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:**
R9-22-202	Amend
R9-22-205	Amend
R9-22-209	Amend
R9-22-210	Amend
R9-22-213	Amend
R9-22-215	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(E) and (F)

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

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 Rulemaking Docket Opening: 20 A.A.R. 729, March 21, 2014

Notice of Proposed Rulemaking: 20 A.A.R. 709, March 21, 2014

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

Name: Mariaelena Ugarte

Address: 701 E. Jefferson St.

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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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking: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 Administration must conduct a rule-making to implement the elements of Arizona Laws 2013, First Special Session, Chapter 10 (House Bill 2010), that relate to changes to covered services regarding well exams, and other cost-effective services. In addition to "clean up" of rules related to scope of services, such as updating cross-references and non-substantive changes to improve clarity. The provisions are necessary to comply with federal or state requirements.

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:

A study was not referenced or relied upon when revising the regulations.

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:

This rulemaking is estimated to have a minimal economic impact on the implementing agencies and taxpayer of approximately $850,000 over a one-year timeframe, which assumes a 5% increase is experienced under the physical therapy clarification. The estimated minimal economic impact for the coverage of well visits is for Federal Fiscal Year (FFY) 2014 $16,450,000 and for FFY 2015 $21,357,000.

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

No changes were made between the proposed rulemaking and the final rulemaking as a result of public input, with the exception of technical changes, such as R9-22-205 (A)(8) where the reference to the exception is made. These changes were made as a result of GRRC review and comments.

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 April 28, 2014.

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:

These rules are consistent with federal laws under the Affordable Care Act. 42 CFR 440.330 et.seq. and 42 USC 1396u-7.

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:

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 2. SCOPE OF SERVICES

Section

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 2. SCOPE OF SERVICES

R9-22-202. General Requirements

A. For the purposes of this Article, the following definitions apply:

1. "Authorization" means 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 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 provide prior authorization for services unless the provider submits documentation of 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 or during the prior quarter coverage.

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

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

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

J. The restrictions, limitations, and exclusions in this Article do not apply to the following:

~~1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27, and~~

~~2.~~ A contractor electing to provide noncovered services.

a. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.

b. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

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

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

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

A. A primary care provider, attending physician, or practitioner shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:

1. Periodic health examination and assessment;
2. Evaluation and diagnostic workup;
3. Medically necessary treatment;
4. Prescriptions for medication and medically necessary supplies and equipment;
5. Referral to a specialist or other health care professional if medically necessary;
6. Patient education;
7. Home visits if medically necessary; and
8. ~~Except as provided in subsection (B), preventive~~ Preventive health services, such as, well visits, immunizations, colonoscopies, mammograms and PAP smears.

B. The following limitations and exclusions apply to attending physician and practitioner services and primary care provider services:

1. Specialty care and other services provided to a member upon referral from a primary care provider, or to a member upon referral from the attending physician or practitioner are limited to the service or condition for which the referral is made, or for which authorization is given by the Administration or a contractor.
2. A member's physical examination is not covered if the sole purpose is to obtain documentation for one or more of the following:
   a. Qualification for insurance,
   b. Pre-employment physical evaluation,
   c. Qualification for sports or physical exercise activities,

d. Pilot's examination for the Federal Aviation Administration,

e. Disability certification to establish any kind of periodic payments,

f. Evaluation to establish third-party liabilities, or

g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).

3. Orthognathic surgery is covered only for a member who is less than 21 years of age;

4. The following services are excluded from AHCCCS coverage:

a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgeries;

b. Pregnancy termination counseling services;

c. Pregnancy terminations, unless required by state or federal law.

d. Services or items furnished solely for cosmetic purposes; and

e. Hysterectomies unless determined medically necessary.~~; and~~

~~f. Preventive services not covered are well exams, meaning physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination.~~

R9-22-209. Pharmaceutical Services

A. An inpatient or outpatient provider, including a hospital, clinic, other appropriately licensed health care facility, and pharmacy may provide covered pharmaceutical services.

