry.
	3rd	If 4 weeks or more have passed since the date of the 2nd dose, a child shall receive the 3rd dose before continued attendance at school, or no later than 15 days following continued attendance at child care.
	4th	If 6 months or more have passed since the date of the 3rd dose, a child shall receive the 4th dose before continued attendance at school, or no later than 15 days following continued attendance at child care.
	5th or more	A child shall receive a 5th dose before continued attendance at school, or no later than 15 days following child care entry. Exception - A 5th dose is not required if the child received the 4th dose after the child's 4th birthday.
b. For a Child 7 Years of Age and Older: Tetanus and Diphtheria containing vaccine (Td) (Pertussis not indicated)	1st	A child shall receive a 1st dose before school entry.
	2nd	If 4 weeks or more have passed since the date of the 1st dose, a child shall receive the 2nd dose before school entry.
	3rd	If 6 months or more have passed since the date of the 2nd dose, a child shall receive the 3rd dose before school entry.
2. Polio	1st	(See Note 1 below.) A child shall receive the 1st dose before school entry, or no later than 15 days following child care entry.
	2nd	If 4 weeks or more have passed since the date of the 1st dose, a child shall receive the 2nd dose before school entry, or no later than 15 days following child care entry.

	3rd	If 4 weeks or more have passed since the date of the 2nd dose, the child shall receive the 3rd dose before school entry, or no later than 15 days following child care entry.
	4th	If 8 weeks or more have passed since the date of the 3rd dose, the child shall receive the 4th dose before school entry. Exception - A 4th dose is not required if the 3rd dose was received after the 4th birthday.
3. MMR – Measles, Mumps, Rubella	1st	A child who is 12 months of age or older shall receive the 1st dose before school entry, or no later than 15 days following child care entry.
	2nd	(See Note 3 below.) If 1 month or more has passed since the date of the 1st dose, a child who is 4 years of age or older shall receive the 2nd dose before school entry.
4. Hib - *Haemophilus influenzae* type b (Not required for individuals aged 5 years of age and older.)	1st through 4th	A child who is younger than 5 years of age shall receive a dose no later than 15 days following child care entry. (See Note 2 below.)
5. Hep B – Hepatitis B	1st	(See Note 4 below.) A child shall receive the 1st dose before school entry, or no later than 15 days following child care entry.
	2nd	If 4 weeks or more have passed since the date of the 1st dose, a child shall receive the 2nd dose before school entry, or no later than 15 days following child care entry.
	3rd	If 2 months or more have passed since the date of the 2nd dose, and 4 months or more have passed since the date of the 1st dose and the child is at least 6 months of age, a child shall receive the 3rd dose before school entry, or no later than 15 days following child care entry. Exception - A child who is 11 through 15 years of age who is receiving the Merck Recombivax HB Adult Formulation vaccine is not required to receive a 3rd dose.
6. Hep A – Hepatitis A Only required for Maricopa County child care	1st	A child who is 24 through 71 months of age shall receive the 1st dose no later than 15 days following child care entry.
	2nd	If 6 months or more have passed since the date of the 1st dose, a child shall receive the 2nd dose no later than 15 days following child care entry.
7. **Varicella**	1st 2nd	(See Note 5 below.) A child who is 12 months of age through 12 years shall receive one dose before school entry, or no later than 15 days following child care entry. If one month or more has passed since the date of the first dose, a child who is 13 years of age or older shall receive a second dose.

1. Polio vaccine is not required for individuals 18 years of age or older.
2. A child who begins the Hib series at 7 months of age or older shall receive Hib according to the following schedule:

Current Age (months)	Prior Immunization History	Recommended Regimen
7-11	1 dose	1 dose at 7-11 months of age and a booster at least 2 months later at 12-15 months of age
7-11	2 doses	1 dose at 7-11 months of age and a booster at least 2 months later at 12-15 months of age
12-14	1 dose before 12 months	2 doses administered at least 2 months apart
12-14	2 doses before 12 months	1 dose
15-59	Any incomplete schedule	1 dose

3. According to the schedule in R9-6-702(B), a child shall receive the 2nd MMR before entering school.
4. According to the schedule in R9-6-702(B), a child shall receive the hepatitis B series before entering school or no later than 15 days following child care entry.
5. A child shall receive the VAR according to the schedule in R9-6-702(D) no later than 15 days following child care entry.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

[R05-43]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-703	Amend
R9-22-705	Amend
R9-22-715	Amend
R9-22-717	Repealed

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. §§ 36-2904 and 36-2903.01

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

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 3296, August 20, 2004
Notice of Rulemaking Docket Opening: 10 A.A.R. 4849, December 3, 2004

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

Name: Mariaelena Ugarte

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

Telephone: (602) 417-4232

Fax: (602) 253-9115

E-mail: AHCCCSRules@ahcccs.state.az.us

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

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

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

No studies were reviewed.

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:

AHCCCS anticipates no impact.

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:	Mariaelena Ugarte
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4232
Fax:	(602) 256-6756
E-mail:	AHCCCSRules@ahcccs.state.az.us

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of February 4, 2005. Please send written comments to the above address by 5:00 p.m., March 21, 2005. E-mail will be accepted.

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

Date:	March 21, 2005
Time:	2:00 p.m.
Location:	AHCCCS 701 E. Jefferson Phoenix, AZ 85034 Gold Room
Nature:	Public Hearing
Date:	March 21, 2005
Time:	2:00 p.m.
Location:	ALTCS: Arizona Long-term Care System 110 S. Church, Suite 1360 Tucson, AZ 85701
Nature:	Public Hearing
Date:	March 21, 2005
Time:	2:00 p.m.
Location:	ALTCS: Arizona Long-term Care System 3480 E. Route 66 Flagstaff, AZ 86004
Nature:	Public Hearing

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:

42 CFR 431.107(b), April 6, 1992, R9-22-703

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-703. Claims Submission to the Administration
R9-22-705. Payments by Contractors
R9-22-715. Hospital Rate Negotiations
R9-22-717. ~~Hospital Claims Review~~ Repealed

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-703. Claims Submission to the Administration

A. AHCCCS registered providers. An AHCCCS registered provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904(E) and 42 CFR 431.107(b) as of April 6, 1992, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

