NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

PREAMBLE

1. Article, Part, or Section Affected (as applicable)	Rulemaking Action:
R9-22-201	Amend
R9-22-204	Amend
R9-22-217	Amend
R9-22-702	Amend
R9-22-703	Amend
R9-22-705	Amend
R9-22-712.09	Amend
R9-22-1205	Amend

2. Citations to the agency's statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):

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

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

3. The effective date of the rule:

The agency selected an effective date of 60 days from the date of filing with the Secretary of State as specified in A.R.S. § 41-1032(A).

4. Citations to all related notices published in the Register to include the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Proposed Exempt Rulemaking: 17 A.A.R. 1518, August 12, 2011

Notice of Public Information: 17 A.A.R. 1723, August 26, 2011

Notice of Exempt Rulemaking: 17 A.A.R. 1868, September 23, 2011

Notice of Proposed Exempt Rulemaking: 17 A.A.R. 1522, August 12, 2011
Notice of Exempt Rulemaking: 17 A.A.R. 1870, September 23, 2011

Notice of Proposed Exempt Rulemaking: 17 A.A.R. 1290, July 15, 2011
Notice of Exempt Rulemaking: 17 A.A.R. 1707, August 26, 2011
Notice of Proposed Exempt Rulemaking: 18 A.A.R. 1310, June 8, 2012
Notice of Exempt Rulemaking: 18 A.A.R. 1745, July 20, 2012

Notice of Rulemaking Docket Opening: 19 A.A.R. 728, April 12, 2013
Notice of Proposed Rulemaking: 19 A.A.R. 676, April 12, 2013

5. The agency's contact person who can answer questions about the rulemaking:

Name:	Mariaelena Ugarte
Address:	701 E. Jefferson St.
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSrules@azahcccs.gov
Web site:	www.azahcccs.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The Governor's Medicaid Reform Plan, announced on March 15, 2011, proposals to reduce nonfederal expenditures for the AHCCCS program by approximately $500 million during state fiscal year 2012. The AHCCCS Administration promulgated limitations to the following rules:

- R9-22-201, R9-22-204, R9-22-702, R9-22-703, R9-22-705, R9-22-712.09– Limitation of covered inpatient days for adults and changes to current rules regarding limitations on providers charging members for services promulgated on August 26, 2011 with an effective date of October 1, 2011.

- R9-22-204 – Limitation of Inpatient Days related to treatment of burns promulgated on July 20, 2012 with an effective date of October 1, 2012.
- R9-22-217 – Limitation of Inpatient days applies to the Federal Emergency Services program, therefore, the Administration is updated rule with cross-references to the Inpatient limit rule R9-22-204. Promulgated on September 23, 2011 with an effective date of October 1, 2011.
- R9-22-1205 - Limitation for respite services promulgated on September 23, 2011 with an effective date of October 1, 2011.

Due to legislation specified in Laws 2012, Chapter 299, Section 7, the rule-making authority authorized in Laws 2011, Chapter 31, Section 34 (SB 1619) was repealed. Additionally, Laws 2012, Chapter 299, Section 8 stipulated that rules adopted through the previous year's authority (SB1619) would expire December 31, 2013 without specific statutory authority.

After an evaluation of the Agency's overall statutory authority regarding covered services, rates, and eligibility, AHCCCS has determined that it will re-promulgate certain rules implementing "program changes" made pursuant to Laws 2011, Chapter 31, Section 34 by identifying the specific statutory authority for the rules to ensure that the rules continue beyond December 31, 2013 in accordance with Laws 2012, Chapter 299, Section 8.

Therefore, to ensure continuity of the rules previously adopted under Section 34, the AHCCCS Administration is re-promulgating the same rules which became effective October 1, 2011. No changes have been made to the language of the rules.

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:

Not applicable.

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

Not applicable.

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

See previous publications listed under item 3 for summaries of economic impacts as applicable.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

No significant changes were made between the proposed rulemaking and the final rulemaking. The publication of Notice of Exempt Rulemaking: 16 A.A.R. 1638, August 27, 2010, and referenced sections has been removed. Although included in the Notice of Proposed rulemaking, these sections have been removed between the proposed and final rulemaking because these rules do not relate to the legislative action that would make these rule expire as originally thought. Legislative action Laws 2012, Chapter 299, Section 8 stipulating that rules adopted through the previous year's authority (SB1619) would expire December 31, 2013 without specific statutory authority. This does not apply to the removed rules.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

No comments were received as of the close of the comment period of May 13, 2013.

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters are applicable.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

Not applicable.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:

None

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 2. SCOPE OF SERVICES

Section

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 2. SCOPE OF SERVICES

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

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

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

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

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

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

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

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

Serious impairment to bodily functions;

Serious dysfunction of any bodily organ or part; or

Serious physical harm to another person.

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

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

Placing the member's health in serious jeopardy,

Serious impairment to bodily functions, or

Serious dysfunction of any bodily organ or part.