B. The Administration or a contractor shall require a provider to make pharmaceutical services:

1. Available during customary business hours, and

2. Located within reasonable travel distance of a member's residence.

C. Pharmaceutical services are covered if:

1. Prescribed for a member by the member's primary care provider, attending physician, practitioner, or dentist;

2. Prescribed by a specialist upon referral from the primary care provider or attending physician; or

3. The contractor or its designee authorizes the service.

D. The following limitations apply to pharmaceutical services:

1. A medication personally dispensed by a physician, 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 new prescription or refill in excess of ~~100-unit doses~~ a 30 day supply is not covered unless:~~. A prescription or refill in excess of a 30-day supply is not covered unless specified in subsection (D)(3).~~

~~3. A prescription or refill in excess of a 30-day supply is covered if:~~

~~a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit doses, whichever is greater.~~

~~b.~~a. 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 ~~100~~ a 90 day supply ~~or 100 unit doses, whichever is greater~~.; or

~~c. The medication is prescribed for contraception and the prescription is limited to no more than a 100 day supply.~~

b. The Contractor authorizes the prescription for an extended time period not to exceed a 90-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 less costly than the covered prescription medication.

E. A contractor 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.

R9-22-210. 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. 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 Administration nor a contractor shall:
   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. 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.

R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)

A. The following E.P.S.D.T. services are covered for a member less than 21 years of age:

1. Screening services including:

a. Comprehensive health and developmental history;

b. Comprehensive unclothed physical examination;

c. Appropriate immunizations according to age and health history;

d. Laboratory tests; and

e. Health education, including anticipatory guidance;

2. Vision services including:

a. Diagnosis and treatment for defects in vision;

b. Eye examinations for the provision of prescriptive lenses; ~~and~~

c. Prescriptive lenses; and

d. Frames.

3. Hearing services including:

a. Diagnosis and treatment for defects in hearing;

b. Testing to determine hearing impairment; and

c. Hearing aids;

4. Dental services including:

a. Emergency dental services as specified in R9-22-207;

b. Preventive services including screening, diagnosis, and treatment of dental disease; and

c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;

5. Orthognathic surgery;

6. Medically necessary, ~~Nutritional~~ nutritional assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;

7. Behavioral health services under 9 A.A.C. 22, Article 12;

8. Hospice services do not include home-delivered meals or services provided and covered through Medicare. The following hospice services are covered:

a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;

b. Services available to a member receiving hospice care are limited to those allowable under 42 CFR 418.202, October 1, 2006, incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments;

~~c. Hospice services do not include:~~

~~i. Medical services provided that are not related to the terminal illness; or~~

~~ii. Home-delivered meals; and~~

~~d. Hospice services that are provided and covered through Medicare are not covered by AHCCCS;~~

9. Incontinence briefs as specified under R9-22-212; and

10. Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5).

B. Providers of E.P.S.D.T. services shall meet the following standards:

1. Ensure that services are provided by or under the direction of the member's primary care provider, attending physician, practitioner, or dentist.

2. Perform tests and examinations under 42 CFR 441 Subpart B, October 1, 2006, which is incorporated by reference and on file with 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.

4. Refer a member as necessary for behavioral health evaluation and treatment services.

C. Contractors shall meet other E.P.S.D.T. requirements as specified in contract.

D. A primary care provider, attending physician, or practitioner shall refer a member with special health care needs under R9-7-301 to CRS.

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:

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;
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; and
12. ~~Inpatient chemotherapy ;~~ 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 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.~~2. Abortion counseling;

~~4.~~3. Services or items furnished solely for cosmetic purposes;

~~5.~~4. Services provided by a podiatrist; or

~~6. More than 15 outpatient physical therapy visits per benefit year with the exception of the required Medicare coinsurance and deductible payment as described in 9 A.A.C. 29, Article 3.~~

5. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of restoring a skill or level of function and maintaining that skill or level of function once restored.

6. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of acquiring a new skill or a new level of function and maintaining that skill or level of function once acquired.