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 was reviewed per Executive Order 2011-05 as issued by Governor Brewer. (See the text of the executive order on page 1726.) The Governor's Office authorized the notice to proceed through the rulemaking process on May 4, 2011.

[R11-115]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-201	Amend
R9-22-204	Amend
R9-22-702	Amend
R9-22-703	Amend
R9-22-705	Amend
R9-22-712.09	Amend

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

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

Implementing statute: A.R.S. § 36-2907 as amended by Laws 2011, Ch. 31, § 13 ("the 2011 Act")

3. The proposed effective date of the rules:

October 1, 2011

4. A list of all previous notices appearing in the *Register* addressing the 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 Governor's Medicaid Reform Plan, as announced on March 15, 2011, includes proposals to reduce nonfederal expenditures for the AHCCCS program by approximately $500 million during state fiscal year 2012. To achieve some of these reductions, the AHCCCS Administration is limiting covered inpatient days for adults. In addition, this rulemaking makes changes to current rules regarding limitations on providers charging members for services.

A.R.S. § 36-2907(D) states that AHCCCS shall adopt rules necessary to limit, to the extent possible, the scope, duration and amount of services, including maximum limitations for inpatient services that are consistent with federal regulations for the Medicaid program. Those federal regulations require (1) that the State Plan for Medicaid must specify the amount, duration, and scope of each covered service, (2) that services must be sufficient in amount, duration, and

scope to reasonably achieve its purpose, and (3) allow each state to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. 42 CFR 440.230. Specifically, the United States Supreme Court has upheld limitations on services such as inpatient hospital services, noting that "Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs" and "gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in 'the best interests of the recipients.'" *Alexander* v. *Choate*, 469 U.S. 287, 303 (U.S. 1985). This rule implements the statutory provision consistent with federal regulations. The limitations to services included in the Arizona State Plan for Medicaid as described in this rule will be included in a State Plan Amendment submitted to the federal government in accordance with requirements for the Medicaid program.

At this time, the AHCCCS Administration is promulgating annual limits for inpatient hospital days for adults.

In light of the proposed expansion of limits to services, AHCCCS undertook a review of its rules regarding the registered providers charging member for services. Federal Medicaid regulations, specifically 42 CFR 447.15 and 447.20, require health care providers participating in Medicaid must accept the Medicaid payment as payment in full (plus any member cost sharing permitted by the Medicaid agency). Those regulations also place restrictions on the ability of providers to attempt to collect from the member or third parties the balance of a bill paid by Medicaid. State law, specifically A.R.S. § 36-2903.01(L) requires AHCCCS to establish procedures applicable to providers that attempt to collect from a member or third party an amount that exceeds the amount that is or should have been reimbursed by the System. This rulemaking: (1) clarifies the existing exceptions to the general prohibition on billing members for services, (2) explicitly addresses charging members for services that are excluded or are subject to limitations, and (3) simplify the requirements for obtaining a member's written consent to direct filling in a manner that balances the administrative burden to the provider yet affords reasonable notice to the member of their financial responsibility.

Arizona Laws 2011, Ch. 31, § 13, the Legislature authorized the agency to adopt rules, including rules relating to limit, to the extent possible, the scope, duration and amount of services, including maximum limitation for inpatient services. Arizona Laws 2011, Ch. 31, § 34 exempts the Administration from the formal rulemaking requirements of A.R.S. Title 41, Chapter 6.

Arizona Law 2011, Ch. 31, § 34, which authorizes this exempt rulemaking, requires public notice with an opportunity for public comment of at least 30 days. Public notice of this rulemaking has been accomplished through publication of this rulemaking on the agency web site on June 23, 2011. A supplemental notice also appeared in the *Arizona Administrative Register* in advance of the close of the comment period. In addition, notice was directed to those individuals who, prior to this proposed rulemaking have notified the agency of their desire to receive such notices directly pursuant to A.R.S. § 36-2903.01(B)(6).

