NOTICES OF FINAL RULEMAKING

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

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

Editor's Note: The following Notice of Final 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 February 28, 2011.

[R11-113]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-101	Amend
R9-22-201	Amend
R9-22-202	Amend
R9-22-204	Amend
R9-22-210	Amend
R9-22-210.01	Amend
R9-22-211	Amend
R9-22-215	Amend
R9-22-217	Amend
R9-22-703	Amend
R9-22-712	Amend

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

Authorizing statute: A.R.S. §§ 36-2903.01, 36-2907

Implementing statute: A.R.S. § 36-2907

3. The effective date of the rules:

August 2, 2011

Effective immediately upon filing with the Secretary of State. The Administration believes that an immediate effective date is necessary since the rule changes are less stringent than the rule that is currently in effect and the rule changes do not have an impact on the public health, safety, welfare or environment, and do not affect the public involvement and public participation process as described under A.R.S. § 41-1032(A)(5).

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

Notice of Rulemaking Docket Opening: 17 A.A.R. 513, April 8, 2011

Notice of Proposed Rulemaking: 17 A.A.R. 478, April 8, 2011

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

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Administrative 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:

The proposed rules will eliminate the requirement for obtaining Prior Authorization (PA) for services such as, but not limited to: dialysis shunt placement, apnea management and training for premature babies up to one year of life, certain eye surgeries, and hospitalizations for labor and delivery not exceeding specific time parameters. Technical changes and striking of redundant rules will be made. In addition, a clarification to the definition of Prior Authorization will be made, to inform the public that prior authorization is not only based on medical necessity but also on the cost effectiveness of the service provided.

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 any analysis of each study and other supporting material:

No study was reviewed or relied upon for this rulemaking.

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 AHCCCS Administration believes that subjecting the identified services to PA adds administrative costs and time-consuming processes to Agency operations, further straining limited program resources without accompanying benefits. This amendment also reduces the administrative burden on health care providers and facilitates members' access to appropriate care.

Currently 95 percent of the cases are approved. The Administration believes that removal of this requirement will save the provider time and money. Each PA takes five-10 minutes and each biller is costing a provider approximately $15 an hour, possibly saving providers $14,000 in a year. The Administration will also save time and money for the cost of the PA nurse's time, estimated to be $28,000 a year. In addition, the Administration will no longer conduct concurrent reviews, which is a review of a patient's medical necessity for hospitalization completed by the Administration at the time of hospitalization, for Federal Emergency Service (FES) members since federal regulations and the state plan prohibit reimbursement of any services which are not emergent. A review of the medical records is completed when the claim is received so it is not necessary to spend time and effort on a concurrent review. Therefore, the reference to concurrent review is not necessary and the PA department can cease conducting these reviews, which numbered 1,980 in calendar year 2010. At $95.00 per review, the total savings estimated by eliminating concurrent review for FES hospitalizations would approach $188,100.00.

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

No additional changes have been made between the proposed rules and the final rules below. The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.

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

The Administration did not receive any comments regarding the rules.

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:

Not applicable

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

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section
R9-22-101. Location of Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-22-201. Scope of Services-related Definitions
R9-22-202. General Requirements
R9-22-204. Inpatient General Hospital Services
R9-22-210. Emergency Medical Services for Non-FES Members
R9-22-210.01. Emergency Behavioral Health Services for Non-FES Members
R9-22-211. Transportation Services
R9-22-215. Other Medical Professional Services
R9-22-217. Services Included in the Federal Emergency Services Program

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-703. Payments by the Administration
R9-22-712. Reimbursement: General

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
"Benefit year" R9-22-201
"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~~ R9-22-101
"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~~ R9-22-101
"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~~ R9-22-101
"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" R9-22-203
"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~~ R9-22-101
"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~~ R9-22-101
"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~~ R9-22-101
"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.

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

"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.

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

"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.

"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.

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

"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.

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

"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).

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

"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.~~ based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable contract provisions. Prior authorization is not a guarantee of payment.

"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.~~

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

"Emergency medical condition for ~~the~~ 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 ~~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~~ written, verbal, or electronic 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.~~ A member may receive behavioral health services as specified in Articles 2 and 12.
7. AHCCCS or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
8. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
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.
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~~ provide prior authorization for services unless the provider submits documentation of ~~documents the diagnosis and~~ the medical necessity of the treatment along with the prior authorization request.

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 ~~one hundred~~ 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), and
9. R9-22-215 (C)(5).

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, excluding a voluntary sterilization procedure. Voluntary sterilization procedure does not require prior authorization; and~~
   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.

~~2.~~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.
   ~~a. A provider shall notify the Administration no later than the fourth day of hospitalization after an emergency admission or no later than the second day after an intensive care unit admission so that the Administration may initiate concurrent review of the hospitalization.~~
   ~~b. Failure of the provider to obtain prior authorization is cause for denial of a claim.~~

R9-22-210. Emergency Medical Services for Non-FES Members

A. General provisions.
1. Applicability. This Section applies to emergency medical services for non-FES members. Provisions regarding emergency behavioral health services for non-FES members are in R9-22-210.01. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definitions.
   a. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS~~,~~ or a subcontractor of ADHS/DBHS, or Children's Rehabilitative Services.
   b. For the purposes of this Section and R9-22-210.01, "fiscal agent" means a person who bills and accepts payment for a hospital or emergency room provider.
3. Verification. A provider of emergency medical services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor.
4. Prior authorization.
   a. Emergency medical services. ~~Prior authorization is not required for emergency medical services for non-FES members.~~ A provider is not required to obtain prior authorization for emergency medical services.
   b. Non-emergency medical services. If a non-FES member's medical condition does not require emergency medical services, the provider shall obtain prior authorization as required by the terms of the provider agreement under R9-22-714(A) or the provider's subcontract with the contractor, whichever is applicable.
5. Prohibition against denial of payment. Neither the ~~The~~ Administration ~~and~~ nor a contractor shall: ~~not limit or deny payment for emergency medical services for the following reasons:~~
   ~~a. On the basis of lists of diagnoses or symptoms,~~
   ~~b. Prior authorization was not obtained, or~~
   ~~c. The provider does not have a subcontract.~~
   a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms,
   b. Deny or limit payment because the provider failed to obtain prior authorization for emergency services,
   c. Deny or limit payment because the provider does not have a subcontract.
6. Grounds for denial. The Administration and a contractor may deny payment for emergency medical services for reasons including but not limited to:
   a. The claim was not a clean claim;
   b. The claim was not submitted timely; and
   c. The provider failed to provide timely notification under subsection (B)(4) to the contractor or the Administration, as appropriate, and the contractor does not have actual notice from any other source that the member has presented for services.

B. Additional requirements for emergency medical services for non-FES members enrolled with a contractor.
1. Responsible entity. A contractor is responsible for the provision of all emergency medical services to non-FES members enrolled with the contractor.
2. Prohibition against denial of payment. A contractor shall not limit or deny payment for emergency medical services when an employee of the contractor instructs the member to obtain emergency medical services.
3. Contractor notification ~~Notification~~. A contractor shall not deny payment to a hospital, emergency room provider, or fiscal agent for an emergency medical service rendered to a non-FES member based on the failure of the hospital, emergency room provider, or fiscal agent to notify the member's contractor within 10 days from the day that the member presented for the emergency medical service.
4. Contractor notification. A hospital, emergency room provider, or fiscal agent shall notify the contractor no later than the 11th day after presentation of the non-FES member for emergency inpatient medical services. A contractor may deny payment for a hospital's, emergency room provider's, or fiscal agent's failure to provide timely notice, under this subsection.

C. Post-stabilization services for non-FES members enrolled with a contractor.
1. After the emergency medical condition of a member enrolled with a contractor is stabilized, a provider shall request prior authorization from the contractor for post-stabilization services.
2. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that have been prior authorized by the contractor.
3. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor for prior authorization of further post-stabilization services;
4. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain, improve, or resolve the member's stabilized condition if:
   a. The contractor does not respond to a request for prior authorization within one hour;
   b. The contractor authorized to give the prior authorization cannot be contacted; or

c. The contractor representative and the treating physician cannot reach an agreement concerning the member's care and the contractor physician is not available for consultation. In this situation, the contractor shall give the treating physician the opportunity to consult with a contractor physician. The treating physician may continue with care of the member until the contractor physician is reached or:
   i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care;,
   ii. A contractor physician assumes responsibility for the member's care through transfer;,
   iii. The contractor's representative and the treating physician reach agreement concerning the member's care;, or
   iv. The member is discharged.

5. Transfer or discharge. The attending physician or practitioner actually treating the member for the emergency medical condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor.

D. Additional requirements for FFS members.

1. Responsible entity. The Administration is responsible for the provision of all emergency medical services to non-FES FFS members.
2. Grounds for denial. The Administration may deny payment for emergency medical services if a provider fails to provide timely notice to the Administration.
3. Notification. A provider shall notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

R9-22-210.01. Emergency Behavioral Health Services for Non-FES Members

A. General provisions.

1. Applicability. This Section applies to emergency behavioral health services for non-FES members. Provisions regarding emergency medical services for non-FES members are in R9-22-210. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definition. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS, a subcontractor of ADHS/DBHS, or Children's Rehabilitative Services.
3. Responsible entity for inpatient emergency behavioral health services.
   a. Members enrolled with a contractor.
      i. ADHS/DBHS. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with the contractor, from one of the following time periods, whichever comes first:
         (1) The date on which the member becomes a behavioral health recipient; or
         (2) The ~~seventy-third~~ 73rd hour after admission for inpatient emergency behavioral health services.
      ii. Contractors. Contractors are responsible for providing inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with a contractor and are not behavioral health recipients, for the first 72 hours after admission.
   b. FFS members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services for non-FES FFS members with psychiatric or substance abuse diagnoses.
4. Responsible entity for non-inpatient emergency behavioral health services for non-FES members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all non-inpatient emergency behavioral health services for non-FES members.
5. Verification. A provider of emergency behavioral health services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is a member enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor, and determine whether the member is a behavioral health recipient as defined in R9-22-102.
6. Prior authorization.
   a. Emergency behavioral health services. ~~Emergency behavioral health services do not require prior authorization.~~ A provider is not required to obtain prior authorization for emergency behavioral health services.
   b. Non-emergency behavioral health services. When a non-FES member's behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the prior authorization requirements of a contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.
7. Prohibition against denial of payment. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services to a non-FES member for the following reasons:
   a. On the basis of lists of diagnoses or symptoms;
   b. Prior authorization was not obtained;
   c. The provider does not have a contract;
   d. An employee of the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS instructs the member to

obtain emergency behavioral health services; or
e. The failure of a hospital, emergency room provider, or fiscal agent to notify the member's contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS within 10 days from the day the member presented for the emergency service.

8. Grounds for denial. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS may deny payment for emergency behavioral health services for reasons including but not limited to the following:
   a. The claim was not a clean claim~~.~~;
   b. The claim was not submitted timely~~.~~; or
   c. The provider failed to provide timely notification under subsection (A)(9) to the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.
9. Notification. A hospital, emergency room provider, or fiscal agent shall notify a contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, whichever is appropriate, no later than the 11th day from presentation of the non-FES member for emergency inpatient behavioral health services.
10. Behavioral health evaluation. An emergency behavioral health evaluation is covered as an emergency behavioral health service for a non-FES member under this Section if:
    a. Required to evaluate or stabilize an acute episode of mental disorder or substance abuse~~.~~;, and
    b. Provided by a qualified provider who is:
       i. A behavioral health medical practitioner as defined in R9-22-112, including a licensed psychologist, a licensed clinical social worker, a licensed professional counselor, and a licensed marriage and family therapist; or
       ii. An ADHS/DBHS-contracted provider.
11. Transfer or discharge. The attending physician or the provider actually treating the non-FES member for the emergency behavioral health condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.

B. Post-stabilization requirements for non-FES members.
1. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have been prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.
2. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor, ADHS/DBHS, or a subcontractor for prior authorization of further post-stabilization services~~.~~;
3. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain, improve, or resolve the member's stabilized condition if:
   a. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, does not respond to a request for prior authorization within one hour;
   b. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS authorized to give the prior authorization cannot be contacted; or
   c. The representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician cannot reach an agreement concerning the member's care and the contractor's, ADHS/DBHS' or the subcontractor's physician, is not available for consultation. The treating physician may continue with care of the member until ADHS/DBHS', the contractor's, or the subcontractor's physician is reached~~.~~; or:
      i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care;
      ii. ADHS/DBHS', a contractor's, or a subcontractor's physician assumes responsibility for the member's care through transfer;
      iii. A representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician reach agreement concerning the member's care; or
      iv. The member is discharged.

R9-22-211. Transportation Services

A. Emergency ambulance services.
1. A member shall receive medically necessary emergency transportation in a ground or air ambulance:
   a. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs~~.~~;, and
   b. If no other appropriate means of transportation is available.
2. The Administration or a member's contractor shall reimburse a ground or air ambulance transport that originates in response to a 911 call or other emergency response system:
   a. If the member's medical condition justifies the medical necessity of the type of ambulance transportation

received,
b. The transport is to the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
c. No prior authorization is required for reimbursement of these transports.
3. The member's medical condition at the time of transport determines whether the transport is medically necessary.
4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure of the provider to ~~obtain prior authorization~~ provide notification is cause for denial.
5. Notification to the Administration of emergency transportation provided to a FFS member is not required, but the provider shall submit documentation with the claim ~~which~~ that justifies the service.

