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 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 19. BOARD OF NURSING

[R05-353]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R4-19-403	Amend
Article 5	Amend
R4-19-501	Amend
R4-19-502	Amend
R4-19-503	Amend
R4-19-504	Renumber
R4-19-504	New Section
R4-19-505	Renumber
R4-19-505	Amend
R4-19-506	Renumber
R4-19-506	New Section
R4-19-507	Repeal
R4-19-507	New Section
R4-19-508	Renumber
R4-19-508	Amend
R4-19-509	New Section
R4-19-510	Renumber
R4-19-510	Amend
R4-19-511	Repeal
R4-19-511	New Section
R4-19-512	Renumber
R4-19-512	New Section
R4-19-513	Renumber
R4-19-513	Amend
R4-19-514	Renumber
R4-19-514	Amend
R4-19-515	Renumber
R4-19-516	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. §§ 32-1606(A)(1), (A)(6), (B)(12), (B)(18), and (B)(21), 32-1456, 32-1921, and 32-3208

Implementing statutes: A.R.S. §§ 32-1601(5), (15), and (16), 32-1635.01, 32-1643, 32-1644, 32-1661, 32-1664(P), 32-1666, and 32-3208

3. The effective date of the rules:

November 12, 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. 507, February 13, 2004

Notice of Public Meeting on Open Rulemaking Docket: 10 A.A.R. 2444, June 18, 2004

Notice of Proposed Rulemaking: 10 A.A.R. 4430, November 5, 2004

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

Name: Pamela K. Randolph
Arizona State Board of Nursing

Address: 1651 E. Morten, Suite 210
Phoenix, AZ 85020

Telephone: (602) 889-5209

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

The Board is initiating rulemaking on this Article to implement the plan in a five-year rule report approved by the Council on February 5, 2002 and to reflect recent statutory changes. The following changes are being proposed:

R4-19-403

The Board is deleting those provisions in this rule that relate to a nurse practitioner prescribing, and updating unprofessional conduct standards to better reflect current practice and national standards for conduct. The changes should clarify for nurses and the public, those actions that the Board considers unprofessional and that could result in action on the nurse's license. The Board is defining both boundary violations and dual relationships for the purpose of clarity and to inform nurses that these types of activities are prohibited. The Board continues to receive complaints alleging that nurses are forming non-professional relationships with patients and subsequently either exploiting them or causing emotional trauma. When nurses befriend their patients, with the intent of exploiting or emotionally harming the patient, they are not engaging in safe practice. Nurses who take patients into their homes and allow others to exploit them are as culpable as the nurse who abuses the patient. These two definitions and the subsections they pertain to will inform nurses that this behavior may lead to disciplinary action by the Board. Other amendments provide clarity on specific behaviors that are considered unprofessional conduct, such as providing false information to the Board in an investigation, falsifying health or other institutional records for any reason, use of force with a client, making a false statement on an employment application, and assisting an unlicensed person in the unlawful practice of registered or practical nursing.

R4-19-501

This rule is being amended to substitute broader categories of advanced practice registered nursing for detailed specialty areas of practice. In this Section the Board establishes the criteria for an advanced practice registered nursing specialty and informs the public of the current specialty areas that meet the criteria. One of the criteria for a specialty area is the availability of an examination to verify competency of an individual nurse. The criteria proposed are consistent with national standards adopted by the National Council of State Boards of Nursing. The Board will also publish an updated list of approved specialty areas on its web site and in its quarterly newsletter.

R4-19-502

The Board is amending its standards for advanced practice registered nursing programs to make them consistent with national standards for advanced practice registered nursing programs. Amendments include requiring a minimum of 500 hours of clinical practice, national accreditation, financial resources adequate to meet the needs of the program, and programs to establish professional conduct standards for students. Minimum requirements for a program director, faculty, and preceptors are also established.

R4-19-503

The Board is amending this rule to be consistent with other proposed rules in this rulemaking. The application reflects the requirements in the previous rule. There is also a provision in this rule for limited approval of programs that have not yet achieved national accreditation.

R4-19-504

The Board is adding this new rule to establish the criteria for rescinding the approval of an advanced practice program. The process is similar to that for pre-licensure programs in A.A.C. R4-19-211.

R4-19-505

In this proposed rule, the Board combines the application requirements for nurse practitioners and clinical nurse specialists into one rule. This will facilitate the use of one application for current advanced practice categories and specialty areas. Recent statute changes require all advanced practice nurses to hold national certification in their category and/or specialty area by July 1, 2004. Standards have been added for nurses educated in a foreign jurisdiction. Currently certified advanced practice nurses have been "grand-fathered." Two alternate mechanisms to certify clinical nurse specialists are being proposed in subsection (A)(4). For those clinical nurse specialists in a narrow specialty area that lacks a certifying exam, proof of successful practice is required. For those nurses practicing as clinical nurse specialists who completed a generic masters in nursing program without a major in a clinical specialty, a portfolio that demonstrates the core competencies may be submitted to meet the education requirement. The Board will utilize the expertise of a CNS educator, a practicing CNS, and the executive director or designee to evaluate the portfolios submitted. These mechanisms, while not consistent with national regulatory standards, were proposed by a group of clinical nurse specialists after a series of focus group meetings. Time limits are incorporated to allow individuals who have been successfully practicing in this evolving field to obtain certification while moving toward adopting national regulatory standards.

R4-19-506

This is a new rule that was added to ensure that advanced practice nurses maintain national certification. Currently advanced practice certificates do not expire. With the inclusion of the criteria for national certification, it will become necessary for the Board to ensure that certification is maintained. This will be linked to the license renewal process.

R4-19-507

A.R.S. § 32-1635.01 allows the Board to issue a temporary advanced practice certification. This new rule establishes the mechanism, requirements, and limits of temporary certification. The Board recognizes that time-frame rules in Article 1 will need to be amended to include the temporary advanced practice certificate. The Board anticipates that the time-frame will be identical to that for temporary licensure.

R4-19-508

The Board is amending the scope of practice of a registered nurse practitioner to reflect recent statutory changes and current practice. The Board is not expanding the scope, but is clarifying the role and responsibilities of the registered nurse practitioner. The rule clarifies those situations in which a registered nurse practitioner must seek consultation from and referral to a physician. Changes to rules allowing registered nurse practitioners to perform radiologic tests are in response to concerns expressed by the Arizona Medical Radiologic Technology Board of Examiners.

R4-19-509

This new Section clarifies the registered nurse practitioner's responsibility in delegating to medical assistants. The Board intends that this rule closely mirror the rules of the Arizona Medical Board for delegation to medical assistants. The date for "grandfathering" persons functioning as medical assistants without formal training reflects the effective date of the Arizona Medical Board rules, to allow a nurse practitioner to continue to utilize a medical assistant who falls into this category. It is not the intent of the Board of Nursing to directly grandfather any persons functioning in this role.

R4-19-510

The Board is amending the rule on title protection to include defined areas of advanced practice registered nursing. The Board believes that this is necessary for the protection of the public. The Board has experienced a recent surge in complaints about nurse imposters. The proposed rule will allow the Board to deal effectively with non-qualified nurses who claim to be advanced practice nurses.

R4-19-511

The Board is amending the application process and requirements for prescribing and dispensing privileges to reflect increased use of distance education modalities and to allow pharmacology hours to be earned up to three years before the Board receives the application. Unprofessional conduct relating to prescribing was moved to this Section so that nurse practitioners with prescribing privileges could better access both the requirements and the prohibited acts relating to prescribing and dispensing in one Section. The Board believes that registered nurse practitioners will be more aware of provisions limiting prescribing if the prohibitions are in the same Section as prescribing privileges.

R4-19-512

These rules were re-organized to separate Sections to distinguish prescribing responsibilities from dispensing responsibilities. The nurse practitioner's responsibilities in prescribing are detailed here and expanded to include educating the patient and not prescribing unless a nurse-patient relationship is established and an examination conducted. The prescribing rules related to controlled substances are consistent with those of the Arizona Medical Board and the Board of Pharmacy.

R4-19-513

The Board is amending the dispensing rules to clarify the nurse practitioner's role and the role of others in assisting in the dispensing process. This rule is amended in response to a request from the Maricopa County Department of Public Health, Health Care for the Homeless Program that the Board allow nurse practitioners to use other personnel in a manner consistent with physicians when dispensing drugs and devices.

R4-19-514

The scope of practice for clinical nurse specialists is updated to reflect the core competencies of clinical nurse specialty practice. This Section incorporates the spheres of influence of CNS practice: the patient, nurses and nursing practice, and organizations/systems.

R4-19-515

This Section is renumbered, but the Board is not changing the substance of the rule.

R4-19-516

In this new Section, the Board is requiring nurses who administer anesthesia to inform the Board and provide proof of competence consistent with A.R.S. § 32-1661. A school that wishes to educate nurses to practice as nurse anesthetists must also notify the Board and provide evidence of accreditation. The scope of practice for nurse anesthetists is detailed in this Section. This scope is consistent with national standards and statewide practice.

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:

None

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 Arizona State Board of Nursing is charged with regulating registered nurses, practical nurses, and certified nursing assistants. The Board currently licenses approximately 54,000 registered nurses and 10,000 practical nurses; and certifies approximately 21,000 nursing assistants. The Board also regulates advanced practice registered nursing (APRN) in the categories of registered nurse practitioner (a.k.a. nurse practitioner), including nurse midwife and clinical nurse specialist. Additionally the Board requires nurses who administer anesthetics to be qualified under A.R.S. § 32-1661. Currently the Board certifies 2,068 nurse practitioners and 108 clinical nurse specialists. The Board has authorized 554 nurse practitioners to prescribe and dispense, and 277 certified registered nurse anesthetists to prescribe. There are currently 16 approved advanced practice registered nurse programs in the state. The Board receives and investigates complaints of unprofessional conduct. In fiscal year 2003-2004, the Board received approximately 44 complaints (2% of certificate holders) of unprofessional conduct against advanced practice nurses.

The major economic impact of the rules will be the indirect beneficial effect for the public and regulated community due to the improved clarity of amended rules.

Nurse practitioner applicants, excluding nurse midwives, will bear the additional burden of paying for national certification exams and re-certification. The Board does not have accurate data on the number of nurse practitioners and persons practicing as clinical nurse specialists who hold national certification, but estimates that the majority of nurse practitioners are nationally certified due to reimbursement issues. Most nurse midwives and registered nurse anesthetists hold national certification because it is required in the setting where these nurses work. The cost for a certifying exam currently ranges from $230 to $500, depending on the specialty and discounts available. The applicant may also have to pay a fee to the certifying agency for sending verification of certification to the Board. Fees for this service are approximately $25.00. The APRN certificate holder will also bear the cost burden of re-certifying. Re-certification costs range from approximately $90-$200 per year depending on the mechanism of re-certification.

The Board will bear the cost of incorporating this requirement into the certification and renewal process for nurse practitioners. The Board is not anticipating a fee increase for initial application. The cost to the Board is expected to be minimal for renewal because re-certification will be linked to license renewal. The Board may, in the future, seek statutory authority to charge a fee for renewal of an advanced practice certificate.

The requirement that advanced practice programs be nationally accredited is not expected to impose an additional economic burden on the schools, because all current programs in the state are nationally accredited and follow the guidelines specified in the rules. The requirement may pose an additional burden on the workload of the Board's Education Consultant in investigating complaints about APRN programs and surveying APRN programs. Because the Board has not received any complaints relating to APRN programs in the last 4 years, this effect is expected to be minimal to moderate.

Issuing a temporary advanced practice certificate is expected to benefit applicants by allowing them to practice while waiting for fingerprint results or before passing a national certification exam. The Board will bear the costs of processing applications and issuing temporary certificates. The cost burden will be minimized because the process will be linked to temporary RN licensure for endorsement candidates or initial certification for new APRN graduates. The Board may find, after analysis, that the charge for initial application will need to be increased to cover the costs of a temporary certificate or seek a statutory change to allow the Board to charge a fee for the temporary certificate. The Board does not anticipate taking this action in the near future. The Board will also bear the burden of rulemaking to establish a time-frame rule for the temporary certificate.

Changes to the dispensing rules to allow other personnel to assist in the process will be of economic benefit to clinics and small businesses that dispense medications to patients. The current rules require that the RNP participate in nearly all aspects of dispensing. The proposed amendments will require that the RNP oversee all aspects of the dispensing process. This will free the RNP of the need to count pills and type labels, and allow more time to diagnose and treat patients. By initialing the dispensed drug label, the public is assured that the RNP has verified that the dispensed product and directions are appropriate and accurate.

The Board is amending R4-19-403 to clarify unprofessional conduct standards for both licensees and the public. These amendments are not expected to impose an economic burden on the Board, any regulated entity, or the public.

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

Various technical, formatting, and grammatical changes were made at the suggestion of G.R.R.C. staff to improve clarity of the rules. Additionally, two non-substantive changes were made. R4-19-403 (A)(1) is changed as follows:

Proposed version: "Failure to maintain professional boundaries" means any conduct or behavior that, regardless of the nurse's intention, could lessen the benefit of care to a patient, client, family, or community including behavior engaged in with the intent of obtaining financial gain in excess of usual compensation.

Final Version: "Failure to maintain professional boundaries" means any conduct or behavior of a nurse that, regardless of the nurse's intention, is likely to lessen the benefit of care to a patient, resident, or the family of a patient or resident and places the patient, resident, or family of the patient or resident at risk of being exploited financially, emotionally, or sexually;

Changes were made in response to the suggestions of G.R.R.C. staff and testimony at the open public hearing and are considered clarifying and non-substantive.

R4-19-403 (B) (15) is changed as follows:

Proposed version: Theft from a patient, employer, co-worker, or member of the public.

Final version: Removing, without authorization, any money, property, or personal possessions, or requesting payment for services not performed from a patient, employer, co-worker, or member of the public.

Changes were made in response to testimony heard at the open public hearing.

Additional changes to R4-19-501 (C) were made at the request of the Board. To provide additional information in rule on specialty areas of advanced practice nursing that meet the rule requirement, the Board is including a listing in rule of the specialty areas that meet the rule requirements for approval. The wording changes continue to allow the Board to approve new specialty areas as they demonstrate conformance to the rule requirements.

Proposed version: R4-19-501C. The Board shall maintain and publish a list of approved specialty areas and examinations for advanced practice registered nursing.

Final version: R4-19-501C. The Board shall determine whether a certification or exam meets the requirements of this Section. The following specialty area certifications and exams meet the requirements of this Section as of the effective date of this rulemaking:

1. For RNP:
   a. American Academy of Nurse Practitioner certification in the specialties of:
      i. Adult nurse practitioner,
      ii. Family nurse practitioner,

   b. American Nurses Credentialing Center certification in the specialties of:
      i. Acute care nurse practitioner,
      ii. Adult nurse practitioner,
      iii. Family nurse practitioner,
      iv. Gerontological nurse practitioner,
      v. Pediatric nurse practitioner,
      vi. Adult psychiatric and mental health nurse practitioner,
      vii. Family psychiatric and mental health nurse practitioner,
   c. Pediatric Nursing Certification Board certification in the specialty of pediatric nurse practitioner,
   d. National Certification Corporation for Obstetric, Gynecological, and Neonatal Nursing Specialties certification in the specialties of:
      i. Women's health nurse practitioner,
      ii. Neonatal nurse practitioner,
   e. American College of Nurse Midwives Certification Council certification in the specialty of nurse midwife,
2. For CNS:
   a. American Association of Critical Care Nurses certification in the specialties of:
      i. Adult critical care CNS,
      ii. Pediatric critical care CNS,
      iii. Neonatal critical care CNS,
   b. American Nurses Credentialing Center certification in the specialties of:
      i. Adult psych/mental health going across the life span CNS,
      ii. Child/adolescent psych mental health CNS,
      iii. Community health CNS,
      iv. Gerontological CNS,
      v. Home health CNS,
      vi. Medical-surgical CNS,
      vii. Pediatric CNS.

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

An oral proceeding was held December 10, 2004. Four persons testified. Two written comments were received that reflected the oral testimony offered. The Board extended the deadline for written comments to December 17, 2004 to allow persons who testified to submit written comments.

The comments and Board response are summarized on the following pages:

Proposed Rule Commented Upon	Summary of Comments or Proposed Change	Board Response
R4-19-403(A)(1) 1. "Failure to maintain professional boundaries" means any conduct or behavior of a nurse that, regardless of the nurse's intention, is likely to lessen the benefit of care to a patient, resident, family, or community and places the patient, resident, family, or community at risk of being exploited financially, emotionally, or sexually; and	AZNA is suggesting that the rule be changed to read: 1. "Failure to maintain professional boundaries" means any conduct or behavior of a nurse that, ~~regardless of the nurse's intentions~~, could be reasonably foreseen to: a. ~~likely to~~ lessen the benefit of care to a patient, resident, family, or community, and 2. Places the patient, resident, family, or community at risk of being exploited financially, emotionally, or sexually; and	Based on consultation with G.R.R.C., the proposed change would require a notice of supplemental proposed rulemaking in the Register and another open hearing. Additionally, the Board believes the proposed change imposes the concept of "foreseeability" upon the Board and may substantially alter the Board's current authority to discipline nurses for boundary violations under the existing definition of unprofessional conduct. The Board believes this change could adversely affect the public health, safety and welfare.
	AZNA representative, Mary Griffith stated they have repeatedly questioned the phrase, "regardless of the nurse's intention" and asked for different language.	Board staff was not aware of opposition for replacing the "intention" clause. At the Open Public Workshop, Griffith testified and did not address opposition to "intention".
	AZNA Executive Director, Marla Weston, stated that at one point AZNA suggested explaining the word "intention" with "could reasonably be foreseen".	Board staff was not aware of the suggested replacement for "intention". The Board, for the reasons stated above, will not amend the proposed rule in this manner.
	Attorney Jay Ryan stated he was representing himself and Teressa Sanzio and they are proposing the following change: 1. "Failure to maintain professional boundaries" means any conduct or behavior of a nurse that, regardless of the nurse's intention, is likely to lessen the benefit of care to a patient, resident, ~~family, or community~~ or patient's family and places the patient, resident, ~~family, or community~~ or family of the patient or resident at risk of being exploited financially, emotionally, or sexually;	This change is non-substantive and provides further clarity. Staff would agree with Ms. Sanzio and Mr. Ryan's suggested changes.

R4-19-403(B)(4). Engaging in sexual conduct with a patient or a patient's family member, who does not have a pre-existing relationship with the nurse, or any conduct in the work place that a reasonable person would interpret as sexual;	Sanzio and Ryan suggest the following change: 4. Engaging in sexual conduct with a patient or a patient's family member, who does not have a pre-existing relationship with the nurse, ~~or any conduct in the work place that a reasonable person would interpret as sexual;~~	The Board has decided not to change R4-19-403(B)(4) for the following reasons: 1. It substantially alters the rule requiring a notice of supplemental proposed rulemaking and publication in the Register, and 2. It does not adequately protect the public from unprofessional conduct. Sexual conduct in the workplace detracts from patient care and places other employees and patients at risk. The Board receives complaints of nurses engaging in sexual behavior with fellow employees and subordinates. This conduct intimidates other workers and distracts their attention to the nurse's conduct rather than the patient's needs. Such conduct includes sexual language, intimidation, coercing others to engage in sexual relations, and inappropriate intimacy with fellow workers such as petting, or kissing without the express permission of the recipient. The Board has received reports from victims of workplace sexual conduct who stated that they felt so fearful, distracted, and intimidated by the conduct, they could not concentrate on their patient care duties. There is a power differential between nurses and other health care workers. The Board believes that a nurse who uses that power to coerce sexual favors from a fellow worker is unprofessional. Behavioral experts also contend that if a nurse engages in sexual conduct at the workplace with persons other than patients, there is a high probability that the behavior is also exhibited in patient relations but is not reported since nurses have frequent unobserved contact with patients. While Ms. Sanzio would contend that this is strictly an employer issue, entrusting the employer to ensure that such nurses are dismissed does not protect the public from the nurse when they move to another employer or when the employer is a nursing registry service.

R4-19-403 (B)(9) 9.Failing to take appropriate action to safeguard a patient's welfare or ~~to~~ follow policies and procedures of the nurse's employer designed to safeguard the patient;	Sanzio and Ryan suggest the following changes: 9.Failing to take appropriate action to safeguard a patient's welfare or ~~to follow policies and procedures of the nurse's employer designed to safeguard the patient;~~	The Board has not proposed substantial change to this rule and to accept Mr. Ryan and Ms. Sanzio's suggestion would constitute a substantial change requiring a notice of supplemental proposed rulemaking. This rule has been in existence for over 10 years. The rationale Ms. Sanzio gives would require that the patient suffer harm before the Board acts upon a nurse's license. The statutes of the Board clearly do not require that harm occur for the Board to take action on a nurse's license. In applying this rule, the Board has the expertise among its members to determine if the policy or procedure was indeed designed to safeguard the patient. Ms. Sanzio's proposed change will alter the Board's authority and discretion in determining whether a nurse committed unprofessional conduct by violating an employer policy or procedure. In over 10 years of enforcing this rule, the Board has not received any challenges or had their decisions overturned because the rule was arbitrary. The Board believes that the rule should not be altered.
10. Failing to take action in a health care setting to protect a patient whose safety or welfare is at risk from incompetent health care practice, or to report ~~such~~ the incompetent health care practice to employment or licensing authorities;	Sanzio and Ryan suggest that incompetent health care practice be defined.	This rule has been in existence for a number of years and never has the Board or public been confused about what constitutes an incompetent health care practice. Every nurse has the basic nursing knowledge to ascertain if a health care practice is competent or not. Because all nurses receive education in competent nursing practice, the Board contends that a definition of incompetent practice is not needed.

