NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

Editor's Note: The following Notice of Exempt Rulemaking is exempt from Laws 2010, Ch. 287, § 18. (See the text of § 18 on page 1679.)

[R10-118]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-101	Amend
R9-22-201	Amend
R9-22-202	Amend
R9-22-203	Amend
R9-22-205	Amend
R9-22-206	Amend
R9-22-207	Amend
R9-22-212	Amend
R9-22-215	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. § 36-2907

Implementing statute: A.R.S. § 36-2907, as amended by HB2010, 49th Legislature, 7th Special Session 2010

3. The proposed effective date of the rules:

October 1, 2010

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

None

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

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Administrative and Legal Services
701 E. Jefferson St., Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4693

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6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from regular rulemaking procedures:

The AHCCCS Administration is proposing rule changes to delineate the service limitations/ exclusions as described in HB2010, 49th Legislature, 7th Special Session of 2010.

The AHCCCS Administration is exempt from the rulemaking requirements of A.R.S. Title 41, Chapter 6, as described in HB2010, 49th Legislature, 7th Special Session of 2010, § 34.

7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to 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 relied upon for the implementation of this rulemaking, but analysis of the outpatient physical therapy services reported through claims and encounters as having provided these services during CY 2009, has assisted the AHCCCS Administration in arriving at the limitation amount of covered outpatient physical therapy services of 15 visits, which represents that the limitation does not affect 85% of members receiving outpatient physical therapy services.

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 Administration estimates that approximately 183,380 members may be impacted by the proposed limitations/ exclusions of services as described in HB2010, 49th Legislature, 7th Special Session of 2010.

Based on the utilization of each type of service during the contract year (CY) 2009 the Administration foresees an approximate savings of $24,024,650 per CY. In addition, the limitation applied to outpatient physical therapy services the Administration foresees an approximate savings of $2,900,000 per CY for members 21 years of age and over.

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

Not applicable

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

The following matrix outlines the comments received as of June 22, 2010 in regards to the Adult Benefit limitations and eliminations as described in A.R.S. § 36-2907, amended by HB2010, 49th Legislature, 7th Special Session 2010.

There were 30 attendees at a public hearing held simultaneously at three locations in Arizona. Of the 30 attendees, 14 attendees commented on the proposed rulemaking and some submitted their comments in writing as well. One commenter did not attend the hearing but submitted written comments only.

The general consensus was that all commenters were against one or more aspects of the rulemaking changes and expressed concerns in regards to how the specific services were selected for elimination or limitation. Many urged that data be reviewed by the agency to ensure that the legislature used current and sound information. Studies were identified and articles provided as information to be reviewed.

Item #	Comment From	Comment	Response
1.	Bruce Reeser Hanger Prosthetics and Orthotics	Is there a final ruling on whether there is a cap on prosthetics or where the microprocessor will be disallowed?	The AHCCCS Administration is not imposing a dollar limit on prosthetics. The only limitation regarding prosthetics is the exclusion of microprocessor-controlled lower limbs and microprocessor-controlled joints for lower limbs. No limitations have been applied to prosthetics for the upper extremities.
2.	Bruce Reeser Hanger Prosthetics and Orthotics	For the individuals who have existing prosthetics, will they be allowed to get them fixed?	Yes, if the prosthetic is one that is no longer covered under the rule, the reasonable cost of repair will be permitted when necessary for continued use. A socket joint or non-microprocessor control joint can be replaced to allow the entire prosthetic to be used. We will not be able to replace the microprocessor, but the reasonable costs of repair of the prosthetic will be covered.
3.	Bruce Reeser Hanger Prosthetics and Orthotics	Children under 21, is there anything that would not be covered that is presently covered?	The limitation in this rule does not apply to individuals under 21 years old.

4.	Bruce Reeser Hanger Prosthetics and Orthotics	For those 21 and older, can you clarify orthotics; does this include everything under the orthotic umbrella?	The statutory language included all orthotics; this will include everything that is under the "L0100 to L4999" codes. There are a few exceptions in that range of codes which are considered supplies which will be covered.
5.	Bruce Reeser Hanger Prosthetics and Orthotics	Do you realize that there is a possibility of higher utilization in other areas to off set the money that you saved by not allowing these patients to have these prosthetics or orthotics?	These issues were considered, along with many others, when making the coverage decisions.
6.	Michael Brewer Maricopa County Medical Center	Written statement provided and articles referenced. The patient's options for referrals are limited very limited for the various problems. Because dermatologists rarely address diabetic foot issues, we the podiatrist are the premier practitioners in this area, some orthopedic surgeons have obtained six months of lower extremity training but the vast majority of foot and ankle care is provided by highly specialized physicians of podiatric medicine. The changes you propose could potentially result in the loss of our residency program as we serve a majority of AHCCCS patients at the County Hospital. This program is considered one of the best in the country as DPMs, MDs and DOs all commiserate in a surgical intern year with identical responsibilities and expectations from attending physicians. The general surgery program relies on our residents to serve in all of these areas and not just in foot and ankle surgery. However you eliminating all services provided by podiatrists jeopardize our position to assist AHCCCS patients in the other capacities. Please take this into consideration.	Federal law allows AHCCCS to eliminate optional services. Podiatrists' services are among the optional services which the Legislature eliminated in HB2010 during the latest legislative session.

7.	Dr. Bryan Roth Maricopa County Medical Center	I am an attending physician for the group of residents. Pulling AHCCCS is a very real thing for the loss of the program, we have had multiple meetings discussing the implications and what this means to our program. We recently had a site survey at the beginning of May; we were recognized as one of the premier teaching facilities and programs in the country. How was the determination made to drop services covered by podiatrists but not limiting or allowing another physician to do that? We are a cheaper service, and we provide services that others do not have time to do, or want to do, or do not deem important. If we vanish from our institution, the rates of amputations, major amputations, below knee amputations will sky rocket. Our concern is that everyone will be flipping the bill for prosthesis, long term disability. We are overall doing a disservice to our patient population. This should be reconsidered.	Federal law allows AHCCCS to eliminate optional services. Podiatrists' services are among the optional services which the Legislature eliminated in HB2010 during the latest legislative session.
8.	Cynthia Driscoll AZ Physical Therapy Association	Statement read The Physical Therapy Association objects to the utilization of an arbitrary cap on outpatient physical therapy services per calendar year. The cap without regard to the diagnosis discriminates to the most vulnerable of patients. A 15 visit cap will not be adequate for a meaningful rehabilitation and positive outcome. The AHCCCS Administration suggests that a 15 visit cap would not affect 85% of members who receive outpatient physical therapy based on their analysis of claims in 2009. It is unclear if this analysis adequately reflects the rehabilitative needs of AHCCCS members or merely reflects the use of PT services that is influenced by many other factors, such as copays, travel expenses, etc. Without useful outcome data it is unclear that the historical rate of utilization is adequate to meet the rehabilitative needs of AHCCCS members. AHCCCS does not address the significant needs of the minority of patients who have needed and used PT services in excess of 15 visits per calendar year. The cap without regard to clinical appropriateness of care fails to meet a reasonable standard of care of these complex patients. This could lead to rationing of care to avoid exhausting benefits too early in a calendar year. And could push members to greater cost of care and seeking uncovered services, such as inpatient settings.	Federal law allows Medicaid Programs to place limits on services which meet the needs of 85% of the population. These limitations have been determined to be permissible. The AHCCCS Administration evaluated program information and data to determine that the 15 PT visit limit meets the needs of 85% of the population.

		We urge you to consider the need of PT members and allow for additional services above the 15 visit limit based on diagnosis, individual evaluation and clinic judgment.	
9.	Kay Wing President AZ Physical Therapy Association	Provided picture and described physical condition of patient. This type of patient is the type of person that will be affected by the 15 visit limit and would inadequately meet his medical needs.	Federal law allows Medicaid Programs to place limits on services which meet the needs of 85% of the population. These limitations have been determined to be permissible. The AHCCCS Administration evaluated program information and data to determine that the 15 PT visit limit meets the needs of 85% of the population.
10.	Patty Telgener Hillrom Manufacturer of Percussive Vests	The population that uses the percussive vests are those with sistic fybrosis, CP, muscular dystrophy, and ALS. These patients have progressive lung disease, frequently leading to pneumonia and hospitalizations. Our concern is that the percussive vests are inadvertently classified as a prosthetic and were eliminated as a benefit, because if considered a prosthetic they did not meet the definition of medically necessary for rehab. The vests are not a prosthetic, they do not replace a body system, and they are clearly listed with Medicare as DME. We would like clarification on how they were classified as a prosthetic. We believe they should be under DME. The Luensa assessment that was done when the savings was reviewed for percussive vests was under $10,000. One of these patients with systic fybrosis or CP with an ICU stay will be over $30,000. Can we get clarification on the benefit categorization and how can we work together to make sure that some of these patients still have access to the percussive vest assuming that they meet your coverage criteria, because after this they will not have any other options. Written comment received 6/22/10: *State Plan Amendment (SPA) #10-006 (attachment 3.1-A Limitations) listed percussive vests as a prosthetic. Percussive vests do NOT meet the definition of prosthesis (**replaces** missing, deformed or malfunctioning portions of the body"). At the public hearing on June 22nd, 2010, the panel stated that percussive vests are actually considered an Orthotic. However, the vest is classified as medical equipment and supplies, not orthotic. Medicare has a national coverage decision for percussive vests and the HCPCS codes are A0483 and E7025 and E7026. These HCPCS codes do NOT fall under the L-group of HCPCS codes which are considered orthotic.*	The agency does not have the discretion to override the legislative decision to exclude percussive vests.