B. The Administration or a contractor covers air ambulance services only if ~~one or more of the criteria~~ at least one criterion in subsection (B)(1) is met and at least one criterion in subsection (B)(2) ~~(2)~~, or the criterion in subsection (B)(3) ~~(3)~~ is met. The criteria are:
1. The air ambulance transport is initiated at the request of:
a. An emergency response unit~~;~~,
b. A law enforcement official~~;~~,
c. A clinic or hospital medical staff member~~;~~, or
d. A physician or practitioner~~;~~, and
2. The point of pickup:
a. Is inaccessible by ground ambulance~~;~~, or
b. Is a great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition and ground ambulance service will not suffice,~~;~~ or
3. The medical condition of the member requires immediate intervention~~:~~
~~a. Intervention~~ from emergency ambulance personnel or providers with the appropriate facilities to treat the member's condition~~, or~~,
~~b. Ground ambulance service will not suffice for the factors listed in subsection (B)(2).~~

C. Coverage of medically ~~Medically~~ necessary nonemergency transportation is limited to the cost of transporting the member to an appropriate provider capable of meeting the member's medical needs.
1. As specified in contract, a contractor shall arrange or provide medically necessary nonemergency transportation services for a member who is unable to arrange transportation to a service site or location.
2. For a fee-for-service member, the Administration shall authorize medically necessary nonemergency transportation for a member who is unable to arrange transportation to a service site or location.

D. For the purposes of this subsection, an individual means a person who is not in the business of providing transportation services such as a family or household member, friend, or neighbor. The Administration or a contractor shall cover expenses for transportation in traveling to and returning from an approved and prior authorized health care service site provided by an individual if:
1. The transportation services are authorized by the Administration or the member's contractor or designee~~;~~,
2. The individual is an AHCCCS registered provider~~;~~, and
3. No other means of appropriate transportation is available.

E. The Administration or a contractor shall cover expenses for meals, lodging, and transportation for a member traveling to and returning from an approved ~~and prior authorized~~ health care service site outside of the member's service area or county of residence.

F. The Administration or a contractor shall cover the expense of meals, lodging, and transportation for:
1. A family member accompanying a member if:
a. The member is traveling to or returning from an approved ~~and prior authorized~~ health care service site outside of the member's service area or county of residence; and
b. The meals, lodging, and transportation services are authorized by the Administration or the member's contractor or designee.
2. An escort who is not a family member as follows:
a. If the member is travelling to or returning from an approved and prior authorized health care service site, including an inpatient facility, outside of the member's service area or county of residence; ~~and~~
b. If the escort services are authorized by the Administration or the member's contractor or designee~~.~~; and
c. Wage paid to an escort as reimbursement shall not exceed the federal minimum wage.

G. A provider shall obtain prior authorization from the Administration for transportation services provided for a member for the following:
1. Medically necessary nonemergency transportation services not originated through a 911 call or other emergency response system when the distance traveled exceeds 100 miles (whether one way or round trip); and
2. All meals, lodging, and services of an escort accompanying the member under this Section.

H. A charitable organization routinely providing transportation service at no cost to an ambulatory or chairbound person

shall not charge or seek reimbursement from the Administration or a contractor for the provision of the service to a member but may enter into a subcontract with a contractor for medically necessary transportation services provided to a member.

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. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services under A.R.S. § 36-2907(D);
9. Private or special duty nursing services ~~when medically necessary and prior authorized~~;
10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
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;
12. Inpatient chemotherapy; and
13. Outpatient chemotherapy.

B. Prior authorization from the Administration for a member is required for services listed in subsections (A)(3)(b), and (A)(4) through (11)~~.~~; except for:
1. Voluntary sterilization;
2. Dialysis shunt placement;
3. Arteriovenous graft placement for dialysis;
4. Angioplasties or thrombectomies of dialysis shunts;
5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis;
6. Eye surgery for the treatment of diabetic retinopathy;
7. Eye surgery for the treatment of glaucoma;
8. Eye surgery for the treatment of macular degeneration;
9. Home health visits following an acute hospitalization (limited up to five visits);
10. Hysteroscopies (up to two, one before and one after) when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization;
11. Physical therapy subject to the limitation in subsection (C);
12. Facility services related to wound debridement,
13. Apnea management and training for premature babies up to the age of 1; and
14. Other services identified by the Administration through the Provider Participation Agreement.

C. The following ~~services are excluded as~~ are not 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;
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~~ benefit year with the exception of the required Medicare coinsurance and deductible payment as described in 9 A.A.C. 29, Article 3.

R9-22-217. Services Included in the Federal Emergency Services Program

A. Definition. For the purposes of this Section, an emergency medical or behavioral health condition for a FES member means a medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute

symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. Placing the member's health in serious jeopardy,
2. Serious impairment to bodily functions,
3. Serious dysfunction of any bodily organ or part, or
4. Serious physical harm to another person.

B. Services. "Emergency services for a FES member" mean those medical or behavioral health services provided for the treatment of an emergency condition. Emergency services include outpatient dialysis services for an FES member with End Stage Renal Disease (ESRD) where a treating physician has certified for the month in which services are received that in ~~his~~ the physician's opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in:
1. Placing the ~~patient's~~ member's health in serious jeopardy, or
2. Serious impairment of bodily function, or
3. Serious dysfunction of a bodily organ or part.

C. Covered services. Services are considered emergency services if all of the criteria specified in subsection (A) are satisfied at the time the services are rendered ~~and timely notification as specified in subsection (E) is given~~. The Administration shall determine whether an emergency condition exists on a case-by-case basis.

D. Prior authorization. A provider is not required to obtain prior authorization for emergency services for FES members. Prior authorization for outpatient dialysis services is met when the treating physician has completed and signed a monthly certification as described in subsection (B).

~~**E.** Notification. A provider shall notify the Administration no later than 72 hours after a FES member receiving emergency medical or behavioral health services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.~~

ARTICLE 7. STANDARDS FOR PAYMENTS

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 shall reduce payment of or deny claims, if an AHCCCS-registered provider fails to obtain prior authorization or notify the Administration under Article 2 of this Chapter and this Article.~~
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.

R9-22-712. Reimbursement: General

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

B. Inpatient and outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS 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, AHCCCS shall reimburse an out-of-state hospital 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 Administration shall pay the claim by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio.

C. Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or the Administration's designated representative in performance of the Administration's utilization control activities. The Administration shall deny a claim for failure to cooperate.

D. Prior authorization. ~~The Administration shall deny a claim for failure to obtain prior authorization as required in R9-22-210.~~ The Administration or contractor may deny a claim if a provider fails to obtain prior authorization as required under R9-22-210.

E. Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers, to prepayment medical review or post-payment review, or both. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims. If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more appropriate level of care, effective on the date when the different level of care was medically appropriate.

F. Claim receipt.

1. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number.
2. Hospital claims are considered paid on the date indicated on disbursement checks.
3. A denied claim is considered adjudicated on the date the claim is denied.
4. Claims that are denied and are resubmitted are assigned new receipt dates.
5. For a claim that is pending for additional supporting documentation specified in A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation.
6. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.

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

1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs are included in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calculate the outpatient hospital cost-to-charge ratio annually for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in R9-22-712.01. The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
   a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital by taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
   b. Cost-to-charge limit. To comply with 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items

that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.

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

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

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

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

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

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

Editor's Note: The following Notice of Final 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 February 28, 2011.

[R11-111]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-31-201	Amend
R9-31-204	Amend
R9-31-215	Amend
Article 16	Amend
R9-31-1601	Amend
R9-31-1602	Repeal
R9-31-1603	Repeal
R9-31-1604	Repeal
R9-31-1605	Repeal
R9-31-1606	Repeal
R9-31-1607	Repeal
R9-31-1608	Repeal
R9-31-1609	Repeal
R9-31-1610	Repeal
R9-31-1611	Repeal
R9-31-1612	Repeal

R9-31-1613	Repeal
R9-31-1614	Repeal
R9-31-1615	Repeal
R9-31-1622	Repeal
R9-31-1625	Repeal

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

Authorizing statute: A.R.S. §§ 36-2903.01, 36-2907

Implementing statute: A.R.S. § 36-2907

3. The effective date of the rules:

August 2, 2011

Effective immediately upon filing with the Secretary of State. The Administration believes that an immediate effective date is necessary since the rule changes are less stringent than the rule that is currently in effect and the rule changes do not have an impact on the public health, safety, welfare or environment, and do not affect the public involvement and public participation process as described under A.R.S. § 41-1032(A)(5).

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

Notice of Rulemaking Docket Opening: 17 A.A.R. 514, April 8, 2011

Notice of Proposed Rulemaking: 17 A.A.R. 501, April 8, 2011

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

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Administrative 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:

The proposed rules will eliminate the requirement for obtaining PA for services such as, but not limited to: dialysis shunt placement, apnea management and training for premature babies up to one year of life, certain eye surgeries, and hospitalizations for labor and delivery not exceeding specific time parameters. Technical changes and striking of redundant rules will be made. In addition, a clarification to the definition of Prior Authorization will be made, to inform the public that prior authorization is not only based on medical necessity but also on the cost effectiveness of the service provided. Article 16 rules are being repealed because the rules were found to be duplicative of many rules in Chapter 22, Article 2. The Administration believes that a cross reference to Article 2 makes the rules more concise and manageable. References to "Native American" are being replaced by "American Indian" because the appropriate term and culturally correct phrase is "American Indian."

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 any analysis of each study and other supporting material:

No study was reviewed or relied upon for this rulemaking.

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 AHCCCS Administration believes that subjecting the identified services to PA adds administrative costs and time-consuming processes to Agency operations, further straining limited program resources without accompanying benefits. This amendment also reduces the administrative burden on health care providers and facilitates members' access to appropriate care.

Currently 95 percent of the cases are approved. The Administration believes that removal of this requirement will save the provider time and money. Each PA takes five-10 minutes and each biller is costing a provider approximately $15 an hour, possibly saving providers $14,000 in a year. The Administration will also save time and money for the cost of the PA nurse's time, estimated to be $28,000 a year. In addition, the Administration will no longer conduct concurrent reviews for Federal Emergency Service (FES) members since federal regulations and state plan prohibit prior authorization for emergency services. The reference to concurrent review in rule is therefore not necessary and the PA

department can cease conducting these reviews, which numbered 1,980 in calendar year 2010. At $95.00 per review, the total savings estimated by eliminating concurrent review for FES hospitalizations would approach $188,100.00.

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

No additional changes have been made between the proposed rules and the final rules below. The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.

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

The Administration did not receive any comments regarding the rules.

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:

Not applicable

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

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 2. SCOPE OF SERVICES

Section
R9-31-201. General Requirements
R9-31-204. Inpatient General Hospital Services
R9-31-215. Other Medical Professional Services

ARTICLE 16. SERVICES FOR ~~NATIVE AMERICANS~~ AMERICAN INDIANS

Section
R9-31-1601. General Requirements
R9-31-1602. ~~General Requirements for Scope of Services~~ Repealed
R9-31-1603. ~~Inpatient General Hospital Services~~ Repealed
R9-31-1604. ~~Physician and Primary Care Physician and Practitioner Services~~ Repealed
R9-31-1605. ~~Organ and Tissue Transplantation Services~~ Repealed
R9-31-1606. ~~Dental Services~~ Repealed
R9-31-1607. ~~Laboratory, Radiology, and Medical Imaging Services~~ Repealed
R9-31-1608. ~~Pharmaceutical Services~~ Repealed
R9-31-1609. ~~Emergency Services~~ Repealed
R9-31-1610. ~~Transportation Services~~ Repealed
R9-31-1611. ~~Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies~~ Repealed
R9-31-1612. ~~Health Risk Assessment and Screening Services~~ Repealed
R9-31-1613. ~~Other Medical Professional Services~~ Repealed
R9-31-1614. ~~NF, Alternative HCBS Setting, or HCBS~~ Repealed
R9-31-1615. ~~Eligibility and Enrollment~~ Repealed
R9-31-1622. ~~The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care~~ Repealed
R9-31-1625. ~~Behavioral Health Services~~ Repealed

ARTICLE 2. SCOPE OF SERVICES

R9-31-201. General Requirements

A. The Administration shall administer the Children's Health Insurance Program under A.R.S. § 36-2982.
B. Scope of services for ~~Native American~~ American Indian fee-for-service members is under Article 16 of this Chapter.
C. A contractor or RBHA shall provide behavioral health services under Article 12 and Article 16.
D. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:
1. Only medically necessary, cost effective, and federally- reimbursable and state-reimbursable services are covered ser-

vices.

2. The Administration or a contractor may waive the covered services referral requirements of this Article.
3. Except as authorized by a contractor, a primary care provider, practitioner, or dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
4. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
5. ~~A member may receive behavioral health evaluation services without a referral from a primary care provider. 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.~~ A member may receive behavioral health services as specified in 9 A.A.C. 22, Articles 2 and 12.
6. 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.
7. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
8. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
   a. A service that is determined by the AHCCCS Chief Medical Officer 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 in R9-31-212.
9. Medical or behavioral health services are not covered if provided to:
   a. An inmate of a public institution;
   b. A person who is a resident of an institution for the treatment of tuberculosis; or
   c. A person who is in an IMD at the time of application, unless provided under Article 12 of this Chapter.

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

E. The Administration or a contractor may deny payment if a provider fails to obtain prior authorization as specified in this Article and Article 7 of this Chapter for non-emergency services. The Administration or a contractor shall not provide prior authorization for services unless the provider submits documentation of the medical necessity of the treatment along with the prior authorization request.

F. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition.

