NOTICES OF FINAL RULEMAKING

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

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

[R05-309]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-201	Amend
R9-22-702	Amend

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

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

Implementing statute: A.R.S. § 36-2903.01(L)

3. The effective date of the rules:

October 1, 2005

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 3978, October 1, 2004

Notice of Proposed Rulemaking: 11 A.A.R. 836, February 25, 2005

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

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E-mail:	Jane.McVay@azahcccs.gov

6. An explanation of the rule, including the agency's reason for initiating the rule:

The rules clarify existing rule language regarding member billing for acute care services provided under the AHCCCS program. The existing rules require modification to clarify the meaning and intent of the rules. Existing rules allow a member who requests an uncovered service or a service not authorized by a contractor or the Administration, to receive the service and under certain circumstances request reimbursement for the provider. The provider must prepare and provide the member a document that lists the overall services and the estimated cost of the services. This document, which the member signs before the member receives the services, states that the member understands and accepts responsibility for payment. The rulemaking was intended to clarify for both providers and members the circumstances under which a member can be billed for services, including a member eligible for emergency services through the Federal Emergency Service Program (FESP).

A qualified alien or noncitizen of the United States who is not eligible for full covered emergency services under Title XIX of the Social Security Act may apply to AHCCCS for coverage of emergency services through the Federal Emergency Services Program (FESP), which is incorporated in R9-22-217. These services are for treatment of an emergency medical condition in FESP as defined in R9-22-217. The existing member billing rule has been interpreted to mean that AHCCCS registered providers are not allowed to bill Federal Emergency Services (FES) members when health care services are provided for a condition the providers believe to be an emergency medical

condition, but the Administration subsequently determines the condition does not meet the criteria for an emergency. In these cases, AHCCCS does not have the authority to reimburse for services to treat a condition that does not meet the federal criteria for an emergency.

These rules will provide additional clarification that providers can bill members for services to treat a condition that does not meet the criteria for an emergency medical condition under the Federal Emergency Services Program (FESP). In addition, the rule authorizes an AHCCCS registered provider to charge and collect payment for services from a member if the member requests an uncovered or unauthorized service if certain conditions are met. The provider must prepare a document for the member describing the services and overall cost. The member must also sign the document, which states that the member accepts responsibility to pay for uncovered or unauthorized services.

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

AHCCCS did not review any studies relating to these rules.

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

Not applicable

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

The rules are expected to have a positive economic impact on AHCCCS registered providers by providing clarity to the issue of member billing. When AHCCCS registered providers deliver services to members in the Federal Emergency Services Program (FESP) in the reasonable belief that the services meet the criteria for an emergency, but the Administration subsequently determines that emergency service criteria were not met, the provider will be able to bill the member.

AHCCCS registered providers will have authority to charge a member for additional services requested that are not covered or not authorized by the Administration or a contractor, by presenting the member with a document showing service cost, and requiring the member to sign the document in advance of the service. Although the overall economic impact of the rules on AHCCCS registered providers in collecting for uncovered or unauthorized services is unknown, the impact could be favorable to them. Because FES and acute care members are indigent, the rules are expected to have only a minimal economic impact on revenues collected by AHCCCS registered providers.

Providers and consumers will clearly understand that a member is financially responsible for services requested that are not covered, or not authorized by a contractor or the Administration, including services to members eligible for FESP that the Administration subsequently determines do not meet emergency services criteria. Because AHCCCS registered providers have been previously giving members a cost document to show the cost of services requested that are not covered or not authorized, these rules will not impose any new costs on the providers.

The agency believes that these rules will reduce the number of inquiries and disputes between the agency and providers and the number of inquiries from members on billing issues. The rules may also reduce the agency's administrative costs to conduct hearings. The rules clarify that AHCCCS registered providers may bill a member who requests services that are not covered or authorized by the Administration. In addition, the rules clarify that an AHCCCS registered provider who provides emergency services to a member eligible for FESP does not need to obtain a signed document from a member accepting financial responsibility before providing emergency services. The agency also hopes to reduce the number of non-emergency uses of the emergency room.

The agency reviews each instance in which emergency services are provided to a member under FESP to determine if an emergency did exist at the time of service. If the agency determines that the service was for a condition that does not meet the federal definition of an emergency medical condition and was not a covered service, the agency denies payment. In these cases, a member eligible under FESP can be billed for these services. Under these circumstances, the rules will have an economic impact on FESP members regarding services they received that the Administration did not have authority to pay, however, the agency is unable to quantify the impact.

The agency also believes that it will be easier and less time-consuming for a provider to comply with the cost document requirement. The current rules require an itemized document that shows the estimated cost of each service. However, under this rule, the provider prepares a document describing the overall services and the approximate cost of the services. The agency feels this requirement will be a more reasonable one with which providers can more easily comply.

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

AHCCCS revised R9-22-201(B)(1) as follows: "Only medically necessary, cost effective, and ~~federally reimbursable~~ federally-reimbursable and state-reimbursable services are covered services~~;~~.

In R9-22-201 AHCCCS revised subsection (F) as follows: "A service is not a covered service if provided outside the GSA unless one of the following applies:"

In R9-22-201(E) the second sentence was revised as follows: "The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

AHCCCS made grammatical and stylistic changes at the suggestion of the Governor's Regulatory Review Council staff.

In addition, AHCCCS has deleted the following language from R9-22-201(B)(11)(d), which provides an exclusion from covered service, from the final rules: "A person under age 22 who is in residence at an IMD, unless the person is receiving inpatient psychiatric services." An existing federal regulation, 42 CFR 435.1008(a)(2), provides that federal funding is available for individuals under age 22, who are patients in an Institution for Mental Diseases and are receiving inpatient psychiatric services. Although there has not been a change in this federal provision, the regulation does not require each state to have a conforming rule on this subject. AHCCCS believes that the agency can rely exclusively on this federal provision for policy direction regarding coverage for inpatient psychiatric services for this population. Neither proposed addition of this language nor deletion of this language from the rule represents a change in policy or practice regarding covered services for persons in an IMD. AHCCCS has covered and will continue to cover inpatient psychiatric services for individuals under age 22 in an IMD. In addition, the scope of services for persons under age 22 who are in residence at an IMD may be the subject of federal policy changes in the future. Following the close of record, a commenter stated that this rule language is unclear regarding covered services for this population. For these reasons, the agency decided that the best course of action is to delete this language from the rules and rely on the existing federal regulation.

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

A commenter requested expansion of the rule to authorize providers to bill AHCCCS members who fail to cooperate to secure primary payment from commercial health insurance plans. An existing AHCCCS rule, R9-22-1004, requires a member to cooperate in identifying potentially legally liable first-party or third-party liability and to notify AHCCCS of the sources. AHCCCS staff provides information staff has obtained from a member to a provider regarding other insurance coverage. This rulemaking deals with member billing for services that are not covered or not authorized within the Federal Emergency Services Program, as well as acute care services requested by a member that are not covered or not authorized by the Administration or a contractor. Addressing the issue of member cooperation with the AHCCCS registered provider to divulge insurance information would be a substantial rule change that is outside the scope of this rulemaking. AHCCCS appreciates the concern of the commenter regarding this issue. The existing rules do require a member to cooperate to identify legally liable first-party or third-party liability. AHCCCS also shares information with providers about other health insurance coverage held by members to assist providers in obtaining third-party reimbursement.

An informal comment was received by AHCCCS regarding the language in R9-22-201(B)(11)(d) after the close of record. The commenter felt that the rule language was unclear regarding covered services for persons under 22 who reside in an Institution for Mental Diseases. Because a federal regulation currently exists regarding inpatient psychiatric services for this population, AHCCCS decided to remove this language from the final rulemaking as further discussed in Preamble number 10 above.

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

Not applicable

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

None

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

No.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 2. SCOPE OF SERVICES

Section
R9-22-201. General Requirements

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-702. ~~Prohibitions Against~~ Charges to Members

ARTICLE 2. SCOPE OF SERVICES

R9-22-201. General Requirements

A. For the purposes of this Article, the following definitions apply:
1. "Authorization" means written or verbal authorization by:
   a. The Administration for services rendered to a fee-for-service member~~, and~~ or
   b. The contractor for services rendered to a prepaid capitated member.
2. Use of the phrase "attending physician" applies only to the fee-for-service population.

B. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:
1. Only medically necessary, cost effective, and ~~federally reimbursable~~ federally-reimbursable and state-reimbursable services are covered services~~;~~.
2. Covered services for the federal emergency services ~~programs~~ program (FESP) are under R9-22-217~~;~~.
3. The Administration or a contractor may waive the covered services referral requirements ~~required by~~ of this Article~~;~~.
4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner ~~shall~~ does not diminish the role or responsibility of the primary care provider~~;~~.
5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider~~;~~.
6. A member may receive behavioral health evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from ~~and in consultation with~~ the primary care provider, or upon authorization by the contractor or ~~its~~ the contractor's designee~~;~~.
7. A member may receive ~~a~~ treatment that is considered the standard of care, or that is approved by the AHCCCS Chief Medical Officer after appropriate ~~consultative~~ input from providers who are considered experts in the field by the professional medical community~~;~~.
8. ~~A member shall receive~~ AHCCCS or a contractor shall provide services ~~according to~~ under the Section 1115 Waiver as defined in A.R.S. § 36-2901~~;~~.
9. An AHCCCS registered provider shall provide covered services within the provider's scope of practice~~;~~.
10. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
    a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
    b. Services or items furnished gratuitously~~;~~, and
    c. Personal care items~~; , and~~
11. Medical or behavioral health services are not covered services if provided to:
    a. An inmate of a public institution;
    b. A person who is in residence at an institution for the treatment of tuberculosis; or
    c. A person age 21 through 64 who is in an IMD, unless provided under Article 12 of this Chapter.

C. The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. ~~Documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.~~ The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

D. Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.

E. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. ~~Diagnostic and treatment procedures for a condition that is unrelated to the emergency medical condition require prior authorization by the Administration or contractor.~~ The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

F. ~~A member shall receive covered services~~ A service is not a covered service if provided outside the ~~contractor's~~ GSA ~~service area only if one of the following apply~~ unless one of the following applies:
1. A member is referred by a primary care provider for medical specialty care ~~out~~ outside ~~of~~ the ~~contractor's area.~~ GSA. If a member is referred ~~out~~ outside ~~of~~ the ~~contractor's service area~~ GSA to receive an authorized medically necessary service, ~~a~~ the contractor shall also provide all other medically necessary covered services for the member~~.~~;
2. There is a net savings in service delivery costs as a result of going outside the ~~service area~~ GSA that does not require undue travel time or hardship for a member or the member's family;

3. The contractor authorizes placement in a nursing facility located out of the ~~contractor's service area~~ GSA; or
4. Services are provided during ~~the~~ prior period coverage. ~~time-frame.~~

G. If a member is traveling or temporarily residing ~~out~~ outside of the ~~member's contractor service area,~~ GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

H. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this ~~Article,~~ Chapter~~,~~ and in contract.

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

~~**J.** If a member requests the provision of a service that is not covered or not authorized by a contractor or the Administration, an AHCCCS registered provider may render the service and request reimbursement from the member if:~~

~~1. The provider prepares and provides the member with a document that lists the requested services and the estimated cost of each service, and~~

~~2. The member signs the document prior to the provision of services indicating that the member understands and accepts the responsibility for payment.~~

~~**K.**~~**J.** The restrictions, limitations, and exclusions in this Article do not apply to the following~~:~~ ~~groups:~~

1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27~~,~~; ~~and benefits not covered by AHCCCS,~~ and
2. A contractor electing to provide noncovered services.
   a. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
   b. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-702. ~~Prohibitions Against~~ Charges to Members

A. Except as provided in ~~subsection (B),~~ subsections (B), (C), and (D), an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration that the person was ~~ineligible for~~ not an eligible person ~~AHCCCS~~ on the date of service:

1. Charge, submit a claim to, or demand or collect payment from a person claiming to be ~~AHCCCS~~ an eligible person~~;~~ ~~eligible;~~ or
2. Refer or report a person claiming to be ~~AHCCCS~~ an eligible person to a collection agency or credit reporting agency.

B. An AHCCCS registered provider that submits a claim shall not charge more than the actual, reasonable cost of providing the covered service.

~~**B.**~~**C.** An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment from a member as follows:

1. To collect an authorized copayment;
2. ~~To pay for non-covered services;~~
3. 2. To recover from a member that portion of a payment made by a ~~third-party~~ third party to the member if the payment duplicates AHCCCS-paid benefits and is not assigned to a contractor~~;~~ or ~~under R9-22-1002(B). An AHCCCS registered provider that makes a claim shall not charge more than the actual, reasonable cost~~ of ~~providing the covered service; or~~
4. 3. To ~~bill~~ obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused ~~the~~ payment to the provider to be reduced or denied.

~~**C.**~~**D.** An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment for services from a member if:

1. The member requests the provision of a service that is not covered or not authorized by the contractor or the Administration; and
2. The provider prepares and provides the member with a document describing the overall services and the approximate cost of the services; and
3. The member signs the document prior to services being provided, indicating that the member understands and accepts responsibility for payment.

~~D.~~**E.** Notwithstanding subsection (D), an AHCCCS registered provider may charge, submit a claim to, or demand or collect payment for services from a member eligible for the FESP if:

1. The provider submits a claim to the Administration in the reasonable belief that the service is for treatment of an emergency medical condition; and
2. The Administration denies the claim because the service does not meet the criteria of R9-22-217.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

[R05-312]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

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

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

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

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

3. The effective date of the rules:

October 1, 2005

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

Notice of Proposed Rulemaking: 11 A.A.R. 759, February 18, 2005

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

Name: Mariaelena Ugarte

Address: AHCCCS
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Phoenix, AZ 85034

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6. An explanation of the rule, including the agency's reason for initiating the rule:

The proposed rules are being amended as a result of a 5-Year-Rule Review, finding that clarification was needed to address how contractors and the Administration make payments. Statutory references were updated and the rule reorganized for clarity.

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

No studies were reviewed.

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

Not applicable

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

AHCCCS anticipates minimal impact.

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

R9-22-705 has an added subsection in General Requirements for providers. This subsection was added for consistency because this same requirement is described in R9-22-703. It applies to providers of fee-for-service services, and to those providers that provide services via a contractor.

References to the new rules that go into effect July 1, 2005 for outpatient services have been added.

R9-22-705 (A) has been rewritten to clarify and condense the verbiage. The meaning remains the same therefore the clarification is not a substantial change.

In addition to the changes identified above, the Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.

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

None received

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

Not applicable

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

42 CFR 431.107(b), March 6, 1992, R9-22-705

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

No.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-703. ~~Claims Submission to the Administration~~ Payments by 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~~ Payments by the Administration

A. General requirements. ~~AHCCCS registered providers. An AHCCCS registered~~ A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § ~~36-2904(E)~~ 36-2904 and 42 CFR 431.107(b) as of ~~April~~ March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. ~~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, 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 for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
   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.
3. Unless a shorter time period is specified in contract, the Administration shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
   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.

C. Claims ~~Processing~~ 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. The Administration shall reimburse a hospital for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and in the manner and at the rate described in A.R.S. § 36-2903.01:
   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 between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
   c. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a fee of one percent per month for each month or portion of a month following the 60th day of receipt of the bill until date of payment.
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 this Article.

~~**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 of this Chapter, and
   c. Make records available for review by the Administration upon request.
2. The Administration shall reduce payment of or deny claims if an AHCCCS registered provider fails to obtain prior authorization or notify the Administration under Article 2 of this Chapter 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 Administration shall pay the claim, or adjust the claim to pay, for the cost of the appropriate level of care.

E. Review of claims and coverage for hospital supplies.

1. The Administration may conduct prepayment and postpayment review of any claims, including but not limited to hospital claims.
2. 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 or disposable razor,
   h. Shaving cream,
   i. Slippers,
   j. Mouthwash,
   k. Shampoo,
   l. Powder,
   m. Lotion,
   n. Comb, and
   o. Patient gown.
3. The following hospital supplies and equipment, if medically necessary and used by the member, 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 instead of a durable item,
   i. Universal precaution,
   j. Stat charge, and
   k. Portable charge.
4. The Administration shall determine in a hospital claims review whether services rendered were:
   a. Covered services as defined in R9-22-102;

b. Medically necessary;
c. Provided in the most appropriate, cost-effective, and 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.

5. If the Administration adjudicates a claim, a person may file a claim dispute challenging the adjudication under 9 A.A.C. 34.

F. Overpayment for AHCCCS services.

1. An AHCCCS registered provider shall notify the Administration when the provider discovers the Administration made an overpayment.
2. The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS registered provider fails to return the overpaid 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 claim dispute 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. A contractor shall contract with providers to provide covered services to members enrolled with the contractor. The contractor is responsible for the reimbursement and coordination of care provided to a member. Except as provided in subsection (A)(2), a contractor is not required to reimburse a noncontracting provider for services rendered to a member enrolled with the contractor.

1. Providers. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
2. A contractor shall reimburse a noncontracting provider for services rendered to a member enrolled with the contractor at the Administration's capped fee-for-service schedule rate if:
   a. The contractor referred the member to the provider or authorized the provider to render the services and the claim is otherwise payable under this Chapter, or
   b. The service is emergent under Article 2 of this Chapter.

~~**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, a contractor shall deem a paper or electronic claim as submitted on the date that the claim is received by the contractor. The contractor shall do one or more of the following for each claim the contractor 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 for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
   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.
3. Unless a shorter time period is specified in contract, a contractor shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
   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.

C. Date of ~~Claim~~ claim. A contractor's date of receipt of an inpatient or an outpatient hospital claim ~~shall be~~ is the date the claim is received by the contractor as indicated by the date stamp on the claim, the system-generated claim reference number, or the system-generated date-specific number ~~system~~ assigned by the contractor. A hospital claim ~~shall be~~ is considered paid on the date indicated on the disbursement check. A denied hospital claim ~~shall be~~ is considered adjudicated on the date of ~~its~~ the claim's denial. ~~A~~ For a claim that is pending for additional supporting documentation specified in A.R.S. §§ 36-2903.01 or 36-2904, ~~shall receive~~ the contractor shall assign a new date of receipt upon receipt of the additional documentation~~; however,~~. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. ~~§ 36-2903.01(J) or 36-2904(K)~~ §§ 36-2903.01 or 36-2904, ~~as applicable, will not receive~~ the contractor shall not assign a new date of receipt. A contractor and a hospital may, through a contract approved as specified in ~~R9-22-715(A)~~ R9-22-715, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.

~~**D.** 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, at either a rate specified by a 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. § 36-2904(K)(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.~~

D. Payment for inpatient hospital services. A contractor shall reimburse an in-state provider and a noncontracting provider for 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 this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715. This subsection does not apply to an urban contractor as specified in R9-22-718 and A.R.S. § 36-2905.01.

~~**E.** 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. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904(K)(1)(b) and A.A.C. R9-22-715. This subsection does not apply to a contractor participating in the pilot program described in R9-22-718.~~

E. Payment for outpatient hospital services.

1. A contractor shall reimburse an in-state provider and a noncontracting provider for outpatient hospital services rendered on or after March 1, 1993 through June 30, 2005, at either a rate specified by a subcontract that complies with R9-22-715 (A) or, in absence of a subcontract, as described in R9-22-712 or under A.R.S. § 36-2903.01, as amended by Laws 2003, Chapter 268, § 3, and as amended by Laws 2004, Second Regular Session, Chapter 279, § 3. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval, under A.R.S. § 36-2904 and R9-22-715.
2. A contractor shall reimburse an in-state provider and noncontracting provider for outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10 and A.R.S. § 36-2903.01 as amended by Laws 2004, Second Regular Session, Chapter 279, § 3 and this Article. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval, under A.R.S. § 36-2904 and 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 service provided to an AHCCCS member at the lesser of the negotiated rate, or the rates as described under A.R.S. § 36-2903.01 and this Article.