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

No studies were relied upon for the implementation of this rulemaking, but analysis of the member utilization of inpatient hospital days reported through claims and encounters for dates of service during SFY 2010, has assisted the AHCCCS Administration in arriving at the proposed limitations. Prior to proposing this rule, AHCCCS reviewed historical information regarding utilization of the services limited by the proposed rule. Based on that review, AHCCCS determined that at least 96% of utilizing members would remain unaffected when these limitations are implemented.

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

Not applicable

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

AHCCCS estimates that the limitations on inpatient days will reduce total expenditures by approximately $64 million in combined state and federal funds for the last three quarters of the state fiscal year ending June 30, 2012 and approximately $85 million for the following state fiscal year. It is difficult to estimate with any degree of certainty whether, or to what extent, this will result in less care being provided. As set forth in rule, in many instances health care providers are permitted to charge patients for services provided but not paid for by AHCCCS as a result of these limitations. It is equally difficult to estimate with any degree of certainty to what extent this rulemaking may result in health care providers rendering care without adequate compensation from sources other than AHCCCS.

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:

Numb:	Date/ Commentor:	Comment:	Response:
1.	07/22/11 Peter Wertheim IASIS Health Care	R9-22-204(C) Concern regarding exception of governmentally-owned burn center. Should be extended to ***any*** medical facility that provides treatment for burns. Every hospital should be incentivized to provide emergency episodic care and not be impeded by Medicaid's billing restrictions. All the other benefits exempt from the inpatient limitation are not limited to a specific facility. We request that the rule for the burn treatment be amended to be consistent with the benefit exemptions.	Cases involving critical burns are more likely to be transferred to a nationally recognized burn unit. AHCCCS believes that current demands for extended treatment of severe burns are met by the facility(ies) described within the rule. However, AHCCCS will monitor the overall utilization of burn treatment and consider the data to determine whether future revisions to the rule are necessary.
2.	07/22/11 Susan Watchman Gammage and Burnham	We believe that "Notice of Action" requirements for plans/contractors (ACOM 414) do not apply to denials of continued stay during inpatient hospitalizations. We believe this exclusion should be revisited with regard to the 25 day limit.	Notice of Action requirements are not within the scope of this rulemaking. However, this comment will be separately reviewed to determine appropriate follow-up actions that may be necessary.
3.	07/22/11 Susan Watchman Gammage and Burnham	The following are rule comments: 1. R9-22-204(C) – Partial Days, Observation, and Same Day Admit Discharge. We think that the parameters of a benefit limitation should be fully expounded in formal agency rules. Even if only 4% of the membership is affected, that 4% should have a single point source that is the legally governing description of this new limit. (a) where subparagraph states "… inpatient days are counted toward the limit if paid in whole or in part…." We are unaware of any circumstance in which an inpatient day is paid "in part" The inpatient days (whether per diem or outlier) are either paid as an inpatient day or they aren't – they are not paid "in part". Concept AHCCCS is seeking to describe is unclear and the regulation should be redrafted.	The term "In whole and in part" is superfluous and will be removed from rule language.

3. *continued*		(b) R9-22-204(C)(1)(d) states that "each 24 hours of paid observation" is counted as one inpatient day. Most plans have established the payment cut of at 23 hours. We assume that AHCCCS intends the regulation literally as written – that only stays for which 24 hours of observation are actually paid will be counted against the limit. This would mean that if the patient is in observation status only 10 hours (even if the total time in the hospital is longer), or the plans pays only 23 hours of a 30 hour observation stay, the stay is not counted as an inpatient day. This interpretation excludes Same Day Admit Discharge services from the limitation. If we are mistaken, we ask that the subparagraph be clarified. We believe that observation and same day should be treated the same and be excluded both from the limit. If something else was intended, please clarify and we urge consistency.	Your interpretation is correct. Observation is only counted when it is paid at 24 hours or more.
		(c)During pre and post payment review AHCCCS plans frequently conclude that inpatient claims of 1-3 days are services that could have been provided in an outpatient basis in less than 24 hours. The plan generally pays or adjusts the claim to the outpatient payment amount. These claims will appear in the encounter system as paid at a "contract" or "settlement" rate. These claims and all days are "adjudicated". However the rule does not clearly describe whether AHCCCS will treat all days billed on the claim as "adjudicated and paid", therefore countable against the limit, or will consider only the 24 hours/ one day actually paid as "adjudicated and paid".	When a hospital submits a claim for inpatient services and is paid, the day is counted towards the limit, regardless of whether that payment is at the tier, contract, or negotiated rate. The amount of reimbursement received is irrelevant.
		(d) AHCCCS and the plans/ contractors frequently pay fewer days than the total number of days billed (e.g. cut back the length of stay). It is unclear if the phrase "adjudicated and paid" for purposes of the limit means all days billed on the claim, or only the days actually paid. This should be explained expressly in the rule.	