G. Under A.R.S. § 36-2989, a member shall receive covered services outside of the GSA only if one of the following applies:
1. A member is referred by a primary care provider for medical specialty care out of the contractor's area. If the member is referred outside of the GSA to receive an authorized medically necessary service, a 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; or
3. The contractor authorizes placement in a nursing facility located outside of the GSA;

H. 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.

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

J. The restrictions, limitations, and exclusions in this Article do not apply to a contractor if the contractor elects to provide noncovered services.
1. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
2. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

R9-31-204. Inpatient General Hospital Services

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, 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 under 9 A.A.C. 31, Article 12.

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 not ordinarily furnished to all patients which are customarily reimbursed as ancillary services.
3. Providers are not required to obtain prior authorization from the Administration for the following inpatient hospital services:
   a. Dialysis shunt placement,
   b. Arteriovenous graft placement for dialysis,
   c. Angioplasties or thrombectomies of dialysis shunts,
   d. Angioplasties or thrombectomies of arteriovenous graft for dialysis,
   e. Hospitalization for vaginal delivery that does not exceed 48 hours,
   f. Hospitalization for cesarean section delivery that does not exceed 96 hours, and
   g. Other services identified by the Administration through the Provider Participation Agreement.

R9-31-215. 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, medication, 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; and
   b. Natural family planning education or referral;
4. Midwifery services provided by a nurse practitioner certified in midwifery;
5. Podiatry services if ordered by a member's primary care provider as specified in A.R.S. § 36-2989;
6. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services in A.R.S. § 36-2989;
9. Private or special duty nursing services ~~if medically necessary and prior authorized~~;
10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology provided under this Article;
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);
12. Inpatient chemotherapy;
13. Outpatient chemotherapy; and
14. Hospice care under R9-22-213.

B. Prior authorization from the Administration for a member is required for services listed in subsections (A)(4) through (11) and (14); except for:
1. Dialysis shunt placement,
2. Arteriovenous graft placement for dialysis,
3. Angioplasties or thrombectomies of dialysis shunts,
4. Angioplasties or thrombectomies of arteriovenous grafts for dialysis,
5. Eye surgery for the treatment of diabetic retinopathy,
6. Eye surgery for the treatment of glaucoma,
7. Eye surgery for the treatment of macular degeneration,
8. Home health visits following an acute hospitalization (limited up to five visits),
9. Hysteroscopies, (up to two, one before and one after, when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization),

10. Physical therapy subject to the limitation in subsection R9-22-215 (C),
11. Facility services related to wound debridement,
12. Apnea management and training for premature babies up to the age of 1, and
13. Other services identified by the Administration through the Provider Participation Agreement.

ARTICLE 16. SERVICES FOR ~~NATIVE AMERICANS~~ AMERICAN INDIANS

R9-31-1601. General Requirements

A. ~~A Native American~~ An American Indian who is a member may receive:
1. Covered acute care services specified in this Chapter from:
   a. Indian Health Service (IHS) under A.R.S. § 36-2982 if IHS has a signed agreement with the Administration,
   b. A Tribal Facility under A.R.S. § 36-2982, ~~or~~
   c. A contractor under A.R.S. § 36-2901~~.~~, or
   d. An AHCCCS registered provider.
2. Covered behavioral health care services as specified in this Chapter from:
   a. IHS under A.R.S. § 36-2982 if IHS has a signed agreement with the Administration,
   b. A Tribal Facility under A.R.S. § 36-2982, or
   c. A RBHA or TRBHA.

B. IHS, a Tribal facility, or a referred provider shall meet the requirements in this Chapter and A.A.C. Chapter 22, Articles 2 and ~~A.A.C. Chapter 22, Article~~ 7 to receive reimbursement for AHCCCS-covered services. ~~The following sections of~~ Title 9 A.A.C. ~~Chapter~~ 22, ~~Article~~ Articles 2 and 7 are applicable to reimbursement for AHCCCS-covered services provided to ~~a Native American~~ an American Indian member under the KidsCare program, except that the term "IHS,"~~,~~ "Tribal facility,"~~,~~ or "referred provider" is substituted for "provider."~~:~~
1. ~~Scope of the Administration's Liability, R9-22-701.10;~~
2. ~~Charges to Members, R9-22-702;~~
3. ~~Prior authorization, R9-22-703(D);~~
4. ~~Claims Review, R9-22-703(E);~~
5. ~~Payments by the Administration, R9-22-703;~~
6. ~~Payments for Services Provided to Eligible Native Americans, R9-22-708;~~
7. ~~Payments to Providers, R9-22-714; and~~
8. ~~Specialty Contracts, R9-22-712(G)(3), R9-22-712.01(10).~~

R9-31-1602. ~~General Requirements for Scope of Services~~ Repealed

~~**A.** In addition to the requirements and the limitations specified in this Chapter, the following general requirements apply:~~
1. ~~Under A.R.S. § 36-2989, covered services provided to a member shall be medically necessary and provided by, or under the direction of, the IHS, a Tribal Facility, a provider, or a dentist. Specialist services are provided under referral from the IHS or a Tribal Facility provider.~~
2. ~~If IHS cannot provide a covered service due to in the appropriation of funds by Congress, the obligation to allocate IHS program resources nationwide, or a fundamental shift in the manner of providing health services to Native Americans on a national basis then a member shall be referred to a non IHS provider or a non IHS facility for the service.~~

~~**B.** As specified in A.R.S. § 36-2989, covered services rendered to a member are provided within the service area of the IHS or a Tribal Facility except when:~~
1. ~~An IHS or a Tribal Facility refers a member out of the area for medical specialty care or behavioral health services,~~
2. ~~A covered service that is medically necessary for a member is not available within the service area, or~~
3. ~~A member is placed in an NF located out of the service area.~~

~~**C.** If a member requests the provision of service that is not covered or not authorized by the IHS or Tribal Facility, an AHCCCS registered provider may provide the service under the following conditions:~~
1. ~~IHS or a Tribal Facility shall prepare and provide the member with a document that lists the requested services and the estimated cost of each service; and~~
2. ~~The member signs a document prior to the provision of services indicating that the member understands the services and accepts the responsibility for payment.~~

~~**D.** Noncovered services provided to a member by the IHS, a Tribal Facility or under referral may be paid by the IHS or a Tribal Facility, but not with Title XXI funds.~~

R9-31-1603. ~~Inpatient General Hospital Services~~ Repealed

~~**A.** A fee-for-service provider or non-contracting provider shall provide the following 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 (NICU);~~
   c. ~~Intensive care (ICU);~~

~~d. Surgery, including surgery room and recovery room;~~
~~e. Nursery;~~
~~f. Routine care; and~~
~~g. Emergency behavioral services under 9 A.A.C. 31, Article 12;~~
~~2. The following ancillary services including:~~
~~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 which are customarily reimbursed as ancillary services.~~

~~**B.** The following limitations apply to inpatient general hospital services that are provided by a FFS provider:~~
~~1. A provider shall obtain prior authorization from the Administration for the following inpatient hospital services:~~
~~a. Nonemergency and elective admission, including psychiatric hospitalization;~~
~~b. Elective surgery, excluding a voluntary sterilization procedure. A voluntary sterilization procedure does not require prior authorization; and~~
~~c. A service or items provided to reconstruct or improve personal appearance after an illness or injury.~~
~~2. The Administration may perform concurrent review for hospitalizations to determine whether there is medical necessity for the hospitalization.~~
~~a. A provider shall notify the Administration no later than the fourth day of hospitalization after an emergency admission or no later than the second day after an intensive care unit admission so that the Administration may initiate concurrent review of the hospitalization.~~
~~b. Failure of the provider to obtain prior authorization is cause for denial of a claim.~~

R9-31-1604. ~~Physician and Primary Care Physician and Practitioner Services~~ Repealed

~~**A.** Primary care services shall be furnished by a physician or a primary care practitioner. Primary care services may be provided in an inpatient or outpatient setting and shall include:~~
~~1. Periodic health examinations and assessments,~~
~~2. Evaluations and diagnostic workups,~~
~~3. Prescriptions for medications and medically necessary supplies and equipment,~~
~~4. Referrals to a specialist or other health care professional when medically necessary as specified in A.R.S. § 36-2989,~~
~~5. Patient education,~~
~~6. Home visits when determined medically necessary,~~
~~7. Covered immunizations, and~~
~~8. Covered preventive health services.~~

~~**B.** As specified in A.R.S. § 36-2989, a second opinion procedure may be required to determine coverage for surgeries for a member referred out of the IHS or a Tribal Facility. Under this procedure, documentation must be provided by at least two physicians as to the need for the proposed surgery.~~

~~**C.** The following limitations and exclusions apply to physician and practitioner services and primary care provider services for a member referred out of the IHS or a Tribal Facility:~~
~~1. Specialty care and other services provided to a member upon referral from a primary care provider shall be limited to the services or conditions for which the referral is made, or for which authorization is given;~~
~~2. If a physical examination is performed with the primary intent to accomplish one or more of the objectives listed in subsection (A), it may be covered by the IHS or a Tribal Facility except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:~~
~~a. Qualification for insurance,~~
~~b. Pre-employment physical evaluation,~~
~~c. Qualification for sports or physical exercise activities,~~
~~d. Pilot's examination (FAA),~~
~~e. Disability certification for establishing any kind of periodic payments,~~
~~f. Evaluation for establishing third party liabilities, or~~
~~g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A).~~
~~3. The following services shall be excluded from Title XXI coverage:~~
~~a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;~~
~~b. Services or items furnished solely for cosmetic purposes;~~
~~c. Hysterectomies, unless determined to be medically necessary;~~

~~d. Abortion counseling or abortion except according to federal law;~~
~~e. Chiropractic services; and~~
~~f. Licensed midwife service for prenatal care and home births.~~

R9-31-1605. ~~Organ and Tissue Transplantation Services~~ Repealed

~~**A.** The following organ and tissue transplantation services are covered for a member as specified in A.R.S. § 36-2989 if prior authorized by the Administration:~~
~~1. Kidney transplantation,~~
~~2. Simultaneous Kidney/Pancreas transplant,~~
~~3. Cornea transplantation,~~
~~4. Heart transplantation,~~
~~5. Liver transplantation,~~
~~6. Autologous and allogenic bone marrow transplantation,~~
~~7. Lung transplantation,~~
~~8. Heart-lung transplantation, and~~
~~9. Other organ transplantation if the transplantation is required by federal law and if other statutory criteria are met.~~
~~**B.** Immunosuppressant medications, chemotherapy, and other related services provided in an IHS, a Tribal Facility, or by a referral provider do not need to be prior authorized.~~

R9-31-1606. ~~Dental Services~~ Repealed

~~Medically necessary dental services shall be provided for children under age 19 as specified in A.R.S. § 36-2989.~~

R9-31-1607. ~~Laboratory, Radiology, and Medical Imaging Services~~ Repealed

~~As specified in A.R.S. § 36-2989, laboratory, radiology, and medical imaging services may be covered services if:~~
~~1. Prescribed for a member by an IHS, a Tribal Facility care provider or a dentist, or if prescribed by a physician or a practitioner upon referral from the IHS, a Tribal Facility provider or a dentist;~~
~~2. Provided in a hospital, a clinic, a physician office, or other health care facility by IHS or a Tribal Facility provider; or~~
~~3. Provided by an IHS or a Tribal Facility provider that meets all applicable state and federal license and certification requirements and provides only services that are within the scope of practice stated in a provider's license or certification.~~

R9-31-1608. ~~Pharmaceutical Services~~ Repealed

~~**A.** Pharmaceutical services may be provided by the IHS, a Tribal Facility, or upon referral from an IHS or a Tribal Facility provider.~~
~~**B.** As specified in A.R.S. § 36-2989, pharmaceutical services are covered if prescribed for a member by the IHS, a Tribal Facility provider or a dentist, or if prescribed by a specialist upon referral from the IHS or a Tribal Facility provider.~~
~~**C.** The following limitations apply to pharmaceutical services:~~
~~1. A medication personally dispensed by a physician or a dentist, or a practitioner within the individual's scope of practice, is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed.~~
~~2. A prescription or refill in excess of 100-unit doses is not covered. A prescription or refill in excess of a 30-day supply is not covered unless specified in subsection (C)(3).~~
~~3. A prescription or refill in excess of a 30-day supply is covered if:~~
~~a. The medication is prescribed for a chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit doses, whichever is greater.~~
~~b. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed a 100-day supply or 100-unit doses, whichever is greater.~~
~~c. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.~~
~~4. An over-the-counter medication in place of a covered prescription medication is covered only if the over-the-counter medication is appropriate, equally effective, safe, and is less costly than the covered prescription medication.~~
~~**D.** The IHS or a Tribal Facility shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being.~~

R9-31-1609. ~~Emergency Services~~ Repealed

~~Emergency medical services provided by the IHS, a Tribal Facility, or a referral provider outside the service area shall be provided based on the prudent layperson standard to a member by the IHS or a Tribal Facility provider registered with AHCCCS to provide services as specified in A.R.S. § 36-2989.~~

R9-31-1610. ~~Transportation Services~~ Repealed

~~The Administration shall provide transportation services under A.A.C. R9-22-211.~~

R9-31-1611. ~~Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies~~ Repealed

~~Durable medical equipment, orthotic and prosthetic devices, and medical supplies, including incontinence briefs, are covered services if provided in compliance with the requirements of this Chapter and A.A.C. R9-22-212. For purposes of this Section, where the phrase "AHCCCS services" is used in R9-22-212, it is replaced with the phrase "Title XXI services." Where the term "provider" or "contractor" is used, it is replaced with the phrase "IHS or Tribal facility."~~