G. Payment for observation days. A contractor ~~may~~ shall reimburse a ~~subcontracting~~ provider 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 R9-22-712, R9-22-712.10, and R9-22-712.45. ~~the AHCCCS hospital specific outpatient cost to charge ratio multiplied by covered charges.~~ An "observation day" means a physician-ordered evaluation period of less than 24 hours to determine the need of treatment or the need for admission as an inpatient.

H. Review of ~~hospital~~ claims and coverage for hospital supplies.

1. A contractor may conduct a review of any claims submitted and 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.~~ When issuing prior authorization, a contractor shall consider the medical necessity of the service, and the availability and cost effectiveness of an alternative treatment. Failure to obtain prior authorization when required is cause for nonpayment or denial of a claim. 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~~ subcontract 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 shall make ~~a~~ the hospital's medical records~~, specific~~ pertaining to a member enrolled with a contractor~~,~~ available for review.

~~2~~3. 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 a contractor~~. ~~Post payment reviews shall be consistent with A.R.S. § 36-2903.01(O), and an erroneously~~ a contractor may make pre payment or post payment review of all claims, including but not limited to a hospital claim. A contractor may recoup an erroneously paid claim ~~is subject to redeployment~~. 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 the appropriate level of care. An adjustment in payment for a different level of care ~~shall be~~ is effective on the date when the different level of care ~~was~~ is 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. 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 or disposable 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 by the member, 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 instead of a durable item,
i. Universal precaution,
j. Stat charge, and
k. Portable charge.

7. The contractor shall determine in a hospital claims review whether services rendered were:
   a. Covered services as defined in R9-22-102;
   b. Medically necessary;
   c. Provided in the most appropriate, cost-effective, and 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.
8. If a contractor adjudicates a claim or recoups payment for a claim, a person may file a claim dispute challenging the adjudication or recoupment as described under 9 A.A.C. 34.

I. Non-hospital claims. A contractor 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-for-service schedule.

~~I.~~J. ~~Timeliness of hospital claim payment~~ Payments to hospitals. ~~Payment by a~~ A contractor shall pay for inpatient hospital admissions and outpatient hospital services rendered on ~~and~~ or 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).~~ as follows and as described in A.R.S. §36-2904:

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 between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
3. 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 the requirements in subsection (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~~ A contractor that negotiates with hospitals for inpatient or outpatient services shall reimburse hospitals for services rendered on or after March 1, 1993, ~~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 in A.R.S. § 36-2903.01 ~~and R9-22-712,~~ and this Article, or at the negotiated rate ~~that, when considered in the aggregate with other hospital reimbursement levels, does not exceed what~~ that, in the aggregate, does not exceed reimbursement levels that would have been paid under A.R.S. § 36-2903.01, ~~and R9-22-712~~, and this Article. 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~~ a hospital at any time during the contract period.
2. Within seven days ~~of the completion of the agreement process~~ before the effective date of a contract, ~~contractors~~ a contractor shall submit copies of ~~their~~ the contractor's negotiated rate agreements with hospitals, 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, 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~~ Repealed

~~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 FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

[R05-304]

PREAMBLE

1. Sections Affected | **Rulemaking Action**

R9-22-712	Amend
R9-22-712.01	New Section
R9-22-712.09	New Section

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

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

Implementing statutes: A.R.S. §§ 36-2904 and 36-2903.01

3. The effective date of the rules:

October 1, 2005

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 3761, September 10, 2004

Notice of Proposed Rulemaking: 11 A.A.R. 840, February 25, 2005

Notice of Exempt Rulemaking: 11 A.A.R. 2297, June 17, 2005

5. 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) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@azahcccs.gov

6. An explanation of the rule, including the agency's reason for initiating the rule:

The rules required amendment as a result of a 5-Year-Rule Review, finding that an update to the rule language was needed for consistency with the current statute, the rule needed to be divided into smaller units for clarity and a clarification was needed to describe that the NICU and Routine tier components are based on peer groups.

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

No studies were reviewed.

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

Not applicable

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

AHCCCS anticipates no impact.

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

In R9-22-712(G)(1), the proposed language describes how the cost-to-charge ratios are compiled and calculated for the period of 03/01/93 through 06/30/05. This subsection referenced a calculation for the initial prospective year of 03/01/93-09/30/94 when it was actually used that year and every year thereafter. Therefore the language has been clarified to read (annually).

There were not any significant changes from the language proposed to the language finalized. Minor technical and grammatical changes were made at the suggestion of G.R.R.C. staff.

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

There was one commenter who did not request changes to the proposed language but asked that an issue regarding further tier splits and tier levels be considered by the agency and added to this rule package.

AHCCCS Administration responded that it is not clear that the agency has the statutory authority to make the changes suggested. The existing statute requires the Administration to base its decisions regarding the establishment of the tiered payment methodology on claims data from 1990-1991, which does not reflect the data needed for tier changes suggested by the commenter.

In addition, the agency responded that the change requested is beyond the scope of this rulemaking. This rulemaking was only intended to clarify the rule and to conform the rule to the current statute. The Administration has not engaged in the extensive analysis that the suggested change would require.

Moreover, the agency responded that in order to consider the changes, significant costs and resources would be required.

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

None

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

None

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

No.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-712. Reimbursement: General
R9-22-712.01. Inpatient Hospital Reimbursement
R9-22-712.02. Reserved
R9-22-712.03. Reserved
R9-22-712.04. Reserved
R9-22-712.05. Reserved
R9-22-712.06. Reserved
R9-22-712.07. Reserved
R9-22-712.08. Reserved
R9-22-712.09. Hierarchy For Tier Assignment

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-712. Reimbursement: General

A. Inpatient and ~~Outpatient Discounts and Penalties~~ outpatient discounts and penalties. If a claim is pended for additional documentation required under A.R.S. § 36-2903.01(H)(4), the ~~additional days that~~ period during which the claim is pended ~~shall not be~~ is not used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § 36-2903.01(H)(5).

B. Inpatient and ~~Outpatient Out-of-State Hospital Payments~~ outpatient out-of-state hospital payments. AHCCCS shall reimburse out-of-state hospitals for covered inpatient and outpatient services provided to ~~AHCCCS members~~ a member at the

lesser of the negotiated rate or the AHCCCS FFS rate as described ~~under~~ in A.R.S. § 36-2903.01 and ~~9 A.A.C., Chapter 22, Article 7~~ this Article.

C. Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall ~~not withhold~~ allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or ~~its~~ the Administration's designated representative in performance of the Administration's utilization control activities. ~~Failure to cooperate may result in denial or non-payment of claims.~~ The Administration shall deny a claim for failure to cooperate.

D. Prior authorization. ~~Failure to obtain prior authorization required by R9-22-210 shall be cause for denial or nonpayment of claims.~~ The Administration shall deny a claim for failure to obtain prior authorization as required in R9-22-210.

E. Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers to prepayment medical review~~,~~ or post-payment review, or both ~~by the Administration~~. ~~Post payment reviews shall be~~ The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01~~(M)~~ and may recoup 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 Administration may adjust the claim to reflect the more appropriate level of care, ~~which shall be~~ effective on the date when the different level of care was medically appropriate.

F. Claim receipt. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number. Hospital claims ~~will be~~ are considered paid on the date indicated on disbursement checks. Denied claims ~~will be~~ are considered adjudicated on the date of their denial. Claims that are denied and are resubmitted ~~will receive new date stamps~~ are assigned new receipt dates. ~~Claims that are pending for additional supporting documentation from hospitals will receive new date stamps upon receipt of the additional documentation, except as provided under R9-22-717. Claims that pend for additional supporting documentation shall not be counted in the calculation of the quick-pay discounts and slow-pay penalties as described under R9-22-712 (A). For purposes of this subsection, the time-frames for submitting claims and the definition of a clean claim are consistent with A.R.S. § 36-2904.~~ For a claim that is pending for additional supporting documentation specified in A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.

~~**G.** Prior period payments. The Administration shall pay for covered hospital services, provided to eligible persons with inpatient hospital admissions and outpatient hospital services before March 1, 1993.~~

~~**H.** Inpatient hospital reimbursement. The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons with admissions on and after March 1, 1993, on a prospective reimbursement basis. The prospective rates shall represent payment in full, excluding quick-pay discounts, slow-pay penalties, noncategorical discounts, and third-party payments for both accommodation and ancillary department services. The rates shall include reimbursement for operating, capital, and medical education costs, as applicable. The Administration shall classify each AHCCCS inpatient hospital day of care into one of several tiers appropriate to the services rendered for payment purposes. The rate for a particular tier is referred to as the tiered per diem rate of reimbursement. Until the time of rebasing, as described in this Section, the number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier or transplant claims or payment to out-of-state hospitals, freestanding psychiatric hospitals, rehabilitation hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.~~

~~1. Tier rate data. To calculate the tiered per diem rates for the initial prospective year, the Administration shall use Medicare Cost Reports for Arizona hospitals for fiscal years ending in 1990 and a database consisting of inpatient hospital claims and encounters for each hospital with beginning dates of service for the period November 1, 1990, through October 31, 1991.~~

~~a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation for the initial prospective rate year, the Administration shall inflate all the costs to a common point in time as described in subsection (H)(2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than one hospital, the Administration shall allocate the costs to each of the respective hospitals. Hospitals shall submit information to assist the Administration in this allocation.~~

~~b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed under A.R.S. § 36-2903.01. The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude claims and encounters that fail these edits from the database. The Administration may make adjustments to the data as required to correct errors. The Administration shall also exclude from the database, the following claims and encounters:~~

i. Those missing information necessary for the rate calculation,
ii. Medicare crossovers,
iii. Those submitted by freestanding psychiatric hospitals, and
iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.