		The Arizona House Bill 2010 states that "durable medical equipment is limited to items covered by Medicare" Percussive vests are considered DME and covered by Medicare; therefore coverage should not be eliminated. The panel stated that Medicaid does not follow Medicare's definition of DME. However, per Arizona OMD Policy Manual, ' 310.16, at 3-31 (effective October 1, 1994) they list the definition of DME to be the following: **"Durable medical equipment means sturdy, long lasting items and appliances that can withstand repeated use, are designed primarily to serve a medical purpose and are not generally useful to a person in the absence of a medical condition, illness or injury."** *So clearly, AZ Medicaid does recognize the definition of medical equipment and supplies outside of orthotics. Percussive vests do meet this definition of medical equipment. In addition, percussive vests have "A" and "E" HCPCS codes that are considered medical equipment and supplies (NOT orthotic "L" codes). We formally request that AHCCCS correctly classify percussive vests as medical equipment/ supplies and NOT orthotics. As stated earlier, the Arizona House Bill 2010 states that "durable medical equipment is limited to items covered by Medicare." Therefore, AHCCCS should continue to provide coverage of percussive vests for patients over the age of 21 years.*	
11.	Kathleen Crout Member	With the upcoming orthotics benefits being eliminated as proposed would be detrimental to my health. I have spina bifida, tethered spinal cord, neuropathy, also drop foot on the right foot and a prosthetic below the left knee and multiple other health issues. If I have to pay for orthotic repair supplies and braces along with what I currently pay for, it would be impossible. I need to stay mobile to maintain muscle tone to my lower extremities, if these coverages are taken away I will be in a wheelchair when something uncovered goes wrong and I cannot afford the necessary supplies I need. Being in a wheel chair for a prolonged time with my expensive health issues will cause a quicker deterioration in my condition. Spina bifida itself can and usually paralyze you from the waist down and put you on kidney dialysis. This concerns me as to which expense would be greater. As a non-emergency medical transportation for childless adults, or non ALTCS members. The time has come and I may need to utilize this benefit.	Repairs will continue to be covered. See the Frequently Asked Questions at: http://www.azahcccs.gov/reporting/Downloads/Legislation/2010seventh/BenefitChanges_FAQs.pdf In regard to non-emergency transportation, the Administration is awaiting approval from the federal government. Once additional information is received from the Center for Medicare and Medicaid Services, AHCCCS will notify the public, and the information will be posted on the AHCCCS web site.

		Do these decisions need to be made at the expense of people's quality of life and livelihood? Each one of us in our case is unique, but we all have in common is our health. I hope what I have touched will be carefully considered for all AHCCCS recipients.	
12.	Jena Freischmidt Member	I am concerned about why it says that specified transplants per HB2010, pancreas … liver for diagnosis of hepatitis C transplants, I am wondering why you are singling out hepatitis C transplants, my husband is 37 years old and has hepatitis C. I understand cuts have to be made and transplants are expensive, but people who need transplants are going to die, it is their last opportunity. If my husband receives a transplant he can go on a therapy that could clear his hepatitis C and he could be better for the rest of his life. I don't understand how you can cut out certain transplants; other things can be taken out.	The legislation identified the specific transplants that are excluded from AHCCCS coverage. These rules put into effect the requirements of HB 2010 as directed by the Legislature.
13.	Robert Lynch Attorney	Some of the regulatory proposal that you have here I cannot find in A.R.S. § 36-2907, specifically the lower limb microprocessor as an exclusion in rule. This does not fall in the list of the statute. And everything else is directly quoted from the statute. So I was curious about that.	State law A.R.S. § 36-2907 provides the AHCCCS Administration with the general authority to limit any service.
		What happens if the expected savings that you called out in this rule do not materialize? Do you have another rulemaking?	The legislation authorizes the AHCCCS Administration to engage in rulemaking to implement the provisions of the law. Therefore, additional rulemakings are an option available to the Agency.
		Will there be another rulemaking under subsection (B)(2)(b), in your discretionary authority? The authority to put a cap on prosthetics, but you decided to leave alone for now. It is not off the table, you're just leaving it alone for now?	You are correct that the Agency still has the authority to implement a cap on prosthetics.
		Tucson Office	
14.	Eric Burns Hanger Prosthetics and Orthotics	There are many studies related in the overall health care system, in regards to orthotic care, chronic conditions, traumatic conditions, and diabetes. These savings are reflected in the reduction of inpatient stays, reduction of long term care … etc. Are these considered when making decisions and changes?	The Agency does not have the discretion to override the legislative decision to exclude orthotics. Information from the AHCCCS Administration which was provided to the Legislature did take into consideration potential increases in other costs due to the elimination of coverage for orthotics.

15.	James Dustin Hanger Prosthetics and Orthotics	On page 26, section A line 8 it states that "orthotic is a device used for healing a weak or deformed body portion." Does this include an orthotic utilized to aid in the healing of fractures due to an injury and/or trauma, such as spinal brace for a spinal fracture, or halo for a cervical fracture? Phoenix Speaker added to this topic: We deal a lot with halo care and it is not something that ends in the hospital, patients are seen in our office to control costs. They are seen monthly if not biweekly to maintain the halo care to prevent ulcers, prevent any need for further surgical procedures. So halo care while maybe covered in the hospital, the codes that are accompanied in treating those patients afterward are done through orthotic coding. In eliminating that, then those patients are on their own in sense. That is not a device a person should be on their own with, you cannot function without help. Keep this in mind and in consideration.	Yes, although in some instances there are other options which are covered by AHCCCS. For example, instead of a spinal brace or walking boot, a cast (which is not considered an orthotic) may be used. An orthotic, including a halo, that is provided as part of an inpatient stay is reimbursed by AHCCCS as part of the inpatient tier per diem payment.
16.	Holly Tuchscherer Hanger Prosthetics and Orthotics	All the care that is preventative care, such as orthotic care diabetic shoes, which are in the A codes, are they still covered? And the diabetic shoe inserts which are A5513, A5512 are they covered? Written comment received 6/22/10: It appears from what is written in the rule that only the physical therapy area has been analyzed before limitations were made. It is concerning that no other areas of eliminated benefits have been analyzed to determine the elimination or limited benefits. It would be beneficial to consider the long-term effects of eliminating orthotic and assistive device coverage for the AHCCCS patients …. There are many scientific studies ….	Diabetic shoes are not orthotics. They are in the A code section as a medical supply. The exclusion for orthotics refers to those items described with an L codes, up to L4999. Yes, the inserts are covered since items described by A codes are not considered orthotics. The Agency does not have the discretion to override the legislative decision to exclude orthotics. Information from the AHCCCS Administration which was provided to the Legislature did take into consideration potential increases in other costs due to the elimination of coverage for orthotics.

17.	Beth Horowitz	Did you look at other ways to deal with cost savings, for example …. 1. In France it would be one third of the costs, significantly cheaper than our medical services, and yet the best by using a card, all the medical records is on this card. This would cut back on billing costs. The savings could go to the patient. 2. Organ transplants can we make it an opt-out system rather than opt-in system to be an organ donor. Then the supply would increase and the cost decrease. 3. Take the profit out of the system. Anyone participating in the system by a certain time has to become a not for profit organization. 4. Have you thought of expanding rather than limiting coverage … the system would pay for itself. Many small business owners cannot get health care coverage, this is detrimental. Expanding the coverage, increase the number of people in the program and have them paying for the program, then the system would pay for itself. Have you considered any of those options?	The purpose of this rule is to implement statutory limitations, including the elimination of certain services. The suggestions that have been made are beyond the scope of this rulemaking.
		Flagstaff Office	
18.	Jim McCalmont Hanger Orthotics and Prosthetics	You said you would cover A codes for diabetics but not L codes, by cutting out the L5000 how does that save you money?	The only A codes devices that are appropriate for the treatment of diabetes are shoes and inserts. Orthotics described by L codes are not covered for diabetic members or any other AHCCCS members. These exclusions result in savings to the AHCCCS Program.
		Tucson Office	
19.	Eric Burns	What other areas are you looking at cutting?	Costs for the AHCCCS Program are from three main areas: the number of members served, the scope of benefits which are provided, and the payment made for these services. The federal health care reform law prohibits the Agency from eliminating covered populations. Therefore, to maximize cost savings while ensuring compliance with federal and state law, the AHCCCS Administration considered measures that would achieve cost savings in an equitable fashion. It has reduced covered services, and it has proposed additional rate reductions for all providers, including physicians, hospitals, and nursing homes. Although AHCCCS recognizes the significant burdens associated with these decisions, it believes that it has achieved the best balance possible given the legal requirements.