15. Theft from a patient, employer, co-worker, or member of the public.	Sanzio and Ryan propose the following: "Conviction of theft from a patient, employer, co-worker, or member of the public.	The Board already has powers to take action on a license for criminal convictions and there would be no benefit to limit the applicability of this rule to conviction only. The Board is aware of many instances where a nurse commits theft, which is witnessed and even admitted to by the nurse, but the employer chooses not to press charges. Such a nurse is at risk to repeat the behavior with vulnerable patients. For the sake of clarity however, the Board re-worded the subsection as follows: ~~Theft~~ Removing, without authorization, any money, property, or personal possessions, or requesting payment for services not performed from a patient, employer, co-worker, or member of the public.
R4-19-403(B)(27) 27. Making a false or misleading statement on a nursing or health care related employment or credential application concerning previous employment, employment experience, education, or credentials;	Sanzio and Ryan request that this rule be deleted because it is strictly and employer-employee issue.	The Board has decided that this rule is needed to protect the public. A false statement on an application can lead to an offer of employment for a nurse who lacks the basic skills of the job description and has the potential to cause harm to patients. A nurse who falsely claims to be certified in CPR or advanced life support but does not hold such certification, would be unable to effectively care for patients experiencing a life-threatening situation, potentially contributing to the patient's death. To burden the employer with verifying every certification would delay hiring qualified nurses and not hold the nurse accountable for his/her behavior.

R4-19-402(B)(28) 28. If a licensee or applicant is charged with a felony or a misdemeanor involving conduct that may affect patient safety, failing to notify the Board, in writing, within 10 days of being charged under A.R.S. § 32-3208. The nurse or applicant shall include the following in the notification: a. Name, address, telephone number, social security number, and license number, if applicable; b. Date of the charge; and c. Nature of the offense; 29. Failing to notify the Board, in writing, of a conviction for a felony or an undesignated offense within 10 days of the conviction. The nurse or applicant shall include the following in the notification: a. Name, address, telephone number, social security number, and license number, if applicable; b. Date of the conviction; and c. Nature of the offense;	Sanzio and Ryan suggest that a definition of "conduct that may affect patient safety" be defined.	According to the statutory analysis by the office of the Attorney General such conduct does not need to be defined in rule. The Board believes that to define the conduct in rule would require a rule change whenever criminal conduct categories change. The purpose of this subsection is to set forth the requirements for the information submitted to meet the statutory obligation to report. The Board agrees with Ms. Sanzio that it has a duty to set forth the specific conduct it believes affect patient safety. The Board will keep a listing of such conduct on the Board's web site, where it is widely available to the public, and periodically publish the list in the newsletter, which is sent to every licensee and certificate holder. The Board believes this will inform the public in a timely and adequate manner of the conduct that should be reported under A.R.S. § 32-3208. The Board is aware that most licensees look to the web site or newsletter for information, not to the rules.
R4-19-505(A)(8)	Bonnie Fahy, Pulmonary CNS, spoke in support of the proposed addition for CNS certification in R4-19-505 (A)(8).	The Board acknowledges and appreciates Ms. Fahy's support.
R4-19-508. Scope of Practice of a Registered Nurse Practitioner	AZNA Executive Director, Marla Weston, acknowledged her support for the clarification and strengthening of the language relating to NP practice in R4-19-508.	The Board acknowledges and appreciates Ms. Weston's support.

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:

The Board is incorporating the national standards of the National Association of Clinical Nurse Specialists in providing an alternate mechanism for meeting the requirement to graduate from a clinical nurse specialist program. The reference is in R4-19-505(A)(4)(c)(i).

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

No.

15. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 19. BOARD OF NURSING

ARTICLE 4. REGULATION

Section
R4-19-403. ~~Competency to Practice Nursing~~ Unprofessional Conduct

ARTICLE 5. ADVANCED AND EXTENDED NURSING PRACTICE

Section
R4-19-501. Categories and Specialty Areas of ~~Registered Nurse Practitioners~~ Advanced Practice Registered Nursing
R4-19-502. Requirements for ~~Courses of Study~~ Advanced Practice Registered Nursing Programs ~~for Registered Nurse Practitioners~~
R4-19-503. Application for Approval of ~~Course of Study for Registered Nurse Practitioners~~ an Advanced Practice Registered Nursing Program; Approval by Board
R4-19-504. Recision of Approval of an Advanced Practice Registered Nursing Program
~~R4-19-504~~R4-19-505.Requirements for ~~Registered Nurse Practitioner~~ Advanced Practice Registered Nursing Certification
R4-19-506. Expiration of Advanced Practice Certificates; Renewal
R4-19-507. ~~Prescribing and Dispensing Authority~~ Temporary Advanced Practice Certificate
~~R4-19-505.~~R4-19-508.Scope of Practice of a Registered Nurse Practitioner
R4-19-509. ~~Repealed~~ Delegation to Medical Assistants
~~R4-19-506.~~R4-19-510.Use of Title ~~of Registered Nurse Practitioner~~
R4-19-511. ~~Requirements for Clinical Nurse Specialist Certification~~ Prescribing and Dispensing Authority; Prohibited Acts
R4-19-512. Prescribing Drugs and Devices
~~R4-19-508.~~R4-19-513.Dispensing ~~of Medications~~ Drugs and Devices
~~R4-19-512.~~R4-19-514.Scope of Practice of the Clinical Nurse Specialist
~~R4-19-513.~~R4-19-515.Prescribing Authority of a Certified Registered Nurse Anesthetist
R4-19-516. Registered Nurse Anesthetist; Notification of the Board; Nurse Anesthetist Programs; Scope of Practice

ARTICLE 4. REGULATION

R4-19-403. ~~Competency to Practice Nursing~~ Unprofessional Conduct

A. For the purpose of this Section:
1. "Failure to maintain professional boundaries" means any conduct or behavior of a nurse that, regardless of the nurse's intention, is likely to lessen the benefit of care to a patient, resident, or the family of a patient or resident and places the patient, resident, or family of the patient or resident at risk of being exploited financially, emotionally, or sexually; and
2. "Dual relationship" means a nurse simultaneously engages in both a professional and nonprofessional relationship with a patient that is avoidable, non-incidental, and results in the patient being exploited financially, emotionally, or sexually.

B. For purposes of A.R.S. § 32-1601(~~11~~16)(d), ~~a~~ any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public includes one or more of the following:
1. A pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice;
2. Intentionally or negligently causing physical or emotional injury;
3. Failing to maintain professional boundaries or engaging in a dual relationship with a patient, resident, or any family member of a patient or resident;
4. Engaging in sexual conduct with a patient, resident, or any family member of a patient or resident who does not have a pre-existing relationship with the nurse, or any conduct in the work place that a reasonable person would interpret as sexual;
~~3.~~5. Abandoning or neglecting a patient ~~requiring~~ who requires immediate nursing care without making reasonable arrangement for continuation of ~~such~~ care;
~~4.~~6. Removing a patient's life support system without appropriate medical or legal authorization;
~~5.~~7. Failing to maintain for ~~each~~ a patient ~~a~~ record ~~which~~ that accurately reflects the nursing assessment, care, ~~and~~ treatment, and other nursing services provided to ~~a~~ the patient;

~~14.~~8. Falsifying or making a materially incorrect, inconsistent, or unintelligible ~~entries~~ entry in any ~~patient records record or in the records of~~ :
   a. ~~any~~ Regarding a patient, health care facility, school, institution, or other work place location~~,~~ ; or
   b. ~~pertaining~~ Pertaining to ~~the~~ obtaining, possessing, or ~~administration of~~ administering any controlled substance as defined in the federal Uniform Controlled ~~Substance~~ Substances Act, 21 U.S.C. 801 et seq., or Arizona's Uniform Controlled ~~Substance~~ Substances Act, A.R.S. Title 36, Chapter 27;

~~6.~~9. Failing to take appropriate action to safeguard a patient's welfare or ~~to~~ follow policies and procedures of the nurse's employer designed to safeguard the patient;

~~8.~~10. Failing to take action in a health care setting to protect a patient whose safety or welfare is at risk from incompetent health care practice, or to report ~~such~~ the incompetent health care practice to employment or licensing authorities;

~~7.~~11. Failing to report to the Board a licensed nurse whose work history includes conduct, or a pattern of conduct, ~~which~~ that leads to ~~actual~~ or may lead to an ~~potential~~ adverse patient ~~consequences~~ outcome ~~threatening public health and safety~~;

~~9.~~12. Assuming patient care responsibilities ~~for which~~ that the nurse lacks the education to perform, ~~or~~ for which the nurse has failed to maintain nursing competence, or that are outside the scope of practice of the nurse;

~~10.~~13. Failing to supervise a ~~persons~~ person to whom nursing functions ~~have been~~ are delegated;

14. Delegating services that require nursing judgment to an unauthorized person;

15. Removing, without authorization, any money, property, or personal possessions, or requesting payment for services not performed from a patient, employer, co-worker, or member of the public.

~~11.~~16. Removing, without authorization, a ~~narcotics~~ narcotic, ~~drugs~~ drug, controlled substance, ~~supplies~~ supply, equipment, or medical ~~records~~ record from any health care facility, school, institution, or other work place location;

~~12.~~17. A pattern of ~~use~~ using or being under the influence of ~~alcoholic~~ alcohol ~~beverages~~, ~~medications~~ drugs, or a similar ~~other substances~~ substance to the extent that judgment may be impaired and nursing practice detrimentally affected, or while on duty in any health care facility, school, institution, or other work location;

~~13.~~18. Obtaining, possessing, administering, or using any narcotic, controlled substance, or illegal ~~drugs~~ drug in violation of any federal or state criminal law, or in violation of the policy of any health care facility, school, institution, or other work location at which the nurse practices;

~~20.~~19. Providing or administering any controlled substance or prescription-only drug for other than accepted therapeutic or research purposes;

~~15.~~20. Engaging in fraud, misrepresentation, or deceit in ~~writing~~ taking ~~the~~ a licensing examination or on an initial or renewal application for ~~licensure~~ a license or certificate ~~or a renewal of license~~;

~~16.~~21. Impersonating ~~professional and licensed practical nurses~~ a nurse licensed or certified under this Chapter;

~~17.~~22. Permitting or allowing another person to use the nurse's license for any purpose;

~~18.~~23. Advertising ~~of~~ the practice of nursing ~~in which~~ with untruthful or misleading statements ~~are made~~;

~~19. Prescribing controlled substances to members of the registered nurse practitioner's immediate family or for oneself;~~

~~21. Prescribing controlled substances by a registered nurse practitioner, including amphetamines and similar class II drugs, in the treatment of exogenous obesity, for a period in excess of 30 days within a 12-month period for an individual; or the non-therapeutic use of injectable amphetamines;~~

~~22. Delegating, by the registered nurse practitioner the prescribing or dispensing of drugs to any other person;~~

~~23.~~24. Practicing nursing without a current license or while the license is suspended;

~~24.~~25. Failing to ~~cooperate with the Board by~~:
   a. ~~Not furnishing~~ Furnish in writing a full and complete explanation ~~covering the~~ of a matter reported pursuant to A.R.S. § 32-1664, or
   b. ~~Not responding~~ Respond to a subpoena issued by the Board;

26. Making a written false or inaccurate statement to the Board or the Board's designee in the course of an investigation;

27. Making a false or misleading statement on a nursing or health care related employment or credential application concerning previous employment, employment experience, education, or credentials;

28. If a licensee or applicant is charged with a felony or a misdemeanor involving conduct that may affect patient safety, failing to notify the Board in writing, as required under A.R.S. § 32-3208, within 10 days of being charged. The licensee or applicant shall include the following in the notification:
   a. Name, address, telephone number, social security number, and license number, if applicable;
   b. Date of the charge; and
   c. Nature of the offense;

29. Failing to notify the Board, in writing, of a conviction for a felony or an undesignated offense within 10 days of the conviction. The nurse or applicant shall include the following in the notification:
   a. Name, address, telephone number, social security number, and license number, if applicable;
   b. Date of the conviction; and
   c. Nature of the offense;

30. For a registered nurse granted prescribing privileges, any act prohibited under R4-19-511 (D); or

~~25~~31. Practicing in any other manner ~~which~~ that gives the Board reasonable cause to believe ~~that~~ the health of a patient or the public may be harmed.

ARTICLE 5. ADVANCED AND EXTENDED NURSING PRACTICE

R4-19-501. Categories and Specialty Areas of ~~Registered Nurse Practitioners~~ Advanced Practice Registered Nursing

~~**A.** The Board shall approve a nurse practitioner education program that meets the standards in R4-19-502 and certify the following specialty areas for registered nurse practitioners:~~

~~1. Nurse midwife,~~
~~2. Pediatric nurse practitioner,~~
~~3. Family nurse practitioner,~~
~~4. Adult nurse practitioner,~~
~~5. Woman's health care nurse practitioner,~~
~~6. Neonatal nurse practitioner,~~
~~7. School nurse practitioner,~~
~~8. Psychiatric and mental health nurse practitioner,~~
~~9. Geriatric nurse practitioner, and~~
~~10. Acute-care nurse practitioner.~~

A. The Board uses the following categories of advanced practice registered nursing:

1. Registered nurse practitioner (RNP) in a specialty area including Certified Nurse Midwife as a specialty area of RNP; and
2. Clinical Nurse Specialist (CNS) in a specialty area.

B. A specialty area of advanced practice registered nursing is a field of practice that meets all of the following criteria. The specialty area is:

1. Approved by the Board as a recognized advanced practice specialty area,
2. Broad enough for an educational program to be developed that prepares a registered nurse to function both within the scope of practice of a category of advanced practice under A.R.S. § 32-1601 and within the specialty area, and
3. Recognized as an advanced practice specialty area by a national certifying body that:
   a. Is accredited by the National Commission for Certifying Agencies, the American Board of Nursing Specialties, or an equivalent organization as determined by the Board;
   b. Has educational requirements that are consistent with the requirements in R4-19-505;
   c. Has an application process and credential review that includes documentation that the applicant's education and clinical practice is in the advanced practice specialty area being certified;
   d. Is national in the scope of its credentialing
   e. Uses an examination as a basis for certification in the advanced practice specialty area that meets all of the following criteria:
      i. The examination is based upon job analysis studies conducted using standard methodologies acceptable to the testing community;
      ii. The examination assesses entry-level practice in the advanced practice category and specialty area;
      iii. The examination assesses the knowledge, skills, and abilities essential for the delivery of safe and effective advanced nursing care to clients;
      iv. Examination items are reviewed for content validity, cultural sensitivity, and correct scoring using an established mechanism, both before first use and periodically;
      v. The examination is evaluated for psychometric performance and conforms to psychometric standards that are routinely utilized for other types of high-stakes testing;
      vi. The passing standard is established using accepted psychometric methods and is re-evaluated periodically;
      vii. Examination security is maintained through established procedures;
      viii. A re-take policy is in place; and
      ix. Conditions for taking the certification examination are consistent with standards of the testing community;
   f. Issues certification based on passing the examination and meeting all other certification requirements;
   g. Provides for periodic re-certification that includes review of qualifications and continued competence;
   h. Has mechanisms in place for communication to the Board regarding timely verification of an individual's certification status and changes in the certification program, including qualifications, test plan, and scope of practice; and
   i. Has an evaluation process to provide quality assurance in its certificate program.

C. The Board shall determine whether a certification or exam meets the requirements of this Section. The following specialty area certifications and exams meet the requirements of this Section as of the effective date of this rulemaking:

1. For RNP:
   a. American Academy of Nurse Practitioner certification in the specialties of:
      i. Adult nurse practitioner,
      ii. Family nurse practitioner,
   b. American Nurses Credentialing Center certification in the specialties of:
      i. Acute care nurse practitioner,
      ii. Adult nurse practitioner,
      iii. Family nurse practitioner,
      iv. Gerontological nurse practitioner,
      v. Pediatric nurse practitioner,
      vi. Adult psychiatric and mental health nurse practitioner,
      vii. Family psychiatric and mental health nurse practitioner,
   c. Pediatric Nursing Certification Board certification in the specialty of pediatric nurse practitioner,
   d. National Certification Corporation for Obstetric, Gynecological, and Neonatal Nursing Specialties certification in the specialties of:
      i. Women's health nurse practitioner,
      ii. Neonatal nurse practitioner,
   e. American College of Nurse Midwives Certification Council certification in the specialty of nurse midwife,
2. For CNS:
   a. American Association of Critical Care Nurses certification in the specialties of:
      i. Adult critical care CNS,
      ii. Pediatric critical care CNS,
      iii. Neonatal critical care CNS,
   b. American Nurses Credentialing Center certification in the specialties of:
      i. Adult psych/mental health going across the life span CNS,
      ii. Child/adolescent psych mental health CNS,
      iii. Community health CNS,
      iv. Gerontological CNS,
      v. Home health CNS,
      vi. Medical-surgical CNS,
      vii. Pediatric CNS.

D. The Board shall approve a specialty area that meets the criteria established in this Section. An entity that seeks approval of a specialty area and is denied approval may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.

R4-19-502. Requirements for ~~Courses of Study~~ Advanced Practice Registered Nursing Programs ~~for Registered Nurse Practitioners~~

A. ~~The Board shall approve a course of study for registered nurse practitioners in a specialty area, only if the course of study complies with the following:~~ An educational institution or other entity that offers an advanced practice registered nursing program for registered nurse practitioners or clinical nurse specialists shall ensure that the program:

1. ~~The course of study is~~ Is offered by or affiliated with a college or university ~~accredited by the North Central Association of Colleges and Schools~~ that is accredited under A.R.S. § 32-1644;
2. ~~The course of study is~~ Is a formal educational program, ~~beyond a diploma, associate degree, or baccalaureate degree~~ that is part of a masters program or a post-masters program in nursing with a concentration in an advanced practice registered nursing category and specialty under R4-19-501.; ~~with a curriculum that is at least nine months in length and includes theory and supervised clinical experience to prepare professional nurses to do the following:~~
   ~~a. Assess the physical and psychosocial health status of individuals and families through health and developmental history taking and physical examination;~~
   ~~b. Evaluate the assessment data to make prospective decisions with other health professionals;~~
   ~~c. Institute and provide routine health care to patients;~~
   ~~d. Provide counseling and health teaching to patients and their families; and~~
   ~~e. Perform the acts described in R4-19-505.~~
3. ~~The course of study has a preceptorship.~~
3. Is nationally accredited by an approved national nursing accrediting agency as defined in R4-19-101;
4. Offers a curriculum that covers the scope of practice for both the category of advanced practice as specified in A.R.S. § 32-1601 and the specialty area;
5. Includes a minimum of 500 hours of clinical practice;
6. Notifies the Board of any changes in hours of clinical practice or accreditation status and responds to Board requests for information;

7. Has financial resources sufficient to support the educational goals of the program; and
8. Establishes academic, professional, and conduct standards that determine admission to the program, progression in the program, and graduation from the program that are consistent with sound educational practices and recognized standards of professional conduct.

B. A faculty member who is educated and nationally certified in the same or a related specialty area and certified as an advanced practice registered nurse by the Board shall coordinate the educational component for the category and specialty in the advanced practice registered nursing program.

~~B.~~C. ~~Each~~ The parent institution of an advanced practice registered nursing program shall ensure that a nursing program faculty member ~~of a course of study for registered nurse practitioners~~ is appointed to oversee any advanced practice registered nursing course that includes a clinical experience. The faculty member appointed shall hold: ~~shall meet the requirements established by an Arizona university or college for faculty membership and one of the following:~~

~~1. Current licensure as a professional nurse in Arizona~~ with a Master's Degree in a nursing or clinical specialty; ~~or~~

1. An unencumbered active license in good standing or a multistate privilege to practice as a registered nurse in Arizona, and

~~2. Current licensure as a physician in Arizona~~

2. A graduate degree with a major in nursing or a clinical specialty.

D. Other licensed health care professionals may teach a non-clinical course or assist in teaching a clinical course in an advanced practice registered nursing program within their area of licensure and expertise.

E. The parent institution of an advanced practice nursing program shall ensure that a preceptor supervising a student in clinical practice:

1. Holds an unencumbered active license or multistate privilege to practice as a registered nurse or physician in the state in which the preceptor practices or, if employed by the federal government, holds an unencumbered active RN or physician license in the United States;
2. Has at least one year clinical experience as a physician or an advanced practice nurse, and
3. For nurse preceptors, has at least one of the following:
   a. National certification in the advanced practice category in which the student is enrolled;
   b. Current Board certification in the advanced practice category in which the student is enrolled; or
   c. If an advanced practice preceptor cannot be found who meets the requirements of (E)(3)(a) or (b), educational and experiential qualifications that will enable the preceptor to precept students in the program, as determined by the nursing program and verified by the Board.

R4-19-503. Application for Approval of ~~Course of Study for Registered Nurse Practitioners~~ an Advanced Practice Registered Nursing Program; Approval by Board

A. An administrator of an educational institution that proposes to offer an advanced practice registered nursing program shall submit the following to the Board:

~~A.~~1. An ~~educational institution proposing to offer a course of study to prepare professional nurses for certification in a specialty area for extended and advanced nursing practice shall submit a completed~~ application ~~to the Board. on a form provided by the Board. The application shall contain~~ that includes all of the following information:

~~1.~~a. Category, ~~Specialty~~ specialty area that meets the criteria in R4-19-501(B), and the faculty member coordinating the ~~of the registered nurse practitioner course of study~~ program under R4-19-502(B);

~~2.~~b. Name, ~~and~~ address, and accreditation status of the applicant or affiliated educational institution~~.~~;

~~3. Discussion of the background development of the course of study,~~

~~4. Statement of philosophy of the applicant institution,~~

~~5. Statement of the purpose for the extended and advanced nursing practice course,~~

~~6. Discussion of the community and state job market for registered nurse practitioners who complete the course of study,~~

~~7.~~c. ~~Description of the~~ The mission, goals, and objectives of the ~~course of study,~~ program consistent with generally accepted standards for advanced practice education;

~~8.~~d. List of the ~~core courses and any specialty~~ required courses, ~~included in the course of study~~ and a description, measurable objectives, and content outline ~~of~~ for each required course~~.~~;

~~9.~~e. ~~Designation of a~~ A proposed time schedule for implementation of the ~~course of study,~~ program;

~~10.~~f. ~~Designation of the~~ The total ~~clock~~ hours ~~required~~ allotted ~~of both~~ for both didactic instruction and supervised clinical practicum in the ~~course of study~~ program;

~~11. Description of the budgetary provisions for the course of study,~~

~~12. List of the names and titles of persons responsible for the course of study,~~

~~13.~~g. List of the names and ~~titles~~ qualifications of ~~the~~ each faculty member~~.~~; and

~~14.~~h. A self-study that provides ~~Evidence~~ evidence of compliance with R4-19-502.