2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on the sum of the following three components: operating, capital, and medical education. The rate for the operating component shall be a statewide rate for each tier except for the ICU tier which is based on peer groups. The rate for the medical education component shall be hospital specific. The rate for the capital component shall be a blend of statewide and hospital-specific values based upon a sliding scale until October 1, 2002. The Administration shall not include the medical education component in the tiered per diem rates if direct medical education payments are made under subsection (H)(12). The Administration shall use the following methodologies to establish the rates for each of these components and to calculate the statewide inpatient cost-to-charge ratio used for payment of outliers and out-of-state hospitals.
   a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the rate for the operating component shall be computed as follows:
      i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost to charge ratios and accommodation costs per day. To comply with federal regulation, 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.
      ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports have been grouped. The ancillary department cost-to-charge ratios for a particular hospital shall be multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters shall be multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day shall exclude medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1991, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs.
      iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these items. For the ICU tier, claims and encounters shall be further assigned to the urban or rural peer group. The tier rate for NICU Level II shall be calculated as 75 percent of the NICU Level III tier rate. For claims and encounters assigned to more than one tier, ancillary department costs shall be allocated to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component of the tiered per diem rates, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (H)(6).
      iv. Operating rate calculation. The rate for the operating component for each tier shall be set by dividing total statewide or peer group hospital costs identified in subsection (H)(2)(a) within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.
   b. Medical education component.
      i. Calculation of medical education costs and component rate. The Administration shall calculate the rate for the medical education component of the tiered per diem rate on a hospital-specific basis by identifying the total direct medical education costs listed on the hospital's Medicare Cost Report. The medical education costs identified for each hospital shall reflect the medical education costs incurred by all the payors for the hospital's services, including AHCCCS. The Administration shall reduce the medical education costs for each hospital by an audit adjustment factor based on available national data and Arizona experience in adjustments to Medicare reimbursable costs. The Administration shall divide the hospital's reduced medical education costs by the hospital's total inpatient days for all patients to yield the rate for the medical education component of the tiered per diem rate. The Administration shall inflate the medical education component to a common point in time, December 31, 1991, using the DRI inflation factor.
      ii. Indexing medical education component to tiers. The Administration shall index the rate for the medical education component for each tier by the relative weighting of that tier's operating component to the operating component of all tiers. The relative weighting factor for each of the hospital's tiers shall be calculated by dividing each tier's operating component rate by the weighted average operating component rate for all tiers.

The weighted average operating component rate is calculated by multiplying the operating component rate for each tier by the number of AHCCCS inpatient hospital days of care for each tier. The total of these products is then divided by the total number of AHCCCS inpatient hospital days of care for all tiers. The relative weighting factor for a tier's medical education component is multiplied by the medical education component to determine the medical education component rate for the particular tier.

iii. New medical education programs. The tiered per diem rates for hospitals with new medical education programs that are not reflected on the Medicare Cost Reports used to establish rates under this Section shall not include a medical education component until the Medicare Cost Reports used in rebasing reflect the costs of the new medical education programs. New medical education programs may be recognized prior to a rebase year at the discretion of the Director. If a hospital has an existing medical education program that is reflected in its Medicare Cost Report but has added a new medical education program that is not reflected, the hospital's tiered per diem rates shall include a rate for the medical education component that reflects only those medical education costs included in the Medicare Cost Report.

e. Capital component.

i. Structure of the capital component. During the 10 year period beginning with the initial prospective rate year, the rate for the capital component of the tiered per diem rate shall represent a blend of statewide and individual hospital capital costs in accordance with A.R.S. § 36-2903.01. After September 30, 2002, the Administration shall combine the rate for the capital component with the rate for the operating component to produce a single statewide rate for the combination of the capital and operating components.

ii. Calculation of statewide capital costs and statewide capital component rate. The capital costs associated with inpatient hospital care shall be calculated in a manner similar to that described for operating costs in subsection (H)(2)(a)(ii). Because of the way costs are reported on the Medicare Cost Report, capital costs are derived by subtracting the costs determined when the ancillary department cost-to-charge ratios and the accommodation costs per day include only operating costs and medical education costs from the costs determined when the ancillary department cost-to-charge ratios and accommodation costs per day include capital costs as well as operating costs and medical education costs. The Administration shall inflate the resulting capital costs for each hospital to December 31, 1991, using the DRI inflation factor and shall reduce the capital costs for each hospital by an audit adjustment factor based on available national data and Arizona experience in adjustments to Medicare reimbursable costs. The statewide per day rate for capital costs shall be calculated by dividing the resulting total capital costs for all hospitals by the total AHCCCS inpatient hospital days of care reflected in the claim and encounter database.

iii. Computation of hospital-specific capital costs and hospital-specific capital component rates. The Administration shall calculate the hospital specific capital costs per day for each hospital by dividing the capital costs identified for each hospital in subsection (H)(2)(c)(ii), as adjusted by the audit factor and inflated to December 31, 1991, by the AHCCCS inpatient hospital days of care for that hospital reflected in the claim and encounter database.

iv. Blending of capital rates. The Administration shall set the rate for the capital component by blending of the statewide and hospital-specific capital rates in accordance with the following schedule:

PROSPECTIVE RATE YEAR	HOSPITAL SPECIFIC	STATEWIDE
3/1/93-9/30/94	90%	10%
10/1/94-9/30/95	80%	20%
10/1/95-9/30/96	70%	30%
10/1/96-9/30/97	60%	40%
10/1/97-9/30/98	50%	50%
10/1/98-9/30/99	40%	60%
10/1/99-9/30/00	30%	70%
10/1/00-9/30/01	20%	80%
10/1/01-9/30/02	10%	90%
On and after 10/01/02	0%	100%

v. Because the rate for the capital component is a blend of the statewide and hospital-specific costs, the capital component shall not be further inflated to the mid-point of the initial prospective rate year.

vi. Indexing capital component to tiers. The Administration shall index the rate for the capital component for each tier by the relative weighting of that tier's operating component to the operating component of all tiers. The relative weighting factor for each of the hospital's tiers shall be calculated by dividing each tier's operating component rate by the weighted average operating component rate for all tiers. The weighted average operating component rate is calculated by multiplying the operating component rate for each tier by the number of AHCCCS inpatient hospital days of care for each tier. The total of these products is then divided by the total number of AHCCCS inpatient hospital days of care for all tiers. The relative weighting factor for a tier's capital component is multiplied by the capital component to determine the capital component rate for the particular tier.

d. Statewide inpatient hospital cost-to-charge ratio. The statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, under subsection (H)(6). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (H)(1) and used to determine the initial tiered per diem rates. For each hospital, the covered accommodation days on the claims and encounters shall be multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters shall be multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital shall be determined in the same way as described in subsection (H)(2)(a) but shall include costs for operating, capital, and medical education. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.

e. Unassigned tiered per diem rates. In the case of a hospital for which no tiered per diem rate is assigned to a tier, the Administration shall pay the statewide rate for the operating component of that tier if the hospital has qualifying claims and encounters subsequent to the base year. The rates for the capital and medical education components of a tiered per diem rate, if applicable, shall be re-weighted for a tier to which no tiered per diem rate is assigned as described in subsections (H)(2)(b) and (H)(2)(c).

3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure or revenue codes, peer group, or NICU classification level or a combination of these items.

a. Tier hierarchy. Assignment of AHCCCS inpatient hospital days of care to a tier shall follow an ordered, hierarchical processing, as defined on the Hierarchy for Tier Assignment, which is included in subsection (I). Claims for inpatient hospital services shall meet medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that is submitted by the hospital. If a hospital changes its designation under Medicare from a rural to an urban hospital, or visa versa, the Administration shall continue to assign claims from that hospital to the rural ICU tiered per diem rate, or visa versa, until the tiered per diem rates are rebased.

b. Tier exclusions. The Administration shall not assign or pay AHCCCS inpatient hospital days of care that do not occur during an individual's eligibility period. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.

c. Seven tiers. The following seven tiers shall be in effect until the time of rebasing:

i. Maternity. The maternity tier shall be identified by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the AHCCCS inpatient hospital days of care on the claim shall be paid the maternity tiered per diem rate.

ii. NICU. The NICU tier shall be identified by a revenue code. For a hospital to qualify for the NICU tiered per diem rate, the hospital must be classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier, those with an NICU revenue code shall be paid at the NICU tiered per diem rate. Any remaining AHCCCS inpatient hospital day or days on the claim not meeting NICU Level II or NICU Level III medical review criteria shall be paid at the nursery tiered per diem rate.

iii. ICU. The ICU tier shall be identified by a revenue code. Among AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the ICU tier, those with an ICU revenue code shall be paid at the ICU tiered per diem rate. If there are any AHCCCS inpatient hospital days on the claim without an ICU revenue code, they may be classified as surgery, psychiatric, or routine tiers.

iv. Surgery. The surgery tier shall be identified by a revenue code in combination with a valid surgical proce-

dure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list shall identify minor procedures such as sutures that do not require the same hospital resources as other procedures. A surgery claim may also have AHCCCS inpatient hospital days of care at the ICU tier. AHCCCS shall pay the surgery tier only when the surgery occurs on a date during which the member is eligible.

v. Psychiatric. The psychiatric tier shall be identified by either: a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. A claim with AHCCCS inpatient hospital days of care in the psychiatric tier may split only with the ICU tier.

vi. Nursery. The nursery tier rate shall be identified by a revenue code. A claim with AHCCCS inpatient hospital days of care in the nursery tier may split only with the NICU tier.

vii. Routine. The routine tier shall be identified by particular revenue codes and shall include AHCCCS inpatient hospital days of care that are not otherwise classified into the proceeding tiers or paid in accordance with subsection (H)(11). The routine tier may split only with the ICU tier.