~~**B.** Timely Submission of Claims.~~

~~1. Under A.R.S. § 36-2904(H)(3), the Administration regards a paper or electronic claim as submitted on the date that it is received by the Administration. The Administration shall do one or more of the following for each claim it receives:~~
~~a. Place a date stamp on the face of the claim;~~
~~b. Assign a system-generated claim reference number; or~~
~~c. Assign a system-generated date-specific number.~~

~~2. Except as provided in subsection (B)(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 a 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 (B)(6), if an AHCCCS registered provider submits an initial claim within the six-month period noted in subsection (B)(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. A claim is clean when it meets the requirements under A.R.S. § 36-2904(H).~~

~~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 contract.~~

B. Timely Submission of Claims.

1. Under A.R.S. § 36-2904(G)(3), the Administration shall deem a paper or electronic claim as submitted on the date that it is received by the Administration. The Administration shall do one or more of the following for each claim it receives:
   a. Place a date stamp on the face of the claim;
   b. Assign a system-generated claim reference number; or
   c. Assign a system-generated date-specific number.
2. Unless a shorter time period is specified in contract, the Administration shall not pay a claim initially submitted for a covered service that does not meet the time limit described below:
   a. Six-months from the date of service, or for an inpatient hospital claim six months from the date of discharge, or
   b. Six months from the date of eligibility posting, whichever is later.

3. Unless a shorter time period is specified in contract, the Administration shall not pay a clean claim for a covered service that does not meet the time limit described below:
   a. Twelve months from the date of service; or for an inpatient hospital claim, twelve months from the date of discharge, or
   b. Twelve months from the date of eligibility posting, whichever is later.
4. A claim is clean when it meets the requirements under A.R.S. § 36-2904(G)(1).

C. Claims Processing

1. The Administration shall notify the AHCCCS registered provider with a remittance advice when a claim is processed for payment.
2. ~~The Administration shall pay valid clean claims in a timely manner according to 42 CFR 447.45, February 15, 1990, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~
   a. ~~90 percent of valid clean claims shall be paid within 30 days of the date of receipt of the claim;~~
   b. ~~99 percent of valid clean claims shall be paid within 90 days of the date of receipt of the 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.~~
2. Payment by the Administration for inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, shall be subject to the following as described under A.R.S. §36-2903.01(H)(5):
   a. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
   b. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent plus a fee of 1 percent penalty of the rate for each month or portion of the month thereafter.
3. A claim is paid on the date indicated on the disbursement check.
4. A claim is denied as of the date of the remittance advice.
5. The Administration shall process a hospital claim ~~according to R9-22-712~~ under 9. A.A.C. 22, Article 7.

~~**D.** Overpayments for AHCCCS Services.~~

1. ~~An AHCCCS registered provider shall notify the Administration when the provider discovers an overpayment was made by the Administration.~~
2. ~~The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS registered provider fails to return the incorrect payment amount to the Administration.~~

~~**E.** 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.~~
2. ~~The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS registered provider fails to return the incorrect payment amount to the Administration.~~
3. ~~The Administration shall document any recoupment of an overpayment on a remittance advice.~~
4. ~~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.~~

~~**F.** 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 hospital admissions under Article 2, and~~
   c. ~~Make records available for review by the Administration.~~
2. ~~The Administration shall reduce payment of or deny claims if an AHCCCS registered provider fails to obtain prior authorization or to notify the Administration under Article 2 and this Article.~~
3. ~~The Administration may conduct prepayment medical review and post-payment review on all hospital claims, including outlier claims.~~
4. ~~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, for the cost of the appropriate level of care.~~
5. ~~Post-payment reviews shall comply with A.R.S. § 36-2903.01.~~

D. Prior Authorization.

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 hospital admissions under Article 2, and
   c. Make records available for review by the Administration.
2. The Administration shall reduce payment of or deny claims if an AHCCCS registered provider fails to obtain prior authorization or to notify the Administration under Article 2 and this Article.
3. 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, for the cost of the appropriate level of care.

E. Claims Review.

1. The Administration may conduct prepayment and postpayment review of all claims, including but not limited to hospital claims.
2. Post-payment reviews shall comply with A.R.S. § 36-2903.01.
3. The Administration and its contractors shall review hospital claims that are timely received as specified in R9-22-703(B).
4. A charge for hospital services provided to a member during a time when the eligible person was not the financial responsibility of the Administration shall be denied.
5. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
   a. Patient care kit,
   b. Toothbrush,
   c. Toothpaste,
   d. Petroleum jelly,
   e. Deodorant,
   f. Septi soap,
   g. Razor,
   h. Shaving cream,
   i. Slippers,
   j. Mouthwash,
   k. Disposable razor,
   l. Shampoo,
   m. Powder,
   n. Lotion,
   o. Comb, and
   p. Patient gown.
6. The following hospital supplies and equipment, if medically necessary and used, are covered services:
   a. Arm board,
   b. Diaper,
   c. Underpad,
   d. Special mattress and special bed,
   e. Gloves,
   f. Wrist restraint,
   g. Limb holder,
   h. Disposable item used in lieu of a durable item,
   i. Universal precaution,
   j. Stat charge, and
   k. Portable charge.
7. The hospital claims review shall determine whether services rendered were:
   a. AHCCCS-covered services;
   b. Medically necessary;
   c. Provided in the most appropriate, cost-effective, least restrictive setting; and
   d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2903.01(H)(4).
8. If a claim is denied by either the Administration or its contractor, a request for a claim dispute challenging the denial may be filed against the entity denying the claim. The request for a claim dispute shall be filed as described under 9 A.A.C. 34.

F. Overpayment for AHCCCS Services.

1. An AHCCCS registered provider shall notify the Administration when the provider discovers an overpayment was made by the Administration.
2. The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS registered provider fails to return the incorrect payment amount to the Administration.
3. The Administration shall document any recoupment of an overpayment on a remittance advice.
4. An AHCCCS registered provider may file a grievance or request for hearing under 9 A.A.C. 34 if the AHCCCS registered provider disagrees with the recoupment action.