R9-31-1612. ~~Health Risk Assessment and Screening Services~~ Repealed

~~**A.** As specified in A.R.S. § 36-2989, the following services shall be covered for a member less than 19 years of age:~~
- ~~1. Screening services, including:~~
  - ~~a. Comprehensive health, behavioral health, and developmental histories;~~
  - ~~b. Comprehensive unclothed physical examination;~~
  - ~~c. Appropriate immunizations according to age and health history;~~
  - ~~d. Health education, including anticipatory guidance; and~~
  - ~~e. Laboratory tests.~~
- ~~2. Vision services including:~~
  - ~~a. Diagnosis and treatment for defects in vision.~~
  - ~~b. Eye examinations for the provision of prescriptive lenses, and~~
  - ~~c. Provision of prescriptive lenses.~~
- ~~3. Hearing services, including:~~
  - ~~a. Diagnosis and treatment for defects in hearing,~~
  - ~~b. Testing to determine hearing impairment, and~~
  - ~~c. Provision of hearing aids.~~

~~**B.** Providers of services shall meet the following standards:~~
- ~~1. Provide services by or under the direction of a member's IHS or a Tribal Facility provider or a dentist;~~
- ~~2. Perform tests and examinations under 42 CFR 441, Subpart B, January 29, 1985, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments;~~
- ~~3. Refer a member as necessary for dental diagnosis and treatment, and necessary specialty care; and~~
- ~~4. Refer a member as necessary for behavioral health evaluation and treatment services as specified in this Article.~~

~~**C.** The IHS or a Tribal Facility shall meet additional conditions for a member as stated in the Intergovernmental Agreement between the Administration and IHS.~~

~~**D.** The IHS or a Tribal Facility provider shall refer a member with special health care needs under A.A.C. R9-7-301 to CRS.~~

R9-31-1613. ~~Other Medical Professional Services~~ Repealed

~~**A.** The following medical professional services are covered services if a member receives these services in an inpatient, an outpatient, or an 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, medication, 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; and~~
  - ~~b. Natural family planning education or referral;~~
- ~~4. Midwife services provided by a certified nurse practitioner;~~
- ~~5. Podiatry services if ordered by an IHS or a Tribal Facility provider;~~
- ~~6. Respiratory therapy;~~
- ~~7. Ambulatory and outpatient surgery facilities services;~~
- ~~8. Home health services;~~
- ~~9. Private or special duty nursing services if medically necessary and prior authorized;~~
- ~~10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology provided under this Article;~~
- ~~11. Total parenteral nutrition services which is the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract;~~
- ~~12. Hospice care under R9-22-213,~~
- ~~13. Inpatient chemotherapy, and~~
- ~~14. Outpatient chemotherapy.~~

~~**B.** The Administration shall prior authorize services in subsections (A)(4) through (12) for a member referred out of the IHS~~

~~or a Tribal Facility service area.~~

R9-31-1614. ~~NF, Alternative HCBS Setting, or HCBS~~ Repealed

~~**A.** Services provided in a NF, including room and board, an alternative HCBS setting, or a HCBS as defined under A.R.S. § 36-2939 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.~~

~~**B.** Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:~~

~~1. Nursing services, including:~~
~~a. Administration of medication;~~
~~b. Tube feeding;~~
~~c. Personal care services, including but not limited to assistance with bathing and grooming;~~
~~d. Routine testing of vital signs; and~~
~~e. Maintenance of catheter.~~
~~2. Basic patient care equipment and sickroom supplies, including:~~
~~a. First aid supplies such as bandages, tape, ointment, peroxide, alcohol, and over the counter remedies;~~
~~b. Bathing and grooming supplies;~~
~~c. Identification device;~~
~~d. Skin lotion;~~
~~e. Medication cup;~~
~~f. Alcohol wipes, cotton balls, and cotton rolls;~~
~~g. Rubber gloves (non-sterile);~~
~~h. Laxatives;~~
~~i. Bed and accessories;~~
~~j. Thermometer;~~
~~k. Ice bag;~~
~~l. Rubber sheeting;~~
~~m. Passive restraints;~~
~~n. Glycerin swabs;~~
~~o. Facial tissue;~~
~~p. Enemas;~~
~~q. Heating pad; and~~
~~r. Diapers.~~
~~3. Dietary services including preparing and administering special diets or adaptive tools for eating;~~
~~4. Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal mandate, state licensure standard, or county certification requirement;~~
~~5. Physical therapy; and~~
~~6. Assistive device or non-customized DME.~~

~~**C.** The Administration shall prior authorize each NF admission outside the IHS or a Tribal Facility's service area.~~

R9-31-1615. ~~Eligibility and Enrollment~~ Repealed

~~The eligibility and enrollment provisions specified in 9 A.A.C. 31, Article 3 apply to a Native American who elects to receive services through the IHS or a Tribal Facility.~~

R9-31-1622. ~~The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care~~ Repealed

~~**A.** Expenses for an emergency or acute medical health condition of a member are reimbursed only until the member's condition is stabilized and the member is transferable, or until the member is discharged following stabilization subject to the requirements of this Chapter and A.R.S. § 36-2989. This Section only applies to those noncontracting hospitals outside the IHS or Tribal Facility network.~~

~~**B.** Subject to subsection (A), if a member cannot be transferred following stabilization to the IHS or a Tribal Facility, the Administration shall pay for all appropriately documented, prior authorized, and medically necessary treatment provided to a member before the discharge date or transfer under R9-31-705.~~

~~**C.** If a member refuses transfer from a noncontracting provider or a noncontracting hospital to the IHS or a Tribal Facility, the Administration is not liable for any costs incurred after the date of refusal if:~~
~~1. After consultation with a member's IHS or a Tribal Facility, a member continues to refuse the transfer; and~~
~~2. A member is provided and signs a written statement, before the date the member is liable for payment informing a member of the medical and financial consequences of refusing to transfer. If a member refuses to sign a written statement, a statement signed by two witnesses indicating that the member was informed may be substituted.~~

R9-31-1625. ~~Behavioral Health Services~~ Repealed

~~**A.** The IHS, a TRBHA, a RBHA or a Tribal Facility may provide any or all of the behavioral health services specified in 9 A.A.C. 31, Article 12, subject to the limitations and specifications stated in 9 A.A.C. 31, Article 12, to a Native American who is a member.~~

~~**B.** The IHS, a Tribal Facility, a contractor, a TRBHA or a RBHA shall cooperate as specified in contract, IGA, or this Chapter when the transition from one entity to another becomes necessary.~~

~~**C.** The IHS and a Tribal Facility shall be considered a provider for the provision of behavioral health services and shall be subject to the requirements of:~~

~~1. A TRBHA if one is operating in a service area, or~~

~~2. A RBHA in a service area that does not have a TRBHA or a contractor for a Native American member with respect to prior authorization and service authorizations.~~

~~**D.** If either the IHS or a Tribal Facility cannot provide a nonemergency inpatient or an outpatient behavioral health service, the IHS or a Tribal Facility shall refer the member to a RBHA or a TRBHA.~~

~~**E.** If a member is enrolled with a contractor and is not enrolled with a TRBHA or a RBHA, the contractor is responsible for the provision of emergency behavioral health services for up to three days per admission, not to exceed 12 days per contract year, and shall refer a member to a TRBHA or a RBHA for continued service authorization and any needed additional services.~~

~~**F.** The provider shall obtain prior authorization for all inpatient hospitalizations and partial care services as authorized in R9-31-1202 and R9-31-1203.~~

~~**G.** A provider shall comply with the requirements specified in subsections (B) and (C). If a provider fails to comply, payment is denied, or if paid, is recouped by the Administration.~~

~~**H.** A behavioral health service provided by the IHS or a Tribal Facility shall be reimbursed as specified in R9-31-1616.~~

NOTICE OF FINAL RULEMAKING

TITLE 17. TRANSPORTATION

CHAPTER 5. DEPARTMENT OF TRANSPORTATION COMMERCIAL PROGRAMS

Editor's Note: The following Notice of Final 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 March 1, 2010.

[R11-112]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R17-5-201	Amend
R17-5-202	Amend
R17-5-203	Amend
R17-5-204	Amend
R17-5-205	Repeal
R17-5-206	Amend
R17-5-208	Amend
R17-5-209	Amend
R17-5-210	Amend
R17-5-211	Amend
R17-5-212	Amend

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

Authorizing statutes: A.R.S. §§ 28-366, 28-962, and 28-5204

Implementing statutes: A.R.S. §§ 28-3223, 28-3306(A)(5), 28-3315(H), 28-5238

3. The effective date of the rules:

August 2, 2011

The Department requests that this rulemaking be effective immediately on filing with the Office of the Secretary of State, as permitted under A.R.S. § 41-1032, to:

Preserve the public peace, health, and safety. The Arizona Department of Transportation (ADOT) and the Department of Public Safety (DPS) inspect commercial trucks and buses under these rules. Since the rules incor-

porate by reference the generally accepted federal standards used by industry and law enforcement personnel to promote safe operation of both interstate and intrastate commercial motor vehicles, the Department's Enforcement & Compliance Division and DPS officers rely on the rules for guidance when finding issues severe enough to warrant concern for public safety and placing commercial motor vehicles out-of-service;

Avoid a violation of federal law or regulation or state law. The Department is statutorily required to administer the driver licensing and medical evaluation activities required of commercial motor vehicle drivers under A.R.S. Title 28, Chapter 8, and these rules. ADOT and DPS have been working diligently to accomplish these rule updates since March 1, 2010, after receiving permission from the Governor's Office to move forward with the rulemaking. These updates are necessary to provide commercial motor vehicle drivers with a clearer and more concise understanding of their responsibilities in relation to Arizona's commercial driver license standards. When adopting rules necessary to enforce and administer A.R.S. Title 28, Chapter 14, relating to motor carrier safety, the Department of Transportation is required under A.R.S. § 28-5204(A)(2) to consider, as evidence of generally accepted safety standards, the publications of the United States Department of Transportation. 49 CFR 384 requires that each state comply with the provisions of section 12009(a) of the Commercial Motor Vehicle Safety Act of 1986 (49 U.S.C. 31311(a)), and adopt and administer a program for testing and ensuring the fitness of persons to operate commercial motor vehicles in accordance with the minimum federal standards contained in 49 CFR 383 by January 30, 2012; and

Comply with deadlines in amendments to an agency's governing statutes or federal programs. The Arizona Department of Public Safety (DPS) administers and enforces the Federal Motor Carrier Safety Assistance Program throughout the state of Arizona under these rules. To remain in compliance with federal mandates, the Federal Motor Carrier Safety Administration requires that each state adopt federal motor carrier safety and hazardous materials regulations that are current to within three years. The possibility exists of either the withholding of, or reduction in, federal funding for the state if these rules are not codified as quickly as possible. Both ADOT and DPS have been working diligently to accomplish these rule updates since March 1, 2010, after receiving permission from the Governor's Office to move forward with the rulemaking.

As a condition of grant approval under the authority of 49 U.S.C. 31102, as amended, if this rulemaking is approved by the Governor's Regulatory Review Council on August 2, 2011, with an immediate effective date, DPS will be eligible to apply for an estimated $3,668,606 in FY 2012 MCSAP funding that may be used for commercial motor vehicle safety programs such as:

- Motor carrier safety programs in accordance with 49 CFR 350.109;
- Size and weight enforcement programs in accordance with 49 CFR 350.309(c)(1);
- Drug interdiction enforcement programs in accordance with 49 CFR 350.309(c)(2); and
- Traffic safety programs in accordance with 49 CFR 350.309(d).

DPS administers federal grants received for enforcing the federal motor carrier safety and hazardous materials regulations. These grants total $5.5 million annually and cover the costs of salaries, equipment, and other expenses for motor carrier and hazmat related enforcement. A requirement of the grants is to adopt federal regulations into state law. Failure to do so jeopardizes possible future grant funding opportunities and places the Department of Transportation at risk for the withholding of up to five percent of the state's federal-aid highway funds apportioned under each of sections 104(b)(1), (b)(3), and (b)(4) of 23 U.S.C. for noncompliance, which could reach approximately $30 million depending on actual appropriations. Notwithstanding the withholding of funds as described above, the Federal Motor Carrier Safety Administration could prohibit the Department of Transportation's Commercial Driver License Program from issuing, renewing, transferring, or upgrading commercial driver licenses in this state if they determine that Arizona is not substantially in compliance with 49 U.S.C. 31311(a).

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

Notice of Rulemaking Docket Opening: 17 A.A.R. 450, April 1, 2011

Notice of Proposed Rulemaking: 17 A.A.R. 530, April 15, 2011

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

Name: John Lindley, Administrative Rules Analyst

Address: Administrative Rules Unit
Department of Transportation
1801 W. Jefferson St., Mail Drop 517M
Phoenix, AZ 85007

Telephone: (602) 712-8804

Fax: (602) 712-3373

E-mail: jlindley@azdot.gov

Please visit the ADOT web site to track progress of this rule and any other agency rulemaking matters at www.azdot.gov/mvd/mvdrules/index.asp.

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

The Arizona Department of Transportation (ADOT), in partnership with the Department of Public Safety (DPS), engages in this rulemaking to incorporate sections of the 2009 edition of the *Code of Federal Regulations*. The United States Department of Transportation requires that states adopt Federal Motor Carrier Safety and Hazardous Materials Regulations to ensure eligibility for federal enforcement grants. Both ADOT and DPS rely on these federal monies to fund numerous enforcement positions especially at Arizona's southern ports of entry.