Written Comment			
20.	James Haynes AZ Hospital and Healthcare Association	We wish to bring to the Administration's attention that we received last month after passage of the FY2011 budget, information from transplant physicians regarding the impact of eliminating certain transplant coverage from the benefit package and the cost-efficiency of transplant coverage as referenced in recent scientific literature. This information raises doubt about the cost effectiveness and impact of eliminating the following transplant services for AHCCCS patients 21 years of age or older: 1. Heart Transplantation for Non-Ischemic Cardiomyopathy; 2 Lung Transplantation; 3. Pancreas – only and Pancreas after Kidney Transplantation; and 4. Liver Transplantation for Patients with hepatitis C. For example, the letter raises concerns that some of the data used to substantiate elimination of these services is outdated. New treatment modalities have dramatically increased survival rates in certain transplant patients. Without receiving transplant services, several patients on the wait list will likely develop secondary complications leading to multiple hospital admissions. Also encouraging AHCCCS Administration to collaborate with the transplant community in an effort to find alternative cost savings in the transplant benefit rather than eliminating the aforementioned benefits. AzHHA urges the Administration to reexamine the scientific literature that informed the earlier recommendation to eliminate certain heart, lung, pancreas, and liver transplant benefits, and bring forth new recommendations as appropriate.	The Agency does not have the discretion to override the legislative directive to exclude certain transplant types. The Az Hospital and Healthcare Association may wish to share this information with the Legislature.

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

Not applicable

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

None

14. Was this rule previously made as an emergency rule? If so, please indicate the *Register* citation:

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 2. SCOPE OF SERVICES

Section
R9-22-201. Scope of Services-related Definitions
R9-22-202. General Requirements
R9-22-203. ~~Repealed~~ Experimental Services
R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services
R9-22-206. Organ and Tissue Transplant Services
R9-22-207. Dental Services
R9-22-212. Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies
R9-22-215. Other Medical Professional 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" R9-22-701
"Act" R9-22-101
"ADHS" R9-22-101
"Administration" A.R.S. § 36-2901
"Adverse action" R9-22-101
"Affiliated corporate organization" R9-22-101
"Aged" 42 U.S.C. 1382c(a)(1)(A) and R9-22-1501
"Aggregate" R9-22-701
"AHCCCS" R9-22-101
"AHCCCS inpatient hospital day or days of care" R9-22-701
"AHCCCS registered provider" R9-22-101
"Ambulance" A.R.S. § 36-2201
"Ancillary department" R9-22-701
"Ancillary service" R9-22-701
"Anticipatory guidance" R9-22-201
"Annual enrollment choice" R9-22-1701
"APC" R9-22-701
"Appellant" R9-22-101
"Applicant" R9-22-101
"Application" R9-22-101
"Assessment" R9-22-1101
"Assignment" R9-22-101
"Attending physician" R9-22-101
"Authorized representative" R9-22-101
"Authorization" R9-22-201
"Auto-assignment algorithm" R9-22-1701
"AZ-NBCCEDP" R9-22-2001
"Baby Arizona" R9-22-1401
"Behavior management services" R9-22-1201
"Behavioral health adult therapeutic home" R9-22-1201
"Behavioral health therapeutic home care services" R9-22-1201
"Behavioral health evaluation" R9-22-1201
"Behavioral health medical practitioner" R9-22-1201
"Behavioral health professional" A.A.C. R9-20-1201

"Behavioral health recipient" R9-22-201
"Behavioral health service" R9-22-1201
"Behavioral health technician" A.A.C. R9-20-1201
"BHS" R9-22-1401
"Billed charges" R9-22-701
"Blind" R9-22-1501
"Burial plot" R9-22-1401
"Business agent" R9-22-701 and R9-22-704
"Calculated inpatient costs" R9-22-712.07
"Capital costs" R9-22-701
"Capped fee-for-service" R9-22-101
"Caretaker relative" R9-22-1401
"Case management" R9-22-1201
"Case record" R9-22-101
"Case review" R9-22-101
"Cash assistance" R9-22-1401
"Categorically eligible" R9-22-101
"CCR" R9-22-712
"Certified psychiatric nurse practitioner" R9-22-1201
"Charge master" R9-22-712
"Child" R9-22-1503 and R9-22-1603
"Children's Rehabilitative Services" or "CRS" R9-22-201
"Claim" R9-22-1101
"Claims paid amount" R9-22-712.07
"Clean claim" A.R.S. § 36-2904
"Clinical supervision" R9-22-201
"CMDP" R9-22-1701
"CMS" R9-22-101
"Continuous stay" R9-22-101
"Contract" R9-22-101
"Contract year" R9-22-101
"Contractor" A.R.S. § 36-2901
"Copayment" R9-22-701, R9-22-711 and R9-22-1603
"Cost avoid" R9-22-1201
"Cost-To-Charge Ratio" R9-22-701
"Covered charges" R9-22-701
"Covered services" R9-22-101
"CPT" R9-22-701
"Creditable coverage" R9-22-2003 and 42 U.S.C. 300gg(c)
"Critical Access Hospital" R9-22-701
"CRS" R9-22-1401
"Cryotherapy" R9-22-2001
"Customized DME" R9-22-212
"Day" R9-22-101 and R9-22-1101
"Date of the Notice of Adverse Action" R9-22-1441
"DBHS" R9-22-201
"DCSE" R9-22-1401

"De novo hearing" 42 CFR 431.201
"Dentures" and "Denture services" R9-22-201
"Department" A.R.S. § 36-2901
"Dependent child" A.R.S. § 46-101
"DES" R9-22-101
"Diagnostic services" R9-22-101
"Director" R9-22-101
"Disabled" R9-22-1501
"Discussion" R9-22-101
"Disenrollment" R9-22-1701
"DME" R9-22-101
"DRI inflation factor" R9-22-701
"E.P.S.D.T. services" 42 CFR 440.40(b)
"Eligibility posting" R9-22-701
"Eligible person" A.R.S. § 36-2901
"Emergency behavioral health condition for the non-FES member" R9-22-201
"Emergency behavioral health services for the non-FES member" R9-22-201
"Emergency medical condition for the non-FES member" R9-22-201
"Emergency medical services for the non-FES member" R9-22-201
"Emergency medical or behavioral health condition for a FES member" R9-22-217
"Emergency services costs" A.R.S. § 36-2903.07
"Encounter" R9-22-701
"Enrollment" R9-22-1701
"Enumeration" R9-22-101
"Equity" R9-22-101
"Experimental services" ~~R9-22-101~~ R9-22-203
"Existing outpatient service" R9-22-701
"Expansion funds" R9-22-701
"FAA" R9-22-1401
"Facility" R9-22-101
"Factor" R9-22-701 and 42 CFR 447.10
"FBR" R9-22-101
"Federal financial participation" or "FFP" 42 CFR 400.203
"Federal poverty level" or "FPL" A.R.S. § 36-2981
"Fee-For-Service" or "FFS" R9-22-101
"FES member" R9-22-101
"FESP" R9-22-101
"First-party liability" R9-22-1001
"File" R9-22-1101
"Fiscal agent" R9-22-210
"Fiscal intermediary" R9-22-701
"Foster care maintenance payment" 42 U.S.C. 675(4)(A)
"FQHC" R9-22-101
"Free Standing Children's Hospital" R9-22-701
"Fund" R9-22-712.07
"Graduate medical education (GME) program" R9-22-701
"Grievance" A.A.C. R9-34-202

"GSA" R9-22-101
"HCPCS" R9-22-701
"Health care practitioner" R9-22-1201
"Hearing aid" R9-22-201
"HIPAA" R9-22-701
"Home health services" R9-22-201
"Homebound" R9-22-1401
"Hospital" R9-22-101
"In-kind income" R9-22-1420
"Insured entity" R9-22-720
"Intermediate Care Facility for the Mentally Retarded" or "ICF-MR" 42 ~~USC~~ U.S.C. 1396d(d)
"ICU" R9-22-701
"IHS" R9-22-101
"IHS enrolled" or "enrolled with IHS" R9-22-708
"IMD" or "Institution for Mental Diseases" 42 CFR 435.1010 and R9-22-201
"Income" R9-22-1401 and R9-22-1603
"Indigent" R9-22-1401
"Individual" R9-22-211
"Inmate of a public institution" 42 CFR 435.1010
"Inpatient covered charges" R9-22-712.07
"Interested party" R9-22-101
"Intermediate Care Facility for the Mentally Retarded" or "ICF-MR" 42 U.S.C. 1396d(d)
"Intern and Resident Information System" R9-22-701
"LEEP" R9-22-2001
"Legal representative" R9-22-101
"Level I trauma center" R9-22-2101
"License" or "licensure" R9-22-101
"Licensee" R9-22-1201
"Liquid assets" R9-22-1401
"Mailing date" R9-22-101
"Medical education costs" R9-22-701
"Medical expense deduction" or "MED" R9-22-1401
"Medical record" R9-22-101
"Medical review" R9-22-701
"Medical services" A.R.S. § 36-401
"Medical supplies" R9-22-201
"Medical support" R9-22-1401
"Medically necessary" R9-22-101
"Medicare claim" R9-22-101
"Medicare HMO" R9-22-101
"Member" A.R.S. § 36-2901
"Mental disorder" A.R.S. § 36-501
"Milliman study" R9-22-712.07
"Monthly equivalent" R9-22-1421 and R9-22-1603
"Monthly income" R9-22-1421 and R9-22-1603
"National Standard code sets" R9-22-701
"New hospital" R9-22-701