~~B.~~ ~~An applicant shall submit the following additional information with the application for approval of the course of study:~~

~~1. Copies of any studies, historical data, or other evidence of need for the course of study; and~~

~~2. Qualifications of each faculty member.~~

~~C.~~**B.** The Board shall ~~grant approval to~~ approve ~~a course of study~~ an advanced practice registered nursing program ~~to prepare professional nurses for certification in a specialty role for extended and advanced nursing practice~~ if approval is in the best interest of the public and the ~~course~~ program meets the requirements of this Article. The Board may grant approval for a period of two years or less to an advanced practice nursing program where the program meets all the requirements of this Article except for accreditation by a national nursing accrediting agency, based on the program's presentation of evidence that it has applied for accreditation and meets accreditation standards.

~~D.~~**C.** An educational institution that is denied approval of ~~a course of study~~ an advanced practice registered nursing program may request a hearing by filing a written request with the Board within ~~10~~ 30 days of service of the Board's order denying its application for approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.

D. Approval of an advanced practice registered nursing program expires 12 months from the date of approval if a class of students is not admitted within that time.

R4-19-504. Recision of Approval of an Advanced Practice Registered Nursing Program

A. The Board may periodically survey an advanced practice registered nursing program to determine whether criteria for approval are being met.

B. The Board shall, upon determining that an advanced practice registered nursing program is not in compliance with R4-19-502, provide to the program administrator a written notice of deficiencies that establishes a reasonable time, based upon the number and severity of deficiencies, to correct the deficiencies. The time for correction may not exceed 18 months.

1. The program administrator shall, within 30 days from the date of service of the notice of deficiencies, consult with the Board or designated Board representative and, after consultation, file a plan to correct each of the identified deficiencies.
2. The program administrator may, within 30 days from the date of service of the notice of deficiencies, submit a written request for a hearing before the Board to appeal the Board's determination of deficiencies. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.
3. If the Board's determination is not appealed or is upheld upon appeal, the Board may conduct periodic evaluations of the program during the time of correction to determine whether the deficiencies have been corrected.

C. The Board shall, following a Board-conducted survey and report, rescind the approval or limit the ability of a program to admit students if the program fails to comply with R4-19-502 within the time set by the Board in the notice of deficiencies provided to the program administrator.

1. The Board shall serve the program administrator with a written notice of proposed rescission of approval or limitation of admission of students that states the grounds for the rescission or limitation. The program administrator has 30 days to submit a written request for a hearing to show cause why approval should not be rescinded or admissions limited. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.
2. Upon the effective date of a decision to rescind program approval, the effected advanced practice registered nursing program shall immediately cease operation and be removed from the official approved-status listing. An advanced practice registered nursing program that is ordered to cease operations shall assist currently enrolled students to transfer to an approved nursing program.

D. The Board may rescind approval of an advanced practice registered nursing program, based on the severity of the violations, if recision is in the best interest of the public or for one or both of the following reasons:

1. For a program that was served with a notice of deficiencies within the preceding three years and timely corrected the noticed deficiencies, subsequent noncompliance with the standards in R4-19-502; or
2. Failure to comply with orders of or stipulations with the Board within the time determined by the Board.

~~R4-19-504~~R4-19-505. Requirements for ~~Registered Nurse Practitioner~~ Advanced Practice Registered Nursing Certification

A. An applicant for certification as a registered nurse practitioner (RNP) or clinical nurse specialist (CNS) in a specialty area, shall:

1. Hold a current Arizona registered nurse (RN) license in good standing or an RN license in good standing from a compact party state with multistate privileges ~~to practice as a professional nurse in Arizona~~; and
2. Submit an application to the Board that provides all of the following:
   ~~a. A notarized application furnished by the Board which provides the following information:~~:
   ~~i~~ a. ~~The applicant's full~~ Full name and any former names ~~used by the applicant~~;
   ~~ii.~~b. ~~The applicant's current~~ Current mailing address and telephone number;
   ~~iii.~~c. ~~The applicant's professional nurse~~ RN license number, application for RN license, or copy of a multistate compact RN license;
   ~~iv.~~d. ~~A description of the applicant's educational~~ Educational background, including the name and location of all advanced practice registered nursing education programs or schools attended, the number of years attended, the length of each program, the date of graduation or completion, and the type of degree or certificate awarded;

~~v.~~e. ~~The~~ Category and specialty area for which the applicant ~~wishes to be certified;~~ is applying;
~~vi.~~f. ~~The applicant's current~~ Each current and previous employer, including address, type of position, and dates of employment;
~~vii.~~g. ~~Whether the applicant has taken and passed a national certification examination,~~ Information regarding national certification or recertification as an advanced practice registered nurse in the category and specialty area, if applicable, for which the applicant is applying, including ~~and~~ the name of the certifying organization, specialty area, certification number, ~~and~~ date of certification, and expiration date;
~~viii.~~h. ~~Whether the applicant has ever had a nursing license denied, suspended, or revoked, and an explanation of any license denial, suspension, or revocation;~~
Whether the applicant is under investigation or has disciplinary action pending against the applicant's nursing license or advanced practice certificate or license in any state, other than Arizona, or territory of the United States;
i. Whether the applicant has ever been convicted, entered a plea of guilty, nolo contendre, or no contest, or ever been sentenced, served time in jail or prison, or had deferred prosecution or sentence deferred in any felony or undesignated offense;
j. Whether the applicant has committed an act of unprofessional conduct as defined in A.R.S. § 32-1601;
~~ix.~~ ~~Whether a disciplinary action, consent order, or settlement agreement has been imposed upon the applicant, and an explanation of any disciplinary action, consent order, or settlement agreement; and~~
k. Completed fingerprint card if the applicant has not submitted a fingerprint card to the Board within the last two years; and
~~x.~~l. ~~A sworn statement by the applicant~~ Signature verifying the truthfulness of the information provided; ~~by the applicant.~~

3. For an RNP applicant, submit an official transcript directly from an institution accredited under A.R.S. § 32-1644 or a Board-approved database that provides evidence of a graduate degree with a major in nursing.
4. For a CNS applicant, submit:
   a. An official transcript directly from an institution accredited under A.R.S. § 32-1644 or a Board-approved database that provides evidence of a graduate degree with a major in nursing; and
   b. Evidence that the applicant completed a program in a clinical specialty that prepared the applicant to practice as a CNS, as part of a graduate degree or post-masters program; or
   c. If applying within one year of the effective date of this Article, an applicant who did not complete a designated Clinical Nurse Specialist program under subsection (A)(4)(b), may submit a portfolio that:
      i. Contains evidence of mastery of core competencies and outcomes of a Clinical Nurse Specialist in a specialty area as prescribed in, *Statement on Clinical Nurse Specialist Practice and Education, 2nd edition, 2004;* which is incorporated by reference and available from the National Association of Clinical Nurse Specialists, 2090 Linglestown Road, Suite 107, Harrisburg, PA 17110, www.nacns.org. This incorporation by reference does not include any later amendments or editions and is on file in the Board office; and
      ii. Is reviewed for consistency with the standards in subsection (i) and recommended for approval by a Board-appointed committee that consists of at least one CNS educator, one practicing CNS, and the Executive Director of the Board or the director's designee.
5. For an RNP applicant who completed a registered nurse practitioner program that was not part of a graduate degree from a regionally accredited university, submit documentation of completing a program in the specialty area for which the applicant is applying. The applicant shall ensure that any one of the following is submitted to the Board either directly from the program or from a Board-approved database:
   ~~b.~~ ~~An official transcript and a copy of a certificate or official letter received from a course of study verifying completion of a registered nurse practitioner course of study in an approved registered nurse practitioner program~~, ~~or a~~ :
   a. An official letter or a copy of a certificate or transcript from a Board-approved RNP program,
   b. An official transcript from an RNP program offered by or affiliated with a ~~regionally accredited~~ college or university accredited under A.R.S. § 32-1644, which was ~~of~~ at least nine months or two full-time semesters in ~~length~~ duration and included theory and clinical experience; ~~to prepare the applicant as a registered nurse practitioner.~~ or
   c. If the ~~course of study~~ program ~~is~~ was not ~~an approved program or~~ provided by ~~a regionally~~ an accredited college or university but is located in the U.S. or territories; an official transcript, a copy of a certificate, or an official letter ~~received from a registered nurse practitioner program which~~ that shows ~~that~~ the program ~~was~~:
      i. Was ~~At~~ at least nine months in length or equivalent to two semesters full-time study, or contained didactic and at least 500 hours clinical instruction; ~~and~~
      ii. Contained theory and clinical experiences sufficient to prepare the graduate to practice within the category and specialty area of practice for which the nurse is applying under A.R.S § 32-1601; and
   ~~ii.~~iii. ~~Included theory and clinical experience to prepare the applicant as a registered nurse practitioner, which pro-~~

~~gram the Board determines to be substantially equivalent to an approved program.~~ Was a RNP program recognized by the jurisdiction where it was located for the purpose of granting nurse practitioner licensure or certification;

6. For an applicant who completed an RNP program, CNS program, or graduate program in a foreign jurisdiction, submit an evaluation from the Commission on Graduates of Foreign Nursing Schools or a Board-approved credential evaluation service that indicates the applicant's program is comparable to a U.S. graduate nursing program, clinical nurse specialist program, or registered nurse practitioner program in the specialty area.

~~d.~~7. ~~If a nurse midwife, evidence~~ For a Clinical Nurse Specialist or Certified Nurse Midwife applicant, or for a Registered Nurse Practitioner applicant submitting an application after July 1, 2004, submit verification of current national certification or recertification in the applicant's category and specialty, as applicable, ~~from the American College of Nurse Midwives or its Certification Council; and~~ from a certifying body that meets the criteria in R4-19-501(B)(3);

8. For a CNS applicant who submits an application to the Board within one year of the effective date of this Article and practices in a specialty that lacks a certification exam under R4-19-501, or is unable to qualify to sit for a certification exam, submit:
   a. A description of the applicant's scope of practice that is consistent with A.R.S. § 32-1601(5),
   b. One of the following:
      i. A letter from a faculty member who supervised the applicant during the master's degree program attesting to the applicant's competence to practice within the defined scope of practice;
      ii. A letter from a supervisor verifying the applicant's competence in the defined scope of practice; or
      iii. A letter from a physician, RNP, or CNS attesting to the applicant's competence in the defined scope of practice; and
   c. A form verifying that the applicant has practiced a minimum of 500 hours in the specialty area within the past two years, which may include clinical practice time in a CNS program; and

~~e.~~9. ~~The~~ Submit the ~~prescribed~~ required fee.

B. ~~An applicant for certification as a registered nurse practitioner on or after January 1, 2001, shall have a master of science degree in nursing or a masters degree in a health-related area.~~ The Board shall continue to certify:

1.~~a~~ An ~~registered nurse practitioner~~ RNP ~~without the masters degree required by this Section who was certified prior to January 1, 2001, if the registered nurse practitioner:~~ without a graduate degree with a major in nursing if the applicant:
   a. Meets all other requirements for certification; and
   b. Was certified or licensed in the applicant's category and specialty area of advanced practice in this or another state:
      i. Before January 1, 2001, if the RNP applicant lacks a graduate degree; or
      ii. Before the effective date of this Section if the RNP's graduate degree is in a health-related area other than nursing.

~~1. Maintains a current license in good standing to practice as a professional nurse in Arizona~~
~~2. Qualifies for certification by endorsement, or~~
~~3. Maintains a current license in good standing to practice as a professional nurse outside the United States and qualifies as a registered nurse practitioner under subsection (A).~~

2. An RNP or CNS applicant without evidence of national certification who received initial advanced practice certification or licensure in another state not later than July 1, 2004 and provides evidence that the certification or licensure is current; and

3. A CNS applicant who received initial certification or advanced practice licensure in this or another state not later than the effective date of this Section without evidence of completing a program in a clinical specialty.

C. The Board shall issue a certificate to practice as a registered nurse practitioner ~~in a specialty area,~~ or a clinical nurse specialist in a specialty area to a ~~professional~~ registered nurse who meets the criteria ~~set forth~~ in this Section. An applicant who is denied a certificate may request a hearing by filing a written request with the Board within ~~10~~ 30 days of service of the Board's order denying ~~the application for~~ certification. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article ~~6~~ 10 and 4 A.A.C. 19, Article 6.

R4-19-506. Expiration of Advanced Practice Certificates; Renewal

A. An advanced practice certificate issued after July 1, 2004, expires if the certificate holder's RN license expires. Certificates issued on or before July 1, 2004 or those issued without proof of national certification under R4-19-505 (A)(8) and (B)(2) do not expire.

B. A registered nurse requesting renewal of an advanced practice certificate shall provide evidence of national certification or recertification under R4-19-505(A)(7).

C. The Board shall renew a certificate to practice as a registered nurse practitioner or a clinical nurse specialist in a specialty area for a registered nurse who meets the criteria in this Section. An applicant who is denied renewal of a certificate may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying renewal of certification. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19,

Article 6.

R4-19-507. ~~Prescribing and Dispensing Authority~~ Temporary Advanced Practice Certificate

~~**A.** The Board shall authorize an RNP to prescribe and dispense medication within the RNP's scope of practice only if the RNP:~~

~~1. Is a professional nurse currently licensed in Arizona in good standing and authorized by the Board to practice within a specialty area identified in R4-19-501;~~

~~2. Submits a completed, notarized application on a form provided by the Board containing the following information:~~

~~a. Name, address, and home phone number;~~

~~b. Professional nurse license number;~~

~~c. Nurse practitioner specialty;~~

~~d. Certification number;~~

~~e. Business address and phone number;~~

~~f. Length of time that applicant has practiced as an RNP and whether full or part time;~~

~~g. If a faculty member, the number of hours of direct patient contact during the year preceding the date of application;~~

~~h. Chronological listing of continuing education obtained by the applicant in pharmacology or clinical management of drug therapy or both in the last two years;~~

~~i. Whether the applicant intends to apply for a DEA number to prescribe controlled substances;~~

~~j. Authority for which the applicant is applying; and~~

~~k. Applicant's sworn statement verifying the truthfulness of the information provided.~~

~~3. Submits evidence of completion of a minimum of 45 contact hours of education in pharmacology or clinical management of drug therapy or both:~~

~~a. An applicant shall complete:~~

~~i. At least six of the 45 hours in the 12-month period immediately prior to the application date; and~~

~~ii. All 45 hours within the two-year period before the application date.~~

~~b. One-half (22 hours) of the required contact hours may be from mediated instruction and self study.~~

~~c. If documented, contact hours may consist of hours of the initial presentations of an RNP who leads, instructs, or lectures to groups of health professionals on pharmacy-related topics in continuing education activities.~~

~~d. An RNP whose primary responsibility is the education of health professionals does not earn contact hours for time expended on normal teaching duties within a learning institution.~~

~~**B.** An applicant who is denied medication P & D authority may request a hearing by filing a written request with the Board within 10 days of service of the Board's order denying the application for P & D authority. Board hearings shall comply with 41 A.R.S. 6, Article 10, and 4 A.A.C. 19, Article 6.~~

~~**C.** An RNP with P & D authority may:~~

~~1. Prescribe medications, medical devices, and appliances;~~

~~2. Provide for refill of prescription only medications for one year from the date of the prescription.~~

~~**D.** An RNP with P & D authority who wishes to prescribe a controlled substance shall apply to the DEA to obtain a DEA registration number before prescribing a controlled substance. The RNP shall file the DEA registration number with the Board.~~

~~**E.** An RNP with a DEA registration number may prescribe a Class II controlled substance as defined in the Federal Controlled Substance Act, 21 U.S.C. § 801 et seq., or Arizona's Uniform Controlled Substance Act, 36 A.R.S. 27, but shall not prescribe refills of the prescription.~~

~~**F.** An RNP with a DEA registration number may prescribe a Class III or IV controlled substance, as defined in the Federal Controlled Substance Act or Arizona's Uniform Controlled Substances Act, and may prescribe a maximum of five refills in six months.~~

~~**G.** An RNP with a DEA registration number may prescribe a Class V controlled substance, as defined in the Federal Controlled Substance Act or Arizona's Uniform Controlled Substance Act, and may prescribe refills for a maximum of one year.~~

~~**H.** An RNP with P & D authority shall ensure that all prescription orders contain the following:~~

~~1. The RNP's name, address, phone number, and specialty area;~~

~~2. The prescription date;~~

~~3. The name and address of the patient;~~

~~4. The full name, strength, dosage form, and directions for use;~~

~~5. Two signature lines for the prescriber with "dispense as written" under the left signature line and "substitution permissible" under the right; and~~

~~6. The DEA registration number, if applicable.~~

~~**I.** The Board of Nursing shall annually send a list of registered nurse practitioners with P & D authority to the Board of Pharmacy, the Board of Medical Examiners, and the Board of Osteopathic Examiners in Medicine and Surgery.~~

~~**J.** An RNP shall not prescribe or dispense medications without prior Board authority. The Board may impose a civil penalty~~

~~for each violation, suspend the RNP's P & D authority, and impose other sanctions under A.R.S. § 32-1606(C). In determining the appropriate sanction, the Board shall consider factors such as the number of violations, the severity of the violation, and the potential or existence of patient harm.~~

A. Based on the registered nurse's qualifications, the Board may issue a temporary certificate to practice as a registered nurse practitioner or a clinical nurse specialist in a specialty area. A registered nurse who is applying for a temporary certificate shall:
1. Apply for certification as an advanced practice nurse;
2. Submit an application for a temporary certificate;
3. Demonstrate authorization to practice as a registered nurse in Arizona on either a permanent or temporary Arizona license or a multistate compact privilege;
4. Meet all requirements of R4-19-505 or meet the requirements or R4-19-505 with the exception of national certification under R4-19-505(A)(7); and
5. Submit evidence that the applicant has applied for and is eligible to take or has taken an advanced practice certifying examination in the applicant's category and specialty area of practice, if applicable.

B. Temporary certification as an advanced practice nurse expires in six months and may be renewed for an additional six months for good cause. Good cause means reasons beyond the control of the temporary certificate holder such as unavoidable delays in obtaining information required for certification.

C. Notwithstanding subsection (B), the Board shall withdraw a temporary advanced practice certificate under any one of the following conditions. The temporary certificate holder:
1. Does not meet requirements for RN licensure in this state or the RN license is suspended or revoked,
2. Fails to renew the RN license upon expiration,
3. Loses the multistate compact privilege,
4. Fails the national certifying examination, or
5. Violates a statute or rule of the Board.

D. A temporary registered nurse practitioner certificate does not qualify an applicant for prescribing or dispensing privileges.

E. An applicant who is denied a temporary certificate may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the temporary certification. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.

~~R4-19-505.~~R4-19-508.Scope of Practice of a Registered Nurse Practitioner

A. An RNP shall refer a patient to a physician or another health care provider if the referral will protect the health and welfare of the patient and consult with a physician and other health care providers if a situation or condition occurs in a patient that is beyond the RNP's knowledge and experience.

B. In addition to the scope of practice permitted a ~~professional nurse~~ registered nurse, ~~an RNP may perform the following acts in collaboration with a physician~~ a registered nurse practitioner, under A.R.S. §§ 32-1601(15) and 32-1606(B)(12), may perform the following acts within the limits of the specialty area of certification:
1. Examine a patient and establish a medical diagnosis by client history, physical examination, and other criteria;
2. ~~Admit a patient into a health care facility~~ For a patient who requires the services of a health care facility:
   a. Admit the patient to the facility,
   b. Manage the care the patient receives in the facility, and
   c. Discharge the patient from the facility;
3. Order~~, perform,~~ and interpret laboratory, radiographic, and other diagnostic tests, and perform those tests that the RNP is qualified to perform;
4. Identify, develop, implement, and evaluate a plan of care for a patient to promote, maintain, and restore health;
5. Perform therapeutic procedures that the RNP is qualified to perform;
6. Prescribe treatments;
~~5.~~7. If authorized under ~~R4-19-507~~ R4-19-511, prescribe and dispense ~~medication~~ drugs and devices; and
~~6.~~8. ~~Refer to and consult with appropriate health care professionals.~~ Perform additional acts that the RNP is qualified to perform.

R4-19-509. ~~Repealed~~ Delegation to Medical Assistants

A. Under A.R.S. § 32-1601(15), an RNP may delegate patient care to a medical assistant in an office or outpatient setting. The RNP shall verify that a medical assistant to whom the RNP delegates meets at least one of the following qualifications:
1. Completed an approved medical assistant training program as defined in R4-16-301;
2. If a graduate of an unapproved medical assistant training program, passed the medical assistant examination administered by either the American Association of Medical Assistants or the American Medical Technologists;
3. Completed an unapproved medical assistant training program and was employed as a medical assistant on a continuous basis since completion of the program before February 2, 2000;
4. Was directly supervised by the same registered nurse practitioner for at least 2000 hours before February 2, 2000; or

5. Completed a medical services training program of the Armed Forces of the United States.

B. A medical assistant may perform, under the delegation and onsite supervision of a registered nurse practitioner, those acts authorized under R4-16-303.