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 any analysis of each study and other supporting material:

None

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

Not applicable

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

DPS administers and enforces the Federal Motor Carrier Safety Assistance Program (MCSAP) throughout the state of Arizona under these rules. The primary cost bearers in relation to these rules are ADOT, DPS, counties, and municipal law enforcement agencies electing to enforce the provisions locally, and privately contracted consultant trainers of law enforcement personnel.

DPS incurs substantial costs (more than $10,000) annually for program administration as well as a not readily quantifiable portion of officer salaries for hazardous materials transportation program enforcement. Business entities bear minimal to moderate costs (under $10,000) in possible federal registration fees, inspection fees, insurance, and equipment maintenance to remain in compliance with the rules. However, these costs arise from the federal law rather than from this rulemaking. Minimal administrative costs are borne by independent consultant trainers who educate law enforcement and business entities on rule compliance.

The Department of Transportation is statutorily required to administer the driver licensing and medical evaluation activities required of commercial motor vehicle drivers under A.R.S. Title 28 and these rules. The Department does not expect this rulemaking to create a significant increase or decrease in costs or benefits to the agency since the rulemaking is generally intended to incorporate by reference an updated version of the federal motor carrier safety and hazardous materials regulations the agency currently has in place.

The Federal Motor Carrier Safety Administration extends annually to the Arizona DPS a substantial grant under MCSAP for state law enforcement of motor carrier safety and hazmat programs. MCSAP funds are distributed chiefly to DPS but may also be sub-allocated to county and municipal enforcement agencies upon application to underwrite local enforcement costs.

Local enforcement cost estimates are difficult to quantify as they are contingent upon whether officers are dedicated to commercial vehicle enforcement or incorporate commercial vehicle enforcement together with other duties. Accordingly, local law enforcement electing to engage in commercial vehicle enforcement could benefit substantially from cost defrayal through receipt of MCSAP fund allocation by application to DPS, the primary recipient of the MCSAP federal grant monies.

To maintain compliance with the provisions of these rules, motor carriers will likely incur moderate costs in the form of equipment, maintenance, insurance, and inspection fees. However, costs arise from the federal law rather than from this rulemaking. There are no new fees associated with this rulemaking. If a motor carrier is found to be noncompliant with provisions of these rules, costs of sanctions under A.R.S. § 28-5238 could range from $5,000 to $25,000 per violation and the possible loss of a commercial driver license as prescribed under A.R.S. § 28-5238. Benefits to motor carriers remaining in compliance with these rules include increased safety, lower financial responsibility premiums, the opportunity to increase profit margin through better customer service, and more expedient administrative processing by law enforcement.

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

Under R17-5-201:

The term "Hearing Office" was changed to "Executive Hearing Office" as used in this Article;

The term "Physiatrist" was expanded for clarification purposes; and

The term "Vision examination report" was clarified to indicate that the report can be completed by an ophthalmologist or a licensed optometrist.

Under R17-5-202:

The contact information of the U.S. Government Printing Office for use in obtaining the incorporated material has been updated and now includes an option for ordering incorporated materials online.

Under R17-5-203:

Subsection (C)(1) was changed to clarify that the exemption from federal motor carrier safety regulations granted by the Department of Public Safety during a local emergency is to the extent necessary for providing vital service to the public.

Under R17-5-208:

Subsection (A) was changed for clarification purposes and to avoid duplication of the language already provided under subsection (C)(4);

The term "intrastate waiver" as used under subsections (C), (D), (E), and (Q) was changed for clarification purposes to "intrastate medical waiver";

The term "medical report and certificate" as used under subsections (D)(1) and (E)(1) was changed for clarification purposes to "medical examination report and medical examination certificate";

The term "examiner" as used under subsections (D)(2)(a)(ii) and (D)(2)(b)(iii) was changed for clarification purposes to "a board qualified or board certified physiatrist or orthopedic surgeon";

The term "certified examiner" as used under subsection (E)(3) was changed for clarification purposes to "federally certified state commercial driver license examiner";

Subsection (K)(1) referencing subsection (E)(3) was corrected to reflect (F)(3);

Subsection (K)(2) referencing subsection (E)(4) was corrected to reflect (F)(4);

Subsection (P)(6) referencing subsection (D)(3) was corrected to reflect (D)(2); and

Subsection (U) referencing the Federal Diabetes Exemption Program was removed since it is already part of the incorporated material. The Federal Motor Carrier Safety Administration has expanded their exemption programs to include a vision exemption. Information on the Federal Exemption Programs can be found online at http://www.fmcsa.dot.gov.

Under R17-5-209:

The contact information of the U.S. Government Printing Office for use in obtaining the incorporated material has been updated and now includes an option for ordering incorporated materials online.

Under R17-5-210:

Subsection (B)(4) referencing 49 CFR 390.15 was corrected to reflect 49 CFR 390.5.

Under R17-5-211:

Subsections (A)(1) and (D)(1) were corrected to include the definition Section of R17-5-201 as applicable to transporters.

Under R17-5-212:

Subsection (A)(1) was corrected to indicate applicability under all ADOT motor carrier safety regulations, which are grouped together under R17-5-201 through R17-5-209;

Subsection (G) referencing the emergency motor carrier hearing process according to R17-5-211(F) was corrected to reflect R17-5-211(E); and

Subsection (G)(1)(b) was corrected by including the terms "manufacturer" and "shipper" as applicable to the emergency motor carrier hearing and suspension process prescribed under A.R.S. § 28-5232.

Minor grammatical and technical corrections were made throughout at the request of the Governor's Regulatory Review Council staff.

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

The Department held an oral proceeding for this rulemaking on May 16, 2011, and received no oral or written comments from the public.

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

None

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

A.A.C. R17-5-202: 49 CFR 40, 379, 382, 383, 390, 391, 392, 393, 395, 396, 397, and 399, revised as of October 1, 2009

A.A.C. R17-5-209: 49 CFR 107, 171, 172, 173, 177, 178, and 180, revised as of October 1, 2009

14. Were these rules previously made as emergency rules?

No

15. The full text of the rules follows:

TITLE 17. TRANSPORTATION

CHAPTER 5. DEPARTMENT OF TRANSPORTATION
COMMERCIAL PROGRAMS

ARTICLE 2. MOTOR CARRIERS

Section
R17-5-201. Definitions
R17-5-202. Motor Carrier Safety: Incorporation of Federal Regulations; ~~Application~~ Applicability
R17-5-203. Motor Carrier Safety: 49 CFR 390 - Federal Motor Carrier Safety Regulations; General ~~Applicability and Definitions; General Requirements and Information~~
R17-5-204. Motor Carrier Safety: 49 CFR 391 - Qualifications of Drivers and Longer Combination Vehicle (LCV) Driver Instructors
R17-5-205. ~~Motor Carrier Safety: 49 CFR 382 - Controlled Substances and Alcohol Use and Testing~~ Repealed
R17-5-206. Motor Carrier Safety: ~~Amendment to~~ 49 CFR 392 - Driving of Commercial Motor Vehicles
R17-5-208. Commercial Driver License ~~Insulin-dependent Diabetic Waiver~~ Intrastate Medical Waiver; Intrastate Alternative Physical Qualification Standards for the Loss or Impairment of Limbs or Monocular Vision; Federal Diabetes Exemption Program
R17-5-209. Hazardous Materials Transportation; Incorporation of Federal Regulations; Applicability
R17-5-210. Motor Carrier Safety: Public Service Corporation, Political Subdivision of this State that is Engaged in Rendering Public Utility Service, or Railroad Contacting State Officials in an Emergency
R17-5-211. Motor Carrier Safety: Inspection, Enforcement, Sanction
R17-5-212. Motor Carrier Safety: Hearing Procedure

ARTICLE 2. MOTOR CARRIERS

R17-5-201. Definitions

~~**A.**~~ In addition to the definitions provided under A.R.S. §§ 28-3001 and 28-5201, the following definitions apply to this Article unless otherwise specified:

"Audit" means any inspection of a transporter's motor vehicle, equipment, books, or records to determine compliance with this Article and A.R.S. Title 28, Chapter 14.

"Co-applicant" means an employer or potential employer.

"Danger to public safety" means any condition of a transporter likely to result in serious peril to the public if not discontinued immediately.

~~"Division" means the Motor Vehicle Division, Arizona Department of Transportation.~~

"Director" means the ~~Assistant~~ Director of the Arizona Department of Transportation ~~for the Motor Vehicle Division~~ or the ~~Assistant~~ Director's designated agent.

"Executive Hearing Office" means the Arizona Department of ~~Transportation, Motor Vehicle Division,~~ Transportation's Executive Hearing Office.

"Medical waiver evaluation summary" means the form, provided by the Department, to be completed by either a board qualified or board certified orthopedic surgeon or physiatrist and mailed to the Department, at the address provided on the form, on behalf of an Arizona intrastate medical waiver applicant.

"Physiatrist" means a doctor of medicine specialized in physical medicine and rehabilitation.

"Transporter" means any person, driver, motor carrier, shipper, manufacturer, or motor vehicle, including any motor vehicle transporting a hazardous material, hazardous substance, or hazardous waste, subject to this Article and A.R.S. Title 28, Chapter 14.

"Violation" means any conduct, act, or failure to act required or prohibited under this Article and A.R.S. Title 28, Chapter 14.

"Vision examination report" means a form provided by the Department to be completed by an ophthalmologist or a licensed optometrist on behalf of a driver or driver applicant and mailed to the Department, at the address provided on the form, for use in determining whether or not a medical condition affects the driver's, or driver applicant's, ability to safely perform the functional skills involved with driving a motor vehicle.

~~**B.**~~ ~~Any definition prescribed under A.R.S. § 28-5201 also applies to this Article.~~

R17-5-202. Motor Carrier Safety: Incorporation of Federal Regulations; ~~Application~~ Applicability

A. The ~~Division~~ Department incorporates by reference 49 CFR 40, 379, 382, 383, 390, 391, 392, 393, 395, 396, 397, and 399, ~~published~~ revised as of October 1, ~~2005~~ 2009, and no later amendments or editions, as amended under ~~R17-5-202 through R17-5-207~~ this Article. ~~The incorporated material is available from the U.S. Government Printing Office, Superintendent of Documents, Mail Stop: SSOP, Washington, DC 20402-0001, and is on file with the Division.~~ The incorporated material is on file with the Department and is available from the U.S. Government Printing Office, P.O. Box 979050, St. Louis, MO 63197-9000. The incorporated material can be ordered online by visiting the U.S. Government Online Bookstore at http://bookstore.gpo.gov.

B. The ~~Sections~~ sections of 49 CFR ~~that are~~ incorporated ~~in~~ under subsection (A) apply as amended under ~~R17-5-203 through R17-5-207~~ this Article to all intrastate and interstate motor carriers operating in Arizona, except as provided under subsection (C).

C. The intrastate operator of a tow truck with a gross vehicle weight rating of 26,000 pounds or less is exempt from the requirements of 49 CFR 390 through 399, except that the driver is subject to the physical qualifications and examination requirements of 49 CFR 391, subpart E.

R17-5-203. Motor Carrier Safety: 49 CFR 390 - Federal Motor Carrier Safety Regulations; General ~~Applicability and Definitions; General Requirements and Information~~

A. 49 CFR 390.3, General applicability, is amended as follows:

~~1.~~ Paragraph (a) is amended to read:
Regulations incorporated in this ~~Section~~ section are applicable to all motor carriers operating in Arizona and any vehicle owned or operated by the state, a political subdivision, or a state public authority that is used to transport a hazardous material in an amount requiring the vehicle to be ~~marked or~~ placarded as prescribed under R17-5-209.

~~2. Paragraph (b) is amended to read:~~
~~A motor carrier driver domiciled in Arizona who operates a commercial motor vehicle as defined under A.R.S. § 28-3001 shall comply with the requirements of A.R.S. Title 28, Chapter 8 and any rule made under that Chapter.~~

~~3. Paragraph (c) is amended to read:~~
~~A motor carrier operating in Arizona in furtherance of a commercial enterprise, shall comply with the financial responsibility requirement specified in A.R.S. Title 28, Chapter 9, Article 2, and 49 CFR 387.~~

~~4. Paragraph (f)(6) is deleted.~~

B. 49 CFR 390.5, Definitions. The definitions listed ~~in~~ under 49 CFR 390.5 are amended as follows:

~~1. If the term~~ "Commercial Motor Vehicle" or "CMV" ~~is used in reference to the controlled substances and alcohol use and testing requirement of 49 CFR 382, the term has the meaning prescribed in 49 CFR 382.107~~ has the same meaning as prescribed under A.R.S. § 28-5201.

~~2. If the term "Commercial Motor Vehicle" or "CMV" is used in reference to the licensing requirements prescribed under A.R.S. § 28-3223, the term has the meaning prescribed under A.R.S. § 28-3001.~~

~~3. If the term "Commercial Motor Vehicle" or "CMV" is not used in reference to the controlled substances and alcohol use and testing requirement of 49 CFR 382 or the licensing requirement prescribed under A.R.S. § 28-3223, the term means a self-propelled, motor-driven vehicle or vehicle combination, used on a public highway in this state in furtherance of a commercial enterprise that:~~

~~a. Has a gross vehicle weight rating (GVWR) as a single vehicle or a gross combination weight rating (GCWR) of 18,001 pounds or more for purposes of intrastate commerce;~~

~~b. Transports passengers for hire and has a design capacity of eight or more persons or transports a hazardous material in an amount requiring marking or placarding as prescribed by the federal regulations incorporated in R17-5-209;~~

~~c. Is not an intrastate-operating tow truck that has a GVWR of 26,000 pounds or less, but a tow truck operator remains subject to all other provisions prescribed under 49 CFR 391.41, 391.43, 391.45, 391.47, and 391.49; or~~

~~d. Operates for purposes of interstate commerce with a GVWR of greater than 10,000 pounds.~~

~~4. "Exempt intracity zone" is deleted and has no application in R17-5-203 through R17-5-207.~~

~~5. "For-hire motor carrier," "private motor carrier," "private motor carrier of passengers (business)," and "private motor carrier of passengers (nonbusiness)" are deleted from R17-5-203 through R17-5-207 and the term "motor carrier" is substituted.~~

~~6. "Regional Director of Motor Carriers" means the Division Director of the Arizona Department of Transportation, Motor Vehicle Division.~~

~~7.~~ "Special agent" means an officer or agent of the Department, the Department of Public Safety, ~~the Division,~~ or a political subdivision, who is trained and certified by the Department of Public Safety to enforce Arizona's Motor Carrier Safety requirements.