4. Annual update. After the initial prospective rate year and between rebasing years, the Administration shall annually update the inpatient hospital tiered per diem rates in accordance with A.R.S. § 36-2903.01 as follows:

a. Inflation factor. The rates for the operating and medical education components of the tiered per diem rate shall be inflated to the midpoint of the prospective rate year, using the DRI inflation factor.

b. Length of stay adjustment. The rate for the operating component of the tiered per diem rate shall be adjusted for any change in the statewide average length of stay for eligible persons. The change in length of stay shall be computed each year by comparing the average length of stay for each tier based on claims and encounters to the average length of stay for each tier calculated in the previous year. The operating component of the tiered per diem rates shall be adjusted by the percentage change in length of stay. If the length of stay increases for a tier, the rate for the operating component shall be adjusted downward. If the length of stay decreases for a tier, the rate for the operating component shall be adjusted upward. Except for the first annual update of the initial prospective rate year, the Administration shall use claims and encounters that are from the federal fiscal year period beginning two years before the prospective rate year that is being updated. For the annual update for the prospective rate year beginning October 1, 1996, the claims and encounters with beginning dates of service from October 1, 1994, to September 30, 1995 shall be used for making any length of stay adjustment. For the annual update of the initial prospective rate year, the Administration shall use claims and encounters with beginning dates of service from March 1, 1993, to September 30, 1993. The Administration shall subject the claim and encounter data to the same data edits described in subsection (H)(1)(b). Outliers shall be excluded as identified in subsection (H)(6)(a).

c. Capital component update. For the capital component of the tiered per diem rate, the Administration shall adjust the hospital specific and statewide average blend described in subsection (H)(2)(c). The Administration shall adjust the hospital-specific part of the capital component by using the capital costs from the hospital's subsequent Medicare Cost Report. The Medicare Cost Report used for the first update is FY1991. The percentage change in the capital costs per day, as shown on the hospital's Medicare Cost Report from one year to the next, shall be applied to the hospital-specific part of the capital component. The Administration shall recalculate the statewide average part of the capital component based on the percentage change in hospital-specific capital costs. The percentage change shall be limited to the initial prospective rate year statewide capital costs increased by the DRI inflation factor. The Administration shall adjust the rate for the capital component of the tiered per diem downward, if after the update, the statewide average rate of the capital component as a percent of the statewide average total tiered per diem rate exceeds the percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered per diem rates for the initial prospective rate year.

5. New Hospitals. The Administration shall calculate the tiered per diem rates for new hospitals differently than the tiered per diem rates for hospitals for which Medicare Cost Reports and claims and encounters were used to establish the tiered per diem rates for the initial prospective rate year or for a rebase year. The tiered per diem rates paid to a new hospital shall be the sum of the operating and capital components. The rate for the operating component for a new hospital shall be the same as the rate for the operating component established in subsection (H)(2)(a). The rate for the capital component for a new hospital shall equal the statewide average rate for the capital component as described in subsection (H)(2)(c)(ii) and shall vary by tier based on an index that represents the statewide relative weight of each tier's operating component to the operating component of all tiers. The tiered per diem rates for new hospitals shall not include a medical education component. The annual update shall be applied to a new hospital's rates for its operating and capital components, except hospital specific capital costs shall not be considered as described in subsection (H)(2)(c)(iii).

6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers in accordance with this Section by multiplying the cover charges on a claim by the statewide inpatient hospital cost-to-charge ratio.

a. Outlier criteria. For the initial prospective rate year, the Administration shall set the statewide outlier cost thresh-

old for each tier at the greater of three standard deviations from the statewide mean operating cost per day within the tier, or two standard deviations from the statewide mean operating cost per day across all the tiers. Because hospitals submit charges, rather than costs, on claims and encounters, the Administration sets hospital specific charge thresholds by dividing the statewide outlier cost threshold for each tier by the hospital's inpatient operating cost-to-charge ratio. If the covered charges per day on a claim or encounter exceed the hospital-specific charge threshold for a tier, the claim or encounter shall be considered an outlier. If there are two tiers on a claim or encounter, the Administration shall determine whether the claim or encounter is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying each tier rate by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital.

b. Update. The Administration shall update the outlier cost thresholds and outlier charge thresholds for each hospital. The outlier cost thresholds are updated annually by recalculating the standard deviations based on the claims and encounters used for the length-of-stay adjustment described in subsection (H)(4)(b). The outlier charge thresholds are updated as defined in subsection (H)(6)(a). Claims and encounters exceeding the updated outlier cost thresholds will be excluded for purposes of calculating the change in length of stay. The Administration shall estimate the operating cost of claims and encounters based on the application of an inpatient hospital-specific operating cost-to-charge ratio.

7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered organ transplant is performed through the terms of a relevant contract agreement. As described under R9-22-716, if the Administration and a hospital that performs a transplant surgery on an eligible person do not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.

8. Rebasing. The Administration shall rebase the tiered per diem rates by the prospective rate year beginning October 1, 1998. The rebasing process shall include the following:

a. Rebasing data. The Administration shall use a hospital's Medicare Cost Report for a fiscal year ending at least two years before the prospective rate year in which the rebase is to begin. For example, for the rebase year of October 1, 1998, the Medicare Cost Reports would be for hospital fiscal years ending in 1996, or earlier. The Administration shall follow the procedures described in subsection (H)(1)(a) for Medicare Cost Report data, except that costs shall be inflated to December 31 of the fiscal year applicable to the Medicare Cost Report year, and a new audit factor shall be derived by the Administration based on available national and Arizona data. To calculate the rebased tiered per diem rates, the Administration may use the ancillary department or line item cost-to-charge ratios from the Medicare Cost Report. In addition for each hospital, the Administration shall use a database consisting of inpatient hospital claims and, if appropriate, encounters with beginning dates of service covered by the hospital's respective Medicare Cost Report reporting period. Claims and encounters included in the database will be those available at the time of rebasing that pass the Administration's data quality, reasonableness, and integrity edits described in subsection (H)(1)(b). The Administration shall exclude or adjust the claims or encounters that do not meet the medical review criteria at R9-22-717 and R9-22-209(C).

b. Rebasing components. The rebased tiered per diem rates shall include rates for the following two components: operating and capital. The Medical education component shall be included unless direct medical education is reimbursed under subsection (H)(12). The Administration shall follow the methodology described in subsection (H)(2) to establish the rebased rates for each of the components. However, during the rebasing process the Administration shall re-examine the current tier structure and may adopt an alternative structure, hierarchy, or number of tiers if analyses conducted by the Administration indicate that an alternative or alternatives is or are appropriate. The Administration shall add cost containment features at the time of rebasing.

c. Rebasing peer groups for the operating component. To rebase the rate for the operating component of the tiered per diem rate, the Administration shall re-analyze whether the operating component shall be peer grouped according to such factors as geographical location or major teaching versus non-major teaching hospital.

d. Rebasing the capital component. The capital component of the tiered per diem rate shall be a blend of statewide and hospital specific capital costs as described under subsection (H)(2)(e). The Administration shall adjust the rate for the capital component of the tiered per diem rate downward if after rebasing the statewide average rate for the capital component as a percent of the statewide average total tiered per diem rate exceeds:

i. The percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered per diem rates for the initial prospective rate year; or

ii. The most recently available national average percentage of capital costs to total inpatient hospital costs.

iii. The adjustment to the rate for the capital component shall be based on the lesser of subsection (i) or (ii).

e. Rebasing outliers. Depending on the payment methodology adopted at the time of rebasing, the Administration may not include provisions for payment of outliers.

f. Psychiatric and rehabilitation hospitals. At the time of rebasing, the Administration shall re-examine the basis of payment for freestanding rehabilitation and psychiatric hospitals. If the decision is made to continue to reimburse these hospitals according to the methodology described in subsection (H)(10), the Administration shall exclude

~~the claims and encounters from these hospitals that are not paid by the tiered per diem reimbursement system.~~

~~g. Data required. Beginning with fiscal years ending in 1996, hospitals shall file with the Administration all Medicaid specific schedules of the Medicare Cost Report at the time the Medicare Cost Report is submitted to the Medicare Intermediary as required in A.R.S. § 36-125.04.~~

~~9. Ownership change. A hospital shall not receive a change in any of the components of the hospital's tiered per diem rates upon an ownership change.~~

~~10. Psychiatric and rehabilitation hospitals. The Administration shall pay freestanding psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Department of Health Services and shall pay freestanding rehabilitation hospitals the rate for the operating component of the routine tiered per diem rate plus the rates for the capital and medical education components as appropriate or an all-inclusive per diem rate that is negotiated by the Administration.~~

~~11. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section as provided by A.R.S. § 36-2903.01.~~

~~12. Direct medical education payments. Instead of including a direct medical education component in the tiered per diem rates, the Administration may reimburse hospitals directly for the hospital's costs associated with direct medical education. In this case, the Administration shall not continue to calculate direct medical education costs using the methodology described in subsection (H)(2)(b)(i), and shall not update direct medical education payments in accordance with subsection (H)(4).~~

~~I.~~ ~~Hierarchy For Tier Assignment.~~

~~TIER~~	~~IDENTIFICATION CRITERIA~~	~~ALLOWED SPLITS~~
~~MATERNITY~~	~~A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx.~~	~~None~~
~~NICU~~	~~Revenue Code of 175 for DOS before 10/1/95 AND the provider has a Level II or Level III NICU, or Revenue Code of 174 for DOS on, or after 10/1/95 AND the provider has a Level II or Level III NICU.~~	~~Nursery~~
~~ICU~~	~~Revenue Codes of 200-204, 207-212, or 219.~~	~~Surgery Psychiatric Routine~~
~~SURGERY~~	~~Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list.~~	~~ICU~~
~~PSYCHIATRIC~~	~~Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx - 316.xx, classify as a psychiatric claim.~~	~~ICU~~
~~NURSERY~~	~~Revenue Code of 17x, not equal to 175 or 174.~~	~~NICU~~
~~ROUTINE~~	~~Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.~~	~~ICU~~

~~J.~~ **G.** Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons with dates of service ~~on and after~~ from March 1, 1993 through June 30, 2005, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the amount of the covered charges.