~~R4-19-506.~~R4-19-510. Use of Title ~~of Registered Nurse Practitioner~~

~~A nurse~~ Under A.R.S. § 32-1666, a person shall not practice as a registered nurse practitioner, ~~in a specialty area~~ also known as a nurse practitioner, a certified nurse midwife, also known as nurse midwife or a clinical nurse specialist, or use any words or letters to indicate the ~~nurse~~ person is a registered nurse practitioner, nurse practitioner, certified nurse midwife, nurse midwife, or clinical nurse specialist unless certified ~~as a registered nurse practitioner~~ by the Board.

R4-19-511. ~~Requirements for Clinical Nurse Specialist Certification~~ Prescribing and Dispensing Authority; Prohibited Acts

~~**A.** An applicant for certification as a clinical nurse specialist shall:~~

~~1. Hold a current license in good standing to practice as a professional nurse in Arizona;~~

~~2. Have a master of science degree in nursing or a master's degree with specialization in a clinical area of nursing practice;~~

~~3. Have evidence of current certification by a national nursing credentialing agency in a clinical area of nursing practice;~~

~~4. Submit to the Board:~~

~~a. A notarized application furnished by the Board which provides the following information:~~

~~i. The applicant's full name and any former names used by the applicant;~~

~~ii. The applicant's current home and business address and phone numbers;~~

~~iii. The applicant's professional nurse license number;~~

~~iv. A description of the applicant's educational background, including the name and location of schools attended, the number of years attended, the date of graduation, and the type of degrees or certificates awarded;~~

~~v. The applicant's current employer, including address, type of position, and dates of employment;~~

~~vi. A description of the applicant's national certification including the name of the national certification examination, name of the certifying organization, specialty area, certification number, and date of certification;~~

~~vii. Whether the applicant has ever had a nursing license denied, suspended, or revoked, and an explanation of any license denial, suspension, or revocation;~~

~~viii. Whether a disciplinary action, consent order, or settlement agreement has been imposed upon the applicant and an explanation of any disciplinary action, consent order, or settlement agreement; and~~

~~ix. A sworn statement by the applicant verifying the truthfulness of the information by the applicant.~~

~~b. An official transcript and a copy of a letter received from the education program verifying completion of the requirement in R4-19-511(A)(2).~~

~~**B.** The Board shall issue a certificate to practice as a clinical nurse specialist to a professional nurse who meets the criteria set forth in this Section. An applicant who is denied a certificate may request a hearing by filing a written request with the Board within 10 days of service of the Board's order denying the application for a certificate. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 6, and 4 A.A.C. 19, Article 6.~~

A. The Board shall authorize an RNP to prescribe and dispense (P&D) drugs and devices within the RNP's specialty area and category of practice only if the RNP does all of the following:

1. Obtains authorization by the Board to practice as a registered nurse practitioner;
2. Applies for prescribing and dispensing privileges on the application for registered nurse practitioner certification;
3. Submits a completed application on a form provided by the Board that contains all of the following information:
   a. Name, address, and home telephone number;
   b. Arizona registered nurse license number, or copy of compact license;
   c. Nurse practitioner specialty;
   d. Nurse practitioner certification number issued by the Board;
   e. Business address and telephone number; and
   f. A sworn statement verifying the truthfulness of the information provided;
4. Submits evidence of a minimum of 45 contact hours of education within the three years immediately preceding the application, covering one or both of the following topics:
   a. Pharmacology, or
   b. Clinical management of drug therapy, and
5. Submits the required fee.

B. An applicant who is denied P & D authority may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the P & D authority. Board hearings shall comply with A.R.S. Title 41, Chapter 6, Article 10, and 4 A.A.C. 19, Article 6.

C. An RNP shall not prescribe or dispense drugs or devices without Board authority or in a manner inconsistent with law. The Board may impose an administrative or civil penalty for each violation, suspend the RNP's P & D authority, or

impose other sanctions under A.R.S. § 32-1606(C). In determining the appropriate sanction, the Board shall consider factors such as the number of violations, the severity of each violation, and the potential for or existence of patient harm.

D. In addition to acts listed under R4-19-403, for a nurse who prescribes or dispenses a drug or device, a practice that is or might be harmful to the health of a patient or the public, includes one or more of the following:
1. Prescribing a controlled substance to one's self or a member of the nurse's family;
2. Providing any controlled substance or prescription-only drug or device for other than accepted therapeutic purposes;
3. Prescribing an amphetamine or similar Class II drug, in the treatment of exogenous obesity, for a period in excess of 30 days within a 12-month period for an individual; or the non-therapeutic use of injectable amphetamines;
4. Delegating the prescribing and dispensing of drugs or devices to any other person; and
5. Prescribing, dispensing, or furnishing a prescription drug or a prescription-only device to a person unless the nurse has examined the person and established a professional relationship, except when the nurse is engaging in one or more of the following:
   a. Providing temporary patient care on behalf of the patient's regular treating and licensed health care professional;
   b. Providing care in an emergency medical situation where immediate medical care or hospitalization is required by a person for the preservation or health, life, or limb; or
   c. Furnishing a prescription drug to prepare a patient for a medical examination.

R4-19-512. Prescribing Drugs and Devices

A. An RNP granted P & D authority by the Board may:
1. Prescribe drugs and devices;
2. Provide for refill of prescription-only drugs and devices for one year from the date of the prescription.

B. An RNP with P & D authority who wishes to prescribe a controlled substance shall obtain a DEA registration number before prescribing a controlled substance. The RNP shall file the DEA registration number with the Board.

C. An RNP with a DEA registration number may prescribe:
1. A Class II controlled substance as defined in the federal Uniform Controlled Substances Act, 21 U.S.C. § 801 et seq., or Arizona's Uniform Controlled Substances Act, A.R.S. Title 36, Chapter 27, but shall not prescribe refills of the prescription;
2. A Class III or IV controlled substance, as defined in the federal Uniform Controlled Substances Act or Arizona's Uniform Controlled Substances Act, and may prescribe a maximum of five refills in six months; and
3. A Class V controlled substance, as defined in the federal Uniform Controlled Substances Act or Arizona's Uniform Controlled Substances Act, and may prescribe refills for a maximum of one year.

D. An RNP whose DEA registration is revoked or expires shall not prescribe controlled substances. An RNP whose DEA registration is revoked or limited shall report the action to the Board.

E. In all outpatient settings or at the time of hospital discharge, an RNP with P & D authority shall personally provide a patient or the patient's representative with the name of the drug, directions for use, and any special instructions, precautions, or storage requirements necessary for safe and effective use of the drug if any of the following occurs:
1. A new drug is prescribed or there is a change in the dose, form, or direction for use in a previously prescribed drug;
2. In the RNP's professional judgment, these instructions are warranted; or
3. The patient or patient's representative requests instruction.

F. An RNP with P & D authority shall ensure that all prescription orders contain the following:
1. The RNP's name, address, telephone number, and specialty area;
2. The prescription date;
3. The name and address of the patient;
4. The full name of the drug, strength, dosage form, and directions for use;
5. The letters "DAW", "dispense as written", "do not substitute", "medically necessary" or any similar statement on the face of the prescription form if intending to prevent substitution of the drug;
6. The RNP's DEA registration number, if applicable; and
7. The RNP's signature.

~~**R4-19-508.**~~**R4-19-513.Dispensing ~~of Medications~~ Drugs and Devices**

A. A registered nurse practitioner (RNP) granted prescribing and dispensing authority by the Board may:
1. Dispense drugs and devices to patients;
2. Dispense samples of drugs packaged for individual use without a prescription order or additional labeling;
3. Only dispense drugs and devices obtained directly from a pharmacy, manufacturer, wholesaler, or distributor; and
4. Allow other personnel to assist in the delivery of medications provided that the RNP retains responsibility and accountability for the dispensing process.

~~**A.**~~**B.**~~Before~~ If dispensing a ~~medication~~ drug or device, an RNP with ~~P & D~~ dispensing authority shall~~:~~ ~~give a patient~~
1. Ensure that the patient has a written prescription that complies with R4-19-512 (F) ~~with the following statement in bold type~~ and inform the patient that ~~: "THIS PRESCRIPTION MAY BE FILLED BY THE REGISTERED NURSE PRACTITIONER OR BY A PHARMACY OF YOUR CHOICE.;"~~ the prescription may be filled by the prescribing

RNP or by a pharmacy of the patient's choice;
2. Affix a prescription number to each prescription that is dispensed; and
3. Ensure that all original prescriptions are preserved for a minimum of seven years and make the original prescriptions available at all times for inspection by the Board of Nursing, Board of Pharmacy, and law enforcement officers in performance of their duties.

~~**B.** An RNP with P & D authority may dispense medications, medical devices, and appliances. An RNP with P & D authority may dispense samples of medications packaged for individual use by licensed manufacturers or repackagers of medication without a prescription order.~~

C. An RNP practicing in a public health facility operated by this state or a county or in a qualifying community health center under A.R.S. § 32-1921 (F) may dispense drugs or devices to patients without a written prescription if the public health facility or the qualifying community health center adheres to all storage, labeling, safety, and recordkeeping rules of the Board of Pharmacy.

~~**C.**~~**D.** An RNP with ~~P & D~~ dispensing authority shall ensure that a drug is dispensed ~~dispense all medication~~ with a label that contains all of the following information:
1. Dispensing ~~The dispensing~~ RNP's name and specialty area;
2. ~~address, phone number,~~ Address and telephone number of the location at which the drug is dispensed~~, and specialty area~~;
~~2.~~3. ~~The date the medication is~~ Date dispensed;
~~3.~~4. ~~The patient's~~ Patient's name and address;
~~4.~~5. ~~The name~~ Name and strength of the drug, ~~medication, manufacturer's name,~~ quantity in the container, directions for ~~its~~ use, and any cautionary statements necessary for the safe and effective use of the drug; ~~and~~
6. Manufacturer and lot number; and
~~5.~~7. Prescription ~~The prescription~~ order number.

~~**D.** In all outpatient settings and at the time of hospital discharge, an RNP with P & D authority shall personally provide to the patient or the patient's representative, directions for use, name of prescribed medication, and any special instructions, precautions, or storage requirements when any of the following occurs:~~
~~1. A new prescribed medication is dispensed to a patient or a new prescription number is assigned to a previously dispensed medication;~~
~~2. A prescription medication has not been previously dispensed to the patient in the same strength or dosage form, or directions for a prescription medication have been changed;~~
~~3. In the RNP's professional judgment, these instructions are warranted; or~~
~~4. The patient or patient's representative requests instruction.~~

E. An RNP with ~~P & D~~ dispensing authority shall ensure that the following information about the drug or device is entered ~~enter~~ into the patient's medical record:
1. ~~The name and~~ Name of the drug, strength, quantity, directions for use, and number of refills; ~~of the medication dispensed;~~
2. ~~The date the medication is~~ Date dispensed; ~~and~~
3. ~~The therapeutic~~ Therapeutic reason; ~~for the medication.~~
4. Manufacturer and lot number; and
5. Prescription order number.

F. An RNP with ~~P & D~~ dispensing authority shall; ~~obtain medication only from a pharmacy, manufacturer, wholesaler, or distributor.~~

~~**G.** An RNP with P & D authority shall:~~
1. Keep all drugs ~~medication~~ in a locked cabinet or room in an area that is not accessible to patients;
~~2. Control access to the cabinet or room by a written procedure; and~~
~~3. Maintain a current inventory of the contents of the cabinet or room~~.
2. If dispensing a controlled substance:
a. Control access by a written policy that specifies:
i. Those persons allowed access, and
ii. Procedures to report immediately the discovery of a shortage or illegal removal of drugs to a local law enforcement agency and provide that agency and the DEA with a written report within seven days of the discovery;

~~**H.** An RNP with P & D authority shall preserve all original prescription orders dispensed for a minimum of three years. The RNP shall make the original prescription orders available at all times for inspection by the Board of Nursing, the Board of Pharmacy, and law enforcement officers in performance of their duties~~

~~**I.** An RNP shall, if dispensing a controlled substance,~~
b. Maintain ~~maintain~~ and make available to the Board upon request an ongoing inventory and record of:
~~1.~~i. A Schedule II controlled substance, as defined in the ~~Federal~~ federal Uniform Controlled ~~Substance~~ Substances Act or Arizona's Uniform Controlled Substances Act, separately from all other records, and a pre-

scription for a Schedule II controlled substance in a separate prescription file; and

~~2.~~ii. A Schedule III, IV, ~~and~~ or V controlled substance, as defined in the ~~Federal~~ federal Uniform Controlled ~~Substance~~ Substances Act or Arizona's Uniform Controlled Substances Act, ~~either separately from all other records or~~ in a form that ~~the information required~~ is readily retrievable from ~~ordinary business~~ other records. ~~A prescription for these substances shall be maintained either in a prescription file for Schedule III, IV, and V controlled substances only or in a form that is readily retrievable from other prescription records. A prescription is readily retrievable if, at the time it is initially filed, the face of the prescription is stamped in red ink in the lower right corner with the letter "C" no less than 1 inch high and filed either in the prescription file for a Schedule II controlled substance or in the usual consecutively numbered prescription file for a non-controlled substance.~~

~~J.~~**C.** ~~An~~ If a prescription order is refilled, an RNP with P & D authority shall record the following information on the back of ~~each~~ the prescription order or in the patient's medical record ~~when the prescription order is refilled~~:

1. Date refilled,
2. Quantity dispensed if different from the full amount of the original prescription, ~~and~~
3. RNP's name or identifiable initials, and~~.~~ ~~By initialing and dating the back of the prescription order, the RNP dispenses a refill for the full amount of the original prescription order~~.
4. Manufacturer and lot number.

~~K.~~ ~~An RNP with P & D authority shall comply with all applicable laws and rules in prescribing, administering, and dispensing a medication or controlled substance, including compliance with labeling requirements of 32 A.R.S. 18.~~

~~L.~~**H.** Under the supervision of an RNP with P & D authority, ~~licensed or unlicensed~~ other personnel may ~~assist the RNP in the following~~:

1. Receive ~~Receiving~~ and record a prescription refill request from a patient or a patient's representative ~~for refilling a prescription medication by prescription order number~~;
2. ~~Accepting a verbal refill authorization from the RNP; and~~
3.2. ~~Recording~~ Receive and record a verbal refill authorization ~~on the back of the original prescription form and in the patient's medical record with~~ from the RNP including:
   a. The RNP's name;
   b. Date of refill;
   c. Name, directions for use, and quantity of ~~medication~~ drug, ; and
   d. Manufacturer and lot number;
4.3. ~~Typing~~ Prepare and ~~affixing~~ affix a prescription ~~labels~~ label; and ~~for prescription medications.~~
4. Prepare a drug or device for delivery, provided that the dispensing RNP:
   a. Inspects the drug or device and initials the label before issuing to the patient to ensure compliance with the prescription; and
   2.b. Ensures that the patient ~~has been~~ is informed of the name of the drug or device, directions for use, precautions, and storage requirements.

~~R4-19-512.~~R4-19-514.Scope of Practice of the Clinical Nurse Specialist

In addition to the functions of ~~the professional~~ a registered nurse, a clinical nurse specialist, under A.R.S. § 32-1601(5), ~~being an expert in a specialty area of clinical nursing practice,~~ may perform one or more of the following for an individual, family, or group within the specialty area of certification:

1. Perform a ~~Comprehensive~~ comprehensive assessment, analysis, and evaluation of ~~individuals, families, communities, or any combination of individuals, families, and communities, with~~ a patient's complex health needs ~~within an area of specialization~~;
2. Diagnose symptoms, functional problems, risk behaviors, and health status;
2.3. Direct ~~patient~~ health care as an advanced clinician ~~within the clinical nurse specialist's specialty area and develop, implement, and evaluate treatment plans within that specialty~~;
4. Develop, implement, and evaluate a treatment plan according to a patient's need for specialized nursing care;
5. Establish nursing standing orders, algorithms, and practice guidelines related to interventions and specific plans of care;
6. Manage health care according to written protocols;
7. Facilitate system changes on a multidisciplinary level to assist a health care facility and improve patient outcomes cost-effectively;
3.8. ~~Consulting~~ Consult with the public and professionals in health care, business, and industry in the areas of research, case management, education, and administration; ~~and,~~
4. ~~Psychotherapy, by clinical nurse specialists with expertise in adult, or child and adolescent psychiatric and mental health nursing.~~
9. Perform psychotherapy if certified as a clinical nurse specialist in adult or child and adolescent psychiatric and mental health nursing;
10. Prescribe and dispense durable medical equipment.; or

11. Perform additional acts ~~for which~~ that the clinical nurse specialist is qualified to perform.

~~R4-19-513.~~R4-19-515.Prescribing Authority of a Certified Registered Nurse Anesthetist

A. No change
1. No change
2. No change
3. No change
4. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
      v. No change
      vi. No change
      vii. No change
   g. No change
   h. No change

B. No change

C. No change

D. No change
1. No change
2. No change
3. No change
4. No change

R4-19-516. Registered Nurse Anesthetist; Notification of the Board; Nurse Anesthetist Programs; Scope of Practice

A. A registered nurse who does not have prescribing authority under R4-19-515 and wishes to administer anesthetics under A.R.S. § 32-1661 shall provide the nurse's name, RN license number, and the following information to the Board before using the title nurse anesthetist, registered nurse anesthetist, or certified registered nurse anesthetist (CRNA) or carrying out any activities under A.R.S. § 32-1661:
1. An official transcript that provides evidence that the nurse graduated from a nationally accredited program in the science of anesthesia; and
2. Whether the applicant has applied for national certification as a certified registered nurse anesthetist, including the date of the application, the name of the certifying agency, and results of any certifying exam; or
3. Evidence of current registered nurse anesthetist certification from an approved certifying agency under R4-19-310.

B. An administrator of an educational institution that wishes to provide a course of study that allows nurses to administer anesthetics under A.R.S. § 32-1661 shall inform the Board and furnish evidence of accreditation by an approved national nursing accreditating agency recognized by the Board under R4-19-101 before accepting students.

C. In addition to the scope of practice permitted a registered nurse under A.R.S. § 32-1601, a registered nurse governed by this Section may perform one or more of the following acts:
1. Assess the health status of an individual as that status relates to the relative risks associated with anesthetic management of an individual;
2. Obtain informed consent;
3. Order and interpret laboratory and other diagnostic tests and perform those tests that the nurse is qualified to perform;
4. Order and interpret radiographic imaging studies that the nurse is qualified to order and interpret;
5. Identify, develop, implement, and evaluate an anesthetic plan of care for a patient to promote, maintain, and restore health;
6. Take action necessary in response to an emergency situation;
7. Perform therapeutic procedures that the nurse is qualified to perform; or
8. Perform additional acts that the nurse is qualified to perform.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

[R05-349]

PREAMBLE

1. Sections Affected | **Rulemaking Action**

R9-22-101	Amend
R9-22-710	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. §§ 36-2904 and 36-2903.01

Implementing statute: A.R.S. § 36-2904

3. The effective date of the rules:

November 12, 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. 3665, September 3, 2004

Notice of Proposed Rulemaking: 11 A.A.R 674, February 11, 2005

Notice of Public Information: 11 A.A.R. 1080, March 11, 2005

Notice of Supplemental Proposed Rulemaking: 11 A.A.R. 1534, April 29, 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 were amended as result of a Five-Year Rule Review, amending the language to clarify how non-hospital payments are made and also specifying where the fee schedules can be found that set the amount of payment that can be received. The fee amounts are not required to be in rule due to the exemption described in A.R.S § 41-1005.