"NICU" R9-22-701
"Noncontracted Hospital" R9-22-718
"Noncontracting provider" A.R.S. § 36-2901
"Non-FES member" R9-22-201
"Non-IHS Acute Hospital" R9-22-701
"Nonparent caretaker relative" R9-22-1401
"Notice of Findings" R9-22-109
"Nursing facility" or "NF" 42 U.S.C. 1396r(a)
"OBHL" R9-22-1201
"Observation day" R9-22-701
"Occupational therapy" R9-22-201
"Offeror" R9-22-101
"Operating costs" R9-22-701
"Organized health care delivery system" R9-22-701
"Outlier" R9-22-701
"Outpatient hospital service" R9-22-701
"Ownership change" R9-22-701
"Ownership interest" 42 CFR 455.101
"Parent" R9-22-1603
"Partial Care" R9-22-1201
"Participating institution" R9-22-701
"Peer group" R9-22-701
"Peer-reviewed study" R9-22-2001
"Penalty" R9-22-1101
"Pharmaceutical service" R9-22-201
"Physical therapy" R9-22-201
"Physician" R9-22-101
"Physician assistant" R9-22-1201
"Post-stabilization services" R9-22-201 or 42 CFR 422.113
"PPC" R9-22-701
"PPS bed" R9-22-701
"Practitioner" R9-22-101
"Pre-enrollment process" R9-22-1401
"Premium" R9-22-1603
"Prescription" R9-22-101
"Primary care provider or "PCP" R9-22-101
"Primary care provider services" R9-22-201
"Prior authorization" R9-22-101
"Prior period coverage" or "PPC" R9-22-701
"Procedure code" R9-22-701
"Proposal" R9-22-101
"Prospective rates" R9-22-701
"Psychiatrist" R9-22-1201
"Psychologist" R9-22-1201
"Psychosocial rehabilitation services" R9-22-201
"Public hospital" R9-22-701
"Qualified alien" A.R.S. § 36-2903.03

"Qualified behavioral health service provider" R9-22-1201
"Quality management" R9-22-501
"Radiology" R9-22-101
"RBHA" or "Regional Behavioral Health Authority" R9-22-201
"Reason to know" R9-22-1101
"Rebase" R9-22-701
"Referral" R9-22-101
"Rehabilitation services" R9-22-101
"Reinsurance" R9-22-701
"Remittance advice" R9-22-701
"Resident" R9-22-701
"Residual functional deficit" R9-22-201
"Resources" R9-22-1401
"Respiratory therapy" R9-22-201
"Respite" R9-22-1201
"Responsible offeror" R9-22-101
"Responsive offeror" R9-22-101
"Revenue Code" R9-22-701
"Review" R9-22-101
"Review month" R9-22-101
"RFP" R9-22-101
"Rural Contractor" R9-22-718
"Rural Hospital" R9-22-712.07 and R9-22-718
"Scope of services" R9-22-201
"Section 1115 Waiver" A.R.S. § 36-2901
"Service location" R9-22-101
"Service site" R9-22-101
"SOBRA" R9-22-101
"Specialist" R9-22-101
"Specialty facility" R9-22-701
"Speech therapy" R9-22-201
"Spendthrift restriction" R9-22-1401
"Sponsor" R9-22-1401
"Sponsor deemed income" R9-22-1401
"Sponsoring institution" R9-22-701
"Spouse" R9-22-101
"SSA" 42 CFR 1000.10
"SSDI Temporary Medical Coverage" R9-22-1603
"SSI" 42 CFR 435.4
"SSN" R9-22-101
"Stabilize" 42 U.S.C. 1395dd
"Standard of care" R9-22-101
"Sterilization" R9-22-201
"Subcontract" R9-22-101
"Submitted" A.R.S. § 36-2904
"Substance abuse" R9-22-201
"SVES" R9-22-1401

"Therapeutic foster care services" R9-22-1201

"Third-party" R9-22-1001

"Third-party liability" R9-22-1001

"Tier" R9-22-701

"Tiered per diem" R9-22-701

"Title IV-D" R9-22-1401

"Title IV-E" R9-22-1401

"Total Inpatient payments" R9-22-712.07

"Trauma and Emergency Services Fund" A.R.S. § 36-2903.07

"TRBHA" or "Tribal Regional Behavioral Health Authority" R9-22-1201

"Treatment" R9-22-2004

"Tribal Facility" A.R.S. § 36-2981

"Unrecovered trauma center readiness costs" R9-22-2101

"Urban Contractor" R9-22-718

"Urban Hospital" R9-22-718

"USCIS" R9-22-1401

"Utilization management" R9-22-501

"WWHP" R9-22-2001

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:

"Act" means the Social Security Act.

"ADHS" means the Arizona Department of Health Services.

"Adverse action" means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

"Affiliated corporate organization" means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation.

"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 covered services.

"Appellant" means an applicant or member who is appealing an adverse action by the Department or Administration.

"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.

"Authorized representative" means a person who is authorized to apply for medical assistance or act on behalf of another person.

"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 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.

"Case record" means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.

"Case review" means the Administration's evaluation of an individual's or family's circumstances and case record in a review month.

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

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

"Continuous stay" means a 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.

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

"Covered services" means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.

"Day" means a calendar day unless otherwise specified.

"DES" means the Department of Economic Security.

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

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

"Discussion" means an oral or written exchange of information or any form of negotiation.

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

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

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

~~"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 the 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 peer-reviewed 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.~~

"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.

"Fee-For-Service" or "FFS" means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a member not enrolled with a contractor.

"FES member" means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.

"FESP" means the federal emergency services program under R9-22-217 which covers services to treat an emergency medical or behavioral health 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 the 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.

"IHS" means Indian Health Service.

"Interested party" means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.

"Legal representative" means a custodial parent of a child under 18, a guardian, or a conservator.

"License" or "licensure" means a nontransferable authorization that is granted based on established standards in law

by a state or a county regulatory agency or board and allows a health care provider to lawfully render a health care service.

"Mailing date" when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered as the date on the document, if there is no legible postmark or postage meter mark.

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

"Medically necessary" means a covered service is 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 to prolong life.

"Medicare claim" means a claim for Medicare-covered services for a member with Medicare coverage.

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

"Offeror" means an individual or entity that submits a proposal to the Administration in response to an RFP.

"Physician" means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

"Practitioner" means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a registered nurse practitioner certified under A.R.S. Title 32, Chapter 15.

"Prescription" means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.

"Primary care provider" or "PCP" means an individual who meets the requirements of A.R.S. § 36-2901(12) or (13), and who is responsible for the management of a member's health care.

"Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services contingent on the medical necessity of the services.

"Prior period coverage" means the period prior to the member's enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, whichever is later, and continues until the day the member is enrolled with a contractor.

"Proposal" means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

"Radiology" means professional and technical services rendered to provide medical imaging, radiation oncology, and radioisotope services.

"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.

"Rehabilitation services" means physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level.

"Responsible offeror" means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

"Responsive offeror" means an individual or entity that submits a proposal that conforms in all material respects to an RFP.

"Review" means a review of all factors affecting a member's eligibility.

"Review month" means the month in which the individual's or family's circumstances and case record are reviewed.

"RFP" means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

"Service location" means a location at which a member obtains a covered 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 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).

"Specialist" means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

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

"SSN" means Social Security number.

"Standard of care" means a medical procedure or process that is accepted as treatment for a specific illness, injury, or 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 that agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

ARTICLE 2. SCOPE OF SERVICES

R9-22-201. Scope of Services-related Definitions

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

"Anticipatory guidance" means a person responsible for a child receives information and guidance of what the person should expect of the child's development and how to help the child stay healthy.

"Behavioral health recipient" means a Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS/DBHS.

"Children's Rehabilitative Services" or "CRS" means the program within ADHS that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.

"Clinical supervision" means a Clinical Supervisor under 9 A.A.C. 20, Article 2 reviews the skills and knowledge of the individual supervised and provides guidance in improving or developing the skills and knowledge.

"DBHS" means the Division of Behavioral Health Services within the Arizona Department of Health Services.

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

"Emergency behavioral health condition for the non-FES member" means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

Placing the health of the person, including mental health, in serious jeopardy;

Serious impairment to bodily functions;

Serious dysfunction of any bodily organ or part; or

Serious physical harm to another person.

"Emergency behavioral health services for the non-FES member" means those behavioral health services provided for the treatment of an emergency behavioral health condition.

"Emergency medical condition for the non-FES member" means treatment for a medical condition, including labor and delivery, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

Placing the member's health in serious jeopardy,

Serious impairment to bodily functions, or

Serious dysfunction of any bodily organ or part.

"Emergency medical services for the non-FES member" means services provided for the treatment of an emergency medical condition.

"Hearing aid" means an instrument or device designed for, or represented by the supplier as aiding or compensating for impaired or defective human hearing, and includes any parts, attachments, or accessories of the instrument or device.

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

"IMD" or "Institution for Mental Diseases" means an Institution for Mental Diseases as described in 42 CFR 435.1010 and licensed by ADHS.

"Medical supplies" means consumable items that are designed specifically to meet a medical purpose.