R9-22-705. Payments by Contractors

~~**A.** Authorization. A contractor shall pay for all admissions and covered services rendered to its members if a covered service~~

~~or an admission has been arranged by a contractor's agent or an employee, a subcontracting provider, or other individual acting on a contractor's behalf and if necessary authorization has been obtained. A contractor shall not require prior authorization for a medically necessary covered service provided during any prior period for which a contractor is responsible. A contractor is not required to pay a claim for a covered service that is:~~

~~1. Submitted more than six months after the date of the service or more than six months after the date of eligibility posting, whichever is later, or~~

~~2. Submitted as a clean claim more than 12 months after the date of the service or more than 12 months after the date of eligibility posting, whichever is later.~~

A. General Requirements.

1. A contractor shall contract with providers to provide covered services to members enrolled with them. The contractor is responsible for the reimbursement and coordination of care provided to a member, including when a member is referred to a provider who is not in the contractors network.
2. If necessary authorization has been obtained and the claim is otherwise payable, a contractor shall reimburse a provider or noncontracting provider for covered services provided to its members. Notwithstanding this provision a contractor shall reimburse emergency care in accordance with Article 2 of this Chapter.
3. A contractor shall reimburse a provider or noncontracting provider for non-hospital services at a rate not less than the Administration's capped fee schedule, in the absence of a contract.
4. For hospital services, the reimbursement levels established under A.R.S. § 36-2903.01 and 9. A.A.C. 22. Article 7 shall apply, if a contractor and a hospital do not agree on reimbursement levels, terms, and conditions.

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

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

~~2. Unless the subcontract specifies otherwise, a contractor shall pay valid clean claims according to 42 U.S.C. 1396u-2, August 5, 1997, which is incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments and states that:~~

~~a. 90% of valid clean claims shall be paid within 30 days of the date of receipt of a claim,~~

~~b. 99% of valid clean claims shall be paid within 90 days of the date of receipt of a claim, and~~

~~c. The remaining 1% of valid clean claims shall be paid within 12 months of the date of receipt of the claim.~~

~~3. Unless the subcontract specifies otherwise, a contractor shall provide notice of a denial or a reduction of a claim for:~~

~~a. 90% of the claims within 30 days of the date of receipt of a claim,~~

~~b. 99% of the claims within 90 days of the date of receipt of a claim, and~~

~~c. The remaining 1% of the claims within 12 months of the date of receipt of a claim.~~

~~4. A notice of denial or reduction shall include a statement describing the right to grieve the contractor's denial or reduction of a claim according to Article 8.~~

B. Timely Submission of Claims.

1. Under A.R.S. § 36-2904(G)(3), a contractor shall deem a paper or electronic claim as submitted on the date that it is received by the contractor. The contractor shall do one or more of the following for each claim it receives:
   a. Place a date stamp on the face of the claim;
   b. Assign a system-generated claim reference number; or
   c. Assign a system-generated date-specific number.
2. Unless a shorter time period is specified in contract, a contractor shall not pay a claim initially submitted for a covered service that does not meet the time limit described below:
   a. Six-months from the date of service, or for an inpatient hospital claim, six months from the date of discharge, or
   b. Six months from the date of eligibility posting, whichever is later.
3. Unless a shorter time period is specified in contract, a contractor shall not pay a clean claim for a covered service that does not meet the time limit described below:
   a. Twelve months from the date of service; or for an inpatient hospital claim, twelve months from the date of discharge, or
   b. Twelve months from the date of eligibility posting, whichever is later.
4. A claim is clean when it meets the requirements under A.R.S. § 36-2904(G)(1).

C. Date of Claim. A contractor's date of receipt of an inpatient or an outpatient hospital claim shall be the date the claim is received by the contractor as indicated by the date stamp on the claim, the claim reference number, or the date-specific number system assigned by the contractor. A hospital claim shall be considered paid on the date indicated on the disbursement check. A denied hospital claim shall be considered adjudicated on the date of its denial. A claim that is pending for additional supporting documentation shall receive a new date of receipt upon receipt of the additional documentation; however, a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01~~(J)~~ (H)(4) or 36-2904~~(K)~~(I)(1)(d), as applicable, will not receive a new date of receipt. A contractor

and a hospital may, through a contract approved as specified in R9-22-715~~(A)~~, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.

~~E~~**D.** Payment for inpatient hospital services. ~~A contractor shall reimburse an out-of-state hospital for the provision of hospital services at negotiated discounted rates, the Arizona average cost-to-charge ratio multiplied by covered charges or, if reasonably and promptly available, the Medicaid rate in effect at the time a service is provided in the state in which the hospital is located, whichever is lowest.~~ A contractor shall reimburse an in-state subcontractor and a noncontracting provider for the provision of inpatient hospital services rendered with an admission date on or after March 1, 1993, at either a rate specified by subcontract or, in absence of the subcontract, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and ~~A.A.C. R9-22-712~~ under 9 A.A.C. 22, Article 7. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904(~~K~~I)(1)(b) and A.A.C. R9-22-715. This subsection does not apply to a contractor participating ~~in the pilot program~~ as an Urban Hospital described in R9-22-718.

~~D~~**E.** Payment for ~~medically necessary~~ outpatient hospital services.

1. A contractor shall reimburse a subcontracting and a noncontracting provider for the provision of outpatient hospital services rendered on or after March 1, 1993 and before July 1, 2004, at either a rate specified by a subcontract or, in absence of a subcontract, as described under A.R.S. § 36-2903.01, as amended by Laws 2003, Chapter 268, Section 3, and as described in 9. A.A.C. 22, Article 7 ~~the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges~~. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval, under A.R.S. § 36-2904(~~K~~I)(1)(b) and A.A.C. R9-22-715.

~~2. A contractor shall pay for all emergency care services rendered to a member by a noncontracting provider or a nonprovider when the services:~~

~~a. Are rendered according to the prudent layperson standard specified in R9-22-210;~~

~~b. Conform to the definitions of emergency medical of behavioral health services in Articles 1 and 12, and conform to the emergency behavioral health emergency services requirements in R9-22-1205(E); and~~

~~c. Conform to the notification requirements in Article 2.~~

2. A contractor shall reimburse a subcontracting and a noncontracting provider for the provision of outpatient hospital services rendered as of July 1, 2004, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under A.R.S. § 36-2903.01 as amended by Laws 2004, Second Regular Session, Chapter 279 Section 3 and as described in 9. A.A.C. 22, Article 7. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval, under A.R.S. § 36-2904(I)(1)(b) and A.A.C. R9-22-715.