1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs ~~shall be~~ are included in the computation but outpatient medical education costs that are included in the inpatient medical education component ~~shall be~~ are excluded. To calculate the outpatient hospital cost-to-charge ratio ~~for the initial prospective rate year~~ annually for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in ~~subsections (H)(1)(a) and (H)(1)(b)~~ R9-22-712.01. The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
   a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters ~~for outpatient hospital services~~. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on

claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.

b. Cost-to-charge limit. To comply with ~~federal regulation,~~ 42 CFR 447.325, the Administration may limit cost-to-charge ratios ~~at~~ to 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.

2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in ~~specialty facilities~~ a specialty facility. For purposes of this subsection, "specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.
4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than 0. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis~~, as described in subsection (J)~~, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. ~~The~~ Services provided in the emergency room, observation area, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every ~~one to~~ four years but no more than once a year using updated Medicare Cost Reports and claim and encounter data.
6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which ~~represent~~ represents an aggregate increase in charges of more than 4.7 percent, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (~~J~~G)(1) through (~~J~~G)(5) ~~of this section shall be adjusted~~ by applying the following formula:

CCR*[1.047/(1+ % increase)]

Where "CCR" means the hospital-specific cost-to-charge ratio as calculated under subsection (~~J~~G)(1) through (~~J~~G)(5) ~~of this Section~~ and "% increase" means the aggregate percentage increase in charges for outpatient services shown on the hospital charge master.

"Charge master" means the schedule of rates and charges as described under A.R.S. § 36-436 and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services ~~pursuant to as described under A.R.S. § 36-436~~.

"Existing outpatient services" means a service provided by the hospital prior to the hospital filing an increase in its charge master, regardless of whether the service was explicitly described in the hospital charge master before filing the increase, or how the service was described in the charge master before filing the increase.

R9-22-712.01. Inpatient Hospital Reimbursement

Inpatient hospital reimbursement. The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons with admissions on and after October 1, 1998, on a prospective reimbursement basis. The prospective rates represent payment in full, excluding quick-pay discounts, slow-pay penalties, and third-party payments for both accommodation and ancillary department services. The rates include reimbursement for operating and capital costs. The Administration shall make reimbursement for direct graduate medical education as described in A.R.S. § 36-2903.01. For payment purposes, the Administration shall classify each AHCCCS inpatient hospital day of care into one of several tiers appropriate to the services rendered. The rate for a tier is referred to as the tiered per diem rate of reimbursement. The number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier claims, transplant claims, or payment to out-of-state hospitals, freestanding psychiatric hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.

1. Tier rate data. The Administration shall base tiered per diem rates effective on and after October 1, 1998 on Medicare Cost Reports for Arizona hospitals for fiscal years ending in 1996 and a database consisting of inpatient hospital claims and encounters for dates of service matching each hospital's 1996 fiscal year end.
   a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation, the Administration shall inflate all the costs to a common point in time as described in subsection (2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If

a single Medicare Cost Report is filed for more than one hospital, the Administration shall allocate the costs to each of the respective hospitals. A hospital shall submit information to assist the Administration in this allocation.

b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed for rates effective on and after October 1, 1998. The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude from the database or adjust claims and encounters that fail these edits. The Administration shall also exclude from the database the following claims and encounters:
   i. Those missing information necessary for the rate calculation,
   ii. Medicare crossovers,
   iii. Those submitted by freestanding psychiatric hospitals, and
   iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.

2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on the sum of the operating and capital components. The rate for the operating component is a statewide rate for each tier except for the NICU and Routine tiers, which are based on peer groups. The rate for the capital component is a blend of statewide and hospital-specific values, as described in A.R.S. § 36-2903.01. The Administration shall use the following methodologies to establish the rates for each of these components and to calculate the statewide inpatient cost-to-charge ratio used for payment of outliers and out-of-state hospitals.
   a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the Administration shall compute the rate for the operating component as follows:
      i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.
      ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports are grouped. The ancillary department cost-to-charge ratios for a particular hospital are multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters are multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day do not include medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1996, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs. The Administration shall further inflate operating costs to the midpoint of the rate year (March 31, 1999).
      iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these. For the NICU tier, the Administration shall further assign claims and encounters to NICU Level II or NICU Level III peer groups, based on the hospital's certification by the Arizona Perinatal Trust. For the Routine tier, the Administration shall further assign claims and encounters to the general acute care hospital or rehabilitation hospital peer groups, based on state licensure by the Department of Health Services. For claims and encounters assigned to more than one tier, the Administration shall allocate ancillary department costs to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (6).
      iv. Operating rate calculation. The Administration shall set the rate for the operating component for each tier by dividing total statewide or peer group hospital costs identified in this subsection within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.
   b. Capital component. For rates effective October 1, 1999 the capital component is calculated as described in A.R.S. § 36-2903.01.
   c. Statewide inpatient hospital cost-to-charge ratio. The statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, as described in subsections (4),(5), and (6), and out-of-state hospitals, as described in R9-22-712(B). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by

using the Medicare Cost Report data and claim and encounter database described in subsection (1) and used to determine the tiered per diem rates. For each hospital, the covered inpatient days of care on the claims and encounters are multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters are multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital are determined in the same way described in subsection (2)(a) but include costs for operating and capital. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.

d. Unassigned tiered per diem rates. If a hospital has an insufficient number of claims to set a tiered per diem rate, the Administration shall pay that hospital the statewide average rate for that tier.

3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure, or revenue codes, peer group, NICU classification level, or a combination of these.
   a. Tier hierarchy. In assigning claims for AHCCCS inpatient hospital days of care to a tier, the Administration shall follow the Hierarchy for Tier Assignment in R9-22-712.09. The Administration shall not pay a claim for inpatient hospital services unless the claim meets medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that are submitted by the hospital.
   b. Tier exclusions. The Administration shall not assign to a tier or pay AHCCCS inpatient hospital days of care that do not occur during a period when the person is eligible. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. The Administration shall pay same day admit and discharge claims that qualify for either the maternity or nursery tiers based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.
   c. Seven tiers. The seven tiers are:
      i. Maternity. The Administration shall identify the Maternity Tier by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the Administration shall pay the AHCCCS inpatient hospital days of care on the claim at the maternity tiered per diem rate.
      ii. NICU. The Administration shall identify the NICU Tier by a revenue code. A hospital does not qualify for the NICU tiered per diem rate unless the hospital is classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier and have a NICU revenue code at the NICU tiered per diem rate. The Administration shall pay any remaining AHCCCS inpatient hospital day on the claim that does not meet NICU Level II or NICU Level III medical review criteria at the nursery tiered per diem rate.
      iii. ICU. The Administration shall identify the ICU Tier by a revenue code. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meets the medical review criteria for the ICU tier and has an ICU revenue code at the ICU tiered per diem rate. The Administration may classify any AHCCCS inpatient hospital days on the claim without an ICU revenue code, as surgery, psychiatric, or routine tiers.
      iv. Surgery. The Administration shall identify the Surgery Tier by a revenue code and a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list identifies minor procedures such as sutures that do not require the same hospital resources as other procedures. The Administration shall only split a surgery tier with an ICU tier. AHCCCS shall pay at the surgery tier rate only when the surgery occurs on a date during which the member is eligible.
      v. Psychiatric. The Administration shall identify the Psychiatric Tier by either a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the psychiatric tier with any tier other than the ICU tier.
      vi. Nursery. The Administration shall identify the Nursery Tier by a revenue code. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the nursery tier with any tier other than the NICU tier.
      vii. Routine. The Administration shall identify the Routine Tier by revenue codes. The routine tier includes AHCCCS inpatient hospital days of care that are not classified in another tier or paid under any other provision of this Section. The Administration shall not split the routine tier with any tier other than the ICU tier.
4. Annual update. The Administration shall annually update the inpatient hospital tiered per diem rates in accordance with A.R.S. § 36-2903.01.

5. New hospitals. For rates effective on and after October 1, 1998, the Administration shall pay new hospitals the statewide average rate for each tier, as appropriate. The Administration shall update new hospital tiered per diem rates annually under A.R.S. § 36-2903.01.
6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers under this Section by multiplying the covered charges on a claim by the statewide inpatient hospital cost-to-charge ratio.
   a. Outlier criteria. For rates effective on and after October 1, 1998, the Administration shall set the statewide outlier cost threshold for each tier at the greater of three standard deviations from the statewide mean operating cost per day within the tier, or two standard deviations from the statewide mean operating cost per day across all the tiers. Because hospitals submit charges, rather than costs, on claims and encounters, the Administration sets hospital-specific charge thresholds by dividing the statewide outlier cost threshold for each tier by the hospital's inpatient operating cost-to-charge ratio. If the covered charges per day on a claim or encounter exceed the hospital-specific charge threshold for a tier, the claim or encounter is considered an outlier. If there are two tiers on a claim or encounter, the Administration shall determine whether the claim or encounter is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying each tier rate by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital.
   b. Update. The Administration shall update the outlier cost thresholds for each hospital as described under A.R.S. 36-2903.01.
7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered transplant as described in R9-22-206 is performed through the terms of the relevant contract. As described in R9-22-716, if the Administration and a hospital that performs transplant surgery on an eligible person do not have a contract for the transplant surgery, the Administration shall not reimburse the hospital more than what would have been paid to the contracted hospital for that same surgery.
8. Ownership change. The Administration shall not change any of the components of a hospital's tiered per diem rates upon an ownership change.
9. Psychiatric hospitals. The Administration shall pay freestanding psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Department of Health Services.
10. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section as provided by A.R.S. § 36-2903.01. For purposes of this subsection, "specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.