"Non-FES member" means an eligible person who is entitled to full AHCCCS services.

"Occupational therapy" means medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual's ability to perform tasks required for independent functioning.

"Pharmaceutical service" means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.

"Physical therapy" means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.

"Post-stabilization services" means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.

"Primary care provider services" means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.

"Psychosocial rehabilitation services" means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:

Living skills training,

Cognitive rehabilitation,

Health promotion,

Supported employment, and

Other services that increase social and communication skills to maximize a member's ability to participate in the community and function independently.

"RBHA" or "Regional Behavioral Health Authority" means the same as in A.R.S. § 36-3401.

"Residual functional deficit" means a member's inability to return to a previous level of functioning, usually after experiencing a severe psychotic break or state of decompensation.

"Respiratory therapy" means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.

"Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

"Speech therapy" means medically prescribed diagnostic and treatment services provided by or under the supervision of a certified speech therapist.

"Sterilization" means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:

Prevent the progression of disease, disability, or adverse health conditions; or

Prolong life and promote physical health.

"Substance abuse" means the chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are 21 years of age or older.

R9-22-202. General Requirements

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

B. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:
1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
2. Covered services for the federal emergency services program (FESP) are under R9-22-217.

3. The Administration or a contractor may waive the covered services referral requirements of this Article.
4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
6. A member may receive behavioral health evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from the primary care provider or upon authorization by the contractor or the contractor's designee.
~~7. A member may receive treatment that is considered the standard of care or that is approved by the AHCCCS Chief Medical Officer after appropriate input from providers who are considered experts in the field by the professional medical community.~~
~~8.~~7. AHCCCS or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
~~9.~~8. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
~~10.~~9. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
   a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
   b. Services or items furnished gratuitously, and
   c. Personal care items except as specified under R9-22-212.
~~11.~~10. Medical or behavioral health services are not covered services if provided to:
   a. An inmate of a public institution;
   b. A person who is in residence at an institution for the treatment of tuberculosis; or
   c. A person age 21 through 64 who is in an IMD, unless the service is covered under Article 12 of this Chapter.

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

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

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

F. A service is not a covered service if provided outside the GSA unless one of the following applies:
1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;
2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family;
3. The contractor authorizes placement in a nursing facility located out of the GSA; or
4. Services are provided during prior period coverage.

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

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

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

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

K. Subject to CMS approval, the restrictions, limitations, and exclusions specified in the following subsections do not apply to American Indians receiving services through IHS or a tribal health program operating under P.L. 93-638 when those services are eligible for 100 percent federal financial participation:
1. R9-22-205(A)(8),

2. R9-22-205(B)(4)(f),
3. R9-22-206,
4. R9-22-207,
5. R9-22-212(C),
6. R9-22-212(D),
7. R9-22-212(E)(8),
8. R9-22-215(C)(2),
9. R9-22-215(C)(5).

R9-22-203. ~~Repealed~~ Experimental Services

A. Experimental services are not covered. A service is not experimental if:
1. It is generally and widely accepted as a standard of care in the practice of medicine in the United States and is a safe and effective treatment for the condition for which it is intended or used.
2. The service does not meet the standard in subsection (A)(1), but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of the evidence in peer-reviewed articles in medical journals published in the United States.
3. The service does not meet the standard in subsection (A)(2) because the condition for which the service is intended or used is rare, but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of opinions from specialists who provide the service or related services.

B. The following factors shall be considered when evaluating the weight of peer-reviewed articles or the opinions of specialists:
1. The mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services.
2. The types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services.
3. The frequency with which the service has been performed in the past.
4. Whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits.
5. The reputation and experience of the authors and/or specialists and their record in related areas.
6. The extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future.
7. Whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study.

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

A. A primary care provider, attending physician, or practitioner shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:
1. Periodic health examination and assessment;
2. Evaluation and diagnostic workup;
3. Medically necessary treatment;
4. Prescriptions for medication and medically necessary supplies and equipment;
5. Referral to a specialist or other health care professional if medically necessary;
6. Patient education;
7. Home visits if medically necessary; and
8. ~~Covered immunizations; and~~
9. ~~Covered preventive~~ Except as provided in subsection (B), preventive health services, such as, immunizations, colonoscopies, mammograms and PAP smears.

B. The following limitations and exclusions apply to attending physician and practitioner services and primary care provider services:
1. Specialty care and other services provided to a member upon referral from a primary care provider, or to a member upon referral from the attending physician or practitioner are limited to the service or condition for which the referral is made, or for which authorization is given by the Administration or a contractor.
2. A member's physical examination is not covered if the sole purpose is to obtain documentation for one or more of the following:
   a. Qualification for insurance;
   b. Pre-employment physical evaluation;
   c. Qualification for sports or physical exercise activities;
   d. Pilot's examination for the Federal Aviation Administration;
   e. Disability certification to establish any kind of periodic payments;
   f. Evaluation to establish third-party liabilities; or
   g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in sub-

section (A).

3. Orthognathic surgery is covered only for a member who is less than 21 years of age;
4. The following services are excluded from AHCCCS coverage:
   a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgeries;
   b. Pregnancy termination counseling services;
   c. ~~For federally funded programs, pregnancy~~ Pregnancy terminations, unless required by state or federal law.
   d. Services or items furnished solely for cosmetic purposes; ~~and~~
   e. Hysterectomies unless determined medically necessary~~.~~; and
   f. Preventive services not covered are well exams, meaning physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination.

R9-22-206. Organ and Tissue Transplant Services

A. Organ and tissue transplant services are covered for a member if prior authorized and coordinated with the member's contractor, or the Administration. The following transplants are covered for individuals 21 years of age or older:
1. Heart~~;~~,
2. Liver~~;~~,
3. Kidney (cadaveric and live donor)~~;~~,
4. Simultaneous Pancreas/Kidney (SPK)~~;~~,
5. Autologous and Allogeneic related Hematopoietic Cell transplants~~;~~,
6. Cornea~~;~~, and
7. Bone.

~~**B.** Pancreas transplants are not covered for individuals 21 years of age or older if it is not performed simultaneously with a kidney transplant (pancreas only transplants). Partial pancreas transplants and autologous and allogeneic pancreas islet cell transplants are not covered even if performed simultaneously with a kidney transplant.~~

B. The following transplants are not covered for members 21 years of age or older:
1. Heart transplants for non-ischemic cardiomyopathy,
2. Liver transplants for members with a diagnosis of hepatitis C,
3. Pancreas only transplants if it is not performed simultaneously with a kidney transplant. Partial pancreas transplants and autologous and allogeneic pancreas islet cell transplants are not covered even if performed simultaneously with a kidney transplant,
4. Pancreas transplants after a kidney transplant,
5. Lung transplants,
6. Allogeneic unrelated Hematopoietic Cell transplants,
7. Intestine transplants, and
8. Any other type of transplant not specifically listed in subsection (A).

~~**C.** Organ and tissue transplant services are not covered for qualified aliens or noncitizens members of FESP under A.R.S. § 36-2903.03(D).~~

C. When there is a transplant of multiple organs, reimbursement will only be made for those covered.

D. Organ and tissue transplant services are not covered for qualified aliens or noncitizens members of FESP under A.R.S. § 36-2903.03(D).

R9-22-207. Dental Services

A. The Administration or a contractor shall cover dental services for a member less than 21 years of age under R9-22-213.

~~**B.** The Administration or a contractor shall cover the following emergency dental care services:~~
~~1. Oral diagnostic examination including laboratory and radiographs if necessary to determine an emergency medical condition;~~
~~2. Immediate and palliative procedures, including extractions if medically necessary, for relief of severe pain associated with an oral or maxillofacial condition;~~
~~3. Initial treatment for acute infection;~~
~~4. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone, or soft tissue;~~
~~5. Preoperative procedures; and~~
~~6. Anesthesia appropriate for optimal patient management.~~

B. For individuals age 21 years of age or older, the Administration or a contractor shall cover medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician.
1. Except as specified in subsection (C). such services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. Covered dental services include examination of the oral cavity, radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate level of anesthesia and the prescription of pain medication and antibiotics.

2. Such services do not include services that physicians are not generally competent to perform such as dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.

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

C. For the purposes of this subsection, simple restorations means silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns. In addition, dental services for an individual 21 years of age or older include:

1. The elimination of oral infections and the treatment of oral disease, which includes dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations as a medically necessary pre-requisite to covered transplantation; and
2. Prophylactic extraction of teeth in preparation for covered radiation treatment of cancer of the jaw, neck or head.

~~D. The following limitations apply to dentures:~~

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

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

~~1. Treatment for the prevention of pulpal death and imminent tooth loss is covered only for non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection. Root canals are covered only to treat active infection or to eliminate pain;~~
~~2. Routine restorative procedures and routine root canal therapy are not emergency services and are not covered;~~
~~3. Radiographs are covered only for symptomatic teeth for use as a diagnostic tool preceding treatment and to support the need for, and provision of, dentures;~~
~~4. Maxillofacial dental services provided by a dentist are not covered unless prescribed for the reduction of trauma, including reconstruction of regions of the maxillae and mandible; and~~
~~5. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.~~

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

~~1. Provision of medically necessary dentures;~~
~~2. Replacement, repair, or adjustment to dentures; and~~
~~3. Provision of obturators or other prosthetic appliances for restoration or rehabilitation.~~

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

A. Durable medical equipment, orthotic and prosthetic devices, and medical supplies, including incontinence briefs as specified in subsection (E), are covered services to the extent permitted in this Section if provided in compliance with requirements of this Chapter~~,~~; and~~:~~

1. Prescribed by the primary care provider, attending physician, or practitioner~~, or dentist~~; or
2. Prescribed by a specialist upon referral from the primary care provider, attending physician, or practitioner~~, or dentist~~; and
3. Authorized as required by the Administration, contractor, or contractor's designee.