~~F. Payment for inpatient emergency behavioral health services. A contractor shall reimburse a provider for inpatient emergency behavioral health services as specified in R9-22-204 and R9-22-210 for members eligible according to A.R.S. § 36-2901(4)(a), (b), (c), (h), or (j). The payment methodology shall be as specified in R9-22-705 or R9-22-718.~~

F. Inpatient and Outpatient Out-of-state Hospital Payments. A contractor shall reimburse out of state hospitals for covered inpatient and outpatient services provided to AHCCCS members at the lesser of: the negotiated rate, the AHCCCS Fee schedule as described under A.R.S.§ 36-2903.01 and 9 A.A.C., Chapter 22, Article 7; or the Medicaid rate in effect in that state at the time the services were provided, if reasonably and promptly available.

G. Payment for observation days. A contractor may reimburse a subcontracting and a noncontracting provider for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, as prescribed under 9. A.A.C. 22, Article 7. ~~the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered charges.~~

H. Review of ~~hospital~~ claims.

1. A contractor may conduct a review of all claims submitted to that contractor. The contractor may recoup any payments made in error.

~~1~~2. ~~If a contractor and a hospital do not agree on reimbursement levels, terms, and conditions, the reimbursement levels established under A.R.S. § 36-2903.01 and A.A.C. R9-22-712 or R9-22-718 shall apply. In these cases, a~~A hospital shall obtain prior authorization from ~~an~~ the appropriate contractor for nonemergency admissions. A contractor shall consider the medical condition of a member, length of stay, and other factors when issuing its prior authorization. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the contract regarding utilization control activities. ~~Failure to obtain prior authorization when it is required shall be cause for nonpayment or denial of a claim.~~ A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and make a hospital's medical records, specific to a member enrolled with a contractor, available for review. Failure to obtain prior authorization when it is required shall be cause for nonpayment or denial of a claim.

~~2~~3. Regardless of prior authorization or concurrent review activities, all claims including but not limited to hospital claims, ~~including outlier claims,~~ are subject to prepayment medical review and post-payment review by a contractor. ~~Post-payment reviews shall be consistent with A.R.S. § 36-2903.01(O), and an erroneously~~ An erroneously paid claim is subject to ~~redeployment~~ recoupment. If prior authorization was given for a specific level of care, but medical review of a claim indicates that a different level of care was medically appropriate, a contractor ~~may~~ shall adjust ~~a claim to reflect the more~~ and pay the claim to reflect the cost for that appropriate level of care. An adjustment in level

of care shall be effective on the date when the different level of care was medically appropriate.

~~3~~4. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures ~~different from those in this subsection if a subcontract binds both parties~~ and meets the requirements of R9-22-715.

5. A contractor shall review hospital claims that are timely received as specified in R9-22-705(B).

6. A charge for hospital services provided to a member, during a time when the member was not the financial responsibility of the contractor, shall be denied, except as provided in Articles 2 and 5 of Chapter 22 of this Title, and as specified in contract.

7. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
   a. Patient care kit,
   b. Toothbrush,
   c. Toothpaste,
   d. Petroleum jelly,
   e. Deodorant,
   f. Septi soap,
   g. Razor,
   h. Shaving cream,
   i. Slippers,
   j. Mouthwash,
   k. Disposable razor,
   l. Shampoo,
   m. Powder,
   n. Lotion,
   o. Comb, and
   p. Patient gown.

8. The following hospital supplies and equipment, if medically necessary and used, are covered services:
   a. Arm board,
   b. Diaper,
   c. Underpad,
   d. Special mattress and special bed,
   e. Gloves,
   f. Wrist restraint,
   g. Limb holder,
   h. Disposable item used in lieu of a durable item,
   i. Universal precaution,
   j. Stat charge, and
   k. Portable charge.

9. The hospital claims review shall determine whether services rendered were:
   a. AHCCCS-covered services;
   b. Medically necessary;
   c. Provided in the most appropriate, cost-effective, least restrictive setting; and
   d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2904(I)(1).

10. If a claim is denied by either the Administration or its contractor, a request for a claim dispute challenging the denial may be filed against the entity denying the claim. The request for a claim dispute shall be filed as described under 9 A.A.C. 34.

I. Non-hospital claims. Claims processed and paid for services other than hospital shall be paid in accordance to contract. Contractors shall pay claims for non-hospital services in accordance with contract, or in the absence of a contract, at a rate not less than the Administration's capped fee schedule.

~~I~~J. ~~Timeliness of hospital claim payment~~ Payments to hospitals. Payment by a contractor for inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, shall be subject to ~~Laws 1993, 2nd Special Session, Ch. 6, § 29, as amended by Laws 1995, 1st Special Session, Ch. 5, § 8; Laws 1993, 2nd Special Session, Ch. 6, § 27, as amended by Laws 1995, 1st Special Session, Ch. 5, § 6; and A.R.S. § 36-2903.01(J)(6).~~the following as described under A.R.S. §36-2904(I)(1):

1. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
2. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent plus a fee of 1 percent penalty of the rate for each month or portion of the month thereafter.

K. Interest payment. In addition to (J), a contractor shall pay interest for late claims as defined by contract.

R9-22-715. Hospital Rate Negotiations

A. Effective for inpatient hospital admissions and outpatient hospital services on or after March 1, 1993, contractors that negotiate with hospitals for inpatient or outpatient services shall reimburse hospitals for member care ~~based on the prospective tiered per diem amount, the AHCCCS hospital specific outpatient cost to charge ratio multiplied by covered charges in~~ as described under A.R.S. § 36-2903.01, ~~and R9-22-712~~, and 9. A.A.C. 22, Article 7, or the negotiated rate that, when considered in the aggregate with other hospital reimbursement levels, does not exceed what would have been paid under A.R.S. § 36-2903.01, ~~and R9-22-712~~, and 9. A.A.C. 22, Article 7. This subsection does not apply to urban hospitals ~~participating in the pilot program~~ described under R9-22-718.