~~8.~~ "State" means a state of the United States or the District of Columbia.

~~9.~~ "Tow truck," as used in the definition of emergency ~~in~~ under 49 CFR 390.5, has the same meaning as prescribed under A.A.C. ~~R13-3-101~~ R13-3-701.

~~**C.** 49 CFR 390.15, Assistance in investigations and special studies. Paragraph (a) is amended to read:~~

~~A motor carrier shall make all records and information pertaining to an accident available to a special agent upon request or as part of any inquiry within the time the request or inquiry specifies. A motor carrier shall give a special agent all reasonable assistance in the investigation of any accident including providing a full, true, and correct answer to any question of the inquiry.~~

~~**D.** 49 CFR 390.19 Motor carrier identification report, Paragraph (a) is amended to read:~~

~~(a) Each motor carrier that conducts operations in interstate commerce, intrastate commerce if the carrier requires a Safety Permit as per 49 CFR 385.400 of this Chapter, or intrastate commerce in a CMV defined under A.A.C. R17-5-203(B)(3) shall file a Motor Carrier Identification Report, Form MCS-150, or the Combined Motor Carrier Identification Report and HM Permit Application, Form MCS-150B for permitted carriers, at the following times:~~

~~(1) Before it begins operations; and~~

~~(2) Every 24 months, according to the following schedule:~~

~~USDOT Number ending in:~~	~~Must file by last day of:~~
~~1~~	~~January~~
~~2~~	~~February~~
~~3~~	~~March~~
~~4~~	~~April~~
~~5~~	~~May~~
~~6~~	~~June~~
~~7~~	~~July~~
~~8~~	~~August~~
~~9~~	~~September~~
~~0~~	~~October~~

~~(3) If the next-to-last digit of its USDOT number is odd, the motor carrier shall file its update in every odd-numbered calendar year. If the next to last digit of the USDOT number is even, the motor carrier shall file its update in every even-numbered calendar year.~~

~~**E.** 49 CFR 390.21 Marking of CMVs. Paragraph (a) is amended to read:~~

~~(a) General. Every self propelled CMV listed under A.A.C. R17-5-203(B)(3), subject to subchapter B of this Chapter shall be marked as specified in paragraph (b), (c), and (d) of 49 CFR 390.21.~~

~~**F.**~~**C.** 49 CFR 390.23, Relief from regulations.

~~1. Paragraph (a) is amended to read:~~

~~Regulations contained in 49 CFR 390 through 397 do not apply to a motor carrier that:~~

~~a. Is exempt from federal jurisdiction, and~~

~~b. Operates a commercial motor vehicle used or designated to provide relief during an emergency.~~

1. Paragraph (a)(2), Local emergencies, is amended by adding:

When a local emergency exists that justifies an exemption from parts 390 through 399 of this chapter, a motor carrier may request the exemption by contacting Commercial Vehicle Enforcement at the Arizona Department of Public Safety, Highway Patrol Division, P.O. Box 6638, Phoenix, AZ 85005. The Arizona Department of Public Safety may grant the exemption with or without restrictions as necessary to provide vital service to the public.

~~2. Paragraphs (a)(1), including (a)(1)(i), (a)(1)(i)(A), (a)(1)(i)(B), and (a)(1)(ii) are deleted.~~

~~3.~~2. Paragraph (a)(2)(i)(A) is amended to read:

~~a. An emergency has been declared by a federal, state, or local government official having authority to declare an emergency; or~~

~~b. An emergency situation exists under A.R.S. § 28-5234(B) as defined under R17-5-210.~~

An emergency has been declared by a federal, state or local government official having authority to declare an emergency; or an emergency situation exists under A.R.S. § 28-5234(B); or

~~4. Paragraph (a)(2)(i)(B) is amended to read:~~

~~The Arizona Department of Public Safety Commercial Vehicle Enforcement Bureau shall determine whether a local emergency exists that justifies an exemption from any or all of these Parts. If the Arizona Department of Public Safety Commercial Vehicle Enforcement Bureau determines relief from these regulations is necessary to provide vital service to the public, relief shall be granted with any restrictions the Arizona Department of Public Safety considers necessary.~~

~~5. "Interstate commerce" as used in paragraph (b) means engagement in a commercial enterprise.~~

~~**G.**~~**D.** 49 CFR 390.25, Extension of relief from regulations - emergencies, is amended ~~to read~~ by adding:

~~A motor carrier seeking to extend a period of relief from these regulations shall obtain approval from the Arizona Department of Public Safety Commercial Vehicle Enforcement Bureau. The motor carrier shall give full details of the additional relief requested. The Arizona Department of Public Safety shall observe time limits for emergency relief from regulations as prescribed under 49 CFR 390.23(a), but may extend a period of relief after considering:~~

~~1. Severity of the emergency;~~

~~2. Nature of relief services to be provided by the motor carrier, and~~

~~3. Other restrictions that may be necessary.~~

A motor carrier seeking to extend a period of relief from these regulations may request the extension by contacting Commercial Vehicle Enforcement at the Arizona Department of Public Safety, Highway Patrol Division, P.O. Box 6638, Phoenix, AZ 85005. The Arizona Department of Public Safety may grant the extension with any restrictions it considers necessary to provide vital service to the public.

~~**H.** 49 CFR 390.27, Locations of motor carrier safety service centers, is amended to read:~~

~~A motor carrier requesting relief from these regulations shall contact the Arizona Department of Public Safety, Commercial Vehicle Enforcement Bureau, Telephone at (602) 223-2212.~~

R17-5-204. Motor Carrier Safety: 49 CFR 391 - Qualifications of Drivers and Longer Combination Vehicle (LCV) Driver Instructors

A. 49 CFR 391.11 ~~Qualifications~~ General qualifications of drivers. Paragraph (b)(1) is amended to read:

Is at least 21 years of age for interstate operation ~~and~~; or is at least 18 years of age for operations restricted to intrastate transportation not involving the transportation of a reportable quantity of hazardous substance, hazardous waste required to be manifested, or hazardous material in an amount requiring a vehicle to be ~~marked or~~ placarded as prescribed under R17-5-209.

~~**B.** 49 CFR 391.49 Alternative physical qualification standards for the loss or impairment of limbs.~~

~~1. Paragraph (a) is amended by adding:~~

~~A person not physically qualified to drive as prescribed under 49 CFR 391.41(b)(1), (b)(2), (b)(3), or (b)(10) but otherwise qualified to drive a motor vehicle, may drive a motor vehicle in intrastate commerce if the Director grants an intrastate waiver to the person. Application for an intrastate waiver shall be submitted according to subsection (C). If granted, an intrastate waiver shall be for a period not to exceed two years. A person granted an intrastate waiver may transfer the intrastate waiver from an original employer to a new employer upon written notification to the Director stating the new employer's name and the type of equipment to be driven.~~

~~2. Paragraph (b) is amended by adding:~~

~~To obtain an intrastate waiver, an applicant or an applicant and co-applicant shall submit a letter of application for an intrastate waiver of a physical qualification to the Motor Vehicle Division, Medical Review Program, P.O. Box 2100, Mail Drop 818Z, Phoenix, Arizona 85001-2100. The applicant shall comply with all the requirements of 49 CFR 391.49(c), "Alternative physical qualification standards for the loss or impairment of limbs,". The driver applicant shall respond to the requirements of 49 CFR 391.49(c)(2)(i) through (c)(2)(v), if the information is known.~~

~~3. Paragraph (c)(1)(iv) is amended to read:~~

~~A description of the driver applicant's limb or visual impairment as applicable to the type of waiver being requested.~~

~~4. Paragraph (d)(3)(i) is amended to read:~~

~~The medical evaluation summary for a driver applicant disqualified under 49 CFR 391.41(b)(1) or (b)(10) shall include:~~

~~5. Paragraph (d)(3)(i)(B) is amended to read:~~

~~A statement by the examiner that the applicant is capable of demonstrating precision prehension (e.g., manipulating knobs and switches) and power grasp prehension (e.g., holding and maneuvering the steering wheel) with each upper limb separately when the intrastate waiver is requested due to a loss or impairment of limbs or a statement by the examiner that an applicant has distant visual acuity at least 20/40 (Snellen), with or without a corrective lens, in one eye, visual field of at least 70° peripheral measurement of the horizontal meridian of the applicant's dominant eye, and the ability to distinguish the colors of a traffic signal or device showing standard red, green, and amber, as applicable to the type of waiver being requested.~~

~~6. Paragraph (j)(1) is amended by adding:~~

~~A person with a distant visual acuity of greater than 20/40 (Snellen), with or without a corrective lens, in one eye; a field of vision of less than 70° peripheral measurement of the horizontal meridian of the person's dominant eye; and the inability to distinguish the colors of a traffic signal or device showing standard red, green and amber, shall not:~~

~~a. Transport any amount of hazardous material required to be marked or placarded as prescribed under R17-5-209, or~~

~~b. Operate a vehicle for the purpose of transporting passengers as prescribed under R17-5-202.~~

~~**C.** Waiver procedure for an intrastate driver.~~

~~1. A person not physically qualified to drive as prescribed under 49 CFR 391.41(b)(1), (b)(2), or (b)(10) but otherwise qualified to drive a motor vehicle, may drive a motor vehicle intrastate commerce if the Director grants an intrastate waiver to the person.~~

~~2. The applicant shall submit an application to the Division as prescribed under 49 CFR 391.49(a), (b), (c), and (d) as amended under this Section.~~

~~3. Upon receipt of an application for an intrastate waiver, the Director shall:~~

~~a. Review the application for waiver to ensure all provisions of 49 CFR 391.49 are met;~~

~~b. Take necessary testimony and accept documentation and information about the application;~~

~~c. Ensure that a driver applying for an intrastate waiver of the visual requirements:~~

~~i. Has driven the type of vehicle to be operated as prescribed in the waiver for at least two of the previous five years; and~~
~~ii. Will not transport passengers for hire, or~~
~~iii. Will not transport a reportable quantity of a hazardous substance, hazardous waste that requires a manifest, or hazardous material that requires marking or placarding as prescribed under R17-5-209;~~
~~d. Send written and dated notification of the approval or denial of the applicant's request for a waiver to the applicant within 10 days of the decision. The notice shall:~~
~~i. Direct the approved applicant to contact the nearest Commercial Driver Licensing office to schedule a commercial driver license pre-inspection, off-road, and on-road tests within 30 days from date of notice; or~~
~~ii. Inform the denied applicant of the right to a hearing and the procedure for requesting an administrative hearing. The administrative hearing is held in accordance with the procedures prescribed under 17 A.A.C. 1, Article 5.~~
~~4. Intrastate waiver form.~~
~~a. The Director shall ensure that the application for waiver form reflects the terms, conditions, or limitations of the waiver.~~
~~b. The Director shall maintain the original waiver form.~~
~~c. The motor carrier shall retain a legible copy of the waiver form:~~
~~i. During the driver's employment as a driver, and~~
~~ii. For a minimum of three years after the driver ceases driving for the motor carrier.~~
~~d. A driver granted a waiver shall possess a legible copy of the waiver when driving a commercial motor vehicle.~~
~~5. If the enforcement of any provision of this Section would result in the loss or disqualification of federal funding for any state agency or program, that provision is invalid.~~

~~D.~~**B.** ~~Subpart F - Files and Records.~~ 49 CFR 391.51 General requirements for driver qualification files. Paragraph (b)(8) is amended by adding:
"; or ~~the Director's letter of notification, granting an intrastate waiver of physical disqualification~~ a copy of the Arizona intrastate medical waiver, if a waiver is granted by the Director as prescribed under ~~this Section~~ R17-5-208."

~~E.~~ ~~The following sections are deleted:~~
~~1. 49 CFR 391.68 Private motor carrier of passengers (nonbusiness).~~
~~2. 49 CFR 391.69 Private motor carrier of passengers (business).~~

R17-5-205. ~~Motor Carrier Safety: 49 CFR 382 - Controlled Substances and Alcohol Use and Testing~~ Repealed

~~A. 49 CFR 382.103 Applicability. Paragraph (a)(1) is amended to read:~~
~~The commercial driver license requirements of the state of Arizona.~~

~~B. 49 CFR 382.115 Starting date for testing programs. Paragraph (a) is amended to read:~~
~~The controlled substances and alcohol use and testing requirements begin for all motor carriers on the date this Section goes into effect.~~

~~C. Paragraph (b) is deleted.~~

R17-5-206. Motor Carrier Safety: ~~Amendment to~~ 49 CFR 392 - Driving of Commercial Motor Vehicles

~~A.~~ 49 CFR 392.5, Alcohol prohibition. Paragraph (e) is amended ~~to read~~ by adding:
Drivers who violate the terms of an out-of-service order as prescribed under this ~~Section~~ section are also subject to the provisions and sanctions of A.R.S. § 28-5241.