B. Covered medical supplies are consumable items that are designed specifically to meet a medical purpose, are disposable, and are essential for the member's health.

C. Covered DME is any item, appliance, or piece of equipment that is not a prosthetic or orthotic; and~~:~~

1. ~~Designed~~ Is designed for a medical purpose, and is generally not useful to a person in the absence of an illness or injury, and
2. ~~Designed to withstand wear~~ Can withstand repeated use, and
3. ~~Generally~~ Is generally reusable by others~~, and~~.
4. ~~Purchased or rented for a member.~~

~~D. Covered prosthetic and orthotic devices are only those items that are essential for the habilitation or rehabilitation of a member.~~

D. Prosthetics are devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed or malfunctioning portion of the body. Only those prosthetics that are medically necessary for rehabilitation are covered, except as otherwise provided in R9-22-215.

E. The following limitations on coverage apply:

1. The DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased.
2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair or adjustment is less than the cost of renting or purchasing another unit.

3. A change in, or addition to, an original order for DME is covered if approved by the prescriber in subsection (A), or prior authorized by the Administration or contractor, and the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for DME may be made after a claim for services is submitted to the member's contractor, or the Administration, without prior written notification of the change or addition to the Administration or the contractor.
4. Reimbursement for rental fees shall terminate:
   a. No later than the end of the month in which the prescriber in subsection (A) certifies that the member no longer needs the DME;
   b. If the member is no longer eligible for AHCCCS services; or
   c. If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified in R9-22-509.
5. Except for incontinence briefs for persons over 3 years old and under 21 years old as provided in subsection ~~(6)~~ (E)(6), personal care items including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition. Personal care items are not covered services if used solely for preventive purposes.
6. Incontinence briefs, including pull-ups are covered to prevent skin breakdown and enable participation in social, community, therapeutic and educational activities under the following circumstances:
   a. The member is over 3 years old and under 21 years old;
   b. The member is incontinent due to a documented disability that causes incontinence of bowel or bladder, or both;
   c. The PCP or attending physician has issued a prescription ordering the incontinence briefs;
   d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder;
   e. The member obtains incontinence briefs from providers in the contractor's network;
   f. Prior authorization has been obtained as required by the Administration, contractor, or contractor's designee. Contractors may require a new prior authorization to be issued no more frequently than every 12 months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. Prior authorization will be permitted to ascertain that:
      i. The member is over age 3 and under age 21;
      ii. The member has a disability that causes incontinence of bladder or bowel, or both;
      iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the contractor; and
      iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.
7. First aid supplies are not covered unless they are provided in accordance with a prescription.
8. ~~Hearing aids are not covered for a member who is age 21 or older.~~
9. ~~Prescriptive lenses are not covered for a member who is age 21 or older unless they are the sole visual prosthetic device used by the member after a cataract extraction.~~
8. The following services are not covered for individuals 21 years of age or older:
   a. Hearing aids;
   b. Prescriptive lenses unless they are the sole visual prosthetic device used by the member after a cataract extraction;
   c. Bone Anchor Hearing Aid (BAHA);
   d. Cochlear implant;
   e. Percussive vest;
   f. Insulin pump;
   g. Microprocesser-controlled lower limbs or microprocessor-controlled joints for lower limbs; and
   h. Orthotics, which are defined as devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body.

F. Liability and ownership.
1. Purchased DME that is provided to a member and no longer needed by the member may be disposed of in accordance with each contractor's policy.
2. The Administration shall retain title to purchased DME provided to a member who becomes ineligible or no longer requires use of the DME.
3. If customized DME is purchased by the Administration or contractor for a member, the equipment shall remain with the person during times of transition to a different contractor, or upon loss of eligibility. For purposes of this subsection, customized DME refers to equipment that is altered or built to specifications unique to a member's medical

needs and that, most likely, cannot be used or reused to meet the needs of another individual.
4. A member shall return DME obtained fraudulently to the Administration or the contractor.

R9-22-215. Other Medical Professional Services

A. The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office setting as follows:
1. Dialysis;
2. The following family planning services if provided to delay or prevent pregnancy:
   a. Medications~~;~~,
   b. Supplies~~;~~,
   c. Devices~~;~~, and
   d. Surgical procedures.
3. Family planning services are limited to:
   a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
   b. Sterilization; and
   c. Natural family planning education or referral;
4. Midwifery services provided by a certified nurse practitioner in midwifery;
5. Midwifery services for low-risk pregnancies and home deliveries provided by a licensed midwife;
~~6. Podiatry services when ordered by a member's primary care provider, attending physician, or practitioner;~~
~~7.~~6. Respiratory therapy;
~~8.~~7. Ambulatory and outpatient surgery facilities services;
~~9.~~8. Home health services under A.R.S. § 36-2907(D);
~~10.~~9. Private or special duty nursing services when medically necessary and prior authorized;
~~11.~~10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
~~12.~~11. Total parenteral nutrition services, which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract;
~~13.~~12. Inpatient chemotherapy; and
~~14.~~13. Outpatient chemotherapy.

B. Prior authorization from the Administration for a member is required for services listed in subsections (A)(4) through ~~(12)~~ (11).

C. The following services are excluded as covered services:
1. Occupational and speech therapies provided on an outpatient basis for a member age 21 or older;
2. Physical therapy provided only as a maintenance regimen;
3. Abortion counseling; ~~or~~
4. Services or items furnished solely for cosmetic purposes~~.~~;
5. Services provided by a podiatrist; or
6. More than 15 outpatient physical therapy visits per contract year with the exception of the required Medicare coinsurance and deductible payment as described in 9 A.A.C. 29, Article 3.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

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

Editor's Note: The following Notice of Exempt Rulemaking is exempt from Laws 2010, Ch. 287, § 18. (See the text of § 18 on page 1679.)

[R10-117]

PREAMBLE

1. Sections Affected — **Rulemaking Action**
R9-28-206 — 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. § 36-2907

Implementing statute: A.R.S. § 36-2907, as amended by HB2010, 49th Legislature, 7th Special Session 2010

3. The proposed effective date of the rules:

October 1, 2010

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

None

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

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Administrative and Legal Services 701 E. Jefferson St., 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 reasons for initiating the rule, including the statutory citation to the exemption from regular rulemaking procedures:

The AHCCCS Administration is proposing rule changes to delineate the service limitations/ exclusions as described in HB2010, 49th Legislature, 7th Special Session of 2010.

The AHCCCS Administration is exempt from the rulemaking requirements of A.R.S. Title 41, Chapter 6, as described in HB2010, 49th Legislature, 7th Special Session of 2010, § 34.

7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to 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 relied upon for the implementation of this rulemaking, but analysis of the outpatient physical therapy services reported through claims and encounters as having provided these services during CY 2009, has assisted the AHCCCS Administration in arriving at the limitation amount of covered outpatient physical therapy services of 15 visits, which represents that the limitation does not affect 85% of members receiving outpatient physical therapy services.

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 Administration estimates that approximately 183,380 members may be impacted by the proposed limitations/ exclusions of services as described in HB2010, 49th Legislature, 7th Special Session of 2010.

Based on the utilization of each type of service during the contract year (CY) 2009 the Administration foresees an approximate savings of $24,024,650 per CY. In addition, the limitation applied to outpatient physical therapy services the Administration foresees an approximate savings of $2,900,000 per CY for members 21 years of age and over.

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

Not applicable

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

The following matrix outlines the comments received as of June 22, 2010 in regards to the Adult Benefit limitations and eliminations as described in A.R.S. § 36-2907, amended by HB2010, 49th Legislature, 7th Special Session 2010.

There were 30 attendees at a public hearing held simultaneously at three locations in Arizona. Of the 30 attendees, 14 attendees commented on the proposed rulemaking and some submitted their comments in writing as well. One commenter did not attend the hearing but submitted written comments only.

The general consensus was that all commenters were against one or more aspects of the rulemaking changes and expressed concerns in regards to how the specific services were selected for elimination or limitation. Many urged that data be reviewed by the agency to ensure that the legislature used current and sound information. Studies were identified and articles provided as information to be reviewed.