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

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

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

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

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

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

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

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

"Psychosocial rehabilitation services" means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may

assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:

Living skills training,

Cognitive rehabilitation,

Health promotion,

Supported employment, and

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

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

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

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

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

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

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

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

Prolong life and promote physical health.

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

R9-22-204. Inpatient General Hospital Services

A. No Change

1. No Change

a. No Change

b. No Change

c. No Change

d. No Change

e. No Change

f. No Change

g. No Change

2. No Change

a. No Change

b. No Change

c. No Change

d. No Change

e. No Change

f. No Change

g. No Change

h. No Change

B. No Change

1. No Change

a. No Change

b. No Change

c. No Change

2. No Change

3. No Change

a. No Change

b. No Change

c. No Change

d. No Change

e. No Change

f. No Change

g. No Change

h. No Change

4. No Change

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

1. For purposes of calculating the limit:

   a. Inpatient days are counted towards the limit if paid by the Administration or a contractor;

   b. Inpatient days will be counted toward the limit in the order of the adjudication date of a paid claim;

   c. Paid inpatient days are allocated to the benefit year in which the date of service occurs;

   d. Each 24 hours of paid observation services is counted as one inpatient day if the patient is not admitted to the same hospital directly following the observation services,

   e. Observation services, which are directly followed by an inpatient admission to the same hospital are not counted towards the inpatient limit; and

   f. After 25 days of inpatient hospital services have been paid as provided for in this ~~rule~~ Section:

      i. Outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered.

      ii. Continuous periods of observation services of less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered.

iii. For continuous periods of observation services of 24 hours or more that are not directly followed by an inpatient admission to the same hospital, 23 hours of observations services are covered.

2. The following inpatient days are not included in the inpatient hospital limitation described in this ~~rule~~ Section:
   a. Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract;
   b. Days related to Behavioral Health:
      i. Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or
      ii. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or
      iii. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.
   c. Days related to treatment for burns and burn late effects at an American College of Surgeons verified burn center ;
   d. Same Day Admit Discharge services are excluded from the 25 day limit; and
   e. Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities.

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

A. No Change

1. No Change
2. No Change
3. No Change
4. No Change

B. No Change

1. No Change

2. No Change

3. No Change

C. No Change

D. No Change

E. Services rendered through the Federal Emergency Services Program are subject to all exclusions and limitation on services in this Article including but not limited to the limitations on inpatient hospital services in R9-22-204.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-702. Charges to Members

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

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

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

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

1. To collect the copayment described in R9-22-711;
2. To recover from a member that portion of a payment made by a third party to the member for an AHCCCS covered service if the member has not transferred the payment to the Administration or the contractor as required by the statutory assignment of rights to AHCCCS;
3. To obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused payment to the provider to be reduced or denied;
4. For a service that is excluded by statute or rule, or provided in an amount that exceeds a limitation in statute or rule, if the member signs a document in advance of receiving the service stating that the member understands the service is excluded or is subject to a limit and that the member will be financially responsible for payment for the excluded service or for the services in excess of the limit;

5. When the contractor or the Administration has denied authorization for a service if the member signs a document in advance of receiving the service stating that the member understands that authorization has been denied and that the member will be financially responsible for payment for the service;
6. For services requested for a member enrolled with a contractor, and rendered by a noncontracting provider under circumstances where the member's contractor is not responsible for payment of "out of network" services under R9-22-705(A), if the member signs a document in advance of receiving the service stating that the member understands the provider is out of network, that the member's contractor is not responsible for payment, and that the member will be financially responsible for payment for the excluded service;
7. For services rendered to a person eligible for the FESP if the provider submits a claim to the Administration in the reasonable belief that the service is for treatment of an emergency medical condition and the Administration denies the claim because the service does not meet the criteria of R9-22-217; or
8. If the provider has received verification from the Administration that the person was not an eligible person on the date of service.

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

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

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

R9-22-703. Payments by the Administration

A. No Change

B. No Change

1. No Change

a. No Change

b. No Change

c. No Change

2. No Change

a. No Change

b. No Change

3. No Change

a. No Change

b. No Change

4. No Change

C. No Change

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D. No Change

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E. No Change

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f. No Change

g. No Change

h. No Change

i. No Change

j. No Change

k. No Change

4. No Change

a. No Change

b. No Change

c. No Change

d. No Change

5. No Change

F. No Change

1. No Change

2. No Change

3. No Change

4. No Change

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

R9-22-705. Payments by Contractors

A. No Change

1. No Change

2. No Change

a. No Change

b. No Change

B. No Change

1. No Change

a. No Change

b. No Change

c. No Change

2. No Change

a. No Change

b. No Change

3. No Change

a. No Change

b. No Change

C. No Change

1. No Change

2. No Change

3. No Change
4. No Change
5. No Change
6. No Change

D. No Change

E. No Change
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F. No Change

G. No Change

H. No Change
1. No Change
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3. No Change
4. No Change
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    b. No Change
    c. No Change
    d. No Change
    e. No Change
    f. No Change
    g. No Change
    h. No Change
    i. No Change
    j. No Change
    k. No Change
    l. No Change
    m. No Change
    n. No Change

o. No Change

p. No Change

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b. No Change

c. No Change

d. No Change

e. No Change

f. No Change

g. No Change

h. No Change

i. No Change

j. No Change

k. No Change

7. No Change

a. No Change

b. No Change

c. No Change

d. No Change

8. No Change

I. No Change

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

1. No Change
2. No Change
3. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a ~~1~~ one percent penalty of the rate for each month or portion of the month following the 60th day of receipt of the bill until date of payment.