R9-22-712.02. Reserved

R9-22-712.03. Reserved

R9-22-712.04. Reserved

R9-22-712.05. Reserved

R9-22-712.06. Reserved

R9-22-712.07. Reserved

R9-22-712.08. Reserved

R9-22-712.09. Hierarchy For Tier Assignment

TIER	IDENTIFICATION CRITERIA	ALLOWED SPLITS
MATERNITY	A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx.	None
NICU	Revenue Code of 174 and the provider has a Level II or Level III NICU.	Nursery
ICU	Revenue Codes of 200-204, 207-212, or 219.	Surgery Psychiatric Routine
SURGERY	Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list.	ICU

PSYCHIATRIC	Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx - 316.xx, classify as a psychiatric claim.	ICU
NURSERY	Revenue Code of 17x, not equal to 174.	NICU
ROUTINE	Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.	ICU

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R05-302]

PREAMBLE

1. Sections Affected **Rulemaking Action**
R9-28-702 Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):
Authorizing statute: A.R.S. § 36-2903.01(F)

Implementing statute: A.R.S. § 36-2903.01(L)

3. The effective date of the rules:
October 1, 2005

4. A list of all previous notices appearing in the *Register* addressing the final rule:
Notice of Rulemaking Docket Opening: 10 A.A.R. 3978, October 1, 2004

Notice of Proposed Rulemaking: 11 A.A.R. 852, February 25, 2005

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

Name:	Jane McVay
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4135
Fax:	(602) 253-9115
E-mail:	Jane.McVay@azahcccs.gov

6. An explanation of the rule, including the agency's reason for initiating the rule:
The Administration is amending the existing member billing rules for the Arizona Long-term Care System to make them more clear, concise, and understandable. The existing rules only allow an AHCCCS registered provider to charge, submit a claim to, demand or collect payment from a member in these situations: (1) To collect an authorized copayment; (2) To pay for non-covered services; (3) To record a portion of a payment made by a third-party to the member if the payment duplicated AHCCCS-paid benefits and is not assigned to a contractor; and (4) To bill a member for medical expenses incurred when the member intentionally withheld information or intentionally provided inaccurate information about the member's eligibility or enrollment that caused the provider's payment to be reduced or denied.

The existing rules require modification to clarify the process by which a member who requests an uncovered service or a service not authorized by a contractor or the Administration, may receive the service and agree to be financially responsible for payment. The provider must prepare and provide the member a document that lists the overall services and the approximate cost of the services. This document, which the member signs before the member receives the services, states that the member understands and accepts responsibility for payment. The rulemaking was intended to clarify for both providers and members the circumstances under which a member who requests unauthorized or uncovered services can be billed for services. When a member requests uncovered or unauthorized services and signs a document prior to receiving services, showing the overall services and the approximate cost, the member is financially responsible for payment and the provider is authorized to bill the member. An AHCCCS registered pro-

vider has clear authority under the rule to submit a claim to a member for payment of services not authorized or not covered by the Administration or a contractor.

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

AHCCCS did not review any studies relating to these rules.

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

Not applicable

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

The rules are expected to have a positive economic impact on AHCCCS registered providers by providing clarity to the issue of member billing. AHCCCS registered providers will have authority to charge a member for additional services requested that are not covered or not authorized by the Administration or a contractor, by presenting the member with a document showing service cost, and requiring the member to sign the document in advance of the service. Providers and members will clearly understand that a member is financially responsible for services requested that are not covered, or not authorized by a contractor or the Administration.

Although the overall economic impact of the rules on AHCCCS registered providers in collecting for uncovered or unauthorized services is unknown, the impact could be favorable to them. Because ALTCS members are indigent, the rules are expected to have only a minimal economic impact on revenues collected by AHCCCS registered providers. The agency believes that these rules will reduce the number of inquiries and disputes between the agency and providers and the number of inquiries from members on billing issues. The rules may also reduce the agency's administrative costs to conduct hearings. The rules clarify that AHCCCS registered providers may bill a member who requests services that are not covered or authorized by the Administration or a contractor.

The rules set forth a clear policy regarding billing members for uncovered or unauthorized services. Members also benefit by receiving information about the cost of uncovered or unauthorized services, and by requiring them to sign a document stating that they are financially responsible for uncovered or unauthorized services.

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

In R9-28-702(A)(2), the rule corrects an error from Arizona Administrative Code language in the proposed rulemaking by reinserting "agency" and deleting "service."

Other technical and grammatical changes suggested by G.R.R.C. staff were made.

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

A commenter requested expansion of the rule to authorize providers to bill AHCCCS members who fail to cooperate to secure primary payment from commercial health insurance plans. An existing AHCCCS rule, R9-28-904, requires a member to cooperate in identifying potentially legally liable first-party or third-party liability and to notify AHCCCS of the sources. AHCCCS staff provides information staff has obtained from a member to a provider regarding other insurance coverage. This rulemaking deals with member billing for services that are not authorized or not covered by the Administration or a contractor. The issue of member cooperation with an AHCCCS registered provider to divulge insurance information would be a substantial change that is outside the scope of this rulemaking. AHCCCS appreciates the concern of the commenter regarding this issue. The existing rules do require a member to cooperate to identify legally liable first-party or third-party liability. AHCCCS also shares information with providers about other health insurance coverage held by its members to assist providers in obtaining third-party reimbursement.

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

Not applicable

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

None

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

No.

15. 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 7. STANDARDS FOR PAYMENTS

Section
R9-28-702. ~~Prohibition Against~~ Charges to Members

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-28-702. ~~Prohibition Against~~ Charges to Members

A. Except as provided in ~~subsection (B),~~ subsections (B), (C), and (D), an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration that the person was ~~ineligible for~~ not an eligible person ~~AHCCCS~~ on the date of service:
1. Charge, submit a claim to, demand or collect payment from a person claiming to be ~~AHCCCS~~ an eligible~~;~~ person; or
2. Refer or report a person claiming to be ~~AHCCCS~~ an eligible person to a collection agency or credit reporting service.

B. An AHCCCS registered provider that submits a claim shall not charge more than the actual, reasonable cost of providing the covered service.

~~B.~~C. An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment from a member as follows:
1. To collect an authorized copayment;
2. ~~To pay for non-covered services;~~
3. ~~3.~~2. To recover from a member that portion of a payment made by a third-party to the member if the payment duplicates AHCCCS-paid benefits and is not assigned to a contractor. ~~under A.A.C. R9-22-1002(B). An AHCCCS registered provider that makes a claim under this Article shall not charge more than the actual, reasonable cost of providing the covered service; or~~
4. ~~4.~~3. To ~~bill~~ obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused ~~the~~ payment to the provider to be reduced or denied.

~~C.~~D. An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment for services from a member if:
1. The member requests the provision of a service that is not covered or not authorized by the contractor or the Administration; and
2. The provider prepares and provides the member with a document describing the overall services and the approximate cost of the services; and
3. The member signs the document prior to the services being provided, indicating that the member understands and accepts responsibility for payment.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R05-301]

PREAMBLE

1. Sections Affected	**Rulemaking Action**
R9-31-201	Amend
R9-31-702	Amend
R9-31-1620	Amend

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

Authorizing statutes: A.R.S. §§ 36-2903.01(F) and 36-2982

Implementing statute: A.R.S. § 36-2903.01(L)

3. The effective date of the rules:

October 1, 2005

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 3979, October 1, 2004

Notice of Proposed Rulemaking: 11 A.A.R. 854, February 25, 2005

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

Name:	Jane McVay
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4135
Fax:	(602) 253-9115
E-mail:	Jane.McVay@azahcccs.gov

6. An explanation of the rule, including the agency's reason for initiating the rule:

The rulemaking is needed to continue to allow AHCCCS registered providers to bill members when they request services that are not covered or not authorized by the Administration or a contractor in the Children's Health Insurance Program. The rules also pertain to services provided to Native Americans by the Indian Health Service or a tribal facility. The provider prepares a document for the member, describing the overall services and the approximate cost of the services. When the member signs the document prior to receiving services, indicating that the member accepts financial responsibility to pay for those services, the member may be billed for the services.

These rules will provide additional clarification that AHCCCS registered providers can bill a member for services that are not authorized or not covered by the Administration if certain conditions are met. The provider must prepare a document for the member describing the services and overall cost. The member must also sign the document, which states that the member accepts responsibility to pay for uncovered or unauthorized services.

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

AHCCCS did not review any studies relating to these rules.

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

Not applicable

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

The rules are expected to have a positive economic impact on AHCCCS registered providers by continuing to allow them to bill a member who requests a service not authorized or covered by the Administration or a contractor. The rules provide clear authority for AHCCCS registered providers to bill a member for these services. By signing a document describing services requested by the member that are not authorized or covered by the Administration or a contractor, a member accepts financial responsibility for the cost of services. Although the economic impact of the rules on AHCCCS registered providers in collecting payment for uncovered or unauthorized services is unknown, the impact could be favorable to them. However, because the households of KidsCare members are indigent, the rules are expected to have only a minimal impact on revenue collections of AHCCCS registered providers.

Members will also understand that they are financially responsible for uncovered or unauthorized services, and will know the approximate cost of the services before they receive the services. Because AHCCCS registered providers were previously required to give members a cost document to show the cost of services requested that are not authorized or covered, these rules will not impose any new costs on providers.

The agency believes that these rules will reduce the number of inquiries and disputes between the agency and providers and the number of inquiries from members on billing issues. In addition, it will be easier and less time-consuming for a provider to comply with the cost document requirement. The current rules require an itemized document that shows the estimated cost of each service. However, under this rule, the provider prepares a document describing the

overall services and the approximate cost of the services. The agency feels this requirement will be a more reasonable one with which providers can more easily comply.

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

In subsection R9-31-201(B), the rules clarify that scope of services is for Native American fee-for-service members.

In subsection R9-31-702(A) the reference to subsection (D) was added. In R9-31-1620(A), after "service" the rules delete the period and restore a colon to conform to the Arizona Administrative Code.