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):

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:

The summary of the comments submitted that relate to provisions contained in this rulemaking and the agency response to them, are as follows:

#	Subsection	Comment	Recommendation
1.	R9-22-710 (A)(3)(c)	Concerned that the amendment would change the capped fee-for-service payment for covered disposable supplies to ADHS regulated ambulance services from 80% to 65%. **03/05 Larry Clark, Arizona Ambulance Association, Consultant**	**Disagree.** The change in the rule is not intended to change the rate of payment. In order to clarify the rule, the **Administration agreed to revise the rule language to refer to the fee schedules for reimbursement of transportation services. As a result the Administration filed a Notice of Supplemental Proposed rulemaking to reflect these changes.** The fee schedules are published on the Web and in the agency's Newsletter.
2.	R9-22-710 (A)(3)(c)	I believe most of the confusion can be attributed to the fact that the "Fee Schedule," as produced and on file at the Administration, failed to include the "fee schedule amount" for covered services provided by ADHS regulated ambulance services. This resulted in the capped fee-for-service schedule for ADHS regulated ambulance services to be found as specific language within the body of the rule regarding payment for ambulance services. (AAC R9-22-710(B)(4)(a), Proposed AAC R9-22-710(A)(2)(c)(i - iv) **05/05 Larry Clark, Arizona Ambulance Association, Consultant**	**Agree.** The information on the AHCCCS Web site has since been updated, clarifying the area of concern, that is, Transportation fees. The "by report" description of the fee schedule has been changed. The "Fee Schedule" published at: http://www.ahcccs.state.az.us/RatesCodes/2004/Codes2004.asp?Group=16 was updated as follows: "BR = By Report. Beginning 10/1/2002, the capped fee-for-service rate for services described as BR is 65% of the covered billed charges, with the exception of ground ambulance services, which the rate is 80% of the covered billed charges. AHCCCS fee schedules are not intended to be an all-inclusive list of procedure and service codes. It simply provides the AHCCCS fee-for-service payment rates for covered procedures and services".
3.	General Comment	Was not pleased that the stakeholders were not brought into the rule review process prior to this public hearing. **05/05 Mark Venuti, Arizona Ambulance Association, President**	**Disagree** The notice of the agency's intention to amend rules had been published in the Arizona Administrative Register for those interested parties on the following dates: 1. Notice of Rulemaking Docket Opening: 10 A.A.R. 3665, September 3, 2004 2. Notice of Proposed Rulemaking: 11 A.A.R 674, February 11, 2005 3. Notice of Public Information: 11 A.A.R. 1080, March 11, 2005 4. Notice of Supplemental Proposed Rulemaking: 11 A.A.R. 1534, April 29, 2005

4.	R9-22-710 (A)	AHCCCS has not complied with the required notice in 42 CFR 447.205 for this change. **05/05 Larry Clark, Arizona Ambulance Association, Consultant**	**AHCCCS did not make a change in how transportation would be paid, therefore the notice was not required.** By statute A.R.S. § 41-1005 (A)(9), formal rules are not required for the fee schedules adopted by AHCCCS. However, under both state (A.R.S. § 36-2903.01(B)(6)) and federal (42 CFR 447.205) law, AHCCCS is required to provide notice to interested parties of changes in policy relating to reimbursement. The agency has no present intention to change reimbursement policies relating to reimbursement of transportation services although it regularly reviews all rates. Before any changes are made, notice will be provided as required by law. The agency is also reviewing the information currently available on current reimbursement policies in this area to ensure that the information is clear and accurate. Todd Schwarz (Rates Analyst) described at the public hearing the venues used to publish public notice. They are: The Arizona Republic The Tucson Daily Star The Yuma Sun The Arizona Daily Sun (Flagstaff)
5.	Preamble	Statute 36-2239 is not an Authorizing or Implementation statutory requirement. **05/05 Larry Clark, Arizona Ambulance Association, Consultant** **05/05 Mark Venuti, Arizona Ambulance Association, President**	**Agree.** The cite to A.R.S. § 36-2239 will be removed from the preamble.
6.	R9-22-710	Recommendation: The capped fee-for-service (fee schedule) payment standard for base rates, mileage and wait time for ADHS-regulated services should be moved onto the Fee schedule as shown on the Web page area were fees/rates are posted for transportation. Recommend the usage of two notes: (1) Note: BR = By Report. Beginning 10/1/2002, the capped fee-for-service rate for services described as BR is 65% of the covered billed charges. (2) Note: ADHS Regulated Ground Ambulance Services. Capped fee-for-service payment is 80% of the ambulance service's general public rates and charges on the date of service. **05/05 Larry Clark, Arizona Ambulance Association, Consultant**	**This comment relates to the fee schedule rather than the proposed rule.** It will be forwarded to the division responsible for publication of the fee schedules.

7.	Preamble Item #6	Mis-cite or Partial-cite of R9-22-710(A) was made in the preamble. Reading as follows: **An explanation of the substantial change which resulted in this supplemental notice:** A technical change was made to R9-22-101 adding a definition for Tribal Facility. The substantial change was made to R9-22-710(A)(2). The fee payment methods covered in this Section were found to be exempt from the rule requirement as stated in A.R.S. § 41-1005(9). The administration has chosen to use the rule to direct where the payment schedule is kept and will provide notice of changes to this schedule as required by 42 CFR 447.205. **05/05 Larry Clark, Arizona Ambulance Association, Consultant**	**Disagree** The reference to R9-22-710(A)(2) was correct when comparing what had been originally proposed for R9-22-710(A) versus the language in the supplemental proposed document.
8.	General	Will the Air Ambulance rates be included in the 2005 Transportation fee schedule? Will there be any changes? **05/05 Mark Venuti, Arizona Ambulance Association, President**	**This comment relates to the fee schedule rather than the proposed rule.** If changes are made, a 30-day public notice will be sent in accordance with A.R.S. § 36-2903.01.

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:

42 CFR 447.205, December 19, 1983, R9-22-710

45 CFR Part 160 and 45 CFR Part 162, October 1, 2004

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 1. DEFINITIONS

Section
R9-22-101. Location of Definitions

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-710. ~~Capped Fee-for-service~~ Payments for Non-hospital Services

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

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

Definition	Section or Citation
"Accommodation"	R9-22-107
"Act"	R9-22-114
"Active case"	R9-22-109
"ADHS"	R9-22-112
"Administration"	A.R.S. § 36-2901
"Administrative law judge"	R9-22-108
"Administrative review"	R9-22-108
"Advanced Life Support" or "ALS"	R9-25-101
"Adverse action"	R9-22-114
"Affiliated corporate organization"	R9-22-106
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-115
"Aggregate"	R9-22-107
"AHCCCS"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-107
"AHCCCS registered provider"	R9-22-101
"Ambulance"	A.R.S. § 36-2201
"Ancillary department"	R9-22-107
"Annual assessment period"	R9-22-109
"Annual assessment period report"	R9-22-109
"Annual enrollment choice"	R9-22-117
"Appellant"	R9-22-114
"Applicant"	R9-22-101
"Application"	R9-22-101
"Assignment"	R9-22-101
"Attending physician"	R9-22-101
"Authorized representative"	R9-22-114
"Auto-assignment algorithm"	R9-22-117
"Baby Arizona"	R9-22-114
"Basic Life Support" or "BLS"	R9-25-101
"Behavior management services"	R9-22-112
"Behavioral health evaluation"	R9-22-112
"Behavioral health medical practitioner"	R9-22-112
"Behavioral health professional"	R9-20-101
"Behavioral health service"	R9-22-112
"Behavioral health technician"	R9-20-101
"Behavior management services"	R9-22-112
"BHS"	R9-22-114
"Billed charges"	R9-22-107
"Blind"	R9-22-115
"Board-eligible for psychiatry"	R9-22-112
"Burial plot"	R9-22-114
"Capital costs"	R9-22-107
"Capped fee-for-service"	R9-22-101
"Caretaker relative"	R9-22-114
"Case"	R9-22-109
"Case record"	R9-22-109
"Case review"	R9-22-109
"Cash assistance"	R9-22-114
"Categorically-eligible"	R9-22-101
"Certified psychiatric nurse practitioner"	R9-22-112
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-22-112
"CMDP"	R9-22-117
"CMS"	R9-22-101
"Complainant"	R9-22-108
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contractor"	A.R.S. § 36-2901
"Copayment"	R9-22-107
"Corrective action plan"	R9-22-109
"Cost-to-charge ratio"	R9-22-107
"Covered charges"	R9-22-107
"Covered services"	R9-22-102
"CPT"	R9-22-107
"CRS"	R9-22-114
"Cryotherapy"	R9-22-120
"Date of eligibility posting"	R9-22-107
"Date of notice"	R9-22-108
"Day"	R9-22-101
"DCSE"	R9-22-114
"De novo hearing"	42 CFR 431.201
"Dentures"	R9-22-102
"Department"	A.R.S. § 36-2901
"Dependent child"	A.R.S. § 46-101
"DES"	R9-22-101
"Diagnostic services"	R9-22-102
"Director"	R9-22-101
"Disabled"	R9-22-115
"Discussions"	R9-22-106
"Disenrollment"	R9-22-117
"District"	R9-22-109
"DME"	R9-22-102
"DRI inflation factor"	R9-22-107
"E.P.S.D.T. services"	42 CFR 441 Subpart B
"Eligible person"	A.R.S. § 36-2901
"Emergency medical condition"	42 U.S.C. 1396b(v)(3)
"Emergency medical services"	R9-22-102
"Emergency services costs"	A.R.S. § 36-2903.07
"Encounter"	R9-22-107
"Enrollment"	R9-22-117
"Enumeration"	R9-22-101
"Equity"	R9-22-101
"Experimental services"	R9-22-101
"Error"	R9-22-109
"FAA"	R9-22-114
"Facility"	R9-22-101
"Factor"	42 CFR 447.10
"FBR"	R9-22-101
"Fee-For-Service" or "FFS"	R9-28-101
"FESP"	R9-22-101
"Finding"	R9-22-109
"First-party liability"	R9-22-110
"Foster care maintenance payment"	42 U.S.C. 675(4)(A)
"Federal poverty level" ("FPL")	A.R.S. § 1-215
"FQHC"	R9-22-101
"Grievance"	R9-22-108
"GSA"	R9-22-101
"Health care practitioner"	R9-22-112
"Hearing"	R9-22-108
"Hearing aid"	R9-22-102
"Home health services"	R9-22-102
"Homebound"	R9-22-114
"Hospital"	R9-22-101
"Intermediate Care Facility for the Mentally Retarded" or "ICF-MR"	42 CFR 483 Subpart I
"ICU"	R9-22-107
"IHS"	R9-22-117
"IMD"	42 CFR 435.1009 and R9-22-112
"Income"	R9-22-114
"Inmate of a public institution"	42 CFR 435.1009
"Interested party"	R9-22-106

"LEEP"	R9-22-120
"Level I trauma center"	R9-22-2101
"License" or "licensure"	R9-22-101
"Mailing date"	R9-22-114
"Management evaluation review"	R9-22-109
"Medical education costs"	R9-22-107
"Medical expense deduction"	R9-22-114
"Medical record"	R9-22-101
"Medical review"	R9-22-107
"Medical services"	A.R.S. § 36-401
"Medical supplies"	R9-22-102
"Medical support"	R9-22-114
"Medically necessary"	R9-22-101
"Medicare claim"	R9-22-107
"Medicare HMO"	R9-22-101
"Member"	A.R.S. § 36-2901
"Mental disorder"	A.R.S. § 36-501
"New hospital"	R9-22-107
"Nursing facility" or "NF"	42 U.S.C. 1396r(a)
"NICU"	R9-22-107
"Noncontracting provider"	A.R.S. § 36-2901
"Nonparent caretaker relative"	R9-22-114
"Notice of Findings"	R9-22-109
"OAH"	R9-22-108
"Occupational therapy"	R9-22-102
"Offeror"	R9-22-106
"Ownership interest"	42 CFR 455.101
"Operating costs"	R9-22-107
"Outlier"	R9-22-107
"Outpatient hospital service"	R9-22-107
"Ownership change"	R9-22-107
"Partial Care"	R9-22-112
"Party"	R9-22-108
"Peer group"	R9-22-107
"Performance measures"	R9-22-109
"Pharmaceutical service"	R9-22-102
"Physical therapy"	R9-22-102
"Physician"	R9-22-102
"Prior period coverage" or "PPC"	R9-22-107
"Post-stabilization care services"	42 CFR 422.113
"Practitioner"	R9-22-102
"Pre-enrollment process"	R9-22-114
"Preponderance of evidence"	R9-22-109
"Prescription"	R9-22-102
"Primary care provider (PCP)"	R9-22-102
"Primary care provider services"	R9-22-102
"Prior authorization"	R9-22-102
"Private duty nursing services"	R9-22-102
"Proposal"	R9-22-106
"Prospective rates"	R9-22-107
"Prospective rate year"	R9-22-107
"Psychiatrist"	R9-22-112
"Psychologist"	R9-22-112
"Psychosocial rehabilitation services"	R9-22-112
"Qualified alien"	A.R.S. § 36-2903.03
"Quality management"	R9-22-105
"Radiology"	R9-22-102
"Random sample"	R9-22-109
"RBHA"	R9-22-112
"Rebasing"	R9-22-107
"Referral"	R9-22-101
"Rehabilitation services"	R9-22-102
"Reinsurance"	R9-22-107
"Remittance advice"	R9-22-107
"Resources"	R9-22-114
"Respiratory therapy"	R9-22-102
"Respondent"	R9-22-108
"Responsible offeror"	R9-22-106
"Responsive offeror"	R9-22-106
"Review"	R9-22-114
"Review period"	R9-22-109
"RFP"	R9-22-106
"Scope of services"	R9-22-102
"SDAD"	R9-22-107
"Section 1115 Waiver"	A.R.S. § 36-2901
"Service location"	R9-22-101
"Service site"	R9-22-101
"SESP"	R9-22-101
"S.O.B.R.A."	R9-22-101
"Specialist"	R9-22-102
"Specified relative"	R9-22-114
"Speech therapy"	R9-22-102
"Spendthrift restriction"	R9-22-114
"Spouse"	R9-22-101
"SSA"	42 CFR 1000.10
"SSI"	42 CFR 435.4
"SSN"	R9-22-101
"Stabilize"	42 U.S.C. 1395dd
"Standard of care"	R9-22-101
"Sterilization"	R9-22-102
"Subcontract"	R9-22-101
"Submitted"	A.R.S. § 36-2904
"Summary report"	R9-22-109
"SVES"	R9-22-114
"Third-party"	R9-22-110
"Third-party liability"	R9-22-110
"Tier"	R9-22-107
"Tiered per diem"	R9-22-107
"Title IV-D"	R9-22-114
"Title IV-E"	R9-22-114
"Tolerance level"	R9-22-109
"Trauma and Emergency Services Fund"	A.R.S. § 36-2903.07
"Tribal Facility"	R9-22-101
"Unrecovered trauma readiness costs"	R9-22-2101
"Utilization management"	R9-22-105
"WWHP"	R9-22-120

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

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

"AHCCCS registered provider" means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A); and

Meets license or certification requirements to provide AHCCCS covered services.

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

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

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

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a fee-for-service member.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific AHCCCS-covered service or equipment provided to a member. A payment is made in accordance with an upper~~,~~ or capped~~,~~ limit established by the Director. This capped limit can either be a specific dollar amount or a percentage of billed charges.

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

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

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

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

"Day" means a calendar day unless otherwise specified.

"DES" means the Department of Economic Security.

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

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

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

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

"Experimental services" means services that are associated with treatment or diagnostic evaluation that meets one or more of the following criteria:

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

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

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

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

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

"FESP" means a federal emergency services program covered under R9-22-217, to treat an emergency medical condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

"FQHC" means federally qualified health center.

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

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

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

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

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

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

"Referral" means the process by which a member is directed by a primary care provider or an attending physician to

another appropriate provider or resource for diagnosis or treatment.

"Service location" means a location at which a member obtains a covered health care service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

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

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

"Spouse" means a person who has entered into a contract of marriage, recognized as valid by Arizona.

"SSN" means social security number.

"Standard of care" means a medical procedure or process that is accepted as treatment for a specific illness, or injury, medical condition through custom, peer review, or consensus by the professional medical community.

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

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

A marketing organization; or

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

"Tribal Facility" means a facility that is operated by an Indian tribe and that is authorized to provide services under Public Law 93-638, as amended.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-710. ~~Capped Fee-for-service~~ Payments for Non-hospital Services

~~A.~~ ~~Service codes. The Administration shall maintain a current copy of the following code manuals at the central office of the Administration for reference use during customary business hours:~~

1. ~~The Physicians' Current Procedural Terminology (CPT) and Health Care Financing Administration Common Procedure Coding System (HCPCS). These manuals identify medical services and procedures performed by physicians and other providers.~~
2. ~~The AHCCCS Transportation, Supply, Equipment, and Appliance codes. These codes identify applicable services or supplied items.~~
3. ~~The International Classification of Diseases.~~
4. ~~Nationally recognized pharmacy coding manual.~~

~~B.~~ ~~Fee schedule. The Administration shall pay providers, including noncontracting providers, at the lesser of billed charges or the capped fee-for-service rates specified in subsections (B)(1) through (5) unless a different fee is specified by contract between the Administration and the provider, or is otherwise required by law. The Administration shall provide notice of changes in methods and standards for setting payment rates for services in accordance with 42 CFR 447.205, effective December 19, 1983, 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.~~

1. ~~Physician services. Fee schedules for payment for physicians services are on file at the central office of the Administration for reference use during customary business hours.~~
2. ~~Pharmacy services. Fee schedules for payment for pharmacy services are exempt from rulemaking procedures under A.R.S. § 41-1005, but are subject to 42 CFR 447.331 through 447.332, effective July 31, 1987, which is incorporated by reference and on file with the Administration and the Office of Secretary of State. These incorporations by reference contain no further editions or amendments.~~
3. ~~Dental services. Fee schedules for payment for dental services are on file at the central office of the Administration for reference use during customary business hours.~~
4. ~~Transportation services:~~
   a. ~~Ground ambulance services. Fee schedules for payment for ambulance services are on file at the central office of the Administration for reference use during customary business hours. For ambulance providers that have charges established by the Arizona Department of Health Services (ADHS), the fee schedule amount is 80% of the ambulance provider's ADHS-approved fees for covered services. For ambulance providers whose fees are not established by ADHS, the fee schedule amount is 80% of the ambulance provider's billed charges or the capped fee-for-service amount for covered services, whichever is less.~~
   b. ~~Air ambulance services. Fee schedules for payment for air ambulance services are on file at the central office of the Administration for reference use during customary business hours.~~
   c. ~~Nonambulance services. Fee schedules for payment for nonambulance services are on file at the central office of~~

~~the Administration for reference use during customary business hours.~~

~~5. Medical equipment. Fee schedules for payment for medical equipment are on file at the central office of the Administration for reference use during customary business hours. The Administration shall reimburse providers once for durable medical equipment (DME) during any two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless authorized by the Administration, no more than one repair and adjustment shall be reimbursed during any two-year period.~~

~~**C.** Capped fee-for-service medical cost pool and payment. The Administration may establish a capped fee-for-service medical cost pool for each county in which there are capped fee-for-service physician contractors. The Administration shall pay all physician fees out of this pool. Fifteen percent of allowable physician fees shall be withheld in the pool. At the end of a contract period, the Administration shall divide any surplus or deficit remaining in the pool evenly between the Administration and the participating physicians subject to the following:~~

~~1. The physician withhold shall be used to offset the physician portion of any deficit. Physicians shall not be responsible for any deficit greater than the aggregate amount withheld. The Administration shall return all withholds not needed to fund a deficit on a pro rata basis.~~

~~2. The Administration shall divide the physician portion of any surplus so two thirds goes to primary care physicians and one-third to referral physicians. These portions shall be divided pro rata among the physicians in each category subject to an upper limit. The physician portion of any surplus is limited so referral physicians receive no more than 115% of the Administration's maximum allowable fees for their services and primary care physicians receive no more than 130%.~~

~~**D.** Distribution of funds. The Administration shall make annual settlements of the medical cost pool on an incurred basis. The Administration shall estimate incurred medical costs for a contract period for settlement purposes when three full months of paid claim data can be summarized following the end of the contract period. The settlement shall occur within 105 days following the end of the contract period.~~

~~**E.** The Administration reserves the right to adjust the percentage of withholding for any individual physician whose utilization rates are deemed to be excessive based on historical physician profiles.~~

A. Capped fee-for-service. The Administration shall provide notice of changes in methods and standards for setting payment rates for services in accordance with 42 CFR 447.205, December 19, 1983, 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.

1. Non-contracted services. In the absence of a contract that specifies otherwise, a contractor shall reimburse a provider or noncontracting provider for non-hospital services according to the Administration's capped-fee-for-service schedule.
2. Procedure codes. The Administration shall maintain a current copy of the National Standard Code Sets mandated under 45 CFR Part 160 (October 1, 2004) and 45 CFR Part 162 (October 1, 2004), 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.
   a. A person shall submit an electronic claim consistent with 45 CFR Part 160 (October 1, 2004) and 45 CFR Part 162 (October 1, 2004).
   b. A person shall submit a paper claim using the National Standard Code Sets as described under 45 CFR Part 160 (October 1, 2004) and 45 CFR Part 162 (October 1, 2004).
   c. The Administration may deny a claim for failure to comply with subsection (A)(2)(a) or (b).
3. Fee schedule. The Administration shall pay providers, including noncontracting providers, at the lesser of billed charges or the capped fee-for-service rates specified in subsections (A)(3)(a) through (A)(3)(d) unless a different fee is specified in a contract between the Administration and the provider, or is otherwise required by law.
   a. Physician services. Fee schedules for payment for physician services are on file at the central office of the Administration for reference use during customary business hours.
   b. Dental services. Fee schedules for payment for dental services are on file at the central office of the Administration for reference use during customary business hours.
   c. Transportation services. Fee schedules for payment for transportation services are on file at the central office of the Administration for reference use during customary business hours.
   d. Medical supplies and durable medical equipment (DME). Fee schedules for payment for medical supplies and DME are on file at the central office of the Administration for reference use during customary business hours. The Administration shall reimburse a provider once for purchase of DME during any two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless prior authorized by the Administration, no more than one repair and adjustment of DME shall be reimbursed during any two-year period.

B. Pharmacy services. The Administration shall not reimburse pharmacy services unless the services are provided by a contracted provider or a provider having a subcontract with a Pharmacy Benefit Manager (PBM) contracted with AHCCCS. The Administration shall reimburse pharmacy services according to the terms of the contract.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

[R05-351]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-27-101	Amend
R9-27-401	Amend
R9-27-402	Repeal
R9-27-405	Repeal
R9-27-406	Repeal
R9-27-408	Repeal
R9-27-501	Repeal
R9-27-503	Repeal
R9-27-504	Repeal
R9-27-505	Repeal
R9-27-506	Repeal
R9-27-507	Repeal
R9-27-509	Amend
R9-27-510	Repeal
R9-27-511	Repeal
R9-27-512	Repeal
R9-27-513	Repeal
R9-27-514	Repeal
R9-27-515	Repeal
R9-27-516	Repeal
R9-27-701	Repeal
R9-27-702	Amend
R9-27-703	Amend
R9-27-704	Amend
R9-27-705	Repeal
R9-27-706	Repeal
R9-27-707	Repeal
R9-27-708	Repeal
R9-27-801	Repeal

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. § 36-2912

Implementing statute: A.R.S. §§ 36-2912

3. The effective date of the rules:

November 12, 2005

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

Notice of Rulemaking Docket Opening: 11 A.A.R. 1725, May 13, 2005

Notice of Proposed Rulemaking: 11 A.A.R. 2195, June 10, 2005

Notice of Public Information: 11 A.A.R. 2505, July 1, 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 that cover AHCCCS' Health Care Group for Private Employers program have been amended to comply with AHCCCS' five-year review report. The rules that are repealed were found to contain provisions that are currently in or should be in contract rather than in rule. In addition, the rules were amended 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 a minimal economic impact through a marginal savings of agency time from not needing to amend rules for provisions that are now only in contract.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):
No significant changes were made.