3. *continued*		(e)The rule does not address how the day limit is applied to QMB and non-QMB duals. We believe it is important to the provider and member advocacy communities that the application of the 25 day limit to all groups be articulated in formal agency rules.	Although some information regarding the QMBs is available in the FAQ's, the Administration will address QMB issues in a separate rulemaking of Chapter 29 specific to Medicare cost-sharing.
		2. R9-22-702 (D)(4) – Charges to Members	
		The rule states that the member may be billed…if the member signs a document in advance of receiving the service stating that the member understands that the ***service is*** excluded or limited and that the member will be financially responsible…" The hospital rarely knows in advance or during hospitalization that the 25 day limit has been met or exceeded. We urge that the Administration modify R9-22-702(D)(4):	The Administration has clarified the rule language and has added a phrase stating that the service may be "subject to a limit."
		For a service that is excluded by statute or rule, or provided in an amount that exceeds a limitation in statute or rule, <u>(a)</u> if the member signs a document in advance of receiving the service stating that the member understands the service is excluded or limited and that the member will be financially responsible for payment for the excluded service or for the services in excess of the limit <u>or (b) for inpatient hospital services subject to R9-22-204(C), if the member signs a document in advance of or during the hospital stay stating that the member understands that some or all of the inpatient stay may later be determined to exceed the limit and that the member will be financially responsible for payment for services in excess of the limit.</u>	

4.	07/22/11 James Haynes AZHHA	We have concerns of the proposed rules financial impact to Arizona hospitals and are strongly opposed to the promulgation of any rule that affects Arizona hospital payments and benefit limits without the opportunity to assess the rules impact. In preamble item 7 the Administration has not provided AZHHA the data analysis or posted the analysis for public review during the public comment period. We believe that the impact of this limitation will be skewed toward large trauma centers and rehabilitation facilities in Arizona that care for the most critically ill patients… We urge AHCCCS to prepare a model showing the estimated impact by hospital. We recommend once the model has been developed, AHCCCS should meet with the hospital representatives to explain the rule and changes…	A meeting has been scheduled for August 15, 2011 to discuss all benefit limits. In addition, data by hospital will be provided prior to the meeting to AZHHA for its members and also made directly available to non-AZHHA members.
4. *continued*		We suggest AHCCCS remove language in R9-22-204(B)(2)(c) that limits payment of coverage for the treatment of burn or burn late effect conditions to treatment of a particular type and location facility after the 25 day limit. Treatment of the burn or burn late effect condition should be exempt from the 25 day limit regardless of the location of the facility where the treatment occurs. Other days are excluded on the basis of the medical condition, not location of service. The rule does not provide flexibility for hospitals in Arizona to expand their services to meet community-based needs, or to respond to needs of increased capacity in regional service networks.	See the response to IASIS Commentor.

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. SCOPE OF SERVICES

Section
R9-22-201. Scope of Services-related Definitions
R9-22-204. Inpatient General Hospital Services

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-702. Charges to Members
R9-22-703. Payments by the Administration
R9-22-705. Payments by Contractors
R9-22-712.09. Hierarchy ~~For~~ for Tier Assignment

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.

"Benefit year" means a one year time period of October 1st through September 30th.

"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.

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

"Emergency medical condition for a 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 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.

"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.