The rules also replace references to the "contractor's service area" with references to the "GSA."

AHCCCS made grammatical and stylistic changes at the suggestion of the Governor's Regulatory Review Council staff.

In addition, AHCCCS has deleted the following language in R9-31-201(D)(9)(d) from the final rules: "A person under age 22 who is in residence at an IMD, unless the person is receiving inpatient psychiatric services." An existing federal regulation, 42 CFR 435.1008(a)(2), provides that federal funding is available for individuals under age 22, who are patients in an Institution for Mental Diseases and are receiving inpatient psychiatric services. Although there has not been a change in this federal provision, the regulation does not require each state to have a conforming rule on this subject. AHCCCS believes that the agency can rely exclusively on this federal provision for policy direction regarding coverage for inpatient psychiatric services for this population. Neither proposed addition of this language nor deletion of this language from the rule represents a change in policy or practice regarding covered services for persons in an IMD. AHCCCS has covered and will continue to cover inpatient psychiatric services for persons under age 22 in an IMD. In addition, the scope of services for persons under age 22 who are in residence at an IMD may be the subject of federal policy changes in the future. Following the close of record, a commenter stated that this rule language is unclear regarding covered services for this population. For these reasons, the agency decided that the best course of action is to delete this language from the rules and rely on the existing federal regulation.

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

A commenter requested expansion of the rule to clearly authorize providers to bill AHCCCS members who do not cooperate to secure primary payment from commercial health insurance plans. The commenter recommended that the Administration amend the existing rules to authorize a provider to bill a member for payment of health care services when the member failed or unreasonably delayed responding to a request from a primary payer for additional information, or otherwise failed to assist a provider pursuing a primary payer, and the Administration or a contractor reduced or denied the claim on the grounds that the member had other insurance.

R9-31-1004 requires a member to cooperate in identifying potentially legally liable first-party or third-party liability and notify AHCCCS of the sources. This rule is not included in this rulemaking. This rule requires a member to cooperate in identifying potentially legally liable first-party or third-party liability and to notify AHCCCS of the sources. AHCCCS staff provides information staff has obtained from a member to a provider regarding other insurance coverage. This rulemaking deals with member billing for services that are not covered or not authorized by the Administration or a contractor. Addressing the issue of member cooperation with the AHCCCS registered provider to divulge insurance coverage information would be a substantial change that is outside the scope of this rulemaking. AHCCCS appreciates the concern of the commenter regarding this issue. The existing rules do require a member to cooperate to identify legally liable first-party or third-party liability. AHCCCS also shares information with providers about other health insurance coverage held by its members to assist providers in obtaining third-party reimbursement.

An informal comment was received by AHCCCS regarding the language in R9-31-201(D)(9)(d) after the close of record. The commenter felt that the rule language was unclear regarding covered services for persons under 22 who reside in an Institution for Mental Diseases. Because a federal regulation currently exists regarding inpatient psychiatric services for this population, AHCCCS decided to remove this language from the final rulemaking as discussed in Preamble #10 above.

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

Not applicable

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

None

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

No.

15. 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 2. SCOPE OF SERVICES

Section
R9-31-201. General Requirements

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-31-702. ~~Prohibitions Against~~ Charges to Members

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

Section
R9-31-1620. ~~Prohibitions Against~~ Charges to Members

ARTICLE 2. SCOPE OF SERVICES

R9-31-201. General Requirements

A. The Administration shall administer the Children's Health Insurance Program under A.R.S. § 36-2982.

B. Scope of services for Native American fee-for-service members is under Article 16 of this Chapter.

C. A contractor or RBHA shall provide behavioral health services under ~~9 A.A.C. 31,~~ Article 12 and Article 16.

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

1. Only medically necessary, cost effective, and ~~federally and state reimbursable~~ federally-reimbursable and state-reimbursable services are covered services~~;~~.
2. The Administration or a contractor may waive the covered services referral requirements ~~required by~~ of this Article~~;~~.
3. Except as authorized by a contractor, a primary care provider, practitioner, or dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner ~~shall~~ does not diminish the role or responsibility of the primary care provider~~;~~ .
4. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider~~;~~.
5. A member may receive behavioral health evaluation services without a referral from a primary care provider. ~~Behavioral health treatment services~~ A member may receive behavioral health treatment services ~~are provided~~ only under referral from ~~and in consultation with~~ the primary care provider, or upon authorization by the contractor or ~~its~~ the contractor's designee~~;~~.
6. A member may receive ~~a~~ treatment that is considered the standard of care, or that is approved by the AHCCCS Chief Medical Officer after appropriate ~~consultative~~ input from providers who are considered experts in the field by the professional medical community~~;~~.
7. An AHCCCS registered provider shall provide covered services within the provider's scope of practice~~;~~.
8. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
   a. A service that is determined by the AHCCCS Chief Medical Officer ~~determines~~ to be experimental or provided primarily for the purpose of research~~;~~,
   b. Services or items furnished gratuitously~~;~~, and
   c. Personal care items~~;~~. ~~and~~
9. Medical or behavioral health services are not covered if provided to:
   a. An inmate of a public institution~~;~~,
   b. A person who is a resident of an institution for the treatment of tuberculosis~~;~~ ;or
   c. A person who is in an IMD at the time of application, unless provided under Article 12 of this Chapter.

E. The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained under this Article and Article 7 of this Chapter. ~~The provider shall submit documentation of diagnosis and treatment for reimbursement of services that require prior authorization.~~ The Administration or a contractor shall not reimburse services

that require prior authorization unless the provider documents the diagnosis and treatment.

F. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. ~~Diagnostic and treatment procedures for a condition that is unrelated to the emergency medical condition require prior authorization by the contractor~~. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

G. Under A.R.S. § 36-2989, a member shall receive covered services outside the ~~contractor service area~~ GSA only if one of the following ~~apply~~ applies:

1. A member is referred by a primary care provider for medical specialty care out of the contractor's area. If ~~a~~ the member is referred ~~out of a contractor's service area~~ outside of the GSA to receive an authorized medically necessary service, a contractor shall also provide all other medically necessary covered services for ~~a~~ the member;
2. There is a net savings in service delivery costs as a result of going outside the ~~service area~~ GSA that does not require undue travel time or hardship for a member or the member's family; or
3. The contractor authorizes placement in a nursing facility located ~~out of the contractor's service area; or~~ outside of the GSA;

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

I. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.

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

~~1. The provider prepares, and provides the member with, a document that lists the requested services and the estimated cost of each service; and~~

~~2. The member signs a document before the provision of services indicating that the member understands the services and accepts the responsibility for payment.~~

~~K.~~J. The restrictions, limitations, and exclusions in this Article do not apply to a contractor if the contractor elects to provide noncovered services~~:~~.

1. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate~~;~~.
2. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-31-702. ~~Prohibitions Against~~ Charges to Members

A. Except as provided in ~~subsection (B),~~ subsections (B), (C), and (D), an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration that the person was ~~ineligible for~~ not an eligible person ~~AHCCCS~~ on the date of service:

1. Charge, submit a claim to, or demand or collect payment from a person claiming to be ~~AHCCCS eligible;~~ an eligible person; or
2. Refer or report a person claiming to be ~~AHCCCS eligible~~ an eligible person to a collection agency or credit reporting agency.

B. An AHCCCS registered provider that submits a claim shall not charge more than the actual, reasonable cost of providing the covered service.

~~B.~~C. An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment from a member as follows:

1. To collect an authorized copayment;
2. ~~To pay for non-covered services;~~
3. ~~.~~2. To recover from a member that portion of a payment made by a ~~third-party~~ third party to the member if the payment duplicates AHCCCS-paid benefits and is not assigned to a contractor; ~~under R9-31-1002(B). An AHCCCS registered provider that makes a claim under this Article shall not charge more than the actual~~, ~~reasonable cost of providing the covered service; or~~ or
4. ~~.~~3. To ~~bill~~ obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused ~~the~~ payment to the provider to be reduced or denied.

~~C.~~D. An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment for services from a member, if:

1. The member requests the provision of a service that is not covered or not authorized by a contractor or the Administration;

2. The provider prepares and provides the member with a document describing the overall services and the approximate cost of the services; and
3. The member signs the document prior to services being provided, indicating that the member understands and accepts responsibility for payment.

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1620. ~~Prohibitions Against~~ Charges to Members

A. Except as provided in ~~subsection (B),~~ subsections (B) and (C), the IHS, a Tribal Facility, or a provider under referral, shall not do either of the following, unless services are not covered or without first receiving verification from the Administration that the person was ~~ineligible for AHCCCS~~ not an eligible person on the date of service:
1. Charge, submit a claim to, demand or collect payment from a person claiming to be ~~AHCCCS~~ an eligible person; or
2. Refer or report a person claiming to be ~~AHCCCS~~ an eligible person to a collection agency or credit reporting agency.

B. An AHCCCS registered provider that makes a claim under this Article shall not charge more than the actual, reasonable cost of providing the covered service.

~~B.~~C. The IHS, a Tribal Facility, or a provider under referral may charge, submit a claim to, demand or collect payment from a member as follows:
1. To collect an authorized copayment;
~~2. To pay for non-covered services;~~
~~3.~~2. To recover from a member that portion of a payment made by a third-party to the member if the payment duplicates AHCCCS-paid benefits and is not assigned to a contractor~~.~~ ; or ~~An AHCCCS registered provider that makes a claim under this Article shall not charge more than the actual, reasonable cost of providing the covered service; or~~
~~4.~~3. To ~~bill~~ obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused ~~the~~ payment to the provider to be reduced or denied.

D. An AHCCCS registered provider may charge, submit a claim to, or demand, or collect payment for services from a member, if:
1. The member requests the provision of a service that is not covered or not authorized by a contractor or the Administration;
2. The provider prepares and provides the member with a document describing the overall services and the approximate cost of the services; and
3. The member signs the document prior to services being provided, indicating that the member understands and accepts responsibility for payment.