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:
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 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

ARTICLE 1. DEFINITIONS

Section
R9-27-101. Location of Definitions

ARTICLE 4. CONTRACTS AND GSAS

Section
R9-27-401. General
R9-27-402. ~~Contract and GSAs~~ Repealed
R9-27-405. ~~Contract and GSA Termination~~ Repealed
R9-27-406. ~~Continuation Coverage~~ Repealed
R9-27-408. ~~Contract Compliance Sanction Alternative~~ Repealed

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section
R9-27-501. ~~Availability and Accessibility of Services~~ Repealed
R9-27-503. ~~Marketing and Discrimination~~ Repealed

R9-27-504. ~~Approval of Advertisements and Marketing Material~~ Repealed
R9-27-505. ~~Member Records and Systems~~ Repealed
R9-27-506. ~~Fraud or Abuse~~ Repealed
R9-27-507. ~~Release of Safeguarded Information~~ Repealed
R9-27-509. Information to Enrolled Members
R9-27-510. ~~Discrimination Prohibition~~ Repealed
R9-27-511. ~~Equal Opportunity~~ Repealed
R9-27-512. ~~Periodic Reports and Information~~ Repealed
R9-27-513. ~~Medical Audits~~ Repealed
R9-27-514. ~~HCG Plan's Internal Quality Management and Utilization Review System~~ Repealed
R9-27-515. ~~Continuity of Care~~ Repealed
R9-27-516. ~~Financial Resources~~ Repealed

ARTICLE 7. STANDARD FOR PAYMENTS

Section
R9-27-701. ~~HCGA Liability; Payments to HCG Plans~~ Repealed
R9-27-702. Prohibition Against Charges to Members
R9-27-703. Payments by HCG Plans
R9-27-704. HCG Plan's Liability to Noncontracting Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members
R9-27-705. ~~Copayments~~ Repealed
R9-27-706. ~~Payments by Employer Groups~~ Repealed
R9-27-707. ~~Reinsurance~~ Repealed
R9-27-708. ~~Payments to Providers~~ Repealed

ARTICLE 8. COORDINATION OF BENEFITS

Section
R9-27-801. ~~Priority of Benefit Payment~~ Repealed

ARTICLE 1. DEFINITIONS

R9-27-101. Location of Definitions

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

Definition	Section or Citation
"Accountable health plan"	A.R.S. § 20-2301
"ADHS"	R9-27-101
"AHCCCS"	R9-27-101
"Ambulance"	A.R.S. § 36-2201
"Certification"	29 U.S.C. 1181
"Clean claim"	A.R.S. § 36-2904
"COBRA continuation provisions"	A.R.S. § 36-2912
"Coinsurance"	R9-27-101
"Copayment"	R9-27-101
"Covered services"	R9-27-101
"Creditable coverage"	A.R.S. § 36-2912
"Day"	R9-27-101
"Deductible"	R9-27-101
"Dependent"	R9-27-101
"Disability"	R9-27-303
"Effective date of coverage"	R9-27-101
"Eligible employee"	A.R.S. § 36-2912
"Emergency ambulance service"	R9-27-101
"Emergency medical services"	R9-27-101
"Employer group"	R9-27-101
"Employee member"	R9-27-101
"Enrollment"	R9-27-101
"Evidence of coverage (EOC)"	R9-27-101
"Experimental services"	R9-27-101
"FDA"	R9-27-101
"Full-time employee"	R9-27-101
"GSA"	R9-27-101
"HCG"	R9-27-101
"HCGA" or "Healthcare Group Administration"	R9-27-101
"HCG benefit plan"	R9-27-101
"HCG Plan"	R9-27-101
"Health care coverage"	R9-27-101
"Health care practitioner"	R9-27-101
"Hospital"	R9-27-101
"Inpatient hospital services"	R9-27-101
"Medical services"	A.R.S. § 36-401
"Medically necessary"	R9-27-101
"Member"	R9-27-101
"Member handbook and evidence of coverage" or "member handbook"	R9-27-101
"Network"	R9-27-101
"Network provider"	R9-27-101
"Political subdivision"	R9-27-101
"Pre-existing condition"	A.R.S. § 36-2912
"Pre-existing condition exclusion"	A.R.S. § 36-2912
"Premium"	R9-27-101
"Pre-payment"	R9-27-101
"Prior authorization"	R9-27-101
"Qualifying event"	R9-27-101
~~"Renewal date"~~	~~R9-27-101~~
"Scope of services"	R9-27-101

"Spouse"	R9-27-101
"Subcontract"	R9-27-101
"Substantial gainful activity"	R9-27-303
~~"Waiting period"~~	~~A.R.S. § 36-2912~~

B. Definitions. In addition to the definitions contained in A.R.S. Title 36, Chapter 29, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"ADHS" means the Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.

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

"Coinsurance" means ~~a predetermined amount~~ an amount specified in a GSA that a member agrees to pay to a provider for covered services. A coinsurance payment is a percentage of the fee schedule rate for the services.

"Copayment" means ~~a monetary amount specified~~ an amount specified in a GSA ~~by the HCGA~~ that a member ~~or dependent~~ pays directly to a provider at the time a covered service is rendered.

"Covered services" means the health and medical services described in ~~9 A.A.C. 27,~~ Article 2 of this Chapter, the GSA, and the member handbook.

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

"Deductible" means a fixed annual dollar amount a member agrees to pay for certain covered services before the HCG plan ~~agrees~~ begins to pay.

"Dependent" means the eligible spouse and children of an employee member under ~~9 A.A.C. 27,~~ Article 3 of this Chapter.

"Effective date of coverage" means the date on which an employee can receive HCG coverage.

"Emergency ambulance service" means transportation by a ground or an air ambulance company for a member requiring emergency medical services in which the emergency medical services are provided by a person certified by ADHS to provide the services before, during, or after the member is transported by a ground or an air ambulance company.

"Emergency medical services" means medical services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, ~~could~~ may reasonably expect the absence of immediate medical attention to result in:

Placing a patient's health in serious jeopardy,

Serious impairment to bodily functions, or

Serious dysfunction of any bodily organ.

"Employer group" means a group or a self-employed person who meets the criteria specified in R9-27-301.

"Employee member" means an enrolled employee of an employer group, a person who is self-employed, or a person who is eligible for a federal health coverage tax credit under 26 U.S.C. 35. A self-employed person shall meet the criteria specified in A.A.C. R9-27-301.

"Enrollment" means the process in which an eligible employee and dependents, if any, are qualified to receive HCG services by selecting an HCG benefit plan and completing and submitting all necessary documentation specified by HCGA under R9-27-302; and the HCG Plan receiving the full required premium no later than the date specified in the GSA.

"Evidence of Coverage (EOC)" means a document that lists covered services, limitations, exclusions, coinsurance, copayments, and deductibles that apply to the member's choice of coverage.

"Experimental services" means services that are associated with treatment or diagnostic evaluation and that are not generally and widely accepted as a standard of care in the practice of medicine in the United States unless:

The weight of evidence in peer-reviewed articles in medical journals published in the United States supports the safety and effectiveness of the service; or

In the absence of such articles, for services that are rarely used, novel, or relatively unknown in the general professional medical community, the weight of opinions from specialists who provide the service attests to the safety and effectiveness of the service.

"FDA" means the U.S. Food and Drug Administration.

"Full-time employee" means an employee or a self-employed person who works at least 20 hours per week.

"GSA" means Group Service Agreement, a contract between an employer group and HCGA, or between HCGA and a person eligible for the federal health coverage tax credit.

"HCG" means Healthcare Group of Arizona, the registered name of the Healthcare Group Program, a medical coverage product marketed by the HCGA to small uninsured businesses and political subdivisions within the state.

"HCGA" or "Healthcare Group Administration" means the section within AHCCCS that directs, determines eligibility, and regulates the continuous development and operation of the HCG Program.

"HCG benefit plan" means the scope of health care and prescription benefit coverage that a member selects on enrollment or renewal.

"HCG Plan" means a health plan offered by HCGA or by an entity that is under contract with the HCGA to provide covered or administrative services to members.

"Health care coverage" means a hospital or medical service corporation policy or certificate, a health care services organization contract, a multiple-employer welfare arrangement, or any other arrangement under which health services or health benefits are provided to two or more persons. Health care coverage does not include the following:

~~1.~~ accident only, dental only, vision only, disability income only or long-term care only insurance, fixed or hospital indemnity coverage, limited benefit coverage, specified disease coverage, credit coverage, or Taft-Hartley trusts;

~~2.~~ coverage that is issued as a supplement to liability insurance;

~~3.~~ Medicare supplemental insurance;

~~4.~~ workers' compensation insurance; or

~~5.~~ automobile medical payment insurance.

"Health care practitioner" means a person who is licensed or certified under Arizona law to deliver health care services.

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

"Inpatient hospital services" means services provided to a member who is admitted to a hospital for medical care and treatment. An inpatient hospital service is provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

"Medically necessary" means a covered ~~services~~ service is determined by the HCG Plan or HCGA Medical Director, and a physician or other licensed health care practitioner within the scope of the physician's or other health care practitioner's practice under state law to:

Prevent disease, disability, ~~and~~ or other adverse health condition or its progression; or

Prolong life.

"Member" means an employee member or a dependent who is enrolled with an HCG Plan.

"Member handbook ~~and evidence of coverage" or "member handbook~~" means the written description that HCGA provides ~~for~~ to each member on enrollment, of the rights and responsibilities of members of HCG~~, as well as a list of covered services, limitations, exclusions, coinsurance, copayments, and deductibles that apply to the member's choice of coverage.~~

"Network" means the providers who have subcontracts with HCG Plans in which members are enrolled.

"Network provider" means a provider who has a subcontract with ~~the~~ a member's HCG Plan and renders covered services to ~~a~~ the member.

"Political subdivision" means the state of Arizona or a county, city, town, or school district within the state, or an entity whose employees are eligible for hospitalization and medical care under Arizona Revised Statutes, Title 38, Chapter 4, Article 4.

"Premium" means the monthly pre-payment amount due to HCGA by the employer group.

"Pre-payment" means submission of the employer group's full premium payment at least 30 days in advance of coverage under the GSA**.**

"Prior authorization" means the process by which the ~~HCG Administration~~ HCGA or the HCG Plan informs a provider that it has made a preliminary determination that ~~the~~ a requested service is medically necessary, appropriate, and is a covered service. Prior authorization is not a guarantee of payment.

"Qualifying event" means a situation as described in the GSA that enables a person to enroll outside a designated open enrollment period or to obtain continuation coverage, if applicable.

~~"Renewal date" means the annual anniversary date for an employer group, which occurs one year from the date that the GSA for the employer group is effective.~~

"Scope of services" means the covered, limited, and excluded services listed in ~~9 A.A.C. 27,~~ Article 2 of this Chapter, the GSA, and the member handbook.

"Spouse" means a husband or a wife of an HCG member who has entered into a marriage recognized as valid by the state of Arizona.

"Subcontract" means an agreement entered into by HCGA or an HCG Plan with any of the following:

A provider of health care services who agrees to furnish covered services to members,

A marketing organization, or

Any other organization to serve the needs of the HCG Plan or HCGA.

ARTICLE 4. CONTRACTS AND GSAS

R9-27-401. General

A. Contracts to provide services. The HCGA shall establish contracts to provide services with qualified HCG Plans under A.R.S. § 36-2912.

B. GSAs with employer groups. The HCGA shall establish GSAs with employer groups under A.R.S. § 36-2912.

C. Contracts and GSAs. Contracts and GSAs ~~entered into~~ under A.R.S. § 36-2912 and on file with the HCGA are public records unless otherwise made confidential by law.

R9-27-402. ~~Contracts and GSAs~~ Repealed

~~**A.** Requirements for a health plan. A health plan shall meet the requirements of A.R.S. § 36-2912 and all HCGA contract requirements.~~

~~**B.** Requirements for an employer group. An employer group shall meet the requirements of A.R.S. § 36-2912 and all GSA requirements.~~

R9-27-405. ~~Contract And GSA Termination~~ Repealed

~~**A.** Contract between the HCGA and an HCG Plan. Under this Article and as specified in contract, the HCGA may suspend, deny, refuse, fail to renew, or terminate a contract or require the HCG Plan to terminate a subcontract for good cause which may include the following reasons:~~

~~1. Submission of any misleading, false, or fraudulent information;~~

~~2. Provision of any services in violation of or not authorized by licensure, certification, or other law;~~

~~3. A material breach of contract;~~

~~4. Failure to provide and maintain quality health care services to members, as determined by standards established by the state; and~~

~~5. Failure to reimburse a medical provider within 60 days of receipt of a clean claim unless a different period is specified by contract.~~

~~**B.** Group Service Agreement between the HCGA and an employer group. The GSA may be terminated with written notice from either the HCGA or an employer group to the other party within time frames specified in the GSA.~~

~~**C.** Termination of a member by the HCGA or HCG Plan.~~

~~1. Cause for immediate termination of coverage. The HCGA or HCG Plan may terminate a member's coverage for the following:~~

~~a. Fraud or misrepresentation when applying for coverage or obtaining services; or~~

~~b. Violence, or threatening or other substantially abusive behavior toward the HCGA or the HCG Plan employees or agents, or contracting or noncontracting providers or their employees or agents.~~

~~2. Cause for termination with 30 days written notice. The HCGA or the HCG Plan may terminate coverage of a member for the following reasons:~~

~~a. Repeated and unreasonable demands for unnecessary medical services;~~

~~b. Failure to pay any copayment, coinsurance, deductible, or required financial obligation; and~~

~~c. Material violation of any provision of the GSA.~~

~~3. Termination by reason of ineligibility.~~

~~a. Termination of employment;~~

~~b. Failure of employer to pay premium. Termination shall be effective the first day of the month for which the premium has not been paid;~~

~~c. Coverage of a dependent member shall automatically cease on the last day of the month in which the dependent member loses coverage, for any reason described in R9-27-406.~~

~~d. Subject to continuation coverage, as described in R9-27-406, on the effective date of termination of coverage, the HCG Plan shall have no further obligation to provide services and benefits to a member whose coverage has been terminated; except that a member confined to a hospital at the effective date of termination shall continue to receive coverage until there has been a determination by the HCG Plan Medical Director or designee that care in the hospital is no longer medically necessary for the condition for which the member was admitted to the hospital; and~~

~~e. An employee member whose coverage terminates according to this subsection shall not be eligible for re-enrollment until the employer group's next open enrollment period. The employee shall meet all the eligibility criteria prescribed by these rules before re-enrollment.~~

~~**D.** The HCGA may exclude employer groups or employee members from enrollment who have committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.~~

R9-27-406. ~~Continuation Coverage~~ Repealed

~~Continuation coverage. Employer groups with at least 20 employees on a typical business day during the preceding calendar year shall provide continuation coverage as required by 29 U.S.C. 1161 et seq. The employer group shall collect the premium from the employee and pay the premium to HCGA.~~

R9-27-408. ~~Contract Compliance Sanction Alternative~~ Repealed

~~The Director may impose a sanction or penalty upon a HCG plan or employer group that violates any provision of the rules as specified in contract or the GSA.~~

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-27-501. ~~Availability and Accessibility of Services~~ Repealed

~~Availability and accessibility of services. An HCG Plan shall ensure that, within each service area, an adequate number of hospitals, medical care facilities, and service providers are available and reasonably accessible to provide covered services, to members. At a minimum, an HCG Plan shall have:~~

1. ~~A designated emergency medical service facility, providing care 24 hours-a-day, seven days-a-week. An emergency medical service facility shall be accessible to members in each service area with at least one physician and registered nurse on call or on duty at the facility at all times.~~
2. ~~An emergency medical service system employing at least one physician, a registered nurse, a physician assistant, or a nurse practitioner, accessible by telephone 24 hours-a-day, seven days-a-week, to:~~
   a. ~~Provide information to providers who need verification of patient membership and treatment authorization; and~~
   b. ~~Provide emergency medical services specified in R9-27-101.~~
3. ~~An emergency medical services call log that contains the following information:~~
   a. ~~Member's name,~~
   b. ~~Member's address,~~
   c. ~~Member's telephone number,~~
   d. ~~Date of call,~~
   e. ~~Time of call, and~~
   f. ~~Instructions given to each member.~~
4. ~~A written procedure plan for the communication of emergency medical service information to the member's primary care provider and other authorized staff.~~
5. ~~An appointment system for each of the HCG Plan's service locations. The HCG Plan shall ensure that:~~
   a. ~~A member with an acute or urgent problem is triaged and provided same-day service when necessary;~~
   b. ~~A time-specific appointment for routine medically necessary care from the primary care provider is available within three weeks of the member's request and on the same day for emergency care; and~~
   c. ~~A referral appointment to a specialist is:~~
      i. ~~On the same day for emergency care,~~
      ii. ~~Within three days for urgent care, and~~
      iii. ~~Within 30 days for routine care.~~
6. ~~Primary care providers that an enrolled member may select or to whom the member may be assigned. An HCG Plan that does not ordinarily include primary care providers shall enter into an affiliation or subcontract with an organization or individual to provide primary care. The HCG Plan shall agree to provide services under the primary care provider's guidance and direction. The primary care provider is responsible for:~~
   a. ~~Supervising, coordinating, and providing initial and primary care to members;~~
   b. ~~Initiating referrals for specialty care; and~~
   c. ~~Maintaining continuity of member care.~~
7. ~~Primary care physicians and specialists providing inpatient services to a member shall have staff privileges in a minimum of one general acute care hospital under subcontract with the contracting health plan, within or near the service area of the HCG Plan.~~

R9-27-503. ~~Marketing and Discrimination~~ Repealed

~~HCGA marketing representatives shall not engage in any marketing or other pre-enrollment practices that discriminate against an applicant or a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.~~

R9-27-504. ~~Approval of Advertisements and Marketing Material~~ Repealed

~~**A.** Submission of marketing material. The HCG Plan shall submit proposed marketing strategies and marketing material in writing to the HCGA for review and approval before distributing the marketing material or implementing any marketing~~

activity.

B. Review of marketing material. The HCGA shall review and approve or disapprove all proposed marketing material and strategies. The HCGA shall notify the HCG Plan in writing of the approval or disapproval of the proposed marketing material and marketing strategies. The notification shall include a statement of objections and recommendations.

C. Drafts. To minimize the expense of revising marketing material or other copy, an HCG Plan may submit the material in draft form subject to final approval.

D. Submission and maintenance of final copies. An HCG Plan shall submit two copies of the proof or final approved copy of material to the HCGA, which shall maintain the proof or copy for five years.

R9-27-505. Member Records and Systems Repealed

Member record. Each HCG Plan shall maintain a member service record for each member that contains encounter data, grievances, complaints, and service information.

R9-27-506. Fraud or Abuse Repealed

Suspected fraud or abuse. All HCG Plans, providers, and noncontracting providers shall advise the HCGA immediately in writing of suspected fraud or abuse.

R9-27-507. Release of Safeguarded Information Repealed

A. Information to be safeguarded concerning an applicant or member of the HCG program includes:
1. Name, address, and social security number;
2. Evaluation of personal information; and
3. Medical data and services including diagnosis and history of disease or disability.

B. Unrestricted information. The restrictions upon disclosure of information shall not apply to summary data, utilization data, and other information that does not identify an individual applicant or member.

C. Safeguarded information concerning a member or applicant shall be disclosed only to:
1. The member or applicant, or, in the case of a minor, the parent, custodial relative, or guardian;
2. Individuals authorized by the member or applicant; and
3. Persons or agencies for official purposes.
4. Safeguarded information may be released to these parties only under the conditions specified in subsections (D), (E), and (F).

D. A member or authorized representative may view the member's medical record after written notification to the provider and at a reasonable time and place.

E. Release to individuals authorized by the individual concerned. The HCGA or a HCG Plan shall release medical records and any other HCG-related confidential information of a member or applicant to individuals authorized by the member or applicant only under the following conditions:
1. Authorization for release of information must be obtained from the member, applicant, or authorized representative. In the case of a minor, the member's or applicant's parent, custodial relative, or guardian shall submit an authorization for release of information.
2. Authorization used for release of information must be, submitted in writing separate from any other document, and must specify the following:
   a. Information or records, in whole or in part, which are authorized for release;
   b. To whom the release shall be made;
   c. The period of time for which the authorization is valid, if limited; and
   d. The dated signature of the member, applicant, or authorized representative. In the case of a minor member or applicant, signature of a parent, custodial relative, or guardian is required unless the minor is able to understand the consequences of authorizing and not authorizing.
3. If a grievance or appeal has been filed, the grievant, appellant, or designated representative shall be permitted to review, obtain, or copy any nonprivileged record necessary for the proper presentation of the case. The grievant or appellant also may authorize release of safeguarded information deemed necessary to the contested issue, to any opposing party in the case.