R9-22-204. Inpatient General Hospital Services

A. A contractor, fee-for-service provider or noncontracting provider shall render inpatient general hospital services including:

1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
   a. Maternity care, including labor, delivery, and recovery room, birthing center, and newborn nursery;
   b. Neonatal intensive care unit (NICU);
   c. Intensive care unit (ICU);
   d. Surgery, including surgery room and recovery room;
   e. Nursery and related services;
   f. Routine care; and
   g. Emergency behavioral health services provided under Article 12 of this Chapter for a member eligible under A.R.S. § 36-2901(6)(a).
2. Ancillary services as specified by the Director and included in contract:
   a. Laboratory services;
   b. Radiological and medical imaging services;
   c. Anesthesiology services;
   d. Rehabilitation services;
   e. Pharmaceutical services and prescription drugs;
   f. Respiratory therapy;
   g. Blood and blood derivatives; and
   h. Central supply items, appliances, and equipment that are not ordinarily furnished to all patients and customarily reimbursed as ancillary services.

B. The following limitations apply to inpatient general hospital services that are provided by FFS providers.

1. Providers shall obtain prior authorization from the Administration for the following inpatient hospital services:
   a. Nonemergency and elective admission, including psychiatric hospitalization;
   b. Elective surgery; and
   c. Services or items provided to cosmetically reconstruct or improve personal appearance after an illness or injury.
2. The Administration or a contractor may deny a claim if a provider fails to obtain prior authorization.
3. Providers are not required to obtain prior authorization from the Administration for the following inpatient hospital services:

a. Voluntary sterilization~~;~~,
b. Dialysis shunt placement~~;~~,
c. Arteriovenous graft placement for dialysis~~;~~,
d. Angioplasties or thrombectomies of dialysis shunts~~;~~,
e. Angioplasties or thrombectomies of arteriovenous graft for dialysis~~;~~,
f. Hospitalization for vaginal delivery that does not exceed 48 hours~~;~~,
g. Hospitalization for cesarean section delivery that does not exceed 96 hours~~;~~, and
h. Other services identified by the Administration through the Provider Participation Agreement.

4. The Administration may perform concurrent review for hospitalizations of non-FES members to determine whether there is medical necessity for the hospitalization. A provider shall notify the Administration no later than 72 hours after an emergency admission.

C. Coverage of in-state and out-of-state inpatient hospital services is limited to 25 days per benefit year for members age 21 and older. The limit applies for all inpatient hospital services with dates of service during the benefit year regardless of whether the member is enrolled in Fee for Service, is enrolled with one or more contractors, or both, during the benefit year.

1. For purposes of calculating the limit:
   a. Inpatient days are counted towards the limit if paid by the Administration or a contractor;
   b. Inpatient days will be counted toward the limit in the order of the adjudication date of a paid claim;
   c. Paid inpatient days are allocated to the benefit year in which the date of service occurs;
   d. Each 24 hours of paid observation services is counted as one inpatient day if the patient is not admitted to the same hospital directly following the observation services;
   e. Observation services, which are directly followed by an inpatient admission to the same hospital are not counted towards the inpatient limit; and
   f. After 25 days of inpatient hospital services have been paid as provided for in this Section:
      i. Outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered.
      ii. Continuous periods of observation services of less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered.
      iii. For continuous periods of observation services of 24 hours or more that are not directly followed by an inpatient admission to the same hospital, 23 hours of observations services are covered.
2. The following inpatient days are not included in the inpatient hospital limitation described in this Section:
   a. Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract;
   b. Days related to Behavioral Health:
      i. Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or
      ii. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or
      iii. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.
   c. Days related to treatment of conditions with diagnoses of burns or burn late effect at a governmental-operated hospital located in an Arizona county with a population of more than 500,000 persons with a specialized burn unit in existence prior to October 1, 2011;
   d. Same Day Admit Discharge services are excluded from the 25 day limit; and
   e. Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-702. Charges to Members

~~**A.** Except as provided in subsections (B), (C), and (D), an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration that the person was not an eligible person on the date of service:~~
~~1. Charge, submit a claim to, or demand or collect payment from a person claiming to be an eligible person; or~~
~~2. Refer or report a person claiming to be an eligible person to a collection agency or credit reporting agency.~~
~~**B.** An AHCCCS registered provider that submits a claim shall not charge more than the actual, reasonable cost of providing the covered service.~~
~~**C.** An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment from a member as follows:~~
~~1. To collect an authorized copayment;~~
~~2. To recover from a member that portion of a payment made by a third party to the member if the payment duplicates~~