1. Contractors may engage in rate negotiations with hospitals at any time during the contract period.
2. Within seven days ~~of the completion of the agreement process~~ prior to the effective date of the contract, contractors shall submit copies of their negotiated rate agreements, including all rates, terms, and conditions, with hospitals to the Administration for approval. ~~Contractors shall demonstrate to the Administration that the effect of their negotiated rate agreement will, when considered in the aggregate, be the same as or produce greater dollar savings than would have been paid under A.R.S. § 36-2903.01, and R9-22-712.~~
   - ~~a. To demonstrate the aggregate effect of its negotiated rate agreement The Administration has the authority to require, contractors shall present their assumptions related to projected utilization of various hospitals to the Administration. The contractor may consider inpatient assumptions related to:~~
     - ~~i. Member mix;~~
     - ~~ii. Admissions by AHCCCS specified tiers;~~
     - ~~iii. Average length of stay by tier and pattern of admissions, excluding emergency admissions;~~
     - ~~iv. Outliers; and~~
     - ~~v. Risk sharing arrangements.~~
   - ~~b. The contractor also may consider outpatient assumptions related to member mix and outpatient service utilization. The Administration reserves the right to approve, deny, or require mutually agreed to modifications of these assumptions.~~
   - ~~c. When a contractor adjusts or modifies an assumption, the reason for the adjustment or modification shall be presented to the Administration, as well as the new assumption. The Administration may approve, deny, or require mutually agreed to modification of an assumption.~~
   - ~~d. To determine whether a negotiated rate agreement produces reimbursement levels that do not in the aggregate exceed what would be paid under A.R.S. § 36 2903.01, and R9 22 712, and R9 22 712.10, a contractor shall require its independent auditors to evaluate the reasonableness of its assumptions as part of its annual audit. The contractor shall ensure that its independent auditor's audit program is consistent with AHCCCS audit requirements and is submitted to the Administration for prior approval.~~
   - ~~e. Negotiated inpatient or outpatient rate agreements with hospitals with a contractor has a related party interest are subject to additional related party disclosure and evaluation. These evaluations are in addition to the procedures described in subsection (A)(2)(c) and shall be performed by the contractor's independent auditors, or, at the contractor's option, by the Administration.~~
   - ~~f. The Administration shall subject a contractor's independent auditor's report to any examination or review necessary to ensure accuracy of all findings related to aggregate rate determinations.~~
   - ~~g. The Administration shall use its standards, consistent with the Request for Proposals and R9-22-502, to determine whether a contractor's inpatient or outpatient hospital subcontractors will limit the availability or accessibility of services. The Administration reserves the right to reject hospital subcontracts that limit the availability or accessibility of services.~~

B. The Administration may negotiate or contract with a hospital on behalf of a contractor for discounted hospital rates and may require that the negotiated discounted rates be included in a subcontract between the contractor and hospital.

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

R9-22-717. ~~Hospital Claims Review~~ Repeal

~~A.~~ ~~The Administration and its contractors shall review hospital claims that are timely received as specified in R9-22-703(B).~~

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

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

1. ~~Patient care kit,~~
2. ~~Toothbrush,~~
3. ~~Toothpaste,~~
4. ~~Petroleum jelly,~~
5. ~~Deodorant,~~

~~6. Septi soap,~~
~~7. Razor,~~
~~8. Shaving cream,~~
~~9. Slippers,~~
~~10. Mouthwash,~~
~~11. Disposable razor,~~
~~12. Shampoo,~~
~~13. Powder,~~
~~14. Lotion,~~
~~15. Comb, and~~
~~16. Patient gown.~~

~~**D.** The following hospital supplies and equipment, if medically necessary and used, are covered services:~~
~~1. Arm board,~~
~~2. Diaper,~~
~~3. Underpad,~~
~~4. Special mattress and special bed,~~
~~5. Gloves,~~
~~6. Wrist restraint,~~
~~7. Limb holder,~~
~~8. Disposable item used in lieu of a durable item,~~
~~9. Universal precaution,~~
~~10. Stat charge, and~~
~~11. Portable charge.~~

~~**E.** The hospital claims review shall determine whether services rendered were:~~
~~1. AHCCCS-covered services;~~
~~2. Medically necessary;~~
~~3. Provided in the most appropriate, cost effective, least restrictive setting; and~~
~~4. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2903.01(J) or 36-2904(K), whichever is applicable.~~

~~**F.** If a claim is denied by either the Administration or its contractor, a grievance challenging the denial may be filed against the entity denying the claim. The grievance shall be filed no later than 12 months from the date of service, 12 months from the date of eligibility posting, or 35 days from the date of notice of adverse action, whichever is latest. Any grievance challenging a postpayment review recoupment action shall be filed by the provider no later than 12 months from the date of service, 12 months from the date of eligibility posting, or 35 days from the date of the notice of recoupment, whichever is latest.~~

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R05-44]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-28-101	Amend
R9-28-107	Repealed
R9-28-701	Amend
R9-28-705	Amend
R9-28-711	Amend
R9-28-713	Amend

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

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

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

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 3297, August 20, 2004
Notice of Rulemaking Docket Opening: 10 A.A.R. 4601, November 12, 2004
Notice of Rulemaking Docket Opening: 10 A.A.R. 4850, December 3, 2004

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

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4232
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@ahcccs.state.az.us

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

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

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

No studies were reviewed

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:

AHCCCS anticipates no impact.

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:	Mariaelena Ugarte
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4232
Fax:	(602) 256-6756
E-mail:	AHCCCSRules@ahcccs.state.az.us

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of February 4, 2005. Please send written comments to the above address by 5:00 p.m., March 21, 2005. E-mail will be accepted.

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

Date:	March 21, 2005
Time:	2:00 p.m.
Location:	AHCCCS 701 E. Jefferson Phoenix, AZ 85034 Gold Room
Nature:	Public Hearing
Date:	March 21, 2005
Time:	2:00 p.m.
Location:	ALTCS: Arizona Long-term Care System

	110 S. Church, Suite 1360 Tucson, AZ 85701
Nature:	Public Hearing
Date:	March 21, 2005
Time:	2:00 p.m.
Location:	ALTCS: Arizona Long-term Care System 3480 East Route 66 Flagstaff, AZ 86004
Nature:	Public Hearing