F. Release to persons or agencies for official purposes.
1. Safeguarded information, case records, and medical services information may be disclosed without the consent of the member, to agents or employees of a review committee.
2. For purposes of this Section, "review committee" means an organizational structure within the Plan whose primary purpose is to:
   a. Evaluate and improve the quality of health care;
   b. Review and investigate the conduct of licensed health care providers to determine whether disciplinary action should be imposed; and
   c. Encourage proper and efficient utilization of health care services and facilities.
3. Any member, agent, or employee of a review committee, who in good faith and without malice, furnishes records, information, or assistance related to the duties of the review committee; or, who takes an action or makes a decision

~~or recommendation related to the duties or functions of the review committee shall not be subject to liability for civil damages as a consequence of the action. This does not relieve a person of liability that arises from that person's medical treatment of a patient.~~

4. ~~Information considered by a review committee related to the duties or functions of the committee, including records of their actions and proceedings, are confidential and are not subject to subpoena or order to produce except:~~
   a. ~~When otherwise subject to discovery as a patient's medical records.~~
   b. ~~In proceedings before an appropriate state licensing or certifying agency. If the information is transferred to an appropriate state licensing or certifying agency, the information shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions.~~
5. ~~A member of a review committee or staff engaged in work for the committee or any other person assisting or furnishing information to the review committee shall not be subpoenaed to testify in a judicial or quasi-judicial proceeding if the subpoena is based solely on review committee activities.~~

~~G.~~ ~~Subcontractors are not required to obtain written consent from a member before transmitting the eligible person's or member's medical records to a physician who:~~

1. ~~Provides a service to the eligible person or member under subcontract with the program contractor,~~
2. ~~Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature, and~~
3. ~~Provides a service under the contract.~~

R9-27-509. Information to Enrolled Members

A. Member handbook. ~~Each HCG Plan~~ HCGA shall produce and distribute a printed member handbook to each enrolled member by the effective date of coverage or as otherwise stated in contract. The member handbook shall include the following:

1. A description of all available services and an explanation of any service limitation, ~~and~~ exclusions from coverage, ~~or~~ and charges for services, when applicable;
2. An explanation of the procedure for obtaining covered services, including a notice stating the HCG Plan ~~shall~~ is only ~~be~~ liable for services authorized by a member's primary care provider or the HCG Plan;
3. ~~A list of the names, telephone numbers, and business addresses of primary care providers available for selection by the member, and a description of the selection process, including a statement that informs members they may request another primary care provider, if they are dissatisfied with their selection;~~
4~~3~~. Locations, telephone numbers, and procedures for obtaining emergency ~~health~~ medical services;
5~~4~~. ~~Explanation~~ An explanation of the procedure for obtaining emergency ~~health~~ medical services outside the HCG Plan's service area;
6~~5~~. Causes for which a member may lose coverage;
7~~6~~. A description of the grievance and request for hearing procedures;
8~~7~~. Copayment, coinsurance, and deductible schedules;
9~~8~~. Information on obtaining health services and on the maintenance of personal and family health;
10~~9~~. Information regarding emergency and medically necessary transportation offered by the HCG Plan; and
11~~10~~.Other information necessary to use the program.

B. Notification of changes in services. ~~Each HCG Plan~~ HCGA shall prepare and distribute to members a printed member handbook insert describing any changes that ~~the HCG Plan~~ HCGA proposes to make in services provided within the HCG Plan's service areas. ~~The insert shall be distributed~~ HCGA shall distribute the insert to all affected members and dependents at least 14 days before a planned change. ~~Notification shall be provided~~ HCGA shall provide notification as soon as possible when unforeseen circumstances require an immediate change in services or service locations.

R9-27-510. ~~Discrimination Prohibition~~ Repealed

~~A.~~ ~~Discrimination. The HCGA or a HCG Plan shall not discriminate against an applicant or a member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex or physical or mental disability in accordance with Title VII of the U.S. Civil Rights Act of 1964, 42 U.S.C., Section 2000 D, regulations promulgated under the Act, or as otherwise provided by law or regulation. For the purpose of providing covered services under contract under A.R.S. Title 36, Chapter 29, discrimination on the grounds of race, creed, color, religion, ancestry, marital status, age, sex, national origin, sexual preference, or physical or mental disability includes the following:~~

1. ~~Denying a member any covered service or availability of a facility for any reason except provided under R9-27-202 or for a pre-existing condition as described in R9-27-210;~~
2. ~~Providing a member any covered service that is different, or is provided in a different manner or at a different time from that provided to other HCG members under contract, except when medically indicated;~~
3. ~~Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service, or restricting a member's enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and~~
4. ~~Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, or physical or mental disability of the member to be~~

served.

B. Provision of covered services. An HCG Plan shall take affirmative action to ensure that a member is provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental disability, except when medically indicated.

R9-27-511. Equal Opportunity Repealed

Equal opportunity requirements. An HCG Plan shall comply with the following equal opportunity employment requirements:

1. All solicitations or advertisements placed by or on behalf of an HCG Plan shall state that it is an equal opportunity employer.
2. An HCG Plan shall send a notice prepared by the HCGA to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding. The notice shall advise the labor union or workers' representative of the HCG Plan's commitment as an equal opportunity employer and shall be posted in conspicuous places available to employees and applicants for employment.

R9-27-512. Periodic Reports and Information Repealed

A. Contract performance. Upon request by the HCGA, each HCG Plan shall furnish to the HCGA information from its records relating to contract performance.

B. Separation of records. Each HCG Plan shall maintain separate records to identify all HCG-related transactions.

R9-27-513. Medical Audits Repealed

A. Conducting a medical audit. HCGA shall conduct a medical audit of each HCG Plan at least once every 12 months. Unless HCGA determines that advance notice will render a medical review less useful, the HCGA shall notify the HCG Plan no later than three weeks in advance of the date of an onsite medical review. HCGA may conduct, without prior notice, an inspection of the HCG Plan facility or perform other elements of a medical review, either in conjunction with the medical audit or as part of an unannounced inspection program.

B. Procedure for medical audit. As part of the medical audit, the HCGA may perform any or all of the following procedures:

1. Conduct private interviews and group conferences with:
   a. Members;
   b. Physicians and other health care practitioners;
   c. Members of the HCG Plan's administrative staff including its principal management persons; and
2. Examine records, books, reports, and papers of the HCG Plan, any management company of the HCG Plan, and all providers or subcontractors providing health care and other services to the HCG Plan. The examination may include:
   a. Minutes of medical staff meetings,
   b. Peer review and quality-of-care review records,
   c. Duty rosters of medical personnel,
   d. Appointment records,
   e. Written procedures for the internal operation of the HCG Plan,
   f. Contracts,
   g. Correspondence with members and providers of health care services and other services to the HCG Plan, and
   h. Additional documentation deemed necessary by the HCGA to review the quality of medical care.

R9-27-514. HCG Plan's Internal Quality Management and Utilization Review System Repealed

A. Quality management and utilization review. An HCG Plan shall comply with the following quality management and utilization review requirements:

1. Annually prepare and submit to HCGA for review and approval a written quality management plan that includes utilization review. The quality management plan must be designed and implemented with actions to promote the provision of quality health care services.
2. Design and implement procedures for continuously reviewing the performance of health care personnel and the utilization of facilities, services, and costs.
3. Medical records and systems:
   a. Ensure that a member's medical records are maintained by the primary care provider, and include a record of all medical services received by the member from the HCG Plan and its subcontracting and noncontracting providers.
   b. Ensure that medical records are maintained in a manner that:
      i. Conforms to professional medical standards and practices,
      ii. Permits professional medical review and medical audit processes, and
      iii. Facilitates a system for follow-up treatment.
4. Develop and implement a program of utilization review methods for hospitals that, at a minimum, includes:
   a. Prior authorization of nonemergency hospital admissions,
   b. Concurrent review of inpatient stays, and
   c. Retrospective review of hospital claims to ensure that covered hospital services are not used unnecessarily or

~~unreasonably.~~

~~**B.** Evaluation of utilization control system. The HCG Plan's utilization control system is subject to evaluation by the HCGA to determine cost effectiveness, and to measure whether quality management and utilization review methods are reducing, controlling, or eliminating unnecessary or unreasonable utilization. An HCG Plan may subcontract with an organization or entity designed to conduct activities regarding prior authorization, concurrent review, retrospective review, or any combination of these activities. A subcontract to conduct quality management or utilization review activities is subject to prior approval by the HCGA.~~

R9-27-515. ~~Continuity of Care~~ Repealed

~~Requirements for continuity of care. An HCG Plan shall establish and maintain a system to ensure continuity of care that includes:~~

1. ~~Referral of members needing specialty health care services,~~
2. ~~Monitoring of members with chronic medical conditions,~~
3. ~~Providing hospital discharge planning and coordination including post-discharge care, and~~
4. ~~Monitoring the operation of the system through professional review activities.~~

R9-27-516. ~~Financial Resources~~ Repealed

~~**A.** Adequate reserves. An HCG Plan shall demonstrate to the HCGA that it has adequate financial reserves, administrative abilities, and soundness of program design to carry out its contractual obligations.~~

~~**B.** Contract provisions. Contract provisions required by the HCGA may include:~~

1. ~~Maintenance of deposits,~~
2. ~~Performance bonds,~~
3. ~~Financial reserves, or~~
4. ~~Other financial security.~~

ARTICLE 7. STANDARD FOR PAYMENTS

R9-27-701. ~~HCGA Liability; Payments to HCG Plans~~ Repealed

~~**A.** Liability for covered services. The HCGA is not liable for the provision of covered services or the completion of a plan of treatment for any member.~~

~~**B.** Liability for subcontracts.~~

1. ~~The HCGA is not liable for subcontracts that the HCG Plan executes for the provision of:~~
   a. ~~Administrative or management services,~~
   b. ~~Medical services,~~
   c. ~~Covered health care services, or~~
   d. ~~For any other purpose.~~
2. ~~Each HCG Plan shall indemnify and hold the HCGA harmless from:~~
   a. ~~Any and all liability arising from the HCG Plan's subcontracts,~~
   b. ~~All judgment and injunctive costs of defense of any litigation for liability,~~
   c. ~~Satisfy any judgment entered against the HCGA arising from an HCG Plan subcontract.~~
3. ~~All deposits, bonds, reserves, and security posted under R9-27-516 are forfeited to the HCGA to satisfy any obligations of this Section.~~

~~**C.** Payments. All payments to an HCG Plan shall be made under the terms and conditions of the contract executed between the HCG Plan and HCGA as specified in this Article.~~

~~**D.** Premium. Premium payments, less HCGA administrative charges and reinsurance fees, shall be paid monthly to an HCG Plan that has either posted a performance bond or has otherwise provided sufficient security to the HCGA.~~

R9-27-702. Prohibition Against Charges to Members

~~Prohibition against charges to members. An HCG Plan, subcontractor, or noncontracting provider reimbursed by an HCG Plan shall not charge, submit a claim, demand, or otherwise collect payment from a member or person acting on behalf of a member for any covered service except to collect an authorized copayment, coinsurance, and deductible. This prohibition shall not apply if the HCGA determines that a member willfully withheld information pertaining to the member's enrollment in an HCG Plan. An HCG Plan shall have the right to recover from a member that portion of payment made by a third party to a member when the payment duplicates HCG benefits and has not been assigned to the HCG Plan.~~

If a member notifies a provider that the member is covered by HCG, the provider shall not charge, submit a claim to, or demand or otherwise collect payment from the member or a person acting on behalf of the member for any covered service, except the provider may collect from or bill the member:

1. For any copayment, coinsurance, or deductible as described in the GSA;
2. If the member requests the provision of services, other than emergency medical services, that are excluded under the GSA or have not been authorized by the HCG Plan; or
3. For the difference between any payment the provider receives from the HCG Plan and billed charges for services

other than emergency services if the provider has obtained, prior to the delivery of the service, the written agreement of the member to accept financial responsibility for the difference.

R9-27-703. Payments by HCG Plans

~~A. Payment for covered services. An HCG Plan shall pay the provider for all covered services rendered to the HCG Plan's member if the services were arranged by the HCG Plan's agent or employee, subcontracting provider, or other individual acting on behalf of the HCG Plan.~~

~~B. Payment for medically necessary outpatient services. An HCG Plan shall reimburse a subcontracting provider or noncontracting provider for covered health care services provided to the HCG Plan member. Reimbursement shall be made within the time period specified by contract between an HCG Plan and a subcontracting provider or noncontracting provider or within 60 days of receipt of a clean claim, if a time period is not specified.~~

~~C. Payment for in-state inpatient and outpatient hospital services including emergency services.~~

~~1. An HCG Plan shall reimburse an in-state subcontracting provider for the provision of inpatient or outpatient hospital services, including emergency services specified in R9-27-209, at the subcontracted rate.~~

~~2. An HCG Plan shall reimburse an in-state noncontracting provider for the provision of inpatient or outpatient hospital services, including emergency services specified in R9-27-209, according to the reimbursement methodology stated in A.R.S. § 36-2903.01(J).~~

~~D. Payment for emergency services. An HCG Plan shall pay for all emergency care services rendered to the HCG Plan member by a noncontracting provider if the services:~~

~~1. Conform to the definition of emergency medical services in Article 1 and Article 2 of these rules; and~~

~~2. Conform to the notification requirements in Article 2 of these rules.~~

~~E. Payment for out-of-state inpatient and outpatient hospital services. An HCG Plan shall reimburse an out-of-state subcontracting provider at the subcontracted rate. An HCG Plan shall reimburse an out-of-state noncontracting provider for the provision of inpatient and outpatient hospital services at the lower of negotiated discounted rates or 80% of billed charges.~~

~~F. Payment for emergency ambulance services. An HCG Plan shall reimburse an out-of-state subcontracting provider at the subcontracted rate. An HCG Plan shall reimburse a noncontracting provider for emergency ambulance services at the lower of negotiated discounted rates or 80% of the billed charges.~~

~~G. Nonpayment of a claim. In the absence of a contract with an HCG Plan, an HCG Plan is not required to pay a claim for a covered service that is submitted more than six months after the date of the service or that is submitted as a clean claim more than 12 months after the date of service.~~

~~H. Notice of a denied claim. An HCG Plan shall provide written notice to a provider whose claim is denied or reduced by an HCG Plan within 30 days of adjudication of the claim. This notice shall include a statement describing the provider's right to:~~

~~1. Grieve the HCG Plan's rejection or reduction of the claim; and~~

~~2. Submit a grievance to the HCGA, or its designee under 9 A.A.C. 27, Article 6~~.

A. A HCG Plan is not responsible for reimbursing a provider if the member requests provision of services, other than emergency medical services, that are excluded under the GSA, have not been authorized by the HCG Plan, or are not the result of a referral to the provider by the HCG Plan or the member's primary care physician.

B. A HCG Plan shall reimburse a network provider for covered services as specified in the subcontract between the HCG Plan and the provider.

C. If a member receives emergency medical services from a provider other than a network provider, or if the HCG Plan authorizes services to be delivered by, or refers a member to, a provider other than a network provider, the HCG Plan shall reimburse the provider for covered services at the lesser of billed charges or an amount negotiated with the provider less any copayment, coinsurance, or deductible as described in the GSA.

D. A HCG Plan shall adjudicate claims from providers within 60 days of receipt of a clean claim from the provider unless a different time is specified in the subcontract between the HCG Plan and the provider.

R9-27-704. HCG Plan's Liability to Noncontracting Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members

~~A. Liability to noncontracting hospitals. An HCG Plan is liable for reimbursement for a member's emergency medical condition:~~

~~1. Until the time the member's condition is stabilized and the member is transferable to a subcontractor; or~~

~~2. Until the member is discharged post-stabilization, subject to the requirements of A.R.S. § 36-2909(E) and Article 2 of these rules.~~

~~B. Liability when transfer of member is not possible. Subject to the provisions of subsection (A), if a member cannot be transferred for post-stabilization services to a facility that has a subcontract with the HCG Plan of record, the HCG Plan shall pay the provider for all appropriately documented medically necessary treatment provided the member before the date of discharge or transfer. The reimbursement is the lower of a negotiated discounted rate or prospective tiered per-diem rate.~~

~~C. Member refusal of transfer. If a member refuses transfer from a noncontracting hospital to a hospital affiliated with the~~

~~member's HCG Plan, neither the HCGA nor the HCG Plan shall be liable for any costs incurred subsequent to the date of refusal if:~~

~~1. After consultation with the member's HCG Plan, the member continues to refuse the transfer; and~~

~~2. The member is provided and signs a written statement of liability, before the date of discharge or transfer informing the member of the medical impact and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by two witnesses indicating that the member was informed may be substituted.~~

A HCG Plan shall reimburse a noncontracting hospital for the provision of emergency and subsequent care to an enrolled member in accordance with the terms of the HCG plan's contract with HCGA and the GSA. Unless the GSA or contract with HCGA states otherwise, a HCG Plan shall meet the following requirements:

1. Liability to noncontracting hospitals. A HCG Plan shall reimburse a noncontracting hospital for a member's emergency medical condition until the member's condition is stabilized and the member is transferable to a contracting hospital or is discharged after the member's condition is stabilized.
2. Member refusal of transfer. If a member refuses transfer from a noncontracting hospital to a contracting hospital, neither the HCGA nor the HCG Plan is liable for any costs incurred after the date of refusal when:
   a. The HCG Plan has consulted with the member and the member continues to refuse the transfer; and
   b. The member is provided and signs a written statement of liability on or before the date of consult by which the member indicates the member is aware of the financial consequences of refusing to transfer, or two witnesses sign a statement indicating that the member was provided the statement of liability but refused to sign.

R9-27-705. ~~Copayments~~ Repealed

~~**A.** Payment of copayment. A member shall be required to pay a copayment directly to a provider at the time covered services are rendered.~~

~~**B.** Determination of copayment. The HCGA shall establish the amount of copayment a member shall be charged. The HCGA shall consider the following in determining the amount of copayment:~~

~~1. The impact the amount of the copayment will have on the population served, and~~

~~2. The copayment amount charged by other group health plans or health insurance carriers for particular services.~~

~~**C.** Copayment provisions. The HCGA shall include the copayment provisions in the contract with an HCG Plan and the employer group.~~

~~**D.** Schedule of copayments. HCGA shall provide a schedule of the copayments to members at the time of enrollment.~~

R9-27-706. ~~Payments by Employer Groups~~ Repealed

~~An employer group shall submit the monthly premium payment to the HCGA by the first day of the month prior to the month of coverage. The monthly premium payment is delinquent if received or postmarked after the 25th day of the month prior to the month of coverage and subject to R9-27-405 and the GSA.~~

~~1. An employer group shall pay the monthly premium to HCGA with sufficient funds in the form of a:~~
   ~~a. Cashier's check,~~
   ~~b. Personal check,~~
   ~~c. Money order,~~
   ~~d. Automatic debit from a checking or savings account, or~~
   ~~e. Other means approved by the HCGA.~~

~~2. An employer group whose payment is returned for nonsufficient funds shall pay the monthly premium in the form of a:~~
   ~~a. Cashier's check,~~
   ~~b. Money order, or~~
   ~~c. Other means approved by the HCGA.~~

R9-27-707. ~~Reinsurance~~ Repealed

~~**A.** Provision of reinsurance. The HCGA may elect to provide reinsurance through a private reinsurer.~~

~~**B.** Insured entity. For purposes of the HCGA's reinsurance program, the insured entity shall be the HCG Plan with which the HCGA contracts.~~

~~1. The HCGA shall deduct a specified amount per member, per month, from the employer group's monthly premium to cover the cost of the reinsurance contract.~~

~~2. The HCG Plan shall comply with the reimbursement requirements of the reinsurance agreement between the reinsurer and the HCGA.~~

R9-27-708. ~~Payments to Providers~~ Repealed

~~The Administration or a contractor shall pay providers under A.A.C. R9-22-714.~~

ARTICLE 8. COORDINATION OF BENEFITS

R9-27-801. ~~Priority of Benefit Payment~~ Repealed

~~**A.** HCG Plans shall coordinate all third-party benefits. Services provided under the HCG Plan are not intended to duplicate other benefits available to a member.~~

~~**B.** Order of payment for members with other insurance. If a member has other coverage, payment for services shall occur in the following order:~~

~~1. A policy, plan, or program that has no coordination of benefits provision or nonduplication provision shall make payment first.~~

~~2. If a member is covered by another plan or policy that coordinates benefits:~~

~~a. The plan that provides or authorizes the service shall make payment first.~~

~~b. A plan, other than a prepaid plan, that covers a person as an employee shall make payment before a plan that covers the person as a dependent.~~

~~3. If coverage is provided to a dependent child and both parents have family coverage:~~

~~a. The plan of the employee whose birthday occurs first in the calendar year shall be primary, and the plan of the employee whose birthday occurs last in the calendar year shall be secondary.~~

~~b. If both employees have the same birthday, the plan of the employee, that has been in force longer shall pay first.~~

~~c. If one of the plans determines the order of benefits based upon the gender of an employee, and the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.~~

~~4. If coverage is provided to a dependent child of divorced employees, the order of benefit shall be:~~

~~a. The plan of the employee with custody of the child shall pay first;~~

~~b. The plan of the spouse of the employee with custody of the child shall pay second; and~~

~~c. The plan of the employee not having custody of the child shall pay last.~~

~~**C.** Primary payors. An HCG Plan shall not be primary payers for claims involving workers' compensation, automobile insurance, or homeowner's insurance.~~

~~**D.** Lien and subrogation rights. An HCG Plan shall have lien and subrogation rights as those held by health care services organizations licensed under A.R.S. Title 20, Chapter 4, Article 9.~~

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R05-350]

PREAMBLE

1. Sections Affected **Rulemaking Action**

R9-28-706	Amend
R9-28-708	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. §§ 36-2904 and 36-2932

Implementing statute: A.R.S. § 36-2904

3. The effective date of the rules:

November 12, 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. 3666, September 3, 2004

Notice of Proposed Rulemaking: 11 A.A.R 683, February 11, 2005

Notice of Public Information: 11 A.A.R. 1080, March 11, 2005

Notice of Supplemental Proposed Rulemaking: 11 A.A.R. 1541, April 29, 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 were amended as a result of a Five-Year Rule Review, amending the language to clarify how non-hospital payments are made and also pointing to were the fee schedules can be found that set the amount of payment that can be received. The fee amounts are not required rule language due to the exemption described in A.R.S § 41-1005.