~~B. 49 CFR 392.9a is deleted.~~

R17-5-208. Commercial Driver License ~~Insulin-dependent Diabetic Waiver~~ Intrastate Medical Waiver; Intrastate Alternative Physical Qualification Standards for the Loss or Impairment of Limbs or Monocular Vision; Federal Diabetes Exemption Program

~~A person not physically qualified to drive as prescribed under 49 CFR 391.41(b)(3) but otherwise qualified to drive a motor vehicle, may drive a commercial motor vehicle if the Federal Diabetes Exemption Program grants a waiver to the person. An insulin-dependent diabetic applicant may request an application for an Insulin-dependent Diabetic Waiver by contacting the Federal Diabetes Exemption Program either by telephone at (703) 448-3094 or in writing at Federal Diabetes Exemption Program, 1200 New Jersey Ave., SE, Room W64-224, Washington, DC 20590.~~

A. A person who is not physically qualified to drive a commercial motor vehicle in interstate commerce due to loss of limb, limb impairment, or monocular vision, as provided under 49 CFR 391.41(b)(1), (b)(2), or (b)(10), may operate a commercial motor vehicle in intrastate commerce if granted an intrastate medical waiver by the Director.

B. A person eligible to apply for an intrastate medical waiver under subsection (A) shall:
1. Meet all other requirements under 49 CFR 391.49(c), Alternative Physical Qualification Standards for the Loss or Impairment of Limbs; and
2. Apply to the Department as prescribed under subsection (C).

C. A driver applicant, or a driver applicant jointly with the motor carrier co-applicant that will employ the driver applicant, may complete and submit an intrastate medical waiver application to the Department's Medical Review Program, P.O.

Box 2100, Mail Drop 818Z, Phoenix, Arizona 85001-2100, which shall:

1. Identify the applicant:
   a. Name and complete address of the driver applicant;
   b. Name and complete address of the motor carrier co-applicant;
   c. U.S. Department of Transportation motor carrier identification number, if known; and
   d. A description of the driver applicant's limb or visual impairment as applicable to the type of waiver being requested;
2. Describe the type of operation the driver applicant will be employed to perform, if the information is known:
   a. Average period of time the driver will be driving or on duty, per day;
   b. Type of commodities or cargo to be transported;
   c. Type of driver operation (i.e., sleeper team, relay, owner operator, etc.); and
   d. Number of years experience operating each type of commercial motor vehicle requested in the intrastate medical waiver application and total years of experience operating all types of commercial motor vehicles;
3. Describe the commercial motor vehicles the driver applicant intends to drive:
   a. Truck, truck tractor, or bus make, model, and year (if known);
   b. Drive train;
      i. Transmission type (automatic or manual - if manual, designate number of forward speeds);
      ii. Auxiliary transmission (if any) and number of forward speeds; and
      iii. Rear axle (designate single speed, two-speed, or three-speed);
   c. Type of brake system;
   d. Steering, manual or power assisted;
   e. Description of types of trailers (i.e., van, flatbed, cargo tank, drop frame, lowboy, or pole);
   f. Number of semitrailers or full trailers to be towed at one time;
   g. For commercial motor vehicles designed to transport passengers, indicate the seating capacity of the commercial motor vehicle; and
   h. Description of any modifications made to the commercial motor vehicle for the driver applicant, attach photographs where applicable;
4. Include a certification statement:
   a. The co-applicant motor carrier shall certify that the driver applicant is otherwise qualified to drive a commercial motor vehicle under the regulations of 49 CFR 391; or
   b. In the case of a unilateral application, the driver applicant shall certify that the driver applicant is otherwise qualified to drive a commercial motor vehicle under the regulations of 49 CFR 391; and
5. Document the signature and date signed:
   a. The driver applicant's signature in the case of a unilateral application; or
   b. The motor carrier official's signature and title if the application has a co-applicant. Depending on the motor carrier's organizational structure (corporation, partnership, or proprietorship), the signer of the application shall be an officer, partner, or the proprietor.

D. The completed intrastate medical waiver application for a driver applicant not physically qualified to drive under 49 CFR 391.41(b)(1) or (b)(2) shall be accompanied by:

1. A copy of the medical examination report and medical examination certificate completed pursuant to 49 CFR 391.43;
2. A medical waiver evaluation summary completed by either a board qualified or board certified physiatrist or orthopedic surgeon. The co-applicant motor carrier or the driver applicant shall provide the physiatrist or orthopedic surgeon with a description of the job-related tasks the driver applicant will be required to perform:
   a. The medical waiver evaluation summary for a driver applicant not physically qualified to drive under 49 CFR 391.41(b)(1) shall include:
      i. An assessment of the functional capabilities of the driver as they relate to the ability of the driver to perform normal tasks associated with operating a commercial motor vehicle; and
      ii. A statement by a board qualified or board certified physiatrist or orthopedic surgeon that the applicant is capable of demonstrating precision prehension (e.g., manipulating knobs and switches) and power grasp prehension (e.g., holding and maneuvering the steering wheel) with each upper limb separately when the intrastate medical waiver is requested due to a loss or impairment of limbs;
   b. The medical waiver evaluation summary for a driver applicant not physically qualified to drive under 49 CFR 391.41(b)(2) shall include:
      i. An explanation as to how and why the impairment interferes with the ability of the applicant to perform normal tasks associated with operating a commercial motor vehicle;
      ii. An assessment and medical opinion of whether the condition will likely remain medically stable over the lifetime of the driver applicant; and
      iii. A statement by a board qualified or board certified physiatrist or orthopedic surgeon that the applicant is capable of demonstrating precision prehension (e.g., manipulating knobs and switches) and power grasp pre-

hension (e.g., holding and maneuvering the steering wheel) with each upper limb separately;
3. A description of the driver applicant's prosthetic or orthotic device worn, if any;
4. A skill performance evaluation performed by a federally certified state commercial driver license examiner;
5. Application for employment:
   a. A copy of the driver applicant's application for employment completed pursuant to 49 CFR 391.21; or
   b. A copy of the unilateral applicant's application for employment from where the unilateral applicant most recently held employment as a commercial motor vehicle driver. If not previously employed as a commercial motor vehicle driver, a statement of explanation to that effect; and
6. A copy of the driver applicant's state motor vehicle driving record for the past three years from each state in which a motor vehicle driver license or permit has been obtained.

E. The completed intrastate medical waiver application for a driver applicant not physically qualified to drive under 49 CFR 391.41(b)(10) shall be accompanied by:
1. A copy of the medical examination report and medical examination certificate completed pursuant to 49 CFR 391.43;
2. A current vision examination report, which an ophthalmologist or a licensed optometrist:
   a. Completes on a form provided by the Department;
   b. Uses to indicate that the applicant has distant visual acuity of at least 20/40 (Snellen), with or without a corrective lens, in one eye, and the applicant's dominant eye has a visual field of at least 70° peripheral measurement in one direction and 35° in the opposite direction of the horizontal meridian and the ability to distinguish the colors of a traffic signal or device showing standard red, green, and yellow, as applicable to the type of medical waiver being requested; and
   c. Mails to the Department at the address provided on the form;
3. A skill performance evaluation administered by a federally certified state commercial driver license examiner at a commercial driver license facility of the Department;
4. Application for employment:
   a. A copy of the driver applicant's application for employment completed pursuant to 49 CFR 391.21; or
   b. A copy of the unilateral applicant's application for employment from where the unilateral applicant most recently held employment as a commercial motor vehicle driver. If not previously employed as a commercial motor vehicle driver, a statement of explanation to that effect;
5. A copy of the driver applicant's state motor vehicle driving record for the past three years from each state in which a motor vehicle driver license or permit has been obtained; and
6. A certification statement by the driver applicant indicating that the driver applicant has driven the type of vehicle for which the waiver is being requested for at least two of the previous five years.

F. Agreement. A motor carrier that employs a driver subject to an intrastate medical waiver granted by the Director under subsection (A), whether the waiver was granted unilaterally to the driver, or to the driver and co-applicant motor carrier, shall agree to:
1. Report to the Department's Medical Review Program, P.O. Box 2100, Mail Drop 818Z, Phoenix, Arizona 85001-2100, in writing, any suspension, revocation, or withdrawal of the subject driver's driver license or permit, and any accident, arrest, or conviction involving the driver within 30 days after the occurrence;
2. Provide to the Department's Medical Review Program, on request, any documents and information pertaining to the driving activities, accidents, arrests, convictions, and driver license or permit suspensions, revocations, or withdrawals involving the subject driver;
3. Evaluate the subject driver with a road test using the trailer types the motor carrier intends the driver to transport, or alternatively accept a certificate of a trailer road test from another motor carrier if the trailer types are similar, or accept the trailer road test completed during the skill performance evaluation if trailer types are similar to that of the prospective motor carrier;
4. Evaluate the subject driver for those non-driving safety related job tasks associated with each type of trailer that will be used and any other non-driving safety related or job related tasks unique to the operations of the employing motor carrier; and
5. Use the subject driver to operate the type of commercial motor vehicle indicated on the intrastate medical waiver only when the driver is in compliance with the conditions and limitations of the waiver.

G. A driver subject to an intrastate medical waiver, issued by the Director under subsection (A), shall supply each employing motor carrier with a copy of the intrastate medical waiver.

H. The Department may require the driver applicant to demonstrate the driver applicant's ability to safely operate the commercial motor vehicle the driver intends to drive.

I. After successful completion of a skill performance evaluation, if the Director grants an intrastate medical waiver under subsection (A), the Department shall mail to the driver applicant and co-applicant motor carrier (if applicable) written approval of the intrastate medical waiver describing the terms, conditions, and limitations of the waiver.

J. The intrastate medical waiver granted by the Director under subsection (A) shall identify:
1. The power unit (bus, truck, truck tractor) for which the waiver is granted; and

2. The trailer type used in the skill performance evaluation, without limiting the waiver to that specific trailer type.

K. A subject driver may use the intrastate medical waiver with other trailer types if the driver successfully completes:
1. A trailer road test administered by the motor carrier under subsection (F)(3) for each type of trailer, and
2. A non-driving safety related or job related task evaluation administered by the motor carrier under subsection (F)(4).

L. The intrastate medical waiver granted by the Director under subsection (A) shall be:
1. Valid for a period of not more than two years from the date of issuance;
2. Renewable 30 days prior to the expiration date; and
3. Transferable from an original motor carrier co-applicant employer to a new motor carrier employer upon written notification to the Department's Medical Review Program, P.O. Box 2100, Mail Drop 818Z, Phoenix, Arizona 85001-2100, stating the new employer's name and the type of equipment to be driven.

M. An intrastate medical waiver granted by the Director under subsection (A) to a driver applicant for monocular vision under subsection (E), shall prohibit the subject driver from transporting:
1. Passengers for hire, and
2. Reportable quantities of hazardous substances, manifested hazardous wastes, and hazardous material required to be placarded.

N. A driver subject to an intrastate medical waiver, issued by the Director under subsection (A), shall have the intrastate medical waiver (or a legible copy) in the subject driver's possession while on duty.

O. The motor carrier employing a subject driver shall maintain a copy of the intrastate medical waiver in its driver qualification file and retain the copy in the motor carrier's file for a period of three years after the driver's employment is terminated.

P. A driver applicant, or a driver applicant jointly with a motor carrier co-applicant whose principal place of business is located in Arizona, may renew an intrastate medical waiver by submitting to the Department's Medical Review Program, P.O. Box 2100, Mail Drop 818Z, Phoenix, Arizona 85001-2100, an intrastate medical waiver renewal application. The intrastate medical waiver renewal application shall contain the following:
1. Name and complete address of the motor carrier currently employing the applicant;
2. Name and complete address of the subject driver;
3. Total miles driven under the current intrastate medical waiver;
4. Number of accidents incurred while driving under the current intrastate medical waiver, including the date of each accident, number of fatalities, number of injuries, and the estimated dollar amount of any property damage;
5. A current medical examination report;
6. A medical waiver evaluation summary, as prescribed under subsection (D)(2), if an unstable medical condition exists;
7. A copy of the subject driver's current state motor vehicle driving record for the period of time the current intrastate medical waiver has been in effect;
8. Notification of any change in the type of tractor the driver will operate;
9. Subject driver's signature and date signed; and
10. Motor carrier co-applicant's signature and date signed (if applicable).

Q. Falsifying information on an intrastate medical waiver application or an intrastate medical waiver renewal application or other information required by this Section of either an applicant or a co-applicant motor carrier is prohibited.

R. The Director may deny an application for the intrastate medical waiver or may grant the waiver in whole or in part and issue the waiver subject to such terms, conditions, and limitations as the Director deems consistent with the public interest.

S. The Director may revoke an intrastate medical waiver after providing, to the person to whom it was issued, written notice of the proposed revocation and a reasonable opportunity to request a hearing.

T. If the enforcement of any provision of this Section would result in the loss or disqualification of federal funding for any state agency or program, that provision is invalid.