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 9. HEALTH SERVICES

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

ARTICLE 1. DEFINITIONS

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

ARTICLE 7. STANDARDS FOR PAYMENTS

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

ARTICLE 1. DEFINITIONS

R9-28-101. General Definitions

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

Definition	Section or Citation
"Administration"	A.R.S. § 36-2931
"ADHS"	R9-22-112
"Aggregate"	R9-22-107
"AHCCCS"	R9-22-101
"AHCCCS Registered Provider"	R9-22-101
"Algorithm"	R9-28-104
"ALTCS"	R9-28-101
"ALTCS acute care services"	R9-28-104
"Alternative HCBS setting"	R9-28-101
"Ambulance"	R9-22-102
"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"	R9-22-112
"Capped fee-for-service"	R9-22-101
"Case management plan"	R9-28-101
"Case manager"	R9-28-101
"Case record"	R9-22-101
"Categorically-eligible"	R9-22-101
"Certification"	R9-28-105
"Certified psychiatric nurse practitioner"	R9-22-112
"CFR"	R9-28-101
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-22-112
"CMS"	R9-22-101
"Community Spouse"	R9-28-104
"Contract"	R9-22-101
"Contract year"	R9-28-101
"Contractor"	A.R.S. § 36-2901
"County of fiscal responsibility"	R9-28-107
"Covered services"	R9-28-101
"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
"Fee-For-Service" or "FFS"	R9-28-101
"Grievance"	R9-22-108
"GSA"	R9-22-101
"Guardian"	A.R.S. § 14-5311
"HCBS" or "Home and community based services"	A.R.S. §§ 36-2931 and 36-2939
"Health care practitioner"	R9-22-112
"Hearing"	R9-22-108
"Home"	R9-28-101
"Home health services"	R9-22-102
"Hospital"	R9-22-101
"ICF-MR" or "Intermediate care facility for the mentally retarded"	42 CFR 483 Subpart I
"IHS"	R9-28-101
"IMD"	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" or "NF"	42 U.S.C. 1396r(a)
"Noncontracting provider"	A.R.S. § 36-2931
"Occupational therapy"	R9-22-102
"Partial care"	R9-22-112
"PAS"	R9-28-103
"Pharmaceutical service"	R9-22-102
"Physical therapy"	R9-22-102
"Physician"	R9-22-102
"Post-stabilization services"	42 CFR 438.114
"Practitioner"	R9-22-102
"Primary care provider (PCP)"	R9-22-102
"Primary care provider services"	R9-22-102
"Prior authorization"	R9-22-102
"Prior period coverage" or "PPC"	R9-22-107
"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" or "RBHA"	A.R.S. § 36-3401
"Radiology"	R9-22-102
"Reassessment"	R9-28-103
"Redetermination"	R9-28-104
"Referral"	R9-22-101
"Reinsurance"	R9-22-107
"Representative"	R9-28-104
"Respiratory therapy"	R9-22-102
"Respite care"	R9-28-102
"RFP"	R9-22-106
"Room and board"	R9-28-102
"Scope of services"	R9-28-102
"Section 1115 Waiver"	A.R.S. § 36-2901
"Speech therapy"	R9-22-102
"Spouse"	R9-28-104
"SSA"	42 CFR 1000.10
"SSI"	R9-22-101
"Subcontract"	R9-22-101
"Utilization management"	R9-22-105
"Ventilator dependent"	R9-28-102

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

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

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

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

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

Group home defined in A.R.S. § 36-551;
State-operated group home under A.R.S. § 36-591;
Group foster home under R6-5-5903;
Licensed residential facility for a person with traumatic brain injury under A.R.S. § 36-2939;
Adult therapeutic foster home under 9 A.A.C 20, Articles 1 and 15;
Level 2 and Level 3 behavioral health agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6; and
Rural substance abuse transitional agencies under 9 A.A.C. 20, Articles 1 and 14; and

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

Adult foster care homes defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939;
Assisted living home or assisted living center, units only, under A.R.S. § 36-401, and as authorized in A.R.S. § 36-2939;
Licensed residential facility for a person with a traumatic brain injury specified in A.R.S. § 36-2939;
Adult therapeutic foster home under 9 A.A.C. 20, Articles 1 and 15;
Level II and Level III 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; and
Alzheimer's treatment assistive living facility demonstration pilot project as specified in Laws 1999, Ch. 313, § 35 as amended by Laws 2001, Ch. 140, § 1 and Laws 2003, Ch. 76, § 1.

"Case management plan" means a service plan developed by a case manager that involves the overall management of a member's care, and the continued monitoring and reassessment of the member's need for services.
"Case manager" means a person who is either a degreed social worker, a licensed registered nurse, or a person with a minimum of two years of experience in providing case management services to a person who is elderly and physically disabled or has developmental disabilities.
"Contract year" means the period beginning on October 1 and continuing until September 30 of the following year.
"CFR" means Code of Federal Regulations, unless otherwise specified in this Chapter.
"Covered Services" means the health and medical services described in Articles 2 and 11 of this Chapter as being eligible for reimbursement by AHCCCS.
"Fee-For-Service" or "FFS" means a method of payment to registered providers on an amount per service basis.
"Home" means a residential dwelling that is owned, rented, leased, or occupied by a member, at no cost to the member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

Health care institution under A.R.S. § 36-401;
Residential care institution under A.R.S. § 36-401;
Community residential setting under A.R.S. § 36-551; or
Behavioral health service under 9 A.A.C. 20, Articles 1, 4, 5, and 6.

"IHS" means the Indian Health Service.
"JCAHO" means the Joint Commission on Accreditation of Healthcare Organizations.

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

~~Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:~~
~~"County of fiscal responsibility" means the county that is financially responsible for the state's share of ALTCS funding.~~

ARTICLE 7. STANDARDS FOR PAYMENTS

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

~~The Administration shall bear no liability for providing covered services or completing a plan of treatment for a member beyond the date of termination of the member's eligibility.~~
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:
"County of fiscal responsibility" means the county that is financially responsible for the state's share of ALTCS funding.