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):
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:
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:
None

13. Incorporations by reference and their location in the rules:
None

14. Was this rule previously made as an emergency rule?
Not applicable

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
R9-28-706. Payments by the Administration for Hospital Services Provided to an Eligible Person
R9-28-708. ~~Capped Fee-for-service~~ Payment for Non-hospital services

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-28-706. Payments by the Administration for Hospital Services Provided to an Eligible Person

A. Payment for medically necessary outpatient hospital services.
1. The Administration shall pay for medically necessary outpatient hospital services provided to an eligible person from the effective date of eligibility to the date of enrollment with a program contractor at the negotiated rate, capped fee-for-service rate, or in the amount of the billed charges, whichever is lowest.
2. An eligible person residing in an area that is not served by a program contractor is eligible for ALTCS-covered ser-

vices. The Administration shall make payment for medically necessary outpatient hospital services provided to the person at the negotiated rate, capped fee-for-service rate, or in the amount of the billed charges, whichever is lowest.

3. The Administration shall pay for medically necessary outpatient hospital services provided to an eligible person by an out-of-state provider at the capped fee-for-service rate under this Article or the Medicaid rate that is in effect for the state in which the provider is located at the time services are provided, whichever is lower.

B. The Administration shall make payment in accordance with 9 A.A.C. 22, Article 7 for covered hospital services provided to an eligible person on or after March 1, 1993.

R9-28-708. ~~Capped Fee-for-service~~ Payment for Non-hospital services

~~**A.** Service codes. The Administration shall maintain a current copy of the following code manuals at the central office of the Administration for reference use during customary business hours:~~

~~1. The Physicians' Current Procedural Terminology (CPT) and Health Care Financing Administration Common Procedures Coding System (HCPCS) shall be utilized to identify medical services and procedures performed by physicians and other providers.~~

~~2. The Code on Dental Procedures and Nomenclature, as published in the Journal of the American Dental Association, shall be utilized to identify dental procedures.~~

~~3. The International Classification of Diseases.~~

~~4. The American Druggist Blue Book.~~

~~**B.** Fee schedule. The Administration shall pay providers and noncontracting providers at the capped fee for service rates specified below unless a different fee is specified by contract or otherwise required by this Article. Notice of changes in methods and standards for setting payment rates for services shall be in accordance with 42 CFR 447.205, January 18, 1984, incorporated by reference herein and on file with the Office of the Secretary of State.~~

~~1. ALTCS services. Payment shall be in accordance with the lower of the negotiated rate or fee schedules which are on file at the central office of the Administration for reference during customary business hours.~~

~~2. Physician services. Payment shall be in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours.~~

~~3. Hospital services. Hospital services provided to eligible persons shall be paid pursuant to A.A.C. R9-22-712.~~

~~4. Pharmacy services. Payment shall be in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours. The maximum allowable rates under the fee schedules shall not exceed the payment levels established pursuant to 42 CFR 447.331 through 447.332, incorporated by reference herein and on file with the Office of the Secretary of State.~~

~~5. Dental services. Payment shall be in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours.~~

~~6. Transportation services. Payment for transportation services shall be made in accordance with A.A.C. R9-22-710.~~

~~7. Medical equipment. Payment for medical equipment shall be in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours. Providers shall be reimbursed once for the durable medical equipment (DME) during any given two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless authorized by the Administration, no more than one repair and adjustment shall be reimbursed during any two-year period.~~

Capped fee-for-service for ALTCS services. The Administration shall pay for ALTCS services in accordance with A.A.C. R9-22-710.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R05-352]

PREAMBLE

1. Sections Affected	Rulemaking Action
R9-31-710	New Section
R9-31-1616	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. §§ 36-2904 and 36-2982

Implementing statute: A.R.S. § 36-2904

3. The effective date of the rules:
November 12, 2005

4. A list of all previous notices appearing in the *Register* addressing the final rule:
Notice of Rulemaking Docket Opening: 11 A.A.R. 415, January 14, 2005

Notice of Proposed Rulemaking: 11 A.A.R 686, February 11, 2005

Notice of Public Information: 11 A.A.R. 1081, March 11, 2005

Notice of Supplemental Proposed Rulemaking: 11 A.A.R. 1544, April 29, 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 rules:
The rules were amended as a result of a Five-Year Rule Review, amending the language to clarify how non-hospital payments are made and also pointing to were the fee schedules can be found that set the amount of payment that can be received. The fee amounts are not required rule language due to the exemption described in A.R.S § 41-1005.

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):
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:
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:
None

13. Incorporations by reference and their location in the rules:
None

14. Was this rule previously made as an emergency rule?
Not applicable

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 7. STANDARDS FOR PAYMENTS

Section
R9-31-710. ~~Reserved~~ Payments for Non-hospital Services

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

Section
R9-31-1616. Standards for Payments

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-31-710. ~~Reserved~~ Payments for Non-hospital Services

Capped fee-for-service. The Administration shall pay for Kids Care services in accordance with A.A.C. R9-22-710.

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1616. Standards for Payments

A. The Administration has no financial responsibility for services provided to a member beyond the effective date of termination of a member's eligibility. A contractor has no financial responsibility for services provided to a member beyond the last date of enrollment except as provided in 9 A.A.C. 22, Articles 2 and 5 ~~of Chapter 22 of this Title,~~ and as specified in contract.

B. The Administration shall make payments to IHS or a Tribal Facility as required under A.R.S. § 36-2987(A).

C. The Administration shall pay inpatient and outpatient hospital services rendered by a provider under referral from the IHS or a Tribal Facility provider based on A.R.S. §§ 36-2987, ~~36-2904,~~ 36-2903.01, ~~A.A.C. R9-22-712 and A.A.C. R9-22-718~~ and 9 A.A.C. 22, Article 7, as applicable. ~~Discounts~~ The Administration shall pay hospital claims using the discounts and penalties ~~are~~ specified in A.R.S. § 36-2987(C).

D. The Administration shall pay for non-hospital services as described in R9-22-710.

NOTICE OF FINAL RULEMAKING

TITLE 17. TRANSPORTATION

CHAPTER 3. DEPARTMENT OF TRANSPORTATION HIGHWAYS

[R05-344]

PREAMBLE

1. Sections Affected **Rulemaking Action**
R17-3-902 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. §§ 28-366 and 28-7311
Implementing statute: A.R.S. § 28-7311

3. The effective date of the rules:
September 15, 2005

The Arizona Department of Transportation and interested stakeholders seek an immediate effective date. This rulemaking adds new activities for the logo sign Attraction category. This rulemaking benefits qualifying businesses and the motoring public. No penalty is associated with a violation of the rule.

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

Notice of Rulemaking Docket Opening: 11 A.A.R. 1287, April 1, 2005

Notice of Proposed Rulemaking: 11 A.A.R. 1410, April 15, 2005

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

Name:	Wendy S. LeStarge, Manager
Address:	Arizona Department of Transportation Maintenance Permits Services 206 S. 17th Ave., MD 004R Phoenix, AZ 85007
Telephone:	(602) 712-4142
Fax:	(602) 712-3484
E-mail:	wlestarge@azdot.gov

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

The logo sign program, created under A.R.S. § 28-7311, allows for the placing of logo signs (or specific service information signs) along the state highway system, in order to provide motorists with service information, such as gas, food, lodging, camping, and attraction. The Arizona Department of Transportation ("ADOT") is amending the rules to include additional activities for the definition of "Attraction." ADOT also is amending the rules to include renumbered references to the new encroachment permit rules.

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:

None

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 interstate and rural logo sign programs are marketed and administered by a private contractor, as allowed under A.R.S. § 28-7311. Under the logo sign programs, the contractor markets the programs to eligible businesses to lease space on a specific service information sign for a business' logo. This rulemaking adds additional activities to the Attraction category and therefore should expand the available customer base of the contractor

ADOT's costs and benefits are not readily quantifiable. ADOT provides administrative oversight for the logo sign program, so its costs include the salaries for those employees overseeing the logo sign program or installation of signs as part of their duties. It is not expected that additional businesses eligible to participate in the logo sign program will increase ADOT's costs. The motoring public benefits through increased convenience and reduced travel time for locating a participating business. Services may cost more due to the costs of displaying directional information, which will be passed onto the motoring public consumer. The Arizona Department of Revenue may benefit through increased tax revenue due to increased sales from participating businesses.

Businesses that provide an attraction will benefit because they can qualify for a logo sign. They will have minimal costs for purchasing the sign and paying monthly lease payments. Businesses should benefit by increased revenue due to displaying directional information through logo signs.

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

Grammatical and organizational changes were made at the suggestion of the Governor's Regulatory Review Council's staff.

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

ADOT did not receive any comments.

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 17. TRANSPORTATION

CHAPTER 3. DEPARTMENT OF TRANSPORTATION HIGHWAYS

ARTICLE 9. HIGHWAY TRAFFIC CONTROL DEVICES

Section
R17-3-902. Logo Sign Program

ARTICLE 9. HIGHWAY TRAFFIC CONTROL DEVICES

R17-3-902. Logo Sign Program

A. Definitions.

"Attraction" means any of the following:

"Arena" means a facility that has a capacity of at least 5,000 seats, and is a:

Stadium or auditorium;

Track for automobile, boat, or animal racing; or

Fairground that has a tract of land where fairs or exhibitions are held, and permanent buildings that include band-stands, exhibition halls, and livestock exhibition pens.

"Cultural" means an organized and permanent facility that is open to all ages of the public, and is a:

Facility for the performing arts, exhibits, or concerts; or

Museum with professional staff, and an artistic, historical, or educational purpose, that owns or uses tangible objects, cares for them, and exhibits them to the public.

"Dude ranch" means a facility offering overnight lodging, meals, horseback riding, and activities related to cattle ranching;

"Educational" means a facility that is a:

Community college, regionally accredited college or university, or state university as defined in R17-3-901(A). Educational excludes a business or research park affiliated with a college or university;

Scientific institution, designated research area, or site of specialized research techniques and apparatus that is accredited by a nationally recognized accreditation educational agency and conducts regular tours; or

Zoological or botanical park that houses and exhibits living animals, insects, or plants to the public.

"Farm-related" means an established area or facility where consumers can purchase directly from Arizona producers locally-grown consumer-picked or pre-picked produce, or local products produced from locally-grown produce.

"Golf course" means a facility offering at least 18 holes of play. Golf course excludes a miniature golf course, driving range, chip-and-putt course, and indoor golf.

"Historic" means a structure, district, or site that is listed on the National or Arizona Register of Historic Places as being of historical significance, and includes an informational device to educate the public as to the facility's historic features.

"Mall" means a shopping area with at least 1,000,000 square feet of retail shopping space.

"Recreational" means a facility for physical exercise or enjoyment of nature that includes at least one of the following activities: walking, hiking, skiing, boating, swimming, picnicking, camping, fishing, playing tennis, horseback riding, skating, hang-gliding, ~~taking air tours,~~ and climbing;

"Scenic tours" means a business that offers guided tours of scenic areas in Arizona through various means, including air, motorized vehicle, animal, walking, or biking;

"Winery or brewery" means a site licensed by the Arizona Department of Liquor Licenses and Control that produces a minimum of 500 gallons annually of wine or beer that is commercially packaged for off-premises sale, and is open to the public for tours to provide an educational format for informing visitors about wine and beer processing.

"Business" means an entity that provides a specific service open for the general public, is located on a roadway within the

required distance of an interstate or rural state highway, and is a primary or secondary business.

"Community logo plan" means a project aspect of the rural logo sign program, agreed to by the Department, the contractor, and a municipality outside an urbanized area to place specific service information signs on a rural state highway for the municipality.

"Contract" means a written agreement between the Department and a contractor to operate a logo sign program that describes the obligations and rights of both parties.

"Contractor" means a person or entity that enters into an agreement with the Department to operate a logo sign program and that is responsible for marketing, furnishing, installing, maintaining, and replacing specific service information signs.

"Department" means the Arizona Department of Transportation.

"Director" means the Director of the Arizona Department of Transportation or the Director's designee.

"Exit ramp" means a roadway by which traffic may leave a controlled access highway to another highway.

"Food court" means a collective food facility that exists in one contiguous area and contains a minimum of three separate food service businesses.

"Highway" has the meaning in A.R.S. § 28-101(49).

"Interchange" means the point at which traffic on a system of interconnecting roadways that have one or more grade separations, moves from one roadway to another at a different level.

"Intersection" has the meaning in A.R.S. § 28-601(7).

"Interstate highway" has the meaning in A.R.S. § 28-7901(4).

"Interstate logo sign program" means a system to install and maintain specific service information signs on certain portions of an interstate highway as provided in A.R.S. § 28-7311(A).

"Lease agreement" means a written contract between a contractor and a responsible operator to lease space for a responsible operator's logo sign on a contractor's specific service information sign.

"Logo sign" means part of a specific service information sign consisting of a lettered board attached to a separate rectangular panel, and that displays an identification brand, symbol, trademark, name, or a combination of these, for a responsible operator.

"Major decision point" means a location at or before the point at which a rural state highway intersects with another rural state highway or a local roadway, that is within a municipality (except an urbanized area), and that the Department determines to be the point at which a driver must make a decision whether to stay on the highway or turn off onto the other highway or local roadway.

"Municipality" means an incorporated city or town.

"Primary business" means:

A gas service business that is within three miles of an intersection or exit ramp, and is in continuous operation to provide services at least 12 hours per day, seven days per week;

A food service business that is within three miles of an intersection or exit ramp terminal, is open for operation no later than 7:00 a.m., provides seating for at least 20, and is in continuous operation to provide service at least three meals per day (breakfast, lunch, and dinner) at least six days per week;

A lodging service business that is within three miles of an intersection or exit ramp terminal;

A camping service business that is within five miles of an intersection or exit ramp terminal; or

An attraction service business, or staging area of that business, that is within three miles of an intersection or exit ramp terminal.

"Ramp terminal" means the area where an exit ramp intersects with a roadway.

"Responsible operator" means a person or entity that:

Owns or operates a business,

Has authority to enter into a lease, and

Enters into a lease for a logo sign through the interstate or rural logo sign program.

"Rural logo sign program" means a system to install and maintain specific service information signs on a rural state highway outside of an urbanized area, as provided in A.R.S. § 28-7311(B).

"Rural state highway" means any class of state highway, other than an interstate highway, located outside of an urbanized area as provided in A.R.S. § 28-7311(B).

"Secondary business" means a business as follows:

A gas service business that is within 15 miles of an intersection or exit ramp terminal, and in continuous operation to

provide services at least eight hours per day, five consecutive days per week;

A food service business that is within 15 miles of an intersection or exit ramp terminal, and is in continuous operation to serve at least two meals per day (either breakfast and lunch, or lunch and dinner) for a minimum of five consecutive days per week;

A lodging service business that is within 15 miles of an intersection or exit ramp terminal;

A camping service business that is within 15 miles of an intersection or exit ramp terminal; or

An attraction service business, or staging area of that business, that is within 15 miles of an intersection or exit ramp terminal.

"Specific service" means gas, food, lodging, camping, or attraction services.

"Specific service information sign" means a rectangular sign panel that contains the following:

The words "GAS," "FOOD," "LODGING," "CAMPING," or "ATTRACTION,"

Directional information; and

One or more logo signs.

"Staging area" means a regular, designated site where a scenic tour begins.

"Straight-ahead sign" means a specific service information sign that provides additional directional guidance to a location, route, or building located straight ahead on a roadway, and that is located before a junction that is a major decision point.

"Trailblazing sign" means a specific service information sign that provides additional directional guidance to a location, route, or building from another highway or roadway.

"Urbanized area" has the meaning in A.R.S. § 28-7311(D).

B. Logo sign program administration.

1. The Department shall solicit offers, as provided in A.R.S. §§ 41-2501 through 41-2673, to select a contractor to operate a logo sign program.
2. The Department may contract separately for each program.
3. The contract shall specify the standards that a contractor shall use including the following:
   a. Manual on Uniform Traffic Control Devices, USDOT/FHWA, current edition as adopted by the Department;
   b. Arizona Department of Transportation Traffic Control Supplement, 1996 edition; and
   c. Arizona Department of Transportation Standard Specifications, 2000 edition.
4. The Department shall approve the form of any lease agreement between the contractor and a responsible operator. The lease agreement shall include, by reference, the terms and conditions of the Department's contract with the contractor under A.R.S. §§ 41-2501 through 41-2673.

C. Eligibility criteria for businesses.

1. Any business is ineligible for a logo sign if it already has a highway guide sign installed by the Department.
2. Gas service business. To be eligible to place a logo sign, a gas service business shall:
   a. Provide fuel, oil, and water for public purchase or use;
   b. Provide restroom facilities and drinking water; and
   c. Provide a telephone available for emergencies to the public during hours of operation.
3. Food service business. To be eligible to place a logo sign, a food service business shall:
   a. Provide restroom facilities for customers;
   b. Provide a telephone available for emergencies to the public during hours of operation; and
   c. If a food service business is part of a food court located within a shopping mall, the shopping mall may qualify as the responsible operator if the food court:
      i. Complies with subsection (C)(3), and
      ii. Has clearly identifiable on-premise signing consistent with the logo sign that is sufficient to guide motorists directly to the entrance to the food court.
4. Lodging service business. To be eligible to place a logo sign, a lodging service business shall:
   a. Provide five or more units of sleeping accommodations, and
   b. Provide a telephone available for emergencies to the public during hours the lobby is open for registration.
5. Camping service business. To be eligible to place a logo sign, a business providing camping facilities shall:
   a. Be able to accommodate all common types of travel trailers and recreational vehicles;
   b. Be equipped to handle a minimum of 15 travel trailers or recreational vehicles;
   c. Provide drinking water and a sewer hook-up or dump station; and
   d. Be available on a year-round basis unless camping in the general area is of a seasonal nature in which case the facilities in question shall be open to the public 24 hours per day, seven days per week during the entire season.
6. Attraction service business. To be eligible to place a logo sign, an attraction service business shall:
   a. Derive less than 50% of its sales from:
      i. The sale of alcohol consumed on the premises, or

ii. Gambling~~,~~ ;

b. Derive more than 50% of its sales or visitors during the normal business season from motorists not residing within a 25-mile radius of the business~~.~~ ;

c. Provide at least 10 parking spaces~~.~~ ;

d. Provide restroom facilities and drinking water; and

e. Be in continuous operation at least six hours per day, six days per week, except:

i. An arena attraction shall hold events at least 28 days annually;

ii. A cultural attraction shall be open at least 180 days annually; ~~or~~

iii. An educational attraction shall operate at least six hours per day, five days per week; ~~and~~

iv A winery or brewery shall be open for tours at least 40 days annually;

v. A farm-related attraction shall be open at least 120 days annually; or

vi. A dude ranch shall be open at least 150 days annually.

~~f. Have a minimum annual attendance of 5,000, except if the attraction business operates on a seasonal basis, the attraction business shall have a minimum annual attendance of 2,500.~~

D. Ranking.

1. If more than six eligible businesses providing the same specific service request lease space for a logo sign on one specific service information sign, the contractor shall use the following ranking criteria to determine which businesses are awarded a lease:
   a. The business closest to an intersection or exit ramp terminal shall receive first priority,
   b. A gas service business or a food service business that provides the most days and hours of service shall receive second priority,
   c. A food service business that provides the most indoor seating capacity shall receive third priority, and
   d. A business that does not have an off-premise advertising sign to direct motorists to its business within five miles of where the specific service information sign is to be located shall receive fourth priority.
2. If two or more businesses have the same ranking in qualifications, the contractor shall award a lease to the first business that requests a logo sign. The contractor shall establish a waiting list for other businesses in sequence of request.
3. The contractor shall not renew the lease of a responsible operator if another eligible business with higher priority requests lease space for a logo sign.

E. Secondary businesses.

1. Lease limitations. For a secondary business, the contractor may enter into a lease for up to five years or renew a lease for up to five years, with the following terms:
   a. The responsible operator is guaranteed a term of two years, providing the responsible operator complies with all other terms of the lease;
   b. After the two-year period, the contractor shall terminate the lease and remove the logo sign if another eligible business with higher priority requests lease space for a logo sign; and,
   c. The contractor shall notify the responsible operator at least six months before terminating the lease and removing the logo sign.
2. The contractor shall display the following additional information on a specific service information sign for a secondary business, as space allows, based on the following ranking order:
   a. Distance,
   b. Days and hours of operation, and
   c. Seasonal operation.

F. Contractor responsibility.

1. The contractor shall follow all Department design standards and specifications for all sign panels, supports, and materials, as provided in the contract.
2. The contractor shall ensure that a business complies with all criteria established in this Section. The contractor shall not enter into a lease agreement or renew a lease agreement if the criteria are not met. If a responsible operator becomes ineligible for a logo sign, the contractor shall remove the logo sign within 20 days after notifying the responsible operator as provided in the lease.
3. The contractor shall require that a responsible operator certify in writing to the contractor that the responsible operator will comply with all applicable federal, state, and local laws, ordinances, rules, and regulations.
4. The contractor shall not place a specific service information sign so as to obstruct or detract from a traffic control device.
5. The contractor shall not remove or relocate an existing traffic control device to accommodate a specific service information sign without prior written approval by the Department, or a local authority under A.R.S. § 28-643.
6. The contractor shall provide a copy of the signed lease agreement to the responsible operator. The responsible operator shall deliver the logo sign to the contractor for installation, or contract with the contractor to fabricate the logo sign to the responsible operator's and the Department's specifications.
7. The contractor shall return any pre-paid lease payments to the responsible operator if the responsible operator's logo

sign is not erected for reasons caused by the Department or the contractor.

8. The contractor shall obtain an encroachment permit under ~~R17-3-702~~ R17-3-501 through R17-3-509 before erecting a specific service information sign along a state highway.
9. If the contractor requests an encroachment permit under ~~R17-3-702~~ R17-3-501 through R17-3-509, the Department's staff shall decide the best placement of a specific service information sign and cooperate with the contractor to provide information to the motoring public as prescribed in subsection (E)(2).
10. If a logo sign program is terminated, the contractor shall:
    a. Notify a responsible operator by certified mail of the termination and the location where the responsible operator may claim its logo sign,
    b. Remove all sign panels and supports, and
    c. Refund any lease payments on a prorated basis to each responsible operator.