Item #	Comment From	Comment	Response
1.	Bruce Reeser Hanger Prosthetics and Orthotics	Is there a final ruling on whether there is a cap on prosthetics or where the microprocessor will be disallowed?	The AHCCCS Administration is not imposing a dollar limit on prosthetics. The only limitation regarding prosthetics is the exclusion of microprocessor-controlled lower limbs and microprocessor-controlled joints for lower limbs. No limitations have been applied to prosthetics for the upper extremities.
2.	Bruce Reeser Hanger Prosthetics and Orthotics	For the individuals who have existing prosthetics, will they be allowed to get them fixed?	Yes, if the prosthetic is one that is no longer covered under the rule, the reasonable cost of repair will be permitted when necessary for continued use. A socket joint or non-microprocessor control joint can be replaced to allow the entire prosthetic to be used. We will not be able to replace the microprocessor, but the reasonable costs of repair of the prosthetic will be covered.
3.	Bruce Reeser Hanger Prosthetics and Orthotics	Children under 21, is there anything that would not be covered that is presently covered?	The limitation in this rule does not apply to individuals under 21 years old.
4.	Bruce Reeser Hanger Prosthetics and Orthotics	For those 21 and older, can you clarify orthotics; does this include everything under the orthotic umbrella?	The statutory language included all orthotics; this will include everything that is under the "L0100 to L4999" codes. There are a few exceptions in that range of codes which are considered supplies which will be covered.
5.	Bruce Reeser Hanger Prosthetics and Orthotics	Do you realize that there is a possibility of higher utilization in other areas to off set the money that you saved by not allowing these patients to have these prosthetics or orthotics?	These issues were considered, along with many others, when making the coverage decisions.
6.	Michael Brewer Maricopa County Medical Center	Written statement provided and articles referenced. The patient's options for referrals are limited very limited for the various problems. Because dermatologists rarely address diabetic foot issues, we the podiatrist are the premier practitioners in this area, some orthopedic surgeons have obtained six months of lower extremity training but the vast majority of foot and ankle care is provided by highly specialized physicians of podiatric medicine.	Federal law allows AHCCCS to eliminate optional services. Podiatrists' services are among the optional services which the Legislature eliminated in HB2010 during the latest legislative session.

		The changes you propose could potentially result in the loss of our residency program as we serve a majority of AHCCCS patients at the County Hospital. This program is considered one of the best in the country as DPMs, MDs and DOs all commiserate in a surgical intern year with identical responsibilities and expectations from attending physicians. The general surgery program relies on our residents to serve in all of these areas and not just in foot and ankle surgery. However you eliminating all services provided by podiatrists jeopardize our position to assist AHCCCS patients in the other capacities. Please take this into consideration.	
7.	Dr. Bryan Roth Maricopa County Medical Center	I am an attending physician for the group of residents. Pulling AHCCCS is a very real thing for the loss of the program, we have had multiple meetings discussing the implications and what this means to our program. We recently had a site survey at the beginning of May; we were recognized as one of the premier teaching facilities and programs in the country. How was the determination made to drop services covered by podiatrists but not limiting or allowing another physician to do that? We are a cheaper service, and we provide services that others do not have time to do, or want to do, or do not deem important. If we vanish from our institution, the rates of amputations, major amputations, below knee amputations will sky rocket. Our concern is that everyone will be flipping the bill for prosthesis, long term disability. We are overall doing a disservice to our patient population. This should be reconsidered.	Federal law allows AHCCCS to eliminate optional services. Podiatrists' services are among the optional services which the Legislature eliminated in HB2010 during the latest legislative session.
8.	Cynthia Driscoll AZ Physical Therapy Association	Statement read (see attachment) The Physical Therapy Association objects to the utilization of an arbitrary cap on outpatient physical therapy services per calendar year. The cap without regard to the diagnosis discriminates to the most vulnerable of patients. A 15 visit cap will not be adequate for a meaningful rehabilitation and positive outcome. The AHCCCS Administration suggests that a 15 visit cap would not affect 85% of members who receive outpatient physical therapy based on their analysis of claims in 2009. It is unclear if this analysis adequately reflects the rehabilitative needs of AHCCCS members or merely reflects the use of PT services that is influenced by many other factors, such as copays, travel expenses, etc. Without useful outcome data it is unclear that the historical rate of utilization is adequate to meet the rehabilitative needs of AHCCCS members.	Federal law allows Medicaid Programs to place limits on services which meet the needs of 85% of the population. These limitations have been determined to be permissible. The AHCCCS Administration evaluated program information and data to determine that the 15 PT visit limit meets the needs of 85% of the population.

		AHCCCS does not address the significant needs of the minority of patients who have needed and used PT services in excess of 15 visits per calendar year. The cap without regard to clinical appropriateness of care fails to meet a reasonable standard of care of these complex patients. This could lead to rationing of care to avoid exhausting benefits too early in a calendar year. And could push members to greater cost of care and seeking uncovered services, such as inpatient settings. We urge you to consider the need of PT members and allow for additional services above the 15 visit limit based on diagnosis, individual evaluation and clinic judgment.	
9.	Kay Wing President AZ Physical Therapy Association	Provided picture and described physical condition of patient. This type of patient is the type of person that will be affected by the 15 visit limit and would inadequately meet his medical needs.	Federal law allows Medicaid Programs to place limits on services which meet the needs of 85% of the population. These limitations have been determined to be permissible. The AHCCCS Administration evaluated program information and data to determine that the 15 PT visit limit meets the needs of 85% of the population.
10.	Patty Telgener Hillrom Manufacturer of Percussive Vests	The population that uses the percussive vests are those with sistic fybrosis, CP, muscular dystrophy, and ALS. These patients have progressive lung disease, frequently leading to pneumonia and hospitalizations. Our concern is that the percussive vests are inadvertently classified as a prosthetic and were eliminated as a benefit, because if considered a prosthetic they did not meet the definition of medically necessary for rehab. The vests are not a prosthetic, they do not replace a body system, and they are clearly listed with Medicare as DME. We would like clarification on how they were classified as a prosthetic. We believe they should be under DME. The Luensa assessment that was done when the savings was reviewed for percussive vests was under $10,000, One of these patients with systic fybrosis or CP with an ICU stay will be over $30,000. Can we get clarification on the benefit categorization and how can we work together to make sure that some of these patients still have access to the percussive vest assuming that they meet your coverage criteria, because after this they will not have any other options.	The agency does not have the discretion to override the legislative decision to exclude percussive vests.

		Written comment received 6/22/10: *State Plan Amendment (SPA) #10-006 (attachment 3.1-A Limitations) listed percussive vests as a prosthetic. Percussive vests do NOT meet the definition of prosthesis (**replaces** missing, deformed or malfunctioning portions of the body"). At the public hearing on June 22nd, 2010, the panel stated that percussive vests are actually considered an Orthotic. However, the vest is classified as medical equipment and supplies, not orthotic. Medicare has a national coverage decision for percussive vests and the HCPCS codes are A0483 and E7025 and E7026. These HCPCS codes do NOT fall under the L-group of HCPCS codes which are considered orthotic.* *The Arizona House Bill 2010 states that "durable medical equipment is limited to items covered by Medicare" Percussive vests are considered DME and covered by Medicare; therefore coverage should not be eliminated. The panel stated that Medicaid does not follow Medicare's definition of DME. However, per Arizona OMD Policy Manual, ' 310.16, at 3-31 (effective October 1, 1994) they list the definition of DME to be the following:* **"Durable medical equipment means sturdy, long lasting items and appliances that can withstand repeated use, are designed primarily to serve a medical purpose and are not generally useful to a person in the absence of a medical condition, illness or injury."** *So clearly, AZ Medicaid does recognize the definition of medical equipment and supplies outside of orthotics. Percussive vests do meet this definition of medical equipment. In addition, percussive vests have "A" and "E" HCPCS codes that are considered medical equipment and supplies (NOT orthotic "L" codes). We formally request that AHCCCS correctly classify percussive vests as medical equipment/ supplies and NOT orthotics. As stated earlier, the Arizona House Bill 2010 states that "durable medical equipment is limited to items covered by Medicare." Therefore, AHCCCS should continue to provide coverage of percussive vests for patients over the age of 21 years.*	

11.	Kathleen Crout Member	With the upcoming orthotics benefits being eliminated as proposed would be detrimental to my health. I have spina bifida, tethered spinal cord, neuropathy, also drop foot on the right foot and a prosthetic below the left knee and multiple other health issues. If I have to pay for orthotic repair supplies and braces along with what I currently pay for, it would be impossible. I need to stay mobile to maintain muscle tone to my lower extremities, if these coverages are taken away I will be in a wheelchair when something uncovered goes wrong and I cannot afford the necessary supplies I need. Being in a wheel chair for a prolonged time with my expensive health issues will cause a quicker deterioration in my condition. Spina bifida itself can and usually paralyze you from the waist down and put you on kidney dialysis. This concerns me as to which expense would be greater. As a non-emergency medical transportation for childless adults, or non ALTCS members. The time has come and I may need to utilize this benefit. Do these decisions need to be made at the expense of people's quality of life and livelihood? Each one of us in our case is unique, but we all have in common is our health. I hope what I have touched will be carefully considered for all AHCCCS recipients.	Repairs will continue to be covered. See the Frequently Asked Questions at: http://www.azahcccs.gov/reporting/Downloads/Legislation/2010seventh/BenefitChanges_FAQs.pdf In regard to non-emergency transportation, the Administration is awaiting approval from the federal government. Once additional information is received from the Center for Medicare and Medicaid Services, AHCCCS will notify the public, and the information will be posted on the AHCCCS web site.
12.	Jena Freischmidt Member	I am concerned about why it says that specified transplants per HB2010, pancreas … liver for diagnosis of hepatitis C transplants, I am wondering why you are singling out hepatitis C transplants, my husband is 37 years old and has hepatitis C. I understand cuts have to be made and transplants are expensive, but people who need transplants are going to die, it is their last opportunity. If my husband receives a transplant he can go on a therapy that could clear his hepatitis C and he could be better for the rest of his life. I don't understand how you can cut out certain transplants; other things can be taken out.	The legislation identified the specific transplants that are excluded from AHCCCS coverage. These rules put into effect the requirements of HB 2010 as directed by the Legislature.
13.	Robert Lynch Attorney	Some of the regulatory proposal that you have here I cannot find in A.R.S. § 36-2907, specifically the lower limb microprocessor as an exclusion in rule. This does not fall in the list of the statute. And everything else is directly quoted from the statute. So I was curious about that. What happens if the expected savings that you called out in this rule do not materialize? Do you have another rulemaking?	State law A.R.S. § 36-2907 provides the AHCCCS Administration with the general authority to limit any service. The legislation authorizes the AHCCCS Administration to engage in rulemaking to implement the provisions of the law. Therefore, additional rulemakings are an option available to the Agency.