~~AHCCCS-paid benefits and is not assigned to a contractor; or~~

~~3. To obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused payment to the provider to be reduced or denied.~~

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

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

~~2. The provider prepares and provides the member with a document describing the overall services and the approximate cost of the services; and~~

~~3. The member signs the document prior to services being provided, indicating that the member understands and accepts responsibility for payment.~~

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

~~1. The provider submits a claim to the Administration in the reasonable belief that the service is for treatment of an emergency medical condition; and~~

~~2. The Administration denies the claim because the service does not meet the criteria of R9-22-217.~~

A. For purposes of this subsection, the term "member" includes the member's financially responsible representative as described under A.R.S. § 36-2903.01.

B. Registered providers must accept payment from the Administration or a contractor as payment in full.

C. Except as provided in subsection (D) a registered provider shall not request or collect payment from, refer to a collection agency, or report to a credit reporting agency an eligible person or a person claiming to be an eligible person.

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

1. To collect the copayment described in R9-22-711;
2. To recover from a member that portion of a payment made by a third party to the member for an AHCCCS covered service if the member has not transferred the payment to the Administration or the contractor as required by the statutory assignment of rights to AHCCCS;
3. To obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused payment to the provider to be reduced or denied;
4. For a service that is excluded by statute or rule, or provided in an amount that exceeds a limitation in statute or rule, if the member signs a document in advance of receiving the service stating that the member understands the service is excluded or is subject to a limit and that the member will be financially responsible for payment for the excluded service or for the services in excess of the limit;
5. When the contractor or the Administration has denied authorization for a service if the member signs a document in advance of receiving the service stating that the member understands that authorization has been denied and that the member will be financially responsible for payment for the service;
6. For services requested for a member enrolled with a contractor, and rendered by a noncontracting provider under circumstances where the member's contractor is not responsible for payment of "out of network" services under R9-22-705(A), if the member signs a document in advance of receiving the service stating that the member understands the provider is out of network, that the member's contractor is not responsible for payment, and that the member will be financially responsible for payment for the excluded service;
7. For services rendered to a person eligible for the FESP if the provider submits a claim to the Administration in the reasonable belief that the service is for treatment of an emergency medical condition and the Administration denies the claim because the service does not meet the criteria of R9-22-217; or
8. If the provider has received verification from the Administration that the person was not an eligible person on the date of service.

E. The signature requirement of subsections (D)(4), (5), and (6) do not apply if:

1. The member is unable or incompetent to sign such a document, or
2. When services are rendered for the purpose of treating an emergency medical condition as defined in R9-22-217 and a delay in providing treatment to obtain a signature would have a significant adverse affect on the member's health.

F. Except as provided for in this Section, registered providers shall not bill a member when the provider could have received reimbursement from the Administration or a contractor but for the provider's failure to file a claim in accordance with the requirements of AHCCCS statutes, rules, the provider agreement, or contract, such as, but not limited to, requirements to request and obtain prior authorization, timely filing, and clean claim requirements.

R9-22-703. Payments by the Administration

A. General requirements. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol

Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

B. Timely submission of claims.
1. Under A.R.S. § 36-2904, the Administration shall deem a paper or electronic claim to be submitted on the date that it is received by the Administration. The Administration shall do one or more of the following for each claim it receives:
   a. Place a date stamp on the face of the claim,
   b. Assign a system-generated claim reference number, or
   c. Assign a system-generated date-specific number.
2. Unless a shorter time period is specified in contract, the Administration shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
   a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
   b. Six months from the date of eligibility posting.
3. Unless a shorter time period is specified in contract, the Administration shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
   a. Twelve months from the date of service or for an inpatient hospital claim, ~~twelve~~ 12 months from the date of discharge; or
   b. Twelve months from the date of eligibility posting.
4. Unless a shorter time period is specified in contract, the Administration shall not pay a claim submitted by an IHS or tribal facility for a covered service unless the claim is initially submitted within 12 months from the date of service, date of discharge, or eligibility posting, whichever is later.