R17-5-209. Hazardous Materials Transportation; Incorporation of Federal Regulations; Applicability

A. Incorporation of federal regulations.
1. ~~The Motor Vehicle Division~~ As relevant to the transportation of hazardous materials by highway, the Department incorporates by reference, as amended under this Section, the following ~~portions~~ Parts of the Federal Hazardous Materials Regulations ~~by reference. Materials incorporated by reference are on file in the Secretary of State's Office. The incorporated Hazardous Materials Regulations are published in~~; revised as of October 1, 2009, and no later amendments or editions, as 49 CFR~~,~~ - Transportation, Subtitle B - Other Regulations Relating to Transportation, Chapter I - ~~Research and Special Programs Administration~~ Pipeline and Hazardous Materials Safety Administration, Department of Transportation:
   a. Subchapter A - Hazardous Materials and Oil Transportation; Part 107 - Hazardous materials program procedures; and
   b. Subchapter C - Hazardous Materials Regulations; Parts:
      i. 171 - General information, regulations, and definitions;
      ii. 172 - Hazardous materials table, special provisions, hazardous materials communications, emergency

response information, ~~and~~ training requirements, and security plans;
iii. 173 - Shippers - general requirements for shipments and packagings;
iv. 177 - Carriage by public highway;
v. 178 - Specifications for packagings; and
vi. 180 - Continuing qualification and maintenance of packagings.

2. ~~These parts are incorporated as printed in the October 1, 2005 edition, and those sections of the October 1, 1991 edition authorized for use under the transitional provisions of Section 171.14 of the October 1, 2005 edition and no later amendments or editions. The incorporated material is available from the U.S. Government Printing Office, Superintendent of Documents, Mail Stop: SSOP, Washington, DC 20402-0001, and is on file with the Division.~~ The material incorporated by reference under this subsection is on file with the Department and is available from the U.S. Government Printing Office, P.O. Box 979050, St. Louis, MO 63197-9000. The incorporated material can be ordered online by visiting the U.S. Government Online Bookstore at http://bookstore.gpo.gov.

B. Application and exceptions.
1. Application.
   a. Regulations incorporated ~~in~~ under subsection (A) apply as amended by subsection (C) to motor carriers, shippers, and manufacturers as defined under A.R.S. § 28-5201.
   b. Regulations incorporated ~~in~~ under subsection (A) also apply to any vehicle owned or operated by the state, a political subdivision, or a state public authority, used to transport a hazardous material, including hazardous substances and hazardous waste.
2. Exceptions. An authorized emergency vehicle, as defined under A.R.S. § 28-101, is excepted from the provisions of this Section.

C. Amendments. The following sections of the Federal Hazardous Materials Regulations, incorporated under subsection (A), are amended as follows:
1. Part 171. General information, regulations, and definitions.
   ~~a. Section 171.1 Purpose and scope.~~
   ~~Paragraph (a) is amended to read:~~
   ~~"The transportation of hazardous materials by and their offering to: (1) interstate, intrastate, and foreign motor carriers; and (2) vehicles owned or operated by the state, a political subdivision or a state public authority, that are used to transport hazardous material."~~
   ~~b.~~ Section 171.8, Definitions and abbreviations. Section 171.8 is amended by revising the definitions for "Carrier," "Hazmat employer," and "Person," and adding a definition for "Highway" as follows:

   "'Carrier' means a person engaged in the transportation of passengers or property by highway as a common, contract, or private carrier and also includes the state, a political subdivision, and a state public authority engaged in the transportation of hazardous material."

   "'Hazmat employer' means a person who uses one or more employees in connection with: transporting hazardous material; causing hazardous material to be transported or shipped; or representing, marking, certifying, selling, offering, reconditioning, testing, repairing, or modifying containers, drums, or packagings as qualified for use in the transportation of hazardous material. This term includes motor carriers, shippers, and manufacturers defined under A.R.S. § 28-5201 and includes the state, political subdivisions, and state public authorities."

   "'Highway' means a public highway defined under A.R.S. § 28-5201."

   "'Person' has the same meaning as defined under A.R.S. § 28-5201."
2. Part 172—, Hazardous materials table, special provisions, hazardous materials communications, emergency response information, ~~and~~ training requirements, and security plans. Section 172.3 Applicability. Paragraph (a)(2) is amended to read: "Each motor carrier that transports hazardous materials, and each state agency, political subdivision, and state public authority that transports hazardous material by highway."
3. Part 177. Carriage by public highway.
   a. Section 177.800, Purpose and scope of this part and responsibility for compliance and training.
   In paragraph (a), the phrase "by private, common, or contract carriers by motor vehicle" is amended to read, "by a motor carrier operating in Arizona, a state agency, a political subdivision, or a state public authority that transports hazardous material by highway."
   b. Section 177.802, Inspection. Section 177.802 is amended to read: "Records, equipment, packagings, and containers under the control of a motor carrier or other persons subject to this part, affecting safety in transportation of hazardous material by motor vehicle, must be made available for examination and inspection by an authorized representative of the Department as prescribed under A.R.S. §§ 28-5204 and 28-5231."

R17-5-210. Motor Carrier Safety: Public Service Corporation, Political Subdivision of this State that is Engaged in Rendering Public Utility Service, or Railroad Contacting State Officials in an Emergency

A. A public service corporation, a political subdivision of this state that is engaged in rendering public utility service, or a railroad shall notify ~~the~~ Commercial Vehicle Enforcement ~~Bureau~~, through the Arizona Department of Public Safety Duty

Office, that an emergency situation under A.R.S. § 28-5234(B) exists. Notification shall be made on a form provided by the Arizona Department of Public Safety and sent by fax transmission to (602) 223-2929 immediately, but in no case longer than three hours from the time the public service corporation, political subdivision of this state that is engaged in rendering public utility service, or railroad determines that the emergency situation exists. The information to be provided includes:

1. Date of the emergency situation,
2. Time that the emergency situation started,
3. Description of the emergency situation,
4. Location of the emergency situation,
5. Projected duration of the emergency situation,
6. Authorized party's signature for determining that an emergency situation exists,
7. Name and contact number of responsible party in the field, and
8. The utility's self-generated Emergency ID or tracking number.

B. A public service corporation, a political subdivision of this state that is engaged in rendering public utility service, or a railroad shall maintain supporting documentation for no less than three years from the date of an emergency situation and shall make the supporting documentation available to a special agent upon request. Supporting documentation includes~~:~~:

1. A list of drivers involved in the emergency situation~~,~~;
2. The duration of the emergency situation~~,~~;
3. The off-duty time provided for the affected drivers after the emergency situation concluded~~,~~; and
4. Any United States Department of Transportation recordable accidents, as defined ~~in 49 CFR 390.15, that~~ under 49 CFR 390.5, which occurred during the emergency situation.

C. After an emergency situation terminates and a driver returns to the principal place of business, the driver shall not drive a commercial motor vehicle unless the driver remains off duty under 49 CFR 395.

R17-5-211. Motor Carrier Safety: Inspection, Enforcement, Sanction

A. Scope. This Section applies to any transporter subject to:

1. ~~R17-5-202~~ R17-5-201 through R17-5-209; and
2. A.R.S. Title 28, Chapter 14.

B. Audits.

1. The ~~Division~~ Department may conduct an audit for cause or without cause.
2. The ~~Division~~ Department may enter the premises of any transporter for the purpose of conducting an audit.
3. The ~~Division~~ Department may inspect a motor vehicle:
   a. Within Arizona at:
      i. A transporter's place of business~~;~~, or
      ii. Any other in-state location~~;~~, or
   b. Outside Arizona at a transporter's place of business.
4. A transporter shall make records available for audit:
   a. During the transporter's normal business hours~~;~~, and
   b. In a specific location as follows:
      i. The transporter's Arizona place of business~~;~~, or
      ii. Either an Arizona location designated by the ~~Division~~ Director or the transporter's out-of-state place of business.
5. The ~~Division~~ Department shall charge a transporter in advance for all expenses to be incurred in performance of an out-of-state audit.

C. Violation notification. Within five days after audit completion, the ~~Division~~ Department shall notify an audited transporter in writing of all violations. The notification shall specify a deadline date for remedy of all violations.

D. Obligation to remedy violations: After receipt of a violation notification, a transporter shall remedy all violations by the specified date to comply with:

1. ~~R17-5-202~~ R17-5-201 through R17-5-209; and
2. A.R.S. Title 28, Chapter 14

E. Noncompliance: Failure to remedy violations. If the ~~Division~~ Department determines a transporter did not remedy a violation by the date specified in a violation notice, the ~~Division~~ Department shall initiate further enforcement action as prescribed under A.R.S. §§ 28-5237 and 28-5238.

F. Danger to public safety. If the ~~Division~~ Director determines a written violation report establishes probable cause of danger to public safety, the ~~Division~~ Director shall issue an order by 5:00 p.m. the next business day suspending the Arizona registration of the motor vehicle owned or leased by the transporter, or a driver's Arizona driver license or nonresident driving privilege.

R17-5-212. Motor Carrier Safety: Hearing Procedure

A. Scope.

1. This Section applies only to a motor carrier enforcement action under:
   a. ~~R17-5-202~~ R17-5-201 through ~~R17-5-207~~ R17-5-209; and
   ~~b. R17-5-209; and~~
   ~~c.~~b. A.R.S. Title 28, Chapter 14.
2. In an enforcement hearing involving a manufacturer, motor carrier, shipper, or driver under this Section, the Department shall follow the procedures prescribed under 17 A.A.C. 1, Article 5, except as ~~specified in~~ modified under subsections (B) through (I).

B. Initiation of proceedings, pleadings.
1. The ~~Division~~ Director shall initiate a hearing under this Section by:
   a. Signing and serving a complaint in the form prescribed under subsection (G) that cites a manufacturer, motor carrier, shipper, or driver for an alleged infraction; and
   b. Serving the cited manufacturer, motor carrier, shipper, or driver with a hearing notice within 15 days after the date the complaint is signed.
2. After the ~~Division~~ Director signs a complaint, the Executive Hearing Office ~~as defined in R17-1-501~~ shall act on the ~~Division~~ Director's behalf through completion of an administrative proceeding under this Section.

C. Order to show cause.
1. When a complaint is served, the Executive Hearing Office shall immediately issue a summons for a respondent to appear at an administrative hearing to explain why the ~~Division~~ Executive Hearing Office should not grant the requested relief.
2. The Executive Hearing Office shall hold a hearing under this Section within 60 days after the date the complaint is served.
3. The parties may resolve a complaint before the hearing date.
   a. The respondent shall file any settlement condition with the Executive Hearing Office.
   b. Complaint settlement terminates the right of both petitioner and respondent to receive additional administrative review.

D. Service.
1. The Executive Hearing Office shall:
   a. Send an order to show cause by certified mail, as prescribed under A.R.S. § 28-5232(B); and
   b. Maintain a proof-of-service file.
2. The date of service is the date of mailing.

E. Answer.
1. Within 15 days after service of a complaint, a respondent shall respond to the complaint by:
   a. Filing a written answer with the Executive Hearing Office; and
   b. Serving the Assistant Attorney General, Transportation Division, representing the ~~Motor Vehicle Division~~ Department with a copy of the answer.
2. A respondent's written answer shall contain:
   a. An admission or denial of each complaint allegation, and
   b. A list of all defenses that the respondent intends to raise during the hearing.
3. In a hearing, the Executive Hearing Office shall consider any allegation not denied in the answer as an admission to the allegation.

F. Default.
1. The Executive Hearing Office shall find in default a respondent that fails to file an answer within 15 days after the service date of a complaint ~~a complaint's service date in default~~.
2. If the Executive Hearing Office finds a respondent in default, the Executive Hearing Office shall:
   a. Consider the respondent's default as an admission of all complaint allegations unless the default is cured under subsection (F)(3); and
   b. Enter an order granting the relief requested in the ~~Division's~~ Department's complaint.
3. A respondent may cure a default by following Rule 60(c) of the Arizona Rules of Civil Procedure.

G. Emergency motor carrier hearings; scope.
1. The ~~Division~~ Director shall initiate an emergency motor carrier hearing process according to R17-5-211(E) by:
   a. Issuing a complaint and order to show cause according to the hearing scope under A.R.S. § 28-5232(C); and
   b. Ordering immediate suspension of the registration of the motor vehicle owned or leased by ~~a~~ the manufacturer, shipper, or motor carrier, or the driver license or driver's ~~non-resident~~ nonresident operating privilege, as prescribed under A.R.S. § 28-5232(A).
2. The Executive Hearing Office shall set an emergency hearing date to occur within 30 days after the date ~~of~~ on the complaint.
3. The complaint and order to show cause shall contain the following:
   a. The ~~Division~~ Department as the designated ~~as the~~ petitioner on the state's behalf;
   b. The respondent's name and the basis of fact for the complaint, including a listing of any alleged violation of

Department statute or rule;
c. The relief sought by the ~~Division~~ Department; and
d. An original copy of the written violation notice issued by a law enforcement agency that was served upon the respondent.

4. At an emergency motor carrier hearing, an Executive Hearing Office administrative law judge shall determine whether the respondent:
   a. Was operating on a public highway and the operation created a danger to the public safety~~;~~.
   b. Was responsible for the danger~~;~~, and
   c. Is responsible for preventing or remedying further danger to public safety.
5. Upon a finding that the factors in subsection (G)(4) are present, the administrative law judge shall order that the motor carrier's registration and operator's driver license or driver's ~~non-resident~~ nonresident operating privilege suspension continue.
6. If a respondent fails to appear at an emergency motor carrier hearing, any suspension previously ordered remains in effect until the respondent appears and meets all requirements under A.R.S. § 28-5232(F).

H. Upon a finding that the factors in subsection (G)(4) are present, the ~~Division~~ Director shall impose a civil penalty as prescribed under A.R.S. §§ ~~28-5232(F), 28-5237(E),~~ 28-5232, 28-5237 and 28-5238.

I. A respondent may request judicial review of a motor carrier safety hearing ~~proceeding~~ as prescribed under A.R.S. § 28-5239.