		Will there be another rulemaking under subsection (B)(2)(b), in your discretionary authority? The authority to put a cap on prosthetics, but you decided to leave alone for now. It is not off the table, you're just leaving it alone for now?	You are correct that the Agency still has the authority to implement a cap on prosthetics.
		Tucson Office	
14.	Eric Burns Hanger Prosthetics and Orthotics	There are many studies related in the overall health care system, in regards to orthotic care, chronic conditions, traumatic conditions, and diabetes. These savings are reflected in the reduction of inpatient stays, reduction of long term care … etc. Are these considered when making decisions and changes?	The Agency does not have the discretion to override the legislative decision to exclude orthotics. Information from the AHCCCS Administration which was provided to the Legislature did take into consideration potential increases in other costs due to the elimination of coverage for orthotics.
15.	James Dustin Hanger Prosthetics and Orthotics	On page 26, section A line 8 it states that "orthotic is a device used for healing a weak or deformed body portion." Does this include an orthotic utilized to aid in the healing of fractures due to an injury and/or trauma, such as spinal brace for a spinal fracture, or halo for a cervical fracture? Phoenix Speaker added to this topic: We deal a lot with halo care and it is not something that ends in the hospital, patients are seen in our office to control costs. They are seen monthly if not biweekly to maintain the halo care to prevent ulcers, prevent any need for further surgical procedures. So halo care while maybe covered in the hospital, the codes that are accompanied in treating those patients afterward are done through orthotic coding. In eliminating that, then those patients are on their own in sense. That is not a device a person should be on their own with, you cannot function without help. Keep this in mind and in consideration.	Yes, although in some instances there are other options which are covered by AHCCCS. For example, instead of a spinal brace or walking boot, a cast (which is not considered an orthotic) may be used. An orthotic, including a halo, that is provided as part of an inpatient stay is reimbursed by AHCCCS as part of the inpatient tier per diem payment.
16.	Holly Tuchscherer Hanger Prosthetics and Orthotics	All the care that is preventative care, such as orthotic care diabetic shoes, which are in the A codes, are they still covered? And the diabetic shoe inserts which are A5513, A5512 are they covered? Written comment received 6/22/10: It appears from what is written in the rule that only the physical therapy area has been analyzed before limitations were made. It is concerning that no other areas of eliminated benefits have been analyzed to determine the elimination or limited benefits. It would be beneficial to consider the long-term effects of eliminating orthotic and assistive device coverage for the AHCCCS patients …. There are many scientific studies ….	Diabetic shoes are not orthotics. They are in the A code section as a medical supply. The exclusion for orthotics refers to those items described with an L codes, up to L4999. Yes, the inserts are covered since items described by A codes are not considered orthotics. The Agency does not have the discretion to override the legislative decision to exclude orthotics. Information from the AHCCCS Administration which was provided to the Legislature did take into consideration potential increases in other costs due to the elimination of coverage for orthotics.

17.	Beth Horowitz	Did you look at other ways to deal with cost savings, for example …. 1. In France it would be one third of the costs, significantly cheaper than our medical services, and yet the best by using a card, all the medical records is on this card. This would cut back on billing costs. The savings could go to the patient. 2. Organ transplants can we make it an opt-out system rather than opt-in system to be an organ donor. Then the supply would increase and the cost decrease. 3. Take the profit out of the system. Anyone participating in the system by a certain time has to become a not for profit organization. 4. Have you thought of expanding rather than limiting coverage … the system would pay for itself. Many small business owners cannot get health care coverage, this is detrimental. Expanding the coverage, increase the number of people in the program and have them paying for the program, then the system would pay for itself. Have you considered any of those options?	The purpose of this rule is to implement statutory limitations, including the elimination of certain services. The suggestions that have been made are beyond the scope of this rulemaking.
		Flagstaff Office	
18.	Jim McCalmont Hanger Orthotics and Prosthetics	You said you would cover A codes for diabetics but not L codes, by cutting out the L5000 how does that save you money?	The only A codes devices that are appropriate for the treatment of diabetes are shoes and inserts. Orthotics described by L codes are not covered for diabetic members or any other AHCCCS members. These exclusions result in savings to the AHCCCS Program.
		Tucson Office	
19.	Eric Burns	What other areas are you looking at cutting?	Costs for the AHCCCS Program are from three main areas: the number of members served, the scope of benefits which are provided, and the payment made for these services. The federal health care reform law prohibits the Agency from eliminating covered populations. Therefore, to maximize cost savings while ensuring compliance with federal and state law, the AHCCCS Administration considered measures that would achieve cost savings in an equitable fashion. It has reduced covered services, and it has proposed additional rate reductions for all providers, including physicians, hospitals, and nursing homes. Although AHCCCS recognizes the significant burdens associated with these decisions, it believes that it has achieved the best balance possible given the legal requirements.

Written Comment			
20.	James Haynes AZ Hospital and Healthcare Association	We wish to bring to the Administration's attention that we received last month after passage of the FY2011 budget, information from transplant physicians regarding the impact of eliminating certain transplant coverage from the benefit package and the cost-efficiency of transplant coverage as reference in recent scientific literature. This information raises doubt about the cost effectiveness and impact of eliminating the following transplant services for AHCCCS patients 21 years of age or older: 1. Heart Transplantation for Non-Ischemic Cardiomyopathy; 2. Lung Transplantation; 3. Pancreas – only and Pancreas after Kidney Transplantation; and 4. Liver Transplantation for Patients with hepatitis C. For example, the letter raises concerns that some of the data used to substantiate elimination of these services is outdated. New treatment modalities have dramatically increased survival rates in certain transplant patients. Without receiving transplant services, several patients on the wait list will likely develop secondary complications leading to multiple hospital admissions. Also encouraging AHCCCS Administration to collaborate with the transplant community in an effort to find alternative cost savings in the transplant benefit rather than eliminating the aforementioned benefits. AzHHA urges the Administration to reexamine the scientific literature that informed the earlier recommendation to eliminate certain heart, lung, pancreas, and liver transplant benefits, and bring forth new recommendations as appropriate.	The Agency does not have the discretion to override the legislative directive to exclude certain transplant types. The Az Hospital and Healthcare Association may wish to share this information with the Legislature.

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

Not applicable

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

None

14. Was this rule previously made as an emergency rule? If so, please indicate the *Register* citation:

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 2. COVERED SERVICES

Section

R9-28-206. ALTCS Services that may be Provided to a Member Residing in either an Institutional or HCBS Setting

ARTICLE 2. COVERED SERVICES

R9-28-206. ALTCS Services that may be Provided to a Member Residing in either an Institutional or HCBS Setting

The Administration shall cover the following services if the services are provided to a member within the limitations listed:

1. Occupational and physical therapies, speech and audiology services, and respiratory therapy:
   a. The duration, scope, and frequency of each therapeutic modality or service is prescribed by the members primary care provider or attending physician;
   b. The therapy or service is authorized by the members contractor or the Administration; and
   c. The therapy or service is included in the members case management plan~~.~~;
   d. AHCCCS will not cover more than 15 outpatient physical therapy visits for the contract year with the exception of the required Medicare coinsurance and deductible payment as described in 9 A.A.C. 29, Article 3.
2. Medical supplies, durable medical equipment, and customized durable medical equipment, which conform with the requirements and limitations of 9 A.A.C. 22, Article 2;
3. Ventilator dependent services:
   a. Inpatient or institutional services are limited to services provided in a general hospital, special hospital, NF, or ICF-MR. Services provided in a general or special hospital are included in the hospitals unit tier rate under 9 A.A.C. 22, Article 7;
   b. A ventilator dependent member may receive the array of home and community based services under R9-28-205 as appropriate.
4. Hospice services:
   a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
   b. Covered hospice services for a member are those allowable under 42 CFR 418.202, December 20, 1994, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and
   c. Covered hospice services do not include:
      i. Medical services provided that are not related to the terminal illness~~.~~, or
      ii. Home delivered meals.
   d. Medicare is the primary payor of hospice services for a member if applicable.