C. Claims processing.
1. The Administration shall notify the AHCCCS-registered provider with a remittance advice when a claim is processed for payment.
2. The Administration shall reimburse a hospital for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and in the manner and at the rate described in A.R.S. § 36-2903.01:
   a. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
   b. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
   c. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a fee of one percent per month for each month or portion of a month following the 60th day of receipt of the bill until date of payment.
3. A claim is paid on the date indicated on the disbursement check.
4. A claim is denied as of the date of the remittance advice.
5. The Administration shall process a hospital claim under this Article.

D. Prior authorization.
1. An AHCCCS-registered provider shall:
   a. Obtain prior authorization from the Administration for non-emergency hospital admissions and covered services as specified in Articles 2 and 12 of this Chapter,
   b. Notify the Administration of hospital admissions under Article 2 of this Chapter, and
   c. Make records available for review by the Administration upon request.
2. The Administration may deny a claim if the provider fails to comply with subsection (D)(1).
3. If the Administration issues prior authorization for a specific level of care but subsequent medical review indicates that a different level of care was medically appropriate, the Administration shall adjust the claim to pay for the cost of the appropriate level of care.

E. Review of claims and coverage for hospital supplies.
1. The Administration may conduct prepayment and postpayment review of any claims, including but not limited to hospital claims.
2. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
   a. Patient care kit,
   b. Toothbrush,
   c. Toothpaste,
   d. Petroleum jelly,
   e. Deodorant,
   f. Septi soap,
   g. Razor or disposable razor,
   h. Shaving cream,
   i. Slippers,
   j. Mouthwash,
   k. Shampoo,

l. Powder,
m. Lotion,
n. Comb, and
o. Patient gown.

3. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
   a. Arm board,
   b. Diaper,
   c. Underpad,
   d. Special mattress and special bed,
   e. Gloves,
   f. Wrist restraint,
   g. Limb holder,
   h. Disposable item used instead of a durable item,
   i. Universal precaution,
   j. Stat charge, and
   k. Portable charge.
4. The Administration shall determine in a hospital claims review whether services rendered were:
   a. Covered services as defined in R9-22-102;
   b. Medically necessary;
   c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
   d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2903.01.
5. If the Administration adjudicates a claim, a person may file a claim dispute challenging the adjudication under 9 A.A.C. 34.

F. Overpayment for AHCCCS services.
1. An AHCCCS-registered provider shall notify the Administration when the provider discovers the Administration made an overpayment.
2. The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS-registered provider fails to return the overpaid amount to the Administration.
3. The Administration shall document any recoupment of an overpayment on a remittance advice.
4. An AHCCCS-registered provider may file a claim dispute under 9 A.A.C. 34 if the AHCCCS-registered provider disagrees with a recoupment action.

G. For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

R9-22-705. Payments by Contractors

A. General requirements. A contractor shall contract with providers to provide covered services to members enrolled with the contractor. The contractor is responsible for reimbursing providers and coordinating care for services provided to a member. Except as provided in subsection (A)(2), a contractor is not required to reimburse a noncontracting provider for services rendered to a member enrolled with the contractor.
1. Providers. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
2. A contractor shall reimburse a noncontracting provider for services rendered to a member enrolled with the contractor as specified in this Article if:
   a. The contractor referred the member to the provider or authorized the provider to render the services and the claim is otherwise payable under this Chapter, or
   b. The service is emergent under Article 2 of this Chapter.

B. Timely submission of claims.
1. Under A.R.S. § 36-2904, a contractor shall deem a paper or electronic claim as submitted on the date that the claim is received by the contractor. The contractor shall do one or more of the following for each claim the contractor receives:
   a. Place a date stamp on the face of the claim,
   b. Assign a system-generated claim reference number, or
   c. Assign a system-generated date-specific number.
2. Unless a shorter time period is specified in subcontract, a contractor shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
   a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
   b. Six months from the date of eligibility posting.

3. Unless a shorter time period is specified in subcontract, a contractor shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
   a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
   b. Twelve months from the date of eligibility posting.