K. No Change

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

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

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

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-22-1205. Scope and Coverage of Behavioral Health Services

A. Inpatient behavioral health services. The following inpatient services are covered subject to the limitations and exclusions in this Article.

1. No Change
    a. No Change
    b. No Change
2. Inpatient service limitations:
    a. No Change
    b. No Change
        i. No Change
        ii. No Change
        iii. No Change
        iv. No Change
        v. No Change
        vi. No Change
        vii. No Change
        viii. No Change
        ix. No Change
    c. A member age 21 through 64 is eligible for behavioral health services provided in a hospital listed in subsection (A)(1)(b) that meets the criteria for an IMD up to 30 days per admission and no more than 60 days per ~~contract~~ benefit year as allowed under the Administration's Section 1115 Waiver with CMS.

B. No Change

1. No Change
2. No Change
3. No Change
    a. No Change
    b. No Change
        i. No Change

ii. No Change

iii. No Change

iv. No Change

v. No Change

vi. No Change

vii. No Change

viii. No Change

ix. No Change

4. No Change

a. No Change

b. No Change

c. No Change

C. Covered Level 1 sub-acute agency services. Services provided in a Level 1 sub-acute agency as defined in A.A.C. R9-20-101 are covered subject to the limitations and exclusions under this Article.

1. No Change

2. Covered ~~level~~ Level 1 sub-acute agency services include room and board and treatment services for behavioral health and substance abuse conditions.

3. No Change

a. No Change

b. No Change

c. No Change

d. No Change

e. No Change

f. No Change

g. No Change

h. No Change

i. No Change

4. No Change

a. No Change

b. No Change

c. No Change

5. A member age 21 through 64 is eligible for behavioral health services provided in a ~~level~~ Level 1 sub-acute agency that meets the criteria for an IMD for up to 30 days per admission and no more than 60 days per ~~contract~~ benefit year as allowed under the Administration's Section 1115 Waiver with CMS. These limitations do not apply to a member under age 21 or age 65 or over.

D.

Level 2 behavioral health residential agency services. Services provided in a ~~level~~ Level 2 behavioral health residential agency are covered subject to the limitations and exclusions in this Article.

1. No Change
2. No Change
3. No Change
   a. No Change
   b. No Change
   c. No Change
   d. No Change
   e. No Change
   f. No Change
   g. No Change
   h. No Change
   i. No Change

E. No Change

1. No Change
2. Covered services include all non-prescription drugs as defined in A.R.S. § 32-1901, non-customized medical supplies, and clinical supervision of the ~~level~~ Level 3 behavioral health residential agency staff. Room and board are not covered services.

3. No Change

a. No Change

b. No Change

c. No Change

d. No Change

e. No Change

f. No Change

g. No Change

h. No Change

i. No Change

F. No Change

1. No Change
2. No Change

G. No Change

1. No Change

a. No Change

b. No Change

c. No Change

d. No Change

e. No Change

2. Outpatient service limitations.

a. The following licensed or certified providers may bill independently for outpatient services:

i. A licensed psychiatrist~~,~~;

ii. A certified psychiatric nurse practitioner~~,~~;

iii. A licensed physician assistant as defined in R9-22-1201~~,~~;

iv. A licensed psychologist~~,~~;

v. A licensed clinical social worker~~,~~;

vi. A licensed professional counselor~~,~~;

vii. A licensed marriage and family therapist~~,~~;

viii. A licensed independent substance abuse counselor~~,~~;

ix. A behavioral health medical practitioner~~,~~; and

x. An outpatient clinic or a Level IV transitional agency licensed under 9 A.A.C. 20, Article 1, that is an AHCCCS-registered provider.

b A behavioral health practitioner not specified in ~~subsection~~ subsections (G)(2)(a)(i) through (x), who is contracted with or employed by an AHCCCS-registered behavioral health agency shall not bill independently.

H. No Change

I. Other covered behavioral health services. Other covered behavioral health services include:

1. No Change
2. No Change
3. No Change
4. No Change
5. Respite care as described within subsection (K);
6. No Change
7. No Change
8. No Change

J. No Change

K. Limited Behavioral Health services. Respite services are limited to no more than 600 hours per benefit year.