R9-28-705. Payments by Program Contractors

~~**A.** Authorization. A program contractor shall pay for all ALTCS covered services rendered to a member when the service or admission has been arranged by a program contractor's agent, an employee, a provider, or other individual acting on a program contractor's behalf, and for which necessary authorization has been obtained.~~
~~**B.** Timeliness of provider claim payment. A program contractor shall pay a claim or shall provide a notice for a denied or a reduced claim as specified in A.A.C. R9-22-705.~~
~~**C.** Payment for a long-term care service in an institutional and a home and community-based setting. A program contractor shall submit annually to the Administration, a program contractor's proposed payment methodology for reimbursement of~~

~~a participating provider for long-term care services in an institutional and a home and community-based setting. All payment methods and rates of payment shall be subject to the approval of the Administration based on the reasonableness of the methods and rates. A program contractor shall use the following types of reimbursement:~~

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

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

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

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

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

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

A. General Requirements. A contractor will contract with providers as described under R9-22-705.
B. Timely Submission of Claims. A contractor will submit claims as described under R9-22-705.
C. Date of Claim. A contractor's date of receipt is described under R9-22-705.
D. Payment for inpatient hospital services. A contractor shall reimburse for inpatient services as described under R9-22-705.
E. Payment for outpatient hospital services. A contractor shall reimburse for outpatient services as described under R9-22-705.
F. Inpatient and Outpatient Out-of-state Hospital Payments. A contractor shall reimburse for out of state services as described under R9-22-705.
G. Payment for observation days. A contractor may reimburse as described under R9-22-705.
H. Review of claims. A contractor shall conduct a review of all claims as described under R9-22-705.
I. Timeliness of hospital claim payment. A contractor may reimburse as described under R9-22-705.
J. Interest payment. A contractor may reimburse as described under R9-22-705.

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

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

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

R9-28-713. Hospital Rate Negotiations

A. A program contractor that negotiates with a hospital for inpatient services shall reimburse hospitals for a member's care under A.A.C. R9-22-715~~(A)~~.
B. ~~If the~~ The Administration may negotiate~~s~~ or contract~~s~~ as described under R9-22-715.~~with hospitals on behalf of program contractors for discounted hospital rates, the negotiated discounted rates shall be included in contracts between a program contractor and a hospital when in the best interest of the state.~~
~~**C.** The Director shall apportion any cost avoidance in the hospital component of provider capitation rates between the Administration and program contractor. The Administration's portion of the cost avoidance shall be reflected in reduced capitation rates paid to a program contractor.~~

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R05-45]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

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

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

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

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

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

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

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

Name: Mariaelena Ugarte

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

Telephone: (602) 417-4232

Fax: (602) 253-9115

E-mail: AHCCCSRules@ahcccs.state.az.us

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

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

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

No studies were reviewed.

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:

AHCCCS anticipates no impact.

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: Mariaelena Ugarte

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

Telephone: (602) 417-4232

Fax: (602) 256-6756

E-mail: AHCCCSRules@ahcccs.state.az.us

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of February 4, 2005. Please send written comments to the above address by 5:00 p.m., March 21, 2005. E-mail will be accepted.

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

Date: March 21, 2005
Time: 2:00 p.m.
Location: AHCCCS
701 E. Jefferson
Phoenix, AZ 85034
Gold Room
Nature: Public Hearing

Date: March 21, 2005
Time: 2:00 p.m.
Location: ALTCS: Arizona Long-term Care System
110 S. Church, Suite 1360
Tucson, AZ 85701
Nature: Public Hearing

Date: March 21, 2005
Time: 2:00 p.m.
Location: ALTCS: Arizona Long-term Care System
3480 E. Route 66
Flagstaff, AZ 86004
Nature: Public Hearing

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 9. HEALTH SERVICES

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

ARTICLE 7. STANDARDS FOR PAYMENTS

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

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

Section
R9-31-1619. Hospital Claims Review

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-31-705. Payments by Contractors

~~A. Authorization. A contractor shall pay for all admissions and covered services rendered to its members if the covered services or admissions have been arranged by the contractor's agents or employees, subcontracting providers, or other indi-~~

viduals acting on the contractor's behalf and if necessary authorization has been obtained. A contractor is not required to pay a claim for covered services that is submitted more than six months after the date of the service or that is submitted as a clean claim more than 12 months after the date of the service.

B. Timeliness of provider claim payment.

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

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

D. Payment for medically necessary outpatient hospital services.

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

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

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

G. Review of hospital claims.

1. If a contractor and a hospital do not agree on reimbursement levels, terms, and conditions, the reimbursement levels established under A.R.S. §§ 36-2987, 36-2904, 36-2903.01, and A.A.C. R9-22-712 or R9-31-718 shall apply. In these cases, a hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. A contractor shall consider the medical condition of the member, length of stay, and other factors when issuing its prior authorization. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of their contract regarding utilization control activities that may include prior authorization of nonemergency admissions. Failure to obtain prior authorization when it is required shall be cause for nonpayment or denial of the claim. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and make the hospital's

~~medical records, specific to a member enrolled with the contractor, available for review.~~

~~2. Regardless of prior authorization or concurrent review activities, all hospital claims, including outlier claims, are subject to prepayment medical review and post-payment review by the contractor. Post-payment reviews shall be consistent with A.R.S. § 36-2987, and erroneously paid claims are subject to recoupment. If prior authorization was given for a specific level of care, but medical review of the claim indicates that a different level of care was appropriate, the contractor may adjust the claim to reflect the more appropriate level of care. An adjustment in level of care shall be effective on the date when the different level of care was medically appropriate.~~

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

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

A. General Requirements. A contractor will contract with providers as described under R9-22-705.

B. Timely Submission of Claims. A contractor will submit claims as described under R9-22-705.

C. Date of Claim. A contractor's date of receipt is described under R9-22-705.

D. Payment for inpatient hospital services. A contractor shall reimburse for inpatient services as described under R9-22-705.

E. Payment for outpatient hospital services. A contractor shall reimburse for outpatient services as described under R9-22-705.

F. Inpatient and Outpatient Out-of-state Hospital Payments. A contractor shall reimburse for out of state services as described under R9-22-705.