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

D. Payment for in-state inpatient hospital services. A contractor shall reimburse an in-state provider of inpatient hospital services rendered with an admission date on or after March 1, 1993, at either a rate specified by subcontract or, in absence of the subcontract, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715. This subsection does not apply to an urban contractor as specified in R9-22-718 and A.R.S. § 36-2905.01.

E. Payment for in-state outpatient hospital services.
1. A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after March 1, 1993 through June 30, 2005, at either a rate specified by a subcontract that complies with R9-22-715(A) or, in absence of a subcontract, as described in R9-22-712 or under A.R.S. § 36-2903.01. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
2. A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other ~~sections~~ Sections of this Article. The terms of the subcontract are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.

F. Inpatient and outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b). In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the contractor shall pay the claim by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio.

G. Payment for observation days. A contractor shall reimburse a provider and a noncontracting provider for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, as prescribed under R9-22-712, R9-22-712.10, and R9-22-712.45. An "observation day" means a physician-ordered evaluation period of less than 24 hours to determine the need of treatment or the need for admission as an inpatient.

H. Review of claims and coverage for hospital supplies.
1. A contractor may conduct a review of any claims submitted and recoup any payments made in error.
2. A hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. When issuing prior authorization, a contractor shall consider the medical necessity of the service, and the availability and cost effectiveness of an alternative treatment. Failure to obtain prior authorization when required is cause for nonpayment or denial of a claim. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the subcontract regarding utilization control activities. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and shall make the hospital's medical records pertaining to a member enrolled with a contractor available for review.
3. Regardless of prior authorization or concurrent review activities, a contractor may make prepayment or post-payment review of all claims, including but not limited to a hospital claim. A contractor may recoup an erroneously paid claim. If prior authorization was given for a specific level of care, but medical review of a claim indicates that a different level of care was medically appropriate, a contractor shall adjust the claim to pay for the cost for the appropriate level of care. An adjustment in payment for a different level of care is effective on the date when the different level of care is medically appropriate.
4. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures

if the subcontract meets the requirements of R9-22-715.

5. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
   a. Patient care kit,
   b. Toothbrush,
   c. Toothpaste,
   d. Petroleum jelly,
   e. Deodorant,
   f. Septi soap,
   g. Razor,
   h. Shaving cream,
   i. Slippers,
   j. Mouthwash,
   k. Disposable razor,
   l. Shampoo,
   m. Powder,
   n. Lotion,
   o. Comb, and
   p. Patient gown.
6. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
   a. Arm board,
   b. Diaper,
   c. Underpad,
   d. Special mattress and special bed,
   e. Gloves,
   f. Wrist restraint,
   g. Limb holder,
   h. Disposable item used instead of a durable item,
   i. Universal precaution,
   j. Stat charge, and
   k. Portable charge.
7. The contractor shall determine in a hospital claims review whether services rendered were:
   a. Covered services as defined in R9-22-102;
   b. Medically necessary;
   c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
   d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2904.
8. If a contractor adjudicates a claim or recoups payment for a claim, a person may file a claim dispute challenging the adjudication or recoupment as described under 9 A.A.C. 34.

I. Non-hospital claims. A contractor shall pay claims for non-hospital services in accordance with contract, or in the absence of a contract, at a rate not less than the Administration's capped fee-for-service schedule or at a lower rate if negotiated between the two parties.

J. Payments to hospitals. A contractor shall pay for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and as described in A.R.S. § 36-2904:

1. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
2. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
3. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a ~~1~~ one percent penalty of the rate for each month or portion of the month following the 60th day of receipt of the bill until date of payment.

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

L. For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

R9-22-712.09. Hierarchy ~~For~~ for Tier Assignment

TIER	IDENTIFICATION CRITERIA	ALLOWED SPLITS
MATERNITY	A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx.	None

NICU	Revenue Code of 174 and the provider has a Level II or Level III NICU.	Nursery
ICU	Revenue Codes of 200-204, 207-212, or 219.	Surgery Psychiatric Routine
SURGERY	Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list.	ICU
PSYCHIATRIC	Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND primary Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx - 316.xx, classify as a psychiatric claim.	ICU
NURSERY	Revenue Code of 17x, not equal to 174.	NICU
ROUTINE	Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.	ICU