G. Payment for observation days. A contractor may reimburse as described under R9-22-705.

H. Review of claims. A contractor shall conduct a review of all claims as described under R9-22-705.

I. Timeliness of hospital claim payment. A contractor may reimburse as described under R9-22-705.

J. Interest payment. A contractor may reimburse as described under R9-22-705.

R9-31-715. Hospital Rate Negotiations

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

~~1. Contractors may engage in rate negotiations with hospitals at any time during the contract period.~~

~~2. Within seven days of the completion of the agreement process, contractors shall submit copies of their negotiated rate agreements, including all rates, terms, and conditions, with hospitals to the Administration for approval. Contractors shall demonstrate to the Administration that the effect of their negotiated rate agreement will, when considered in the aggregate, be the same as or produce greater dollar savings than would have been paid under A.R.S. § 36-2987 and A.A.C. R9-22-712.~~

~~a. To demonstrate the aggregate effect of its negotiated rate agreement, contractors shall present their assumptions related to projected utilization of various hospitals to the Administration. The contractor may consider inpatient assumptions related to:~~

~~i. Member mix;~~

~~ii. Admissions by AHCCCS-specified tiers;~~

~~iii. Average length of stay by tier and pattern of admissions, excluding emergency admissions;~~

~~iv. Outliers; and~~

~~v. Risk-sharing arrangements.~~

~~b. The contractor also may consider outpatient assumptions related to member mix and outpatient service utilization. The Administration reserves the right to approve, deny, or require mutually-agreed-to modifications of these assumptions.~~

~~c. When a contractor adjusts or modifies an assumption, the reason for the adjustment or modification shall be presented to the Administration, as well as the new assumption. The Administration may approve, deny, or require mutually-agreed-to modification of an assumption.~~

~~d. To determine whether a negotiated rate agreement produces reimbursement levels that do not in the aggregate exceed what would be paid under A.R.S. § 36-2987 and A.A.C. R9-22-712, a contractor shall require its independent auditors to evaluate the reasonableness of its assumptions as part of its annual audit. The contractor shall ensure that its independent auditor's audit program is consistent with AHCCCS audit requirements and is submitted to the Administration for prior approval.~~

~~e. Negotiated inpatient or outpatient rate agreements with hospitals with a contractor has a related-party interest are subject to additional related party disclosure and evaluation. These evaluations are in addition to the procedures described in subsection (A)(2)(c) and shall be performed by the contractor's independent auditors, or, at the con-~~

~~tractor's option, by the Administration.~~

~~f. The Administration shall subject a contractor's independent auditor's report to any examination or review necessary to ensure accuracy of all findings related to aggregate rate determinations.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

R9-31-1619. Hospital Claims Review

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

NOTICE OF PROPOSED RULEMAKING

TITLE 12. NATURAL RESOURCES

CHAPTER 7. OIL AND GAS CONSERVATION COMMISSION

[R05-55]

PREAMBLE

1. Sections Affected **Rulemaking Action**
R12-7-103 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. §§ 27-516(A) and 27-656

Implementing statutes: A.R.S. §§ 27-516(A)(3) and 27-654

3. A list of all previous notices concerning the rules:
Notice of Rulemaking Docket Opening: 10 A.A.R. 4122, October 8, 2004

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

Name:	Steven L. Rauzi, Oil & Gas Administrator
Address:	Arizona Geological Survey 416 W. Congress, Suite 100 Tucson, AZ 85701-1315
Telephone:	(520) 770-3500
Fax:	(520) 770-3505

5. An explanation of the rule, including the agency's reasons for initiating the rule:
R12-7-103 specifies bonding requirements and amounts. The agency is amending R12-7-103 to provide sufficient surety for plugging abandoned wells and to improve clarity and understandability.

6. A reference to any study that the agency proposes to rely on or not 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:
These rules directly impact companies drilling for oil, gas, and geothermal resources. The rule is mostly procedural in nature and will not significantly impact the economy or have a significant impact upon small businesses or consumers. The amount of an individual well bond is not changed. The amount of a blanket bond is increased. The bond is conditioned on the performance by the operator to drill each well in a manner to prevent waste, plug each dry or abandoned well, repair each well causing waste or pollution, and maintain and restore the wellsite. The proposed rulemaking will benefit the regulated community by clarifying reporting requirements.

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:	Steven L. Rauzi, Oil & Gas Administrator
Address:	Arizona Geological Survey 416 W. Congress, Suite 100 Tucson, AZ 85701-1315
Telephone:	(520) 770-3500
Fax:	(520) 770-3505

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule or, if no proceed-

ing is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date:	May 13, 2005
Time:	10:00 a.m.
Location:	1616 W. Adams, Room 321 Phoenix Arizona 85007
Nature:	Oral proceeding to adopt amended rules

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. Incorporation by reference and their location in the rules:

None

13. The full text of the rules follows:

TITLE 12. NATURAL RESOURCES

CHAPTER 7. OIL AND GAS CONSERVATION COMMISSION

ARTICLE 1. OIL, GAS, HELIUM, AND GEOTHERMAL RESOURCES

Section
R12-7-103. Bond

ARTICLE 1. OIL, GAS, HELIUM, AND GEOTHERMAL RESOURCES

R12-7-103. Bond

A. An operator shall file a performance bond with the Commission prior to approval of a permit to drill a new well, re-enter an abandoned well, or assume responsibility as operator of existing wells. ~~The bond amount shall be $10,000 for a well drilled to a total depth of 10,000 feet or less, $20,000 for a well drilled deeper than 10,000 feet, or $25,000 as a blanket bond to cover all wells and~~ The performance bond shall be payable to the Oil and Gas Conservation Commission, State of Arizona, and conditioned upon the faithful performance by the operator of the duty to drill each well in a manner to prevent waste, plug each dry or abandoned well, repair each well causing waste or pollution, and maintain and restore the well site.

1. The bond amount shall be $10,000 for a well drilled to a total depth of 10,000 feet or less or $20,000 for a well drilled deeper than 10,000 feet.
2. A blanket bond may be used to cover all wells as follows:
   a. $25,000 for 10 or fewer wells;
   b. $50,000 for more than 10 but fewer than 50 wells; and
   c. $250,000 for more than 50 wells.

B. The Commission shall accept a bond in the form of a surety bond, executed by the operator as principal and a corporate surety authorized to do business in Arizona, a certified check, or a certificate of deposit at a federally insured bank authorized to do business in Arizona.

C. Transfer of property does not release the bond. If a property is transferred and the principal desires to be released from the bond, the procedure shall be as follows:

1. The principal on the bond shall notify the Commission in writing of the proposed transfer, giving the location of each well, the date and number of each permit to drill, and the name, address, and telephone number of the proposed transferee.
2. The transferee of any well or of the operation of any well shall declare to the Commission in writing acceptance of the transfer and of the responsibility of each well and shall submit a new bond or bonds unless the transferee's blanket bond applies to the well or wells.
3. When the Commission approves the transfer, the transferor is released from all responsibility with respect to the well or wells, and the Commission shall notify the principal and the bonding company in writing that the transferor's applicable bond or bonds